Opioid Use Disorder Diagnosis and Treatment Guideline

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Last guideline approval: December 2020

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.
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

It is illegal for providers to treat opioid use disorders or opioid withdrawal with opioid medications except under very specific circumstances. In outpatient settings, specific opioid medications may only be used by certain providers with a special DEA waiver or by specially regulated opioid treatment programs to treat opioid use disorders.

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, drug-seeking behaviors, or red flags/repeated aberrant behaviors. Red flags/aberrant behaviors include:
  - 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
  - CRAFFT

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

Note: For patients who are prescribed opioid medications, there is an expectation that they will have therapeutically induced physical dependence, so criteria 10 and 11 for tolerance and withdrawal would be excluded.

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

A combination of pharmacologic and psychosocial interventions is recommended for OUD treatment. However, if a patient declines psychosocial treatment, it should not pose a barrier to starting or receiving medication. 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.
OUD medications reduce the risk of opioid overdose death and relapse more than non-pharmacologic treatment. Opioid withdrawal management (i.e., detoxification) on its own, without ongoing treatment for OUD, is not considered a treatment method for OUD and is not recommended. 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).

For patients with history of intravenous drug use (IVDU), screening for hepatitis B, C and HIV is recommended. See the KPWA HIV Screening and PrEP 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.
- If OUD treatment is started in the UC/ED or hospital, a clear hand-off to a qualified clinician for follow-up and treatment is essential.
- Continuation of OUD treatment may be managed in Primary Care, Women’s Health, Mental Health and Wellness, or Addiction and Recovery Services.
  - A DEA waiver is only 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 waivered to provide buprenorphine treatment, 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**—If a patient is seeking OUD treatment with buprenorphine and is initially seen by a provider without a DEA waiver, Ref Fam Med should be used to find a waivered provider (choose suboxone in the drop-down menu). Currently, waivered providers are available in multiple KPWA clinics, which can be selected in the referral. 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 and coordinate their care with an appropriate provider.
- **Ref Social Work**—A warm hand-off or virtual warm hand-off to an Integrated Mental Health LCSW 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 IMH LCSW may be needed.
- **Ref Chemical Dependency**—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 provider for substance use disorder,
  - The patient needs treatment with methadone,
  - An internal provider is not accessible for treatment with buprenorphine,
  - The complexity of illness indicates need for specialty input, or
  - The severity of illness requires a higher level of care (e.g., residential, inpatient).

**Pharmacologic treatment**

Medications to treat OUD include buprenorphine, methadone, and naltrexone. These medications reduce cravings for opioids, lessen withdrawal symptoms, and/or block opioids’ euphoric and sedating effects. Use of medications for the treatment of opioid use disorder has been shown to be more effective than psychosocial therapies or medically supervised withdrawal or abstinence alone. 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.
The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a shared decision-making tool on OUD treatment options that patients may find helpful: [https://mat-decisions-in-recovery.samhsa.gov/Default.aspx](https://mat-decisions-in-recovery.samhsa.gov/Default.aspx)

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 intranet.

Table 1. Medications for treatment of opioid use disorder

<table>
<thead>
<tr>
<th>Overview</th>
<th>Naltrexone</th>
<th>Buprenorphine/Naloxone</th>
<th>Methadone</th>
</tr>
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| Overview           | • Full opioid antagonist  
                    | • No euphoric effects  
                    | • Reduces cravings  
                    | • For prevention of return to use |
|                    | • Partial opioid agonist  
                    | • Some euphoric effects and lower risk of respiratory depression than methadone  
                    | • For withdrawal management and treatment of OUD |
| Appropriate patient| Not currently using opioids, but has history of OUD and is at risk for returning to use  
                    | Able to be treated in office-based setting  
                    | Has chronic pain requiring ongoing opioid management  
                    | Highly motivated to abstain from opioids  
                    | Meets diagnostic criteria for OUD  
                    | Meets diagnostic criteria for OUD  
                    | Not interested in agonist therapy to treat OUD  
                    | Does not have chronic pain requiring ongoing opioid management beyond buprenorphine/naloxone  
                    | Able to be treated daily at a federally licensed methadone clinic  
                    | Has history of alcohol use disorder  
                    | Has had poor response to buprenorphine/naloxone in outpatient setting  
| Opioid status      | Must be abstinent for 10–14 days prior to starting  
                    | Start 12–24 hours after last use when patient is in withdrawal  
                    | Abstinence not required  
                    | Oral 50 mg daily or 3 times weekly dosing with two 100-mg doses followed by one 150-mg dose.  
                    | Treatment is initiated at doses of 2–8 mg and titrated to a dose effective for relieving opioid withdrawal and preventing illicit opioid use. Typical maintenance doses range from 8–24 mg daily. Evidence (ASAM 2020) suggests 16 mg per day may be more effective than lower doses.  
                    | For treatment of OUD, methadone is 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.  
| Dosing             | 380 mg IM every 4 weeks  
                    | Oral 50 mg daily or 3 times weekly dosing with two 100-mg doses followed by one 150-mg dose.  
                    | Treatment is initiated at doses of 2–8 mg and titrated to a dose effective for relieving opioid withdrawal and preventing illicit opioid use. Typical maintenance doses range from 8–24 mg daily. Evidence (ASAM 2020) suggests 16 mg per day may be more effective than lower doses.  
                    | For treatment of OUD, methadone is 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.  
| DEA Waiver         | Not needed  
                    | Required  
                    | Only dispensed at federally certified opioid treatment programs (OTP) (i.e. methadone clinic)  

1 Patients are advised to wait to start taking buprenorphine until they have at least 5 of the following symptoms: yawning, sweating, runny nose, goosebumps, shaking, hot flashes, bone/muscle aches, inability to sit still, nausea/vomiting, muscle twitching, stomach cramps, or the urge to use.  
2 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.  
3 When starting buprenorphine treatment, patients are prescribed an induction kit to help reduce side effects, which includes: 14 buprenorphine tablets (8 mg), ibuprofen (200 mg), clonidine (0.1 mg), and loperamide (2 mg).
Naltrexone
Naltrexone can be prescribed by any clinician, including Primary Care providers. It completely blocks the actions of opioids so that any opioids that are used do not have an effect. Naltrexone may be offered once the patient is completely off opioids and not experiencing withdrawal symptoms. It is available as a daily pill or a monthly injection. Typically, patients using short-acting opioids will need to be off all opioids for 10–14 days before starting naltrexone. Injectable naltrexone is strongly preferred over oral for helping patients to maintain opioid abstinence. 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. Naltrexone can be prescribed by any health care provider with prescriptive authority. Patients with OUD should remain on naltrexone for a minimum of 12 months. Naltrexone can cause hepatoxicity and is contraindicated in patients with active hepatitis (hepatitis or LFT > 3x normal limit). Consider checking LFTs if signs or concern for acute liver disease. If LFTs are greater than 5 times upper limit of normal, initiation of naltrexone should be delayed until liver enzymes are improving or the patient is receiving treatment to address the underlying cause of liver disease.

Buprenorphine/naloxone
Buprenorphine is an opioid partial agonist, so it can relieve pain and create opioid dependence. The formulation that should primarily be used in outpatient settings is a combination product with buprenorphine and naloxone in a 4:1 dose ratio. (Note: The term buprenorphine is often used interchangeably with Suboxone, which was the original brand name for this formulation.) 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. Patients with OUD should be in withdrawal when starting buprenorphine treatment and should remain on it for a minimum of 12 months. Longer medication treatment is better, and patients should be encouraged to continue long-term maintenance treatment. Buprenorphine/naloxone can only be prescribed by health care professionals (physicians, nurse practitioners, physician assistants) who have a federal DEA waiver to prescribe buprenorphine. Buprenorphine is metabolized by CYP3A4; therefore, potential drug-drug interactions may occur when given with medications that affect CYP3A4 activity (e.g., antiretrovirals, azole antifungals, anticonvulsants).

Methadone
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. Patients with OUD should remain on methadone for a minimum of 12 months. Methadone is subject to drug-drug interactions with medications that impact CYP3A4, CYP2B6, CYP2C19, and to a lesser extent CYP2C9 and CYP2D6. Drugs co-administered with methadone should be evaluated for drug-drug interaction potential. Methadone can cause QT interval prolongation, so providers should be cautious when starting patients on other QT interval–prolonging medications (e.g., fluoroquinolones, antipsychotics, antidepressants) or drugs capable of inducing electrolyte disturbances (e.g., diuretics). Patients on methadone doses > 120 mg/day may require EKG monitoring.

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 during pregnancy is not an indication for referral to Addiction and Recovery Services for pharmacologic treatment, as prenatal care can be safely managed by a DEA-waivered pregnancy care clinician.
- 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 recommended for OUD treatment 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.

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

The most effective harm-reduction strategy is to prescribe naloxone whenever opioids or medications to treat OUD—including buprenorphine, methadone, and naltrexone—are prescribed. 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.
- For intravenous drug users, educating patient on safe sex, and considering referral for PrEP if patient is at particularly high risk of HIV infection. See the KPWA HIV Screening and PrEP Guideline 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 weekly until the patient is stable, then monthly.
- Alternating in-person and virtual visits is reasonable if clinically appropriate.
- All visits should include **PDMP monitoring.**
- **Urine drug screening (UDS):** Expert recommendations suggest UDS as a therapeutic tool to support recovery.
  - UDS should be scheduled frequently—as often as weekly—prior to induction, at the beginning of treatment, and early in recovery.
  - Alcohol use will increase the risk of overdose. If there is concern for undisclosed alcohol use, a stand-alone test for alcohol biomarkers in urine can be ordered: ethyl glucuronide (EtG), which can detect low levels of alcohol up to 5 days after consumption. See the KPWA Lab Technical Bulletin “Testing Additions to Suboxone Drug Screens” on the staff intranet for more information.
  - As the patient becomes more stable in recovery, UDS can be done less frequently, but at least monthly. Less frequent testing may be considered when a patient is in ongoing stable recovery.
  - **If the patient returns to substance use** after a period of abstinence, resume an early-recovery UDS schedule, possibly in conjunction with an intensified treatment plan.
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

- 2020 American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: Focused Update
- 2020 USPSTF Screening for Unhealthy Drug Use
- 2018 Canadian Research Initiative on Substance Misuse (CRISM)
- 2018 National Institute on Drug Abuse (NIDA) Screening and Assessment Tools Chart
- 2018 NIDA Medications to Treat Opioid Use Disorder
- 2017 ACOG Opioid Use and Opioid Use Disorder in Pregnancy
- 2017 Bree Collaborative OUD Diagnosis and Treatment Guideline
- 2016 American Academy of Pediatrics (AAP) Medication-Assisted Treatment of Adolescents With Opioid Use Disorders
- 2016 SAMHSA: Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update
- 2015 ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

Key Questions

1. What are the validated tools for opioid use disorder (OUD) diagnosis?
   The American Society of Addiction Medicine (ASAM) 2020 indicates that the diagnosis of OUD should be based mainly on history and comprehensive assessment through physical and laboratory testing, including drug testing. Corroborating information reported by significant others can be used to confirm the diagnosis.
   According to the ASAM, the Objective Opioid Withdrawal Scale (OOWS), the Subjective Opioid Withdrawal Scale (SOWS), and the Clinical Opioid Withdrawal Scale (COWS) are validated scales that assess withdrawal symptoms and may be used in the assessment of OUD.

2. What is the effectiveness of withdrawal management as standalone treatment in patients with OUD?
   ASAM 2020 does not recommend withdrawal management alone due to relapse, overdose and death.

3. 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.
4. What is the effectiveness of oral or injectable naltrexone in preventing relapse to illicit opioid use in patients with OUD who have achieved cessation?

ASAM 2020 recommends injectable naltrexone in patients who are no longer physically dependent on opioids but does not recommend oral naltrexone except under limited circumstances. The Canadian Research Initiative on Substance Misuse (CRISM) 2018 indicated that “oral naltrexone may be considered as an adjunct medication if cessation of opioid is achieved.”

5. Pregnancy: What is the effectiveness of methadone, buprenorphine, and naltrexone in limiting neonatal abstinence syndrome (NAS) severity? Will reducing the dose of pharmacotherapy (buprenorphine, methadone) reduce NAS expression or severity?

6. Pregnancy: What is the effectiveness of opioid agonist treatment combined with psychosocial interventions in pregnant women * with OUD?

SAMHSA 2018 indicates that opioid agonist treatment (methadone, buprenorphine) combined with evidence-based behavioral interventions in pregnant women * 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.

*Although women is the term used most frequently in the published literature, this information applies to any person who is pregnant, including transgender men and non-binary individuals.

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

8. Adolescents: What is the effectiveness of opioid agonist treatment combined with psychosocial interventions in adolescents with OUD?

ASAM 2020 recommends buprenorphine, methadone, naltrexone, and psychosocial interventions.

9. What is the effectiveness of OUD medications (buprenorphine, methadone, naltrexone) in the emergency department setting?

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

There is a lack of studies assessing naltrexone in the ED setting.

10. What is the effectiveness of OUD treatment in inpatient versus outpatient (office-based) settings?

ASAM 2020 indicates that methadone can only be provided in opioid treatment programs (inpatient, outpatient, or residential settings) and acute care settings (under limited circumstances). Buprenorphine and naltrexone can be provided in any setting.

The literature is poor regarding the comparative effectiveness of inpatient versus outpatient OUD treatment. Only two studies were identified. The first study (Day 2011) reported that there was no statistically significant difference between the groups in terms of abstinence rates and completion of detoxification. The second study (Day 2005) reported a lack of high-quality studies to assess the effectiveness of OUD treatment in inpatient versus outpatient settings for detoxification. There is a lack of high-quality studies directly comparing inpatient versus outpatient OUD treatment.

In addition, several studies evaluating OUD treatment in different settings (but not randomized by treatment setting) suggest that OUD treatment (buprenorphine, methadone, naltrexone) may be effective in both settings.
11. In patients with OUD on an opioid agonist, does taking alcohol or sedatives (lorazepam, Zolpidem/Ambien, Alprazolam/Xanax) compared to not taking alcohol or sedatives change overdose risk?

ASAM 2020 indicates: “The prescribing of benzodiazepines or other sedative-hypnotics should be used with caution in patients who are prescribed methadone or buprenorphine for the treatment of an opioid use disorder. The use of benzodiazepines and other sedative-hypnotics should not be a reason to withhold or suspend treatment with methadone or buprenorphine. While the combined use of these medications increases the risk of serious side effects, the harm caused by untreated opioid use disorder can outweigh these risks.”

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

13. In patients with OUD who opted for withdrawal management alone, what is the comparative effectiveness of slow opioid agonist taper (≥ 1 month) and rapid taper (< 1 week) (in an outpatient or residential setting)? What is the effectiveness of slow opioid agonist taper in patients who have achieved success and want to stop medications?

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.”

14. What is the accuracy or utility of testing for alcohol biomarkers—ethyl glucuronide (EtG), gamma-glutamyl transferase (GGT), Carbohydrate-deficient transferrin (CDT), Phosphatidyl ethanol (Peth)—in the urine drug screening of OUD patients?

A review (Andresen-Streichert 2018) suggested that the sensitivities and specificities of alcohol biomarkers vary significantly. In addition, EtG in urine and Peth may have the best sensitivities.

References


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 December 2020.

Team

The following specialties were represented on the development and/or update team: addiction and recovery services, adolescent medicine, anesthesiology, clinical laboratory, family medicine, hospitalists, Kaiser Permanente Washington Research Institute, mental health and wellness, nursing, pain team, patient safety, pharmacy, pulmonology, residency, women’s health, and urgent care.

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Disclosure of conflict of interest

Kaiser Permanente requires that team members participating on a guideline team disclose and resolve all potential conflicts of interest that arise from financial relationships between a guideline team member or guideline team member’s spouse or partner and any commercial interests or proprietary entity that provides or produces health care–related products and/or services relevant to the content of the guideline.

Team members listed above have disclosed that their participation on the Opioid Use Disorder Guideline team includes no promotion of any commercial products or services, and that they have no relationships with commercial entities to report.