KAISER PERMANENTE

Opioid Use Disorder Diagnosis and Treatment Guideline

Last guideline approval: February 2024

Guidelines are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.

Major Changes as of February 2024

- Recommendations for starting buprenorphine/naloxone in the urgent care or ER setting have been added.
- Three options for initiation of buprenorphine/naloxone were added: the 3-day protocol (most common, for patients using any type of opioids, including fentanyl), the microdosing protocol (for patients cross-tapering from prescribed opioids), and the full withdrawal protocol (for patients experiencing severe withdrawal symptoms on presentation).
- A stronger recommendation for continuing OUD treatment long-term was added.
- A new recommendation for consideration of long-acting injectable extended-release buprenorphine for a subset of patients who meet prior authorization criteria was added.
- Considerations for OUD treatment for patients using kratom were added.
- Updated monitoring requirements for patients taking buprenorphine were added.

Guideline Scope and Purpose

Kaiser Foundation Health Plan of Washington has developed this guideline to provide recommendations for diagnosis and treatment of opioid use disorder (OUD) in adults, adolescents (ages 13 through 17), and pregnant individuals with and without chronic pain. OUD treatment recommendations include both pharmacologic (buprenorphine/naloxone, methadone, and naltrexone) and psychosocial treatment options.

The purpose of this guideline is sixfold:

- To create reliable pathways to OUD treatment from all points of entry into the KPWA health system—including Primary Care, Urgent Care/Hospital, Mental Health and Wellness, Specialty Care, and Women's Health—such that there is "no wrong door" for patients wanting to access OUD treatment, and no patient abandonment.
- To decrease the difficulty of making accurate OUD diagnoses, particularly in patients who are prescribed opioids.
- To increase awareness of the multiple effective medication treatment options for OUD.
- To create a harm reduction pathway for patients who are not ready to stop their opioid use (e.g., needle exchange, naloxone, monitoring).
- To provide a clear process for reducing the return to use.
- To increase understanding of OUD as a chronic disease and decrease the stigma that prevents people from seeking help.

Expectations and Legal/Regulatory Requirements

Elimination of the DEA X-Waiver requirement allows providers with a DEA license to prescribe schedule III, IV and V medications that are FDA-approved for treatment of opioid use disorder.

- Currently, buprenorphine is the only medication meeting these criteria. All prescriptions for buprenorphine for opioid use disorder now require only a standard DEA registration number.
- There are no longer any limits on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
- Patients with opioid use disorder can be treated with buprenorphine in any health care setting where treatment is provided by a healthcare practitioner with a DEA license: inpatient hospitals, skilled nursing facilities or rehabilitation centers, emergency rooms or urgent care settings, and outpatient ambulatory settings.
- The schedule II medication methadone can only be prescribed by federally licensed Opioid Treatment Programs for treatment of opioid use disorder in an outpatient setting. Other scheduled opioid medications cannot be used to treat opioid use disorder or opioid withdrawal.

Assessment for Opioid Use Disorder

Assessment for OUD may be triggered by any of the following:

- Patient may **self-identify** as having problems with substance use.
- Patient may be **identified clinically** by presenting with withdrawal symptoms, overdose history, positive urine drug screen (UDS), acute intoxication, or red flags/repeated aberrant behaviors. Red flags/aberrant behaviors include:
    - Engaging in health care with a primary intent to obtain opioids or medications with misuse potential, especially in irregular ways (e.g., presenting in an urgent setting for treatment of a chronic condition, requesting specific high-potency forms of medications)
    - Frequent early refill requests
    - Escalating dose without consulting physician
    - Multiple emergency room/urgent care presentations for opioid treatment
    - Seeking opioids from multiple prescribers
    - Recurrent lost or stolen medications
    - Stealing or borrowing from others
    - Disruptive behavior
    - Not taking as prescribed
- **Parent may report** concerns about their adolescent having substance use problems.
- Pharmacy may identify patient through a **new member medication review.**
- **Positive screen** on:
    - Annual Mental Health Questionnaire
    - Maternal Mental Health Screening Tool
    - Screening to Brief Intervention (S2BI) (in Teen Annual Mental Health Questionnaire)

Assessment for OUD consists of interviewing the patient and gathering supporting information using chart review, UDS, the Substance Use Symptom Checklist, and the Prescription Monitoring Program (PMP), to determine if the patient meets DSM-5 criteria for OUD.

Type of opioid: It is important to get a comprehensive history of what type(s) of opioids a patient has been using, what dose, and for how long. In terms of diagnosis of OUD, it does not matter the type of opioid, but it may affect expected withdrawal symptoms and recommendations for treatment initiation.

- **Fentanyl** is now commonly found in nearly all illicit opioids in Washington state, and you can assume that if a patient is getting opioids illicitly, they are very likely exposed to fentanyl.
- **Kratom** is an herbal supplement sold over-the-counter in Washington state that has opioid-like and stimulant-like properties, and patients using kratom may meet criteria for OUD and benefit from treatment. The potency of kratom is typically lower than other illicit opioids.

Diagnosis of Opioid Use Disorder: DSM-5 Criteria

Opioid use disorder (OUD) is a problematic pattern of opioid use leading to clinically significant impairment or distress. It is diagnosed using the DSM-5 criteria, which require that at least two of the following are met within a 12-month period.

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.

8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

The last two diagnostic criteria, related to tolerance and withdrawal, are not considered to be met for individuals taking opioids solely under appropriate medical supervision:

10. Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
    - Markedly diminished effect with continued use of the same amount of an opioid.

11. Withdrawal, as manifested by either of the following:
    - The characteristic opioid withdrawal syndrome, or
    - Opioids (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

The severity of OUD is determined by the number of symptoms that are present.

- Mild: Presence of 2–3 symptoms
- Moderate: Presence of 4–5 symptoms
- Severe: Presence of 6 or more symptoms

The **Substance Use Symptom Checklist** in KP HealthConnect allows patients to self-report their experience of symptoms over the previous 12 months; when this information is entered, a score interpretation is provided that corresponds with DSM-5 criteria. Patient responses must be validated with a clinical interview. Because it is common for patients who use opioids to use multiple substances, the clinical interview helps to confirm that the symptoms reported are related to opioids and not solely to other substances.

Treatment of Opioid Use Disorder

Treatment overview

- Pharmacologic treatment is recommended for all patients with OUD. While many patients with OUD will benefit from a combination of pharmacologic and psychosocial treatment, choosing to decline psychosocial treatment should not prevent the patient from starting or receiving medication. OUD medications reduce the risk of opioid overdose death and relapse more than non-pharmacologic treatment.
- Treatment options for OUD are the same regardless of the source of the opioids (prescribed or illicit) and should be offered universally to all patients with OUD.
- Opioid withdrawal management (i.e., detoxification) **on its own**, without ongoing treatment for OUD, is **not** considered a treatment method for OUD. Treatment of withdrawal symptoms to increase comfort is recommended and should be offered along with treatment for OUD.
- Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating opioid use disorder (ASAM 2020). Dose should be titrated to control cravings and withdrawal. Treatment duration should be individualized based on patient goals. A longer—even potentially lifelong—duration of treatment is better, given the high risk of relapse.
- Based on behavioral risk patterns, consider sexually transmitted infection (STI) screening for patients with OUD. See the CDC STI Treatment Guidelines and the KPWA Sexually Transmitted Infection Guideline for more information on screening.

Treatment setting

Clinical setting does not impact effectiveness of OUD treatment. Almost all health care settings are appropriate. **There is no wrong door for starting treatment**.

- Best practice is to begin OUD treatment in whichever clinical setting it is first diagnosed.
- OUD treatment initiated in the UC/ED or hospital is safe, effective, and marked by high adherence, provided there is a clear hand-off to a qualified clinician upon discharge (refer urgently to Addiction and Recovery Services).

- Continuation of OUD treatment may be managed in Primary Care, Women's Health (during pregnancy), or Addiction and Recovery Services.
    - A DEA registration that includes Schedule III medications is required for prescribing buprenorphine.
    - Any provider with prescriptive authority may prescribe naltrexone for OUD treatment.
    - Methadone is only prescribed by federally regulated facilities: so-called opioid treatment programs (OTPs).

Care pathways for patients seeking OUD treatment

Patients can self-refer by contacting the Mental Health Access Center (MHAC), which in turn will facilitate evaluation by either an internal family medicine provider or an internal or external addiction medicine specialist.

There are three different referrals that may be used for a patient seeking OUD treatment:

- **Ref Fam Med**—This referral can be used to find a provider who has OUD treatment experience listed in their skills matrix (choose Suboxone option). Some patients may need to go to a different clinic for OUD treatment than their home clinic. Once a patient is referred, a primary care RN will reach out to the patient to complete a phone intake assessment (see Tip Sheet) and coordinate their care with an appropriate provider.
- **Ref Mental Health (choose option for SUD treatment)**—This referral order goes to MHAC and can direct patients to the full range of treatment options for OUD. This order is needed when:
    - The patient seeks either an internal or external specialty provider for substance use disorder,
    - The patient needs treatment with methadone,
    - The complexity of illness indicates need for specialty input, or
    - The severity of illness requires a higher level of care (e.g., residential, inpatient).
- **Ref Social Work**—A warm hand-off or virtual warm hand-off to an Integrated Mental Health LICSW for OUD care coordination is available at the time of a visit in most clinics, but if no LICSW is available or a warm hand-off is not feasible, a referral to Mental Health is the best option. Patients assessed by Mental Health who are ambivalent about care options may still be appointed with Social Work to help develop goals and a plan, or they could be appointed with a specialist provider.

Pharmacologic treatment

Medications to treat OUD include **naltrexone, buprenorphine/naloxone (Suboxone), and methadone.** These medications reduce cravings for opioids, lessen withdrawal symptoms, and/or block opioids' euphoric and sedating effects. Use of medications for the treatment of OUD has been shown to be more effective than psychosocial therapies or medically supervised withdrawal or abstinence alone.

Mechanisms of action and prescribing details

- **Naltrexone** is an opioid antagonist that completely blocks the actions of opioids so that any opioids that are used do not have an effect. It can be prescribed by any clinician with prescriptive authority.

- **Buprenorphine/naloxone (Suboxone):** Buprenorphine is a partial opioid agonist. The naloxone is not absorbed when buprenorphine/naloxone is taken sublingually, but if injected or snorted, the naloxone blocks opioid receptors completely, so its addition decreases the potential for misuse and diversion. A DEA waiver is no longer needed to prescribe.

- **Methadone,** a long-acting full opioid agonist, reduces opioid craving and withdrawal and blunts or blocks the euphoric effects of opioids. It is dosed daily and there are strict regulations for how each patient receives care. Methadone can only be prescribed at a federally licensed methadone clinic.

Additional considerations when using OUD treatment medications

Patients who are using kratom
As kratom potency is lower than illicit opioids, doses of OUD medication required to control opioid withdrawal and craving are typically lower. However, symptoms due to kratom's stimulant properties (e.g., trouble concentrating, fatigue, depressed mood) are not expected to respond to buprenorphine treatment and can last for weeks or longer after discontinuation of kratom.

Patients who are also using sedatives or alcohol

Medication treatment should ***not*** be withheld for patients who are found to be concurrently using sedatives or alcohol; however, the patient should be warned about the risks and strongly encouraged to stop. To support patient safety, the frequency of monitoring should increase, and the refill intervals should be decreased. Treatment to address other substance misuse/disorder should be implemented if possible.

Note: **Treatment options are the same regardless of the type or source of opioid used.**

The Substance Abuse and Mental Health Services Administration (SAHMSA) has developed a **shared decision-making tool** on OUD treatment options that patients may find helpful: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4993.pdf.

All patients with OUD should be given **take-home naloxone** (for both patient and family members) to treat an accidental overdose. A Pharmacy patient handout on naloxone nasal spray is available on the staff SharePoint site.

Naltrexone

Appropriate for patients who:

- Are not currently using opioids, but have history of OUD and are at risk for returning to use
- Are highly motivated to abstain from opioids
- Are not interested in agonist therapy to treat OUD
- Have a history of alcohol use disorder

Opioid status
Naltrexone may be offered once the patient is abstinent from any opioid use and not experiencing withdrawal symptoms. Typically, patients using short-acting opioids need to be off all opioids for 10–14 days before starting naltrexone.

Dosing
Naltrexone is available as a daily pill or a monthly injection. The injectable (IM) form is strongly preferred over oral form for helping patients to maintain opioid abstinence due to greater efficacy. Oral naltrexone is an acceptable option for patients who decline or have a contraindication to using the injectable form. There is no physical dependence on naltrexone, so it can be stopped abruptly with no withdrawal symptoms.

IM 380 mg every 4 weeks *
OR
Oral 50 mg daily or 3 times weekly with two 100-mg doses followed by one 150-mg dose

* IM naltrexone is ordered as a CAM (clinic-administered medication) and the patient would be instructed to come to the treatment/injection room at their local clinic for their monthly injections. Dosing every 3 weeks may be considered if patient feels efficacy wearing off before 4 weeks.

Duration
Patients with OUD should remain on naltrexone for a minimum of 12 months.

Contraindications/considerations
Naltrexone is not recommended for treatment of patients with acute hepatitis or hepatic failure.

Buprenorphine/naloxone or methadone

Appropriate for first-line treatment for most patients with OUD

Table 1. Comparison: Medications for treatment of opioid use disorder		
	Buprenorphine/Naloxone	**Methadone** (Methadone clinic settings only; not prescribed/dispensed at KPWA)
Overview	• Partial opioid agonist • Some euphoric effects • Lower risk of respiratory depression than methadone	• Full opioid agonist • Some euphoric effects
Treatment setting	Patient: • Is able to be treated in office-based setting	Patient: • Is able to be treated daily at a federally licensed methadone clinic • Has had poor response to buprenorphine/naloxone in outpatient setting
Dosing	Effective for relieving opioid withdrawal and preventing illicit opioid use. See **"Buprenorphine/naloxone initiation"** following this table. Typical maintenance doses range from 8 to 32 mg daily. Evidence (ASAM 2020) suggests 16 mg daily may be more effective than lower doses.	Typically started at 30 mg daily and titrated to a maintenance dose. Best outcomes are seen with higher maintenance doses in the range of 80–100 mg daily.
Duration	Minimum of 12 months. Longer medication treatment is better, and patients should be encouraged to continue **long-term** maintenance treatment.	Minimum of 12 months.
Contra-indications and considerations	Potential drug-drug interactions may occur when given with medications that affect CYP3A4 activity (e.g., antiretrovirals, azole antifungals, anticonvulsants).	Methadone is subject to drug-drug interactions with medications that impact CYP3A4, CYP2B6, CYP2C19, and to a lesser extent CYP2C9 and CYP2D6. Methadone can cause QT interval prolongation, so providers should be cautious when starting patients on other QT interval–prolonging medications.

Buprenorphine/naloxone initiation

The **Buprenorphine Management SmartSet** provides medication order sets, documentation templates, patient AVS, and follow-up options for three different buprenorphine/naloxone initiation protocols: The **3-day protocol** (most common, for patients using any type of opioids, including fentanyl), the **microdosing protocol** (for patients cross-tapering from prescribed opioids), and the **full withdrawal protocol** (for patients experiencing severe withdrawal symptoms on presentation).

Which buprenorphine/naloxone initiation protocol is appropriate for my patient?

For detailed dosing protocols, see Appendix, p. 19.

3-day protocol (most patients)

- Patient hasn't entered full/severe withdrawal.
- Patient hasn't stopped using opioids.
- Patient has used illicit opioids (presumed to include fentanyl).
- Patient is transitioning off kratom and would benefit from simplified instructions.
- Patient would benefit from simplified instructions.
- Assumes that patient will have follow-up by RN or provider on day 3; this may be by secure message. May repeat day 3 instructions if follow-up is delayed until day 4.
- Use Suboxone 3-Day Initiation AVS.

Microdosing protocol

- Patient is using only **prescribed** opioids available for **cross-taper** and can reliably follow complex instructions.
    - Patients may be instructed to self-taper so that they are no longer using any other opioid by day 8. Some patients find they are able to discontinue earlier than day 8.
    - For patients taking methadone, it is advisable to taper a patient to 20–30 mg methadone, and to maintain that dose for a week or more prior to initiating buprenorphine.
- Patient has not used fentanyl.
- Patient is transitioning off kratom and can follow complex instructions.
- Use Suboxone Microdosing Initiation AVS.

Full withdrawal protocol

- Patient presents in **full opioid withdrawal.** Use in patients who are not in full withdrawal may cause precipitated (sudden/severe) withdrawal.
- Patient has used prescribed and/or illicit opioids (presumed to include fentanyl).
- Use Suboxone Full Withdrawal Initiation AVS.

Instructions for all buprenorphine/naloxone initiation protocols

- Patients should be instructed to stop increasing when they reach the daily dose that controls craving and withdrawal. Some people only need 1 or 2 mg total to control their symptoms and never need to increase to larger doses.
- Patients should be instructed to stop increasing if they are experiencing sedation, poor balance, or falls.
- Patients should not swallow their saliva while the tablet/film is dissolving under the tongue. This can cause nausea or decreased effectiveness of the medicine. To avoid this, patients should lean forward while taking the medication.
- For patients using prescribed opioids or kratom, symptoms are usually controlled using up to 24 mg total daily Suboxone dose, with up to 32 mg occasionally necessary. For patients previously exposed to fentanyl it is often necessary to increase total daily dose to 32 mg.

As-needed medications to treat withdrawal symptoms

The **Buprenorphine Management SmartSet** includes medication orders for withdrawal management:

- Clonidine for sweats, agitation, chills, anxiety and insomnia
- Tylenol for discomfort
- Ibuprofen for discomfort
- Methocarbamol for muscle spasms
- Ondansetron for nausea
- Imodium for diarrhea
- Hydroxyzine for anxiety and insomnia

A note about injectable extended-release buprenorphine (Sublocade)

Patients started on buprenorphine/naloxone may switch to the long-acting extended-release subcutaneous buprenorphine (Sublocade) if they meet the following PA criteria.

Patient has a diagnosis of moderate to severe opioid use disorder or opioid dependence and meets all of the following:

1. Patient is currently maintained on a transmucosal or sublingual buprenorphine dose for at least 7 days prior to initiation of Sublocade
2. In the past year, the patient has had one or more of the following related to opioid use:
    - Emergency room visit
    - Hospital admission
    - Opioid overdose reversal intervention
3. Patient is not covered for treatment of chronic pain
4. Reauthorization required 3 months after initiation:
    - Documentation that patient is stabilized and benefiting from monthly injections
    - Rationale for inability to safely transition to sublingual buprenorphine, including attestation that patient will not receive supplemental doses of sublingual or transmucosal buprenorphine

Duration of medication treatment

A longer—even lifelong—duration of medication treatment for opioid use disorder is encouraged, given the high risk of relapse. If patient develops medication side effects, such as hypogonadal response or dental issues, treat side effects rather than stopping or tapering medication, as it is potentially life-threatening to stop/taper. Consider consulting MindPhone or refer to ARS before starting a taper.

Psychosocial treatment

Psychosocial therapy is recommended **in combination with medication treatment**, as it can help address the psychosocial factors associated with opioid use and increase the likelihood of treatment adherence. Psychosocial therapy includes psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services. Since many patients with OUD have comorbid conditions such as multi-substance use and mental illness, psychosocial therapy can provide a more robust, whole-person approach for OUD treatment. At KPWA, patients with OUD are four times more likely to have depression and/or anxiety, and eight times more likely to have PTSD, than our general patient population.

Note: If a patient declines psychosocial treatment, it should **not** pose a barrier to starting or receiving medication.

Treatment recommendations for special populations

Treating OUD during pregnancy

- ***Buprenorphine alone*** (not in combination with naloxone) is the preferred medication therapy for pregnant individuals with OUD, as the benefits in reducing the severity of neonatal abstinence syndrome (NAS) outweigh the potential risks to the fetus. There is no known risk of increased birth defects with pharmacotherapy for OUD.
- Dosing of buprenorphine may need to be increased throughout pregnancy as metabolism increases. However, buprenorphine dosing should **not** be decreased. NAS expression and severity are not correlated with maternal pharmacotherapy dose.
- Consider switching to buprenorphine in pregnant people who are already taking buprenorphine/naloxone, as it is more effective in reducing NAS severity.
- Pregnant individuals taking buprenorphine need increased monitoring for new or increasing symptoms of OUD, although they do not necessarily need additional prenatal visits beyond the standard prenatal schedule. A diagnosis of OUD that is stable during pregnancy is not necessarily an indication for referral to, specialty addiction services, as prenatal care can be safely managed by a pregnancy care clinician with a DEA registration that includes Schedule III medications. If a pregnant patient has unstable OUD, a referral for specialty care is recommended.
- Methadone can also be considered as an OUD treatment in pregnancy.
- Naltrexone has not been well studied in pregnant individuals, so it is not recommended; however, if a pregnant person is already stable on naltrexone, it may be continued.

Postpartum interventions to reduce severity of neonatal abstinence syndrome

- Encourage newborn rooming-in with mother or gestational parent.
- Encourage breastfeeding when possible.
- In the first week after birth, advise keeping lights low, speaking softly, avoiding too much stimulation, and providing frequent skin-to-skin contact with newborn.
- Dispense take-home naloxone.

Treating OUD in adolescents (ages 13 through 17)

- The combination of medication and psychosocial interventions is the preferred treatment for OUD in adolescents.
- Adolescents presenting with OUD are likely to have co-occurring mental health disorders.
- If an adolescent declines psychosocial treatment, it should not pose a barrier to starting and receiving medication.
- Buprenorphine/naloxone is the preferred medication for adolescents, but methadone may be used if there is a poor response. Methadone is approved for patients aged 16 or over.
- Involving family members increases the success rate of OUD treatment and is one way to ensure that adolescent patients have naloxone-trained individuals in their support network. While encouraging family involvement is recommended whenever possible, bear in mind that under Washington State Consent and Confidentiality law, minors aged 13 years or older have the right to consent to their own treatment and deny the release of medical information.

Teen Confidential Care in Washington State

The medical care of minors (those under 18 years of age) requires parental or guardian consent except in the limited situations listed below.

While adult involvement in the care of adolescents is always encouraged, KPWA policy, in accordance with Washington State law and regulations, notes the following:

1. **Minors 13 years old or older** may provide their own informed consent for care related to mental health, including chemical dependency (substance use disorder treatment).
2. **Minors 14 years old or older** must provide informed consent or refusal for health care related to sexually transmitted infections.
3. **Minors of any age** can consent to all other sexual and reproductive health care, including contraception and abortion services.
4. **Legally emancipated minors** (as evidenced by a court-ordered Decree of Emancipation) may give informed consent or refusal to any treatment for themselves.

When a minor patient has the legal right to consent to care, the minor patient also controls the release of medical information generated in connection with that care.

See the Teen Confidential Care at KPWA Practice Resource for more information.

Harm reduction

Harm reduction is a set of **practical strategies and ideas aimed at reducing negative consequences associated with drug use.** These measures should be initiated for patients who are not ready to stop opioid use.

An important harm-reduction strategy is to **prescribe naloxone** whenever opioids or medications to treat OUD—including buprenorphine, methadone, and naltrexone—are prescribed to further reduce the risk for overdose and death. See the FDA labeling requirement that provides more detail on this recommendation: www.fda.gov/news-events/press-announcements/fda-requiring-labeling-changes-opioid-pain-medicines-opioid-use-disorder-medicines-regarding

Other recommended harm reduction strategies include:

- Offering psychosocial treatment for comorbid mental health conditions.
- Using motivational interviewing techniques to get patient more ready for treatment.
- Encouraging safe storage and proper disposal of medications.
- Educating patient on local resources for needle exchange and observed injection sites.
- Continuing regular urine drug screens to monitor for concurrent use of benzodiazepines, alcohol, THC, and illicit substances that increase the risk of overdose.
- Educating patient on safer sex, and considering referral for PrEP if patient is at particularly high risk of HIV infection. See the KP Interregional HIV Treatment Practice Resource and the KPWA Infectious Disease Quick Care Guide for more information on PrEP.
- Hepatitis B vaccination.

Recovery support

OUD is a chronic, relapsing disease. Patients who return to use after a period of abstinence are at very high risk of overdose due to their reduced tolerance to opioids. Planning interventions for recovery support is an essential part of OUD treatment.

Recommended interventions to support recovery include:

- Assessing and managing **triggers for return to use**
    - To help patients manage exposure to **emotional or financial stressors or environmental cues** (e.g., return to a place or activity associated with past substance use), consider referral to a Community Resource specialist. These specialists can help patients find solutions to financial, housing, or transportation problems, and connect to community support groups.

    - To manage **medical triggers** such as surgery or acute pain/injury, consider consultation from Anesthesia or acute pain service for inpatients. See the KPWA Pain Management Practice Resource for more information.
- Increasing the **frequency of follow-up/monitoring visits** (by decreasing the time between refills) to provide additional support.
- Addressing **co-occurring disorders**, such as anxiety, depression, insomnia, or chronic pain.
- Increasing **psychosocial health support** if needed/available and desired.
- Considering a **higher level of care** (e.g., inpatient, intense outpatient care) if meeting goals in outpatient setting is unsuccessful or patient is medically unstable.
- Encouraging participation in **mutual support groups:**
    - Narcotics Anonymous www.na.org
    - Alcoholics Anonymous www.aa.org
    - Smart Recovery www.smartrecovery.org
    - Women for Sobriety www.womenforsobriety.org
    - Celebrate Recovery www.celebraterecovery.com
    - Alateen al-anon.org/newcomers/teen-corner-alateen/

Monitoring/Follow-up

Monitoring and follow-up plan should be individualized.

- **Visit frequency:**
  - Generally, follow-up visits should occur frequently (weekly) until the patient is stabilized, then monthly. Stabilization is generally indicated by abstinence from illicit opioid use and absence of withdrawal symptoms or significant cravings to use opioids.
  - Once in early remission (criteria for OUD not met for at least 90 days), visits can be reduced to every 2 months.
  - Long-term patients on stable doses in sustained recovery (criteria for OUD not met for at least 12 months) may be followed every 3 months.
- **Virtual visits** are reasonable if clinically appropriate.
- All suboxone refills require **PMP monitoring.**
- **Urine drug screening (UDS):** Expert recommendations suggest ordering the Suboxone UDS + ethyl glucuronide (EtG) as a therapeutic tool to support recovery.
  - The Suboxone UDS + ETG should ideally be scheduled prior to initiation of Suboxone and frequently during relapses and in early recovery. Typically, these are conducted at the same frequency as visits (see above).
  - Alcohol use increases the risk of overdose. The test for alcohol biomarkers in urine is EtG, which can detect low levels of alcohol up to 5 days after consumption; EtG is now a standard component of Suboxone UDS + ETG order.
  - Fentanyl is now a standard component of Suboxone UDS except when stat Suboxone screening is used (Urgent Care).

A note about perioperative OUD treatment

In most cases, patients do **not** need to stop OUD treatment prior to procedure; see Perioperative Buprenorphine Management. Surgical outcomes are often better when patients continue Suboxone perioperatively rather than stopping completely. **E-Consult Anesthesia** well ahead of surgery for patients who are on high-dose Suboxone or are expected to need full opioid agonists for individualized recommendations by patient and procedure/surgery.

Evidence Summary

The Opioid Use Disorder Diagnosis and Treatment Guideline was developed using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

As part of our improvement process, the Kaiser Permanente Washington guideline team is working towards developing new clinical guidelines and updating the current guidelines regularly. To achieve this goal, we are adapting evidence-based recommendations from high-quality national and international external guidelines, if available and appropriate. The external guidelines should meet several quality standards to be considered for adaptation. They must: be developed by a multidisciplinary team with no or minimal conflicts of interest; be evidence-based; address a population that is reasonably similar to our population; and be transparent about the frequency of updates and the date the current version was completed.

In addition to identifying the recently published guidelines that meet the above standards, a literature search was conducted to identify studies relevant to the key questions that are not addressed by the external guidelines.

External guidelines eligible for adapting

- 2021 Multisociety Expert Panel: Buprenorphine Management in the Perioperative Period
- 2021 SAMHSA: Medications for Opioid Use Disorder
- 2020 American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: Focused Update
- 2018 Canadian Research Initiative on Substance Misuse (CRISM)
- 2018 SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants
- 2016 American Academy of Pediatrics (AAP) Medication-Assisted Treatment of Adolescents With Opioid Use Disorders

Key questions addressed in the KPWA evidence review

1. **What is the effectiveness of opioid agonist treatment combined with psychosocial interventions in adult patients with OUD?**

   ASAM 2020 recommends psychosocial interventions in combination with any pharmacotherapy. The review did not find any new, high-quality studies that challenge this recommendation.

2. **Adolescents: What is the efficacy and safety of buprenorphine, methadone, and psychosocial treatment in adolescents with OUD?**

   ASAM 2020 recommends buprenorphine, methadone, naltrexone, and psychosocial interventions. The review did not find any new, high-quality studies that challenge these recommendations.

3. **Pregnancy: What is the effectiveness of methadone, buprenorphine, and naltrexone in limiting neonatal abstinence syndrome (NAS) severity?**

   SAMHSA 2018 indicates that opioid agonist treatment (methadone, buprenorphine) combined with evidence-based behavioral interventions in pregnant individuals with OUD is effective. Each of these medications is effective, and buprenorphine seems to be preferred or more effective than methadone. Reducing the dose of pharmacotherapy does not reduce NAS severity. There is insufficient evidence about the safety of injectable naltrexone during pregnancy and the effects of intrauterine exposure to this medication. No new high-quality studies challenge the 2018 SAMHSA recommendations.

4. What is the effectiveness of OUD medications in the emergency department setting?

Low-quality evidence from randomized controlled trials (RCTs) and observational studies suggests that buprenorphine is effective and safe in the ED setting. However, there is variation in dosing strategies in the ED. The evidence is insufficient for methadone and naltrexone.

5. In people with OUD treated with medication, what is the optimal duration of treatment?

ASAM 2020 indicates: "While there is limited research on optimal length of addiction treatment, available research generally suggests that longer duration of treatment results in better outcomes. Generally, treatment participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is associated with more positive long-term outcomes. For patients treated with methadone, 12 months is considered the minimum. There is no recommended length of treatment with naltrexone. Insufficient evidence is available on the relative effectiveness of different rates of tapering the buprenorphine dose." No new high-quality studies challenge the ASAM recommendations.

6. What is the comparative efficacy of sublingual and long-acting subcutaneous buprenorphine in adults with OUD?

The evidence on the comparative efficacy of subcutaneous buprenorphine and sublingual buprenorphine is limited and/or of low quality. The studies reviewed demonstrate that subcutaneous buprenorphine may be non-inferior to sublingual buprenorphine. Lintzeris 2021 reported patients with OUD who received depot buprenorphine were satisfied compared to those receiving sublingual buprenorphine. In an RCT of 428 patients, Lofwall 2018 found that long-acting buprenorphine depot formulations seem to be non-inferior to sublingual buprenorphine. The proportion of opioid-negative urine samples was 1,347 of 3,834 (35.1%) and response rate was 37 of 213 participants (17.4%) for the subcutaneous depot buprenorphine group compared with 1,099 of 3,870 (28.4%) and 31 of 215 participants (14.4%), respectively, for the sublingual buprenorphine-naloxone group. More studies are warranted for a strong conclusion.

7. What is the efficacy of OUD medications for fentanyl users? What is the most effective dosing regimen for initiating buprenorphine in fentanyl users?

Very low-quality evidence from retrospective studies, case series, and surveys suggests that buprenorphine or methadone may be effective in patients with OUD who are fentanyl users. There is a lack of evidence regarding the most effective dosing regimen for initiating buprenorphine in fentanyl users.

Wakeman 2019: This is a retrospective cohort study of 251 adult patients who initiated office-based buprenorphine treatment. At baseline before initiation, there were 3 groups, those who tested positive for fentanyl (n = 48), those with heroin-positive toxicology (n = 19), and those with negative toxicology (n = 184). Treatment retention rates, at 6 months, were not different between the fentanyl-positive and heroin-positive groups (38% [n = 18] vs 47% [n = 9]; P = 0.58), or between the fentanyl-positive and negative toxicology groups (38% [n = 18] vs 51% [n = 93]; P = 0.14). The fentanyl-positive group had a lower abstinence rate at 6 months compared to those with negative toxicology at baseline (55% [n = 6] vs 93% [n = 63]; P = 0.004). Opioid abstinence at 6 months did not differ between the fentanyl-positive and heroin-positive groups.

Varshneya 2022: This survey indicates that 36.5% (n = 250/685) of patients who reported fentanyl use and took buprenorphine within 24 hours of fentanyl experienced severe opioid withdrawal. In contrast, 15% (n = 30/200) of patients who reported fentanyl use and took methadone within 24 hours of fentanyl experienced severe opioid withdrawal. In addition, the percentage of complete reduction of opioid withdrawal in patients taking buprenorphine is 38.4% (n = 68/177) compared to 44.3% (n = 43/97) among patients taking methadone.

Socias 2022: This secondary analysis of a Canadian trial (comparing flexible take-home dosing buprenorphine/naloxone and supervised methadone models of care) suggests that, irrespective of fentanyl exposure, buprenorphine/naloxone and methadone may be useful for prescription OUD. Fentanyl was not associated with reduced odds of MOUD initiation. Fentanyl exposure did not negatively impact MOUD initiation.

Antoine 2021: This case series included four patients with severe OUD who were fentanyl users. Fentanyl exposure was recent, in the 30 days prior to induction. Induction of buprenorphine consisted of 4 mg of buprenorphine/naloxone following COWS ≥ 9, then another 4 mg of buprenorphine after 180 minutes. COWS rating increased after dosing. However, in two patients, buprenorphine/naloxone (first dose 2 mg of buprenorphine/naloxone following COWS ≥ 13, and a second dose of 2 mg after 85 minutes to 368 minutes) did not precipitate withdrawal with COWS ranging from 3 to 14.

8. **What is the optimal perioperative management of patients on buprenorphine for opioid use disorder? Should it be continued or discontinued?**
   The literature is composed of case series, retrospective studies, reviews, and case reports, none of which challenge the recommendations of the 2020 ASAM or 2021 Multisociety guidelines. These guidelines should be adapted.
   2021 Multisociety Guidelines: Available evidence indicates buprenorphine can be continued in the perioperative period while maintaining analgesia. One of the studies suggests that the adequate dose at which buprenorphine should be maintained is inconsistent. There is lack of evidence, especially prospective clinical trials, to determine the optimal dose of buprenorphine in the perioperative period.
   2020 ASAM: “Discontinuation of methadone or buprenorphine before surgery is not required. Higher-potency intravenous full agonists opioids can be used perioperatively for analgesia in addition to the patient’s regular dose of methadone or buprenorphine (except to the extent that doses may be skipped during the NPO [nothing per orem] period before surgery). Discontinuation of methadone or buprenorphine is also not recommended before elective cesarean section.
   “If it is decided that buprenorphine or methadone should be discontinued before a planned surgery, this may occur the day before or the day of surgery, based on surgical and anesthesia team recommendations. Higher-potency intravenous full agonists opioids can be used perioperatively for analgesia. Methadone or buprenorphine can be resumed postoperatively when the need for intravenous analgesia has resolved, with additional considerations for post-operative pain management as described for acute pain above.”

9. **What is the comparative efficacy of q3 week dosing versus traditional q4 week dosing when initiating patients on IM naltrexone (Vivitrol) for OUD?**
   There is a lack of studies comparing the efficacy of q3 week dosing vs traditional q4 week dosing when initiating patients on IM naltrexone (Vivitrol) for OUD.

10. **What disparities currently exist in identifying and diagnosing OUD amongst chronic pain patients (i.e., Is there a different rate of diagnosis of OUD amongst general population versus people of color)?What are evidence-based interventions that can mitigate such disparities?**
    Low-quality evidence suggests racial disparities in the rate of diagnosis of OUD. OUD is most prevalent in whites, but Native Americans and African Americans are more likely to die than whites (which explains disparity in treatment). Similarly, the rate of OUD increases over the year among blacks in comparison to whites. Other differences include socioeconomic status and type of medical insurance. See ad-hoc evidence review: opioids and disparities (question 4) for more information.

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Development Process/Team

Development process

This guideline was adapted from externally developed evidence-based guidelines and organizations that establish the community standards for opioid use disorder management. The guideline team reviewed additional evidence using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis. For details, see Evidence and References.

This edition of the guideline was approved for publication by the Guideline Oversight Group in February 2024.

Team

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Appendix: Buprenorphine/Naloxone Initiation Protocols - Detail

Note: The **Buprenorphine Management SmartSet** provides medication order sets, documentation templates, patient AVS, and follow-up options for the three buprenorphine/naloxone initiation protocols.

3-day protocol (most patients)

- Patient hasn't entered full/severe withdrawal.
- Patient hasn't stopped using opioids.
- Patient has used illicit opioids (presumed to include fentanyl).
- Patient is transitioning off kratom and would benefit from simplified instructions.
- Patient would benefit from simplified instructions.
- Assumes that patient will have follow-up by RN or provider on day 3; this may be by secure message. May repeat day 3 instructions if follow-up is delayed until day 4.
- Use Suboxone 3-Day Initiation AVS.

Day 1: Take ½ of 2 mg/0.5 mg tablet or film four times per day.

Day 2: Take 2 mg/0.5 mg tablet or film four times per day.

Day 3: Take 8 mg/2 mg tablet or film two times per day.

Follow up with patient on day 3 to determine next adjustments.

Microdosing protocol

- Patient is using only **prescribed** opioids that are available for **cross-taper** and can reliably follow complex instructions.
    - Patients may be instructed to self-taper so that they are no longer using any other opioid by day 8. Some patients find they are able to discontinue earlier than day 8.
    - For patients taking methadone, it is advisable to taper a patient to 20–30 mg methadone, and to maintain that dose for a week or more prior to initiating buprenorphine.
- Patient has not used fentanyl.
- Patient is transitioning off kratom and can follow complex instructions.
- Use Suboxone Microdosing Initiation AVS.

Either tablet or film can be used, but films are reported to be easier to split into quarters for day 1 and 2 dosing.

Day 1: Take ¼ of 2 mg/0.5 mg tablet or film once daily.

Day 2: Take ¼ of 2 mg/0.5 mg tablet or film twice a day.

Day 3: Take ½ of 2 mg/0.5 mg tablet or film twice a day.

Day 4: Take 1 whole 2 mg/0.5 mg tablet or film twice a day.

Day 5: Take 1 whole 2 mg/0.5 mg tablet or film three times a day.

Day 6: Take 1 whole 8 mg/2 mg tablet or film once daily.

Day 7: Take 1 whole 8 mg/2 mg tablet or film in AM and ½ of 8 mg/2 mg tablet or film in PM.

Day 8: Take 2 whole 8 mg/2 mg tablets or films daily.

Increase by 4 mg each day after day 8 until craving and withdrawal is resolved.

Full withdrawal protocol

- Patient presents in **full opioid withdrawal**. Use in patients who are not in full withdrawal may cause precipitated (sudden/severe) withdrawal.
- Patient has used prescribed and/or illicit opioids (presumed to include fentanyl).
- Use Suboxone Full Withdrawal Initiation AVS.

Day 1: Start with ½ of the 8 mg/2 mg tablet or film under your tongue. Wait 2 hours; if you still feel sick or uncomfortable, take the other half.

Day 2: Take the same total dose you took the day before. Wait 2 hours; if you still feel sick or uncomfortable, take ½ of another 8 mg/2 mg tablet or film. Continue to check symptoms throughout the day. If you continue to feel withdrawal, take the other half.

Day 3: Take the same total dose you took the day before (up to 16 mg). Wait 2 hours; if you still feel sick or uncomfortable, take ½ of another 8 mg/2 mg tablet or film.

Day 4: Take the same total dose you took the day before (up to 20 mg). Wait 2 hours; if you still feel sick or uncomfortable, take ½ of another 8 mg/2 mg tablet or film.

Continue on your day 4 dose until your next follow-up visit.