

Opioid Addiction: ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (2020)

About the Guideline

- The purpose of this guideline is to provide evidence-based treatment recommendations for opioid use disorder.
- The guideline was developed by the American Society of Addiction Medicine (ASAM) using the RAND Corporation/University of California, Los Angeles (UCLA) Appropriateness Method that combines clinical knowledge and scientific evidence.
- An independent committee was selected to oversee the development of this guideline, to assist in writing the guideline, and to review the treatment scenarios.
- The committee was comprised of ten researchers, as well as experts from medical specialties and subspecialties including internal medicine, family medicine, addiction medicine and psychiatry, general psychiatry, pharmacology, obstetrics/gynecology, academic research, and clinical neurobiology.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you care for patients with or at risk for opioid use disorder.

Assessment

- Identify and refer the patient appropriately for any developing or pressing problems involving psychiatric or medical concerns that may include an overdose or impairment that is drug related.
- A complete medical history should include contraception methods, pregnancies (current or past), acute trauma, current and past substance use, related medical conditions, and infectious diseases.
 - Initiation of pharmacotherapy for opioid use disorder should not be delayed until medical history is complete.
- Assessments should include a physical exam and evaluation of mental health status, environment and social factors, and any possible psychiatric disorders.
- Lab testing should include hepatitis B virus (HBV), hepatitis C virus (HCV), tuberculosis and human immunodeficiency virus (HIV) screening, a pregnancy test for females of childbearing age, testing for sexually transmitted diseases, a complete blood count, a liver function test, and a urine drug screen.
- Opioid use disorder treatment should not be withheld if the patient is currently using cannabis, stimulants, alcohol, benzodiazepines, or other types of sedative-hypnotics; a risk-benefit analysis should be performed to determine if the harm from untreated opioid use disorder outweighs the treatment risks.
 - A more intense level of care and support may be needed for patients with polysubstance use seeking opioid use disorder treatment.
- Cessation of tobacco use and/or nicotine electronic devices is recommended.

Diagnosis

- Confirmation of an opioid use disorder should be obtained by the prescriber before medication is recommended and prescribed.
- Opioid use disorder is diagnosed by the history of the patient and a complete physical exam.
- Measurement of withdrawal symptoms should be evaluated by validated clinical scales such as the Clinical Opioid Withdrawal Scale (COWS), the Subjective Opioid Withdrawal Scale (SOWS), and the Objective Opioid Withdrawal Scale (OOWS).
- Ongoing urine drug testing should be performed during assessment and throughout treatment.
 - The frequency is determined by the type of treatment, the treatment setting, and the stability of the patient.

Treatment Options

- Patients should have all FDA-approved medications available to them for treatment of opioid use disorder.
 - Treatment options should be discussed and decided by the patient and the practitioner.
 - Practitioners should consider past treatment history and setting, as well as the patient's preferences.
- There is no recommended time limit on pharmacological treatment.
- There are four levels of treatment settings, noted as levels 1, 2, 3, and 4.
 - Level 1: outpatient setting
 - Level 2: intensive outpatient setting, such as a community health center, or partial hospitalization in an addiction treatment center
 - Level 3: residential treatment center for addiction
 - Level 4: hospital inpatient setting
- The treatment venue should be carefully considered.
 - Opioid treatment programs (OTPs) and acute care settings (in certain circumstances) can provide methadone.
 - Waivered clinicians can prescribe buprenorphine.
 - Any prescribing clinician can prescribe naltrexone.
 - Program options should be determined by the patient's risk of diversion, psychosocial situation, and any co-occurring disorders.
- Psychosocial treatment should be offered, if appropriate, but should not delay or preclude pharmacotherapy.
- Office-based opioid treatment (OBOT) where medications are prescribed may not be optimal for patients actively using substances such as alcohol, hypnotic substances, and/or sedatives, or for patients who are already in treatment for those substances.
- A risk-benefit analysis should be performed before co-prescribing benzodiazepines or other sedative-hypnotics because they can increase the risk of serious side effects.
- Daily dosing of methadone may be helpful for patients in an OTP or for patients who have previously had unsuccessful treatment in an OBOT or OTP.
- Chronic pain opioid dosing guidelines are not applicable to opioid use disorder treatment medications.
- For patients with a history of relapse, treatment with oral naltrexone may be beneficial. The practitioner should consider observed dosing to ensure the patient's compliance.

- Patients who have a history of or who are being treated for opioid use disorder should be provided naloxone. Education and training on naloxone use should be provided to the patient and family.

Treating Opioid Withdrawal

- Withdrawal management for opioids using buprenorphine or methadone is recommended over abrupt cessation.
- Inform the patient about relapse risks and safety concerns.
- The management of withdrawal on its own, without ongoing treatment, is not recommended.
- Medical history and physical exams should be performed as part of withdrawal management.
- Methadone prescribing for withdrawal must be completed in an OTP or inpatient setting. Buprenorphine is also used when there are objective signs of opioid withdrawal.
- Combining low doses of oral naltrexone and buprenorphine is not currently recommended.
- Alpha-2 adrenergic agonists, such as lofexidine (FDA approved) and clonidine (off-label), are safe to treat withdrawal symptoms, but not as effective as methadone and buprenorphine.
- Using anesthesia ultrarapid opioid detoxification (UROD) is not recommended because of the associated risks including death.

Medication Therapy

- Methadone
 - Methadone may be used, along with an appropriate treatment plan for psychosocial interventions, for patients who can provide informed consent, who are physiologically opioid dependent, and who have no contraindications.
 - The recommended initial dose may range from 10 to 30 mg. Reassessment should be performed 2 to 4 hours after initial dosing; 2.5 to 10 mg should be used in patients with low or no opioid tolerance.
 - Daily doses usually range from 60 to 120 mg following withdrawal stabilization. Doses may be increased every 5 days in 5 to 10 mg increments. Dosing is dependent upon clinical response.
 - Monitoring is recommended for methadone administration due to the risk of diversion and misuse.
 - Psychosocial treatment should be used in conjunction with methadone treatment but should not delay or preclude methadone treatment.
 - If a relapse occurs or if the patient is at high risk for relapse after completing therapy, methadone should be restarted at the recommended initial dose and titration.
 - Relapse prevention should be included in the addiction plan.
 - If side effects occur, the patient may be switched to another medication.
 - Before switching to buprenorphine from methadone, the patient should remain on a low dose of methadone to help with the transition. A low dose of methadone is 30 to 40 mg or less per day.
 - Complete withdrawal from methadone must be accomplished before switching a patient to naltrexone in either an oral formulation or an extended-release injection. The exception would be a patient who has been admitted to a naltrexone facility for withdrawal management.
 - Patients should be informed about the risks of overdose and death if methadone or buprenorphine is stopped, and opioid use is resumed.

- Buprenorphine
 - Buprenorphine is a recommended treatment for patients who have no contraindications and who are able to give informed consent.
 - The first dose of buprenorphine should not be administered until the patient displays objective signs of opioid withdrawal.
 - Buprenorphine may be initiated 6 to 12 hours after the last heroin usage. If methadone was used, buprenorphine may be started 24 to 72 hours after the last dose.
 - Dosages should begin with 2 to 4 mg and may be increased in 2 to 8 mg increments.
 - The practitioner should observe the patient during administration and carefully consider the setting for initiation of therapy.
 - After induction of treatment, titration should occur to alleviate symptoms and enable patients to refrain from illicit opioid use (16 to 24 mg daily). A daily dose limit of 24 mg per day is recommended to decrease the risk of diversion.
 - Psychosocial treatment should be used in conjunction with buprenorphine but should not delay or preclude buprenorphine treatment.
 - To prevent and reduce diversion of buprenorphine, practitioners should test the patient's urine for drugs and schedule frequent office visits that include pill counts. Weekly visits should be part of the initial treatment plan to assess the stabilization of the patient.
 - Close monitoring of the patient is recommended when tapering or discontinuing buprenorphine.
 - There should be a 7- to 14-day gap between medications when switching from buprenorphine to naltrexone.
 - No time delay is required when switching from buprenorphine to methadone.
 - Tapering and discontinuation of buprenorphine is a slow process that requires time.
 - Inform patients of the risk of overdose and death when buprenorphine is discontinued, and opioids are used.

- Naltrexone
 - Naltrexone extended-release injectable is recommended for preventing relapse in opioid use disorder.
 - The set dosage is 380 mg by deep IM injection and should be given every 4 weeks; some patients may need dosing every 3 weeks.
 - Under limited circumstances, oral naltrexone may be an option.
 - Treating patients with naltrexone together with psychosocial therapy is recommended but should not preclude or delay naltrexone treatment.
 - There is no recommendation for the length of treatment with injectable, extended-release, or oral naltrexone.
 - Planning and monitoring should be done when a patient is switching from naltrexone to buprenorphine or methadone.
 - Inform patients of the risk of overdose and death when naltrexone is discontinued and opioids are used.

Psychosocial Treatment

- Psychosocial treatment should include recommendations to available community services, counseling, associations for family support, and assessment for psychosocial needs.

- Collaboration should occur with behavioral healthcare practitioners to develop the treatment plan that best serves the patient; if the patient is not compliant with the plan, referrals for other psychosocial treatments should be made.
- It is recommended that patients have concurrent psychosocial treatment when taking buprenorphine or methadone. Psychosocial treatment should also be offered when the patient is taking extended-release injectable or oral naltrexone.
- Patients have the right to decline psychosocial treatment, and the presence or absence of psychosocial treatment should not preclude or delay pharmacological opioid use disorder treatment.

Special Populations

People who are Pregnant

- Evaluation for opioid use disorder in people who are pregnant should prioritize evaluation for any urgent or developing medical conditions requiring clinical intervention or referral.
- A psychosocial assessment and medical examination are recommended. Pharmacotherapy for treatment of opioid use disorder should not be delayed or precluded by completion of all assessments.
 - Psychosocial treatment should be offered, as appropriate, but its absence should not delay or preclude pharmacological treatment of opioid use disorder.
- Gynecologists and obstetricians should be notified of signs and symptoms related to opioid use disorder.
- HIV-testing and counseling are recommended. Testing for hepatitis B, hepatitis C, and liver function tests are suggested. If hepatitis testing is negative, vaccinations for hepatitis A and B are recommended.
- Once informed consent has been acquired, urine should be tested to confirm or detect drug use.
- If a person who is pregnant is physically dependent on opioids, treatment with buprenorphine mono-product or methadone should be used instead of opioid abstinence or withdrawal management.
- The patient's obstetrician should collaborate with an addiction specialist practitioner when providing care.
- Methadone treatment should be started as early as possible.
 - The initiation dose range is 10 to 30 mg.
 - Incremental doses of 5 to 10 mg may be given every 3 to 6 hours, as required, for the treatment of withdrawal symptoms.
 - 30 to 40 mg is the recommended first-day dose.
 - After initiation, the dose can be increased in increments of 10 mg every 5 days. The lowest maintenance dose should be used to achieve control of withdrawal symptoms and reduce the desire for additional opioids.
 - In an outpatient clinic, patients may only be able to receive a single daily dose of methadone, as it may not be practical to administer methadone twice daily—even though twice daily administration is more effective.
- Hospitalization may be required when methadone or buprenorphine is initiated due to the potential adverse effects.
- Practitioners should be knowledgeable regarding the pharmacokinetics of methadone and its effects on pregnancy.
- As an alternative to methadone, a buprenorphine mono-product may be used. It is not recommended to combine naloxone and buprenorphine as a treatment.

- Naltrexone should be discontinued if pregnancy occurs; there is insufficient research on the risks of continued naltrexone use during pregnancy. However, if relapse occurs because of opioid use, then treatment with buprenorphine or methadone is recommended.
- Naloxone should be used in people who are pregnant only if a life-threatening overdose occurs.
- Breastfeeding should be encouraged if patient is receiving buprenorphine mono-product and methadone.

Individuals with Pain

- Correct diagnosis and treatment should be determined on an individual basis.
- When treatment with medications is considered, the practitioner should first try nonsteroidal anti-inflammatory drugs (NSAIDs) or acetaminophen.
- Buprenorphine or methadone should be considered for individuals who are diagnosed with active opioid use disorder and who are not currently receiving treatment.
- Psychosocial therapy and pharmacotherapy should be used together for patients who have an active opioid use disorder and are experiencing pain.
- Postoperative patients on methadone due to an opioid use disorder may need short-acting full agonist opioid medication for pain. Doses may be higher compared to opioid naïve postoperative patients. Temporarily increasing buprenorphine may help to relieve mild acute pain post procedure.
 - For patients receiving buprenorphine, short-acting full agonist opioids may be needed to treat severe pain but are only recommended in an acute or hospital setting where close monitoring can occur.
 - It is not necessary to discontinue methadone or buprenorphine before surgery.
- The anesthesiologist and surgeon should consult before adjusting or discontinuing buprenorphine prior to surgery.
- If methadone or buprenorphine will be discontinued prior to surgery, it can occur up to 24 hours before surgery and then be restarted postoperatively when the need for an opioid agonist analgesia has passed. If resumed within 72 hours, pre-surgery daily doses can be resumed.
- A patient will not have the same reaction to an opioid analgesic when on naltrexone. Mild pain should be treated with NSAIDs, and moderate to severe pain may be treated with ketorolac.
- Discontinuation of oral naltrexone 72-hours before surgery and discontinuation of extended-release or injectable naltrexone 30 days before surgery is recommended. These patients should be closely monitored.

Adolescents

- Opioid user disorder in adolescents should be treated with a wide range of options, including medications.
- Naltrexone (an opioid antagonist), buprenorphine and methadone (opioid agonists) should be considered for treatment. The practitioner should consider the age of the patient and obtain approvals for those under 18 years of age.
- It is recommended that adolescents receive psychosocial treatment, but the absence or refusal of psychosocial treatment should not delay or preclude pharmacological treatment of opioid use disorder.
- Comprehensive treatment should include screening and treatment for blood-borne viruses and sexually transmitted infections to reduce transmission and promote prevention.
- A specialized treatment facility may be of benefit for the adolescent needing treatment.

Individuals with Co-occurring Psychiatric Disorders

- Assessment should include a determination of the patient's mental health status.
 - Immediately refer anyone with homicidal or suicidal ideation for treatment and possible hospitalization.
- For patients at risk for suicide, management should include close monitoring, reducing risk, identifying and managing any underlying factors, and follow-up.
- The patient's history should be obtained and should include any previous suicidal behavior or ideation, attempts, monitoring, and psychiatric medication. Pharmacological therapy for opioid use disorder should not be delayed or precluded by the completion of these assessments.
- Reassess the patient using a mental status exam after the patient has been stabilized with naltrexone, buprenorphine, or methadone.
- Psychosocial treatment is recommended along with pharmacotherapy, but the absence or refusal of psychosocial treatment should not delay or preclude pharmacological treatment of opioid use disorder.
- Patients with opioid use disorder and schizophrenia, a history of homelessness, and repeated hospitalizations should be considered for intensive community treatment.

Individuals in the Criminal Justice System

- Treatment for opioid use disorder should be made available, include all FDA approved medications, and be based on the patient's individual choice and clinical needs.
- Beginning or continuing treatment with pharmacotherapy for opioid use disorders is recommended for parolees and prisoners. There should be no forced opioid withdrawal.
- Patients in this population should be offered both psychosocial treatment and pharmacotherapy for opioid use disorder. Refusal or unavailability of psychosocial treatment should not delay or preclude pharmacological treatment.
- Patients should continue with naltrexone, buprenorphine, or methadone, as indicated, and should not be forced to transition from one pharmacological treatment to another.
- Transition from methadone to buprenorphine may be needed if an OTP is not accessible.
- Pharmacotherapy should be stabilized before release from prison, and treatment should be coordinated and individualized with community providers.
- Correctional facilities should have naloxone kits available. Individuals treated for opioid use disorder should be provided a naloxone kit on release, and education and training on naloxone use should be provided to the patient and family.

Naloxone for the Treatment of Opioid Overdose

- Administer naloxone to anyone suspected to have overdosed.
- Administer naloxone to people who are pregnant to save the pregnant person's life.
- The patient, family, and significant other should be provided with a prescription for naloxone, or be given a naloxone kit, along with training on how to use the drug in case of an overdose.
- All first responders (i.e., emergency medical services [EMS], firefighters, and law enforcement) should be trained and authorized to administer naloxone.

Reference

American Society of Addiction Medicine. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update*.

https://journals.lww.com/journaladdictionmedicine/Fulltext/2020/04000/Executive_Summary_of_the_Focused_Update_of_the_4.aspx