

## Withdrawal Management Protocols for OASAS 816.7 Program B

### The Medication Assisted Treatment Program

**Date:** September 2019

#### **Policy:**

All patients/clients who are eligible for treatment will be educated regarding the benefits and risks of Medication Assisted Treatment (MAT) for Substance Use Disorders (SUDs), the availability of on-site treatment, and the availability of alternative treatments by the interdisciplinary team. Patients/clients will provide voluntary informed consent for MAT and appropriate referrals for aftercare made to ensure continuity of care. MAT is available at all levels of care for our patients utilizing all FDA approved medications.

#### **Purpose/Background:**

Medication Assisted Treatment (MAT) for persons diagnosed with a substance-use disorder (SUD) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders (SUDS). Research shows that when treating substance use disorders, a combination of medication and behavioral therapies can be most successful. The duration of treatment should be based on the needs of the individuals served.

Several Food and Drug Administration (FDA) medications have been found to be effective in treating addiction to opioids, alcohol, and/or nicotine in adults. There are currently no FDA-approved medications to treat addiction to cannabis, cocaine, or methamphetamine in any age group.

Our licensed programs include Medically Supervised Inpatient Withdrawal, Stabilization, and Inpatient Rehabilitation, provide a unique opportunity and a supportive recovery environment for the provision of MAT within our continuum of care.

#### **Opioid Use Disorders:**

Buprenorphine and methadone are the first-line treatments for Opioid Use Disorder (OUD) and are associated with significant decreases in both fatal and non-fatal opioid overdoses. Oral and long-acting naltrexone (Vivitrol) also may be considered as a treatment option. Care needs to be individualized and patient centered when choosing the appropriate medication. For patients/clients with opioid use disorder and in opioid withdrawal, a transition and stabilization onto medication assisted treatment (MAT) rather than tapering withdrawal management medication is the safest and most evidence-based standard of care.

***Buprenorphine*** reduces or eliminates opioid withdrawal symptoms, including drug cravings, without producing the “high” or dangerous side effects of heroin and other opioids. It does this by both

activating and blocking opioid receptors in the brain (i.e., it is what is known as a partial opioid agonist). Many buprenorphine formulations are available, both oral and injectable products, which can be offered in many treatment settings.

**Methadone** also prevents withdrawal symptoms and reduces craving in individuals with OUD by activating opioid receptors in the brain (it is called a "full opioid agonist"). It has a long history of use in the treatment of opioid dependence. Methadone maintenance treatment is highly regulated by federal and state agencies in the United States and is therefore only available in specially licensed opioid treatment programs. Methadone can be used for detoxification from opioids, to maintain patients who are participating in a licensed methadone program or for induction onto methadone maintenance treatment with a referral to a licensed Opioid Treatment Program after discharge to continue treatment.

**Naltrexone** is approved for the prevention of relapse in adults following complete detoxification from opioids. It acts by blocking the brain's opioid receptors (it is an opioid antagonist), preventing opioid drugs from acting on them and thus blocking the high the user would normally feel and/or causing withdrawal if recent opioid use has occurred. It can be taken orally in tablets or as a once-monthly injection given onsite (a preparation called Vivitrol®). It is not a controlled substance and does not produce physical dependence.

#### **Alcohol Use Disorders:**

**Acamprosate** (Campral®) reduces withdrawal symptoms by normalizing brain systems disrupted by chronic alcohol consumption in adults.

**Disulfiram** (Antabuse®) inhibits an enzyme involved in the metabolism of alcohol, causing an unpleasant reaction if alcohol is consumed after taking the medication.

**Naltrexone** decreases alcohol-induced euphoria and is available in both oral tablets and long-acting injectable preparations as Vivitrol (as in its use for the treatment of opioid addiction, above).

#### **Nicotine Use Disorders:**

**Bupropion**, commonly prescribed for depression, also reduces nicotine cravings and withdrawal symptoms in adult smokers.

**Nicotine Replacement Therapies (NRTs)** help smokers wean off cigarettes by activating nicotine receptors in the brain. They are available in the form of a patch, gum, lozenge, nasal spray, or inhaler. These preparations can be used as maintenance medication to prevent withdrawal symptoms if patients are not interested in smoking cessation while in treatment in non-smoking environments.

**Varenicline** reduces nicotine cravings and withdrawal in adult smokers by mildly stimulating nicotine receptors in the brain.

**Procedure:**

- On application for admission all patients are screened for SUDs and a CLIA Waived Point of Care (POC) toxicology screen for drugs of use performed on site. A breathalyzer used to determine alcohol levels. Vital signs are obtained to assess medical stability and degree of withdrawal.
- A medical, psychiatric and substance use history is obtained (drugs of use and treatment history).
- The LOCATR 3.0 is performed upon admission and that the concurrent review module of the LOCATR is performed at least once during the program admission, with the frequency and timing of subsequent concurrent review modules determined as clinically appropriate given the care setting.
- The patient has a routine history and physical performed by a licensed medical provider, within 24 hours of admission to the Medically Supervised Withdrawal and Stabilization services and 72 hours of admission to the Inpatient Rehabilitation Services.
- Routine admission laboratory testing includes urinalysis, a complete blood count (CBC), a complete metabolic panel with liver functions tests, screening for tuberculosis (utilizing the TB Quantiferon test) and syphilis. Screening for HIV, hepatitis BsAG and hepatitis C AB (with reflex Hepatitis C viral load testing if the patient is HCV AB positive) is offered, patients may opt out. A PT and INR and other tests may be ordered as indicated.
- Patients with **tobacco use disorder** or nicotine dependence will be offered nicotine replacement therapy to prevent nicotine withdrawals while they are at the program and unable to use tobacco products, even if they are not willing to consider tobacco cessation.
- Patients with **opioid use disorder (OUD)** and withdrawal symptoms or the expectation of withdrawal will be offered Medication Assisted Treatment as first line treatment, or a withdrawal protocol with either methadone or oral buprenorphine if the patient refuses MAT. A withdrawal protocol can be halted and switched to a dose stabilization and induction model with the informed consent of the patient to start medication assisted treatment.

- **Vivitrol for OUD:** For those patients currently using short acting opioids and who request a Vivitrol Injection prior to discharge from the medically supervised withdrawal and stabilization program, we offer an opioid free, symptomatic treatment only utilizing ancillary medications opioid withdrawal. A PT and INR will be included in the admission labs and the Vivitrol ordered on admission after the consent for Naltrexone treatment is signed. Patients will be informed of the need for a repeat POC toxicology screening test for opioids and possibly a naltrexone challenge administered prior to the Vivitrol Injection. If the patient decides on a detoxification protocol with buprenorphine or methadone initially, a longer wash out period is indicated and can be completed while in rehab, waiting a minimum of two weeks prior to the Vivitrol injection, to prevent precipitated withdrawal.
- Patients with ***alcohol use disorder*** and withdrawal symptoms or the expectation of withdrawal symptoms will be offered a detoxification protocol utilizing benzodiazepine medications and symptomatic treatments. If patients are medically stable after the last dose of medication or after a 24 hours observation period as clinically indicated, the patient may receive the 1<sup>st</sup> dose of Vivitrol after consents are signed and labs reviewed (ideally a PT and INR are ordered on admission).
- After the initial injection of a medication for OUD or AUD or both, a patient can remain in the inpatient rehabilitation program for an additional 27 days if insurance approval is obtained for stabilization and the second dose of the injectable medication administered on the day of discharge, ideally 28 days after the first dose.
- MAT educational groups will be held by qualified health care professionals and individual appointments with X-waivered medical providers are available at all times.
- **Overdose prevention:** education and a naloxone kit (or a prescription for naloxone) will be provided to all patients prior to discharge from the program.
- Patients on buprenorphine products or naltrexone may choose to be referred to an outpatient counseling program or long term residential providing MAT or to receive the medication from a physician (Office Based Opioid Treatment). Patient's on MAT with methadone will be referred to an OTP for maintenance treatment with methadone once discharged from the program, either a linked program or a program of the patient's preference Continuity support to enhance engagement at the next level of care will be provided with the use of a warm handoff, peer engagement, check in phone call, a next-day appointment, etc. **See related program policies and procedures.**

## **Diversion Control Plan Program Components**

1. All inpatients will have the ingestion of medications observed by nursing staff while in the facility.
2. The preferred buprenorphine medication is the buprenorphine/naloxone combination for induction as well as stabilization unless contraindicated or patient insurance does to provide coverage. Buprenorphine alone will be used when treating pregnant women. The buprenorphine/naloxone combination serves to minimize diversion and intravenous abuse. Injectable buprenorphine products can also be recommended to prevent diversion.
3. A query of the State Prescription Monitoring Program is performed each time a controlled substance is prescribed, and the reference number should be entered into the clinical record.
4. Each patient will be offered addiction counseling, individual/group counseling, self-help and recovery support, and therapy for co-occurring disorders. While counseling is a recommended component of Medication Assisted Treatment, a patient may continue to receive prescribed buprenorphine even if not participating in the counseling in the outpatient setting. This decision should be based on the provider's clinical judgment.
5. The Medical Provider and/or Counselor may conduct a pill or film count in the outpatient setting and observe the ingestion of medication.
6. Random toxicology screening (oral or urine) with compliance testing for the methadone and buprenorphine metabolite as indicated will be conducted in the outpatient setting and inpatient as indicated. Positive toxicology results for illicit substances are not ground for termination from the program but may indicate the need for a higher level of care or the provision of additional services/counseling. Toxicology testing will be performed as clinically indicated and as required by regulations. Any change in the treatment plan will not be based on the results of a single test. A confirmatory test will be available as needed. Toxicology testing results are not to be used punitively in any way.

## **Buprenorphine Medication Assisted Treatment Program for Opioid Use Disorder**

**Policy:** Treatment with buprenorphine for opioid use disorders is considered an evidence-based best practice. The decision to begin buprenorphine as the preferred pharmacologic agent for Medication Assisted Treatment should be conducted through shared-decision making with the patient/client and is voluntary. This should include a review of the evidence, risks, and benefits of all medication assisted therapy modalities and alternative treatments/options. Other SUDs and prescribed sedatives/benzodiazepines are NOT a contraindication to the use of buprenorphine.

### Inclusion criteria:

- DSM 5 or ICD 10 diagnosis of Opioid Use Disorder.
- Provides voluntary informed consent to follow clinic policy and procedures.
- Consent to coordinate care with outside providers and for aftercare referrals.

### Exclusion Criteria:

- Allergy to buprenorphine products.
- Patient refuses treatment with buprenorphine.
- Drug interactions with buprenorphine are noted making prescribing unsafe for patient. The risk of continued opioid overdose must be weighed against the benefits and risks of buprenorphine treatment when denying treatment with patient input.
- Refusal to sign informed consent and allow care coordination with outside providers.

**Procedure:** Prior to starting the MAT buprenorphine induction protocol a diagnosis of Opioid Use Disorder is made (see Appendix A) and documented in the medical record. A voluntary informed consent must be obtained from each patient (see Appendix B), treatment risks, benefits and alternative treatment modalities reviewed. Any patient questions regarding treatment will be answered. The patient will identify a provider which he/she will transfer care to when discharged from inpatient care. Arrangements will be made by the counselor. Continuity support to enhance engagement at the next level of care will be provided with the use of a warm handoff, peer engagement, check in phone call, a next-day appointment, etc. **See related program policies and procedures:**

1. The Induction Phase is the medically monitored startup of buprenorphine. The medication is administered when a person with an opioid use disorder has abstained from using short acting opioids (heroin, oxycodone, Percocet) for 6 to 24 hours and is in the early stages of opioid withdrawal. It is important to note that buprenorphine can bring on acute precipitated withdrawal for patients who are not in the early stages of withdrawal and who have other opioids in their bloodstream. The Clinical Opiate Withdrawal Scale (COWS – Appendix F) will be

used to guide therapy by staff. When medically safe and appropriate, protocols will begin treatment of opioid withdrawal/buprenorphine induction at mild-to moderate ranges (e.g., COWS 8-12). Buprenorphine induction after methadone use should be done with close supervision and patients should not be encouraged to discontinue methadone maintenance treatment if they are stable. Home induction is generally encouraged to decrease the risk of precipitated withdrawal and facilitate initiating treatment in the outpatient setting. Ancillary medications may be utilized during the induction phase for withdrawal management. (see Ancillary Medication Policy).

2. The Stabilization Phase begins after a patient has discontinued or greatly reduced their misuse of the problem drug, no longer has cravings, and experiences few, if any, medication side effects. The buprenorphine dose may need to be adjusted during this phase.
3. The Maintenance Phase occurs when a patient is doing well on a steady dose of buprenorphine. The length of time of the maintenance phase is tailored to each patient and could be indefinite.

## **Buprenorphine Film/Tablet Stabilization Orders:**

Day 1: D/C suboxone withdrawal order set if on withdrawal protocol.

Day 1-3: 4-8mg suboxone s/l x1 dose when patient is in mild - moderate withdrawal utilizing the COWS score (8-12) or has been free of short acting opiates/opioids 12- 24 hours. Additional 4mg doses may be administered, every 4 hours if the patient continues to report cravings up to 16mg total first daily dose. Refer to home induction instructions (appendix C), inpatient inductions require observed ingestion of medication by nursing staff. If precipitated withdrawal occurs or withdrawal symptoms worsen contact physician for guidance. The total previous daily dose administered should be given as single dose in the morning the following day.

Days 3-7: 8MG - 32 MG daily, adjust dose in 4mg increments to eliminate cravings up to 32 mg maximum daily dose.

Day 8: consider Sublocade 300MG SQ (administered by trained nursing staff only) on abdominal wall) vs maintenance with oral buprenorphine.

Pregnant woman and fast metabolizers may benefit from divided dosing and the use of naloxone free buprenorphine. An adequate dose is when the patient no longer reports cravings or the desire to use. If buprenorphine does not eliminate craving or desire to use, ensure patient is ingesting medication properly or consider injectable buprenorphine or transfer to methadone maintenance protocol. Patients who discontinue or do not achieve the desired therapeutic outcomes for OUD may switch to another treatment modality/medication. Switching from buprenorphine to a different MAT modality should be planned, considered, and monitored.

## **Methadone Medication Assisted Treatment Program for Opioid Use Disorder**

**Policy:** Treatment with methadone for opioid use disorders is considered an evidence-based best practice. The decision to begin methadone as the preferred pharmacologic agent for Medication Assisted Treatment should be conducted through shared-decision making with the patient. This should include a review of the evidence, risks, and benefits of all medication assisted therapy modalities. Other SUDs and benzodiazepine prescribed use are NOT a contraindication to the use of methadone. Methadone can only be dispensed (not prescribed) by SAMSHA approved/DEA licensed Opioid Treatment Programs.

Inclusion criteria:

- DSM 5 or ICD 10 diagnosis of Opioid Use Disorder.
- Provides voluntary informed consent to follow clinic policy and procedures.
- Consent to coordinate care with outside providers and for aftercare referrals.

Exclusion Criteria:

- Allergy to methadone.
- Patient refuses treatment with methadone
- Refusal to allow care coordination with outside providers.
- Sever contraindications to the use of methadone for maintenance (to be determined by a medical provider). The risk of continued opioid overdose must be weighed against the benefits and risks of methadone treatment when denying treatment with patient input.

**Procedure:** Prior to starting the methadone induction protocol a diagnosis of Opioid Use Disorder is made and documented in the medical record. A voluntary informed consent must be obtained from each patient (Appendix D). The risks and benefits of methadone maintenance will be discussed, and alternative treatment modalities reviewed with the patient. A physician must evaluate the patient to make the initial methadone dose determination and admit to the OTP. The patient will identify a licensed outpatient OTP which he/she will transfer to when discharged from inpatient care. Arrangements will be made by the counselor. Continuity support to enhance engagement at the next level of care will be provided with the use of a warm handoff, peer engagement, check in phone call, a next-day appointment, etc. [See related program policies and procedures.](#)

## **Methadone Induction and Stabilization Orders:**

Day 1: D/C methadone/suboxone withdrawal order set if on withdrawal protocol.

Day 1: The initial dose determination and admission to a methadone maintenance program is made by the program physician: 10 -20mg PO x1 dose is administered by the nursing staff based on opioid use history, if there is no sedation and the patient still has cravings (or objective signs of withdrawal after administering a COWS) they may dispense an additional dose of methadone, 10-20 mg PO 2-4 hours after the first dose. A total methadone daily dose of 40 mg on the first day of treatment is the maximum total daily dose as per federal regulations.

Day 2: methadone 10- 40mg PO q AM, if cravings persist the patient may have an additional methadone dose of 10mg PO qHs = 20- 50mg max total daily dose on Day 2.

The methadone dose can be increased by 10mg every 3-5 days until the patient no longer has cravings or a desire to use, pregnant women may require a more rapid titration of medication based on objective signs and physical symptoms. Reduce or hold the methadone dose if any signs of sedation. There is no upper limit on the methadone dose. Pregnant woman and fast metabolizers may benefit from divided dosing. The methadone induction period and dose stabilization can be the most dangerous for risk of overdose by the patient. The medication may accumulate so that a dose tolerated on the first day may cause sedation respiratory depression after 3-5 days particularly if administered with benzodiazepines for detoxification from alcohol or other sedatives/benzodiazepines. A medical provider should be immediately notified and called to assess the patient. The patient needs to be monitored closely after each dose increase. An adequate dose is when the patient no longer reports cravings or the desire to use. Switching from methadone to a different MAT modality should be planned, considered, and monitored.

A nursing assessment of methadone dose adequacy and signs of sedation should be monitored by nursing staff prior and after the daily dose administration. A physician or medical provider needs to be notified if any irregularities are noted and the dose held until an assessment can be made.

## **Naltrexone Medication Assisted Treatment for Opioid and Alcohol Use Disorder**

**Policy:** The decision to begin naltrexone as the preferred pharmacologic agent for Medication Assisted Treatment (MAT) for OUD or AUD should be conducted through shared-decision making with the patient. This should include a review of the evidence, risks, and benefits of all medication assisted therapy modalities. Alternative Therapies are reviewed.

Inclusion criteria:

- DSM 5 or ICD 10 diagnosis of Opioid Use Disorder and/or Alcohol Use Disorder.
- The patient must provide a signed informed consent.

Exclusion Criteria:

- Chronic pain condition requiring treatment with opioid medications.
- Acute liver disease.
- Coagulopathy.
- Renal Impairment.
- Precipitated withdrawal with a naloxone challenge.
- POC toxicology screening positive for opiates or opioids.
- Patient refuses treatment with naltrexone.

**Procedure:** Prior to starting naltrexone or Vivitrol, a voluntary informed consent must be obtained from each patient (see Appendix C), risks and benefits are discussed, and alternative treatment modalities reviewed. The patient will identify a provider which he/she will transfer care to when discharged from inpatient care. Arrangements will be made by the counselor. Continuity support to enhance engagement at the next level of care will be provided with the use of a warm handoff, peer engagement, check in phone call, a next-day appointment, etc. [See related program policies and procedures.](#)

**Naltrexone Induction Protocol:**

1. Patients must be abstinent from short-acting opioids (including tramadol) a minimum of 7 days or long-acting opioids (e.g., methadone, buprenorphine) for 14 days. A naltrexone challenge and POC toxicology is advised prior to administering the injection. Annual Physical and bloodwork must be reviewed prior to the injection. Ideally and PT and INR reviewed.
2. The duration of treatment depends on clinical judgment and the client/patient's individual circumstances. While there is no physical dependence with naltrexone, evidence shows that many people may require ongoing treatment. Involuntary termination of treatment should be avoided, but if it is done referrals are made to an appropriate level of care (e.g. medically supervised withdrawal and stabilization services, methadone maintenance).
3. Patients who discontinue or do not achieve the desired therapeutic outcomes with naltrexone for OUD may switch to buprenorphine or methadone MAT. Switching from naltrexone to a different MAT modality should be planned, considered, and monitored.

Appendix A: DSM 5 OUD DX Form

Appendix B: Informed Consent for Buprenorphine Treatment

Appendix C: Home Induction Instructions

Appendix D: Informed Consent for Methadone Treatment

Appendix E: Informed Consent for Naltrexone Treatment

Appendix F: Clinical Opiate Withdrawal Scale (COWS)

Appendix G: CIWA- Ar Scale

# **Medically Supervised Withdrawal and Stabilization Policy and Procedures**

Date: September 2019

## **A. OPIOIDS/HEROIN WITHDRAWAL AND STABILIZATION PROTOCOLS**

**Policy:** The program will provide a safe medically supervised withdrawal and/or stabilization services to patients with a diagnosis of Opioid Use Disorder (OUD) and physiological dependence on opioids with the goal of minimizing discomfort and to improve patient treatment outcomes. When appropriate and desired by the patient, Medicated Assistance Treatment (MAT) induction and dose stabilization will be offered utilizing buprenorphine and/or methadone or naltrexone for OUD (see MAT program overview). This is the safest and most evidence-based standard of care. Patient's with OUD ideally will be discharged from the facility on some form of MAT. MAT induction/dose stabilization can also be started in the Inpatient Rehabilitation program after a medically supervised withdrawal, even if initially declined in favor of a medication taper. Patient's will leave the facility after being offered overdose prevention education and a naloxone kit/or prescription for a reversal agent.

### **Inclusion Criteria for detoxification:**

- Diagnosis of opioid use disorder.
- Physiological dependence with withdrawal symptoms.

The following conditions are not exclusion criteria:

- Controlled epilepsy (no seizures past 6 months) on medication.
- Stable comorbid medical and psychiatric illness.
- Older age
- Co-occurring alcohol, benzodiazepine and other polysubstance use.
- Elevated vital signs
- Pregnant women requesting induction and dose stabilization. Pregnant women requesting detoxification from opioid medication or heroin will be referred to a higher level of care.

### **Exclusion Criteria:**

- Recent history of withdrawal seizures (past 6 months).
- Unstable acute medical or psychiatric comorbidity.
- Current suicidal ideation or suicide risk based on history.
- Severe unstable liver disease with ascites and/or encephalopathy.
- Uncontrolled epilepsy not on medication.
- Recent hospitalizations with an acute unstable illness.
- Anyone with a communicable illness potentially communicable by casual contact.
- COWS above or equal to 23.

- Pregnant women requesting detoxification from opioids will be transferred to an appropriate level of care.
- Patients on an Opioid Treatment Program on doses of methadone greater than 30mg are not eligible for inpatient medically supervised detoxification from methadone at Elev8 Centers.

Patients not eligible for admission or developing complications during their admission will be transferred to an appropriate/higher level of care or to the nearest hospital. Staff will be directed to call 911 and notify the physician/NP or on call medical provider. Referral and reasons for referral will be documented in the case record. Patient returning will need to have a medical clearance prior to readmission by a physician/NP.

### **Procedure:**

- On application for admission all patients are screened for SUDs and a CLIA Waived Point of Care (POC) toxicology screen for drugs of use performed on site, and a breathalyzer used to determine alcohol levels. Vital signs are taken and recorded.
- A medical, psychiatric and substance use history is obtained (drugs of use and treatment history). Risks of self-harm/suicide and violence are screened prior to admission by trained admission staff and again by the admitting RN after admission to the program. Patients at a potentially elevated risk will be referred to a higher level of care or to the on-site psychiatrist/psychiatric Nurse Practitioner for further assessment if available prior to admission. Once admitted, psychiatric evaluations and assessments, including medication management from a psychiatrist or psychiatric Nurse Practitioner are available on-site. Medications will be prescribed as needed to stabilize a patient or the patient can be referred out to a higher level of care.
- The LOCATR 3.0 is performed upon admission and that the concurrent review module of the LOCATR is performed at least once during the program admission, with the frequency and timing of subsequent concurrent review modules determined as clinically appropriate given the care setting.
- The patient has a routine history and physical performed by a licensed medical provider within 24 hours of admission to the Medically Supervised Withdrawal and Stabilization service. The patient is carefully assessed for complicated and/or serious withdrawal on admission and throughout the admission. The domains of assessment include but are not limited to length and amount of recent use, poly-substance use including alcohol and benzodiazepines, a history of serious withdrawal complications (e.g., intensive care admissions, delirium tremens, seizures, suicidal ideation, self-harming or violent behaviors). Unstable co-morbid medical and psychiatric

conditions will be referred to a higher more appropriate level of care. The determination of the appropriate level of care and patient centered individualized protocols will be made by the medical provider.

- Routine admission laboratory testing includes urinalysis, a complete blood count (CBC), a complete metabolic panel with liver functions tests, screening for tuberculosis (utilizing the TB Quantiferon test) and syphilis. Screening for HIV, hepatitis BsAG and hepatitis C AB (with reflex Hepatitis C viral load testing if the HCV AB is positive) is offered, patients may opt out. A PT and INR and other tests may be ordered as indicated. Patients who are readmitted within 6 months may have the laboratory tests reviewed by the Medical Provider instead of repeated if no changes are reported, at the discretion of the medical provider.
- Patients with **tobacco use disorder** or nicotine dependence will be offered nicotine replacement therapy to prevent nicotine withdrawals while they are at the program and unable to use tobacco products, even if they are not willing to consider tobacco cessation.
- Patients with **opioid use disorder (OUD)** and withdrawal symptoms or the expectation of withdrawal will be offered Medication Assisted Treatment or a withdrawal protocol with either methadone or oral buprenorphine if the patient refuses MAT. A detoxification protocol can be halted and switched to a dose stabilization and induction model with the informed consent of the patient to start MAT.
- **Vivitrol for OUD:** For those patients currently using short acting opioids and who request a Vivitrol Injection prior to discharge from the medically supervised withdrawal and stabilization program, we have an opioid free, symptomatic treatment only utilizing ancillary medications opioid withdrawal protocol. A PT and INR will be included in the admission labs and the Vivitrol ordered on admission after the consent for Naltrexone treatment is signed. Patients will be informed of the need for a repeat POC toxicology screening test for opioids and possibly a naltrexone challenge administered prior to the Vivitrol Injection. If the patient decides on a withdrawal protocol with buprenorphine or methadone initially, a longer wash out period is indicated and can be completed while attending the program inpatient rehab, waiting a minimum of two weeks prior to the Vivitrol injection is advised, to prevent precipitated withdrawal.
- Patients with **alcohol use disorder** and withdrawal symptoms or the expectation of withdrawal symptoms will be offered a detoxification protocol utilizing benzodiazepine medications and symptomatic treatments in addition to the opioid withdrawal or induction protocol.

- All patient with a history of Opioid use disorder (OUD) will be assessed with a clinical Opiate Withdrawal Scale or COWS (Appendix F) on admission. All admitted patients with a diagnosis of OUD on a withdrawal protocol will have vital signs and a COWS administered by nursing staff q6h x 48 hours and as indicated thereafter. A COWS score of greater than 23 will require notifying the physician/NP/on-call medical provider and transferring the patient to a higher level of care by calling 911.
- The patient will be closely observed during detoxification for the appearance of any withdrawal symptoms/syndromes and/or medical/ neurological complications with the potential for life threatening complications, in which case the physician or licensed provider (PA, NP) will be notified and the patient will be transferred to the hospital emergency room by ambulance after calling 911. The medical provider will also be notified for unstable vital signs: tachycardia or bradycardia, hypertension or hypotension, and fever; when acute medical problems or adverse drug effects are suspected, when withdrawal severity is increasing despite treatment (even if mild –to – moderate), and when withdrawal severity is assessed to be high-moderate (CIWA –Ar 13 or greater, COWS if 20 or greater).
- Medications will be held for sedation and the physician/NP/medical provider on call notified. Protocols can be shortened or decreased based on clinical presentation or medical necessity at the discretion of the medical provider to provide individualized patient centered care.
- Methadone, Zubsolv or Suboxone will be utilized for opioid withdrawal depending on the clinical presentation or taking into consideration patient preference. Subutex or methadone will be utilized for induction and dose stabilization in pregnant women. Any protocol may be individualized to meet the needs of the patient.
- Patients will be given Folic Acid 1mg, Thiamine 100mg and a Multivitamin preparation daily to compensate for any possible nutritional deficiencies and to prevent Wernicke’s encephalopathy if there is possible co-occurring alcohol misuse.
- Ancillary medications will be available for the symptomatic treatment of withdrawal. These include but are not limited to: Colace (100MG capsules 1 PO QHS will be ordered for patients started on MAT), Senna 2 tablets tid prn, Melatonin 5MG tablets 1 PO QHS, for sleep scheduled, Valium 10MG tablets 1PO QHS PRN for insomnia and secondary to withdrawal symptoms unrelieved by other medications, Clonidine 0.1MG-0.2MG PO up to a maximum daily dose of 1.0mg for anxiety/withdrawal symptoms, with parameters to hold for BP less than 100/60, vital signs must be taken prior to administration, Baclofen 10mg tablets PO TID prn for muscle spasms/pain. Flexeril 5-10mg po q8h if baclofen ineffective. Tylenol up to a max daily dose of 3g or less for patients with liver disease, ibuprofen, and magnesium containing antacids as well. Other medications will be ordered as indicated. See policy for ancillary withdrawal medications.

- On each day of protocol, the patient is highly encouraged to participate in the therapeutic groups if he/she is physically capable of participation.
- **Overdose prevention:** education and a naloxone kit (or a prescription for naloxone) will be provided to all patients prior to discharge from the program.

**Opioid Protocol- Preliminary for Starting Treatment:**

- Prior starting any opioid induction protocol, a voluntary informed consent must be obtained from each patient.
- Urine toxicology must be consistent with reported use and checked prior to administering the first dose of medication by the nurse, if an opioid is not noted on admission in the urine toxicology screen and a protocol ordered, the nurse must notify the prescriber to ensure patient meets criteria.
- The objective and validated Clinical Opiate Withdrawal Scale (Appendix F: COWS) will be administered: for detoxification utilizing buprenorphine the patient must be in mild - moderate withdrawal (a COWS score of 8-12) and/or have not used opioids for 12-24 hours prior to admission. A score of 23 or greater must be referred to a higher level of care (either medically managed withdrawal services or hospital). The medical provider is notified and the patient is transported after calling 911.

**Zubsolv Withdrawal Protocol:** protocol may be individualized to meet the needs of the patient.

Days 1: Zubsolv range of 2.9MG/0.71MG – 5.7MG/1.4mg S/L

Days 2-3: Zubsolv range of 2.9mg/0.71mg - 8.6mg/2.1mg S/L

Patient may switch to MAT protocol on day 3, must notify prescriber to assess and order stabilization order set.

Day 4: Zubsolv range 2.9mg/0.71mg -5.7mg/1.4mg S/L

DAY 5: Zubsolv range 1.4mg/0.36mg - 2.9mg /0.71mg S/L

DAY 6: Zubsolv range 1.4mg/0.36mg - 2.9MG/0.71MG S/L

**Suboxone Withdrawal Protocol:** protocol may be individualized to meet the needs of the patient.

Day 1 Suboxone range 4mg/1mg - 8mg//2mg S/L

DAYS 2-3 Suboxone range 4mg/1mg- 12mg/3mg S/L

Patient may switch to MAT on day 3, must notify prescriber to assess and order stabilization order set.

Day 4: Suboxone range 4mg/1mg- 8MG/2mg S/L

Day 5: Suboxone range 2mg/0.5mg -4mg/1mg S/L

Day 6: Suboxone range 2mg/0.5mg -4mg/1mg S/L

**Methadone Withdrawal Protocol:** may be individualized to meet the need of the patient.

Day 1: 15mg PO x1 dose on admission to floor, if no sedation may have second 15mg dose PO x1 2-4 hours after initial dose = 30mg first day dose total.

Day 2: 25mg PO q AM.

Day 3: 20mg PO q AM.

Day 4: 15mg PO q AM. Day 5: 10 PO q AM.

Day 6: 5mg PO q AM.

## B. ALCOHOL WITHDRAWAL PROTOCOLS

Date: September 2019

**Policy:** Alcohol Withdrawal Syndrome (AWS) is potentially life-threatening. Patients with symptoms of alcohol withdrawal require non-pharmacological and pharmacological interventions. Clinical judgement is necessary to assess a patient's degree of alcohol tolerance in the context of their symptoms, signs and blood alcohol levels obtained utilizing a breathalyzer. Our goal is to provide a safe and effective withdrawal from alcohol with the minimization of the multiple impacts of alcohol withdrawal to achieve improved treatment outcomes. Patients stable on MAT for OUD, on either methadone or buprenorphine, will be able to continue while undergoing alcohol withdrawal.

Inclusion Criteria:

- Diagnosis of alcohol use disorder.
- Moderate withdrawal symptoms or expected moderate withdrawal symptoms based on history.

The following conditions are not exclusion criteria:

- Repeated episodes of relapse after withdrawal.
- Stable comorbid medical and psychiatric illness.
- Older age
- Co-occurring alcohol use disorder and polysubstance use.
- Elevated vital signs
- Controlled epilepsy on medication brought to facility by patient.
- High BAL <300 and expected withdrawal symptoms.
- Elevated Vital signs.

Exclusion Criteria:

- History of Delirium Tremens in past with comparable alcohol consumption.
- Recent history of withdrawal seizures (within past 6 months)
- Unstable acute medical or psychiatric comorbidity.
- Current suicidal ideation or suicide risk based on history (no one with a history of suicide attempt within the last 6 months).
- BAL>300
- Severe unstable liver disease with ascites and/or encephalopathy.
- Epilepsy not on medication or not controlled on medication
- Anyone with a communicable illness potentially communicable by casual contact.
- CIWA >18

- Pregnant women requesting detoxification will be referred to a higher level of care.

Patients not eligible for admission or developing complications during their admission will be transferred to a higher level of care or the nearest hospital. A medical provider will be informed and the staff will be directed to transfer the patient safely. Referral and reasons for referral will be documented in the case record.

### **Procedure:**

- On application for admission all patients are screened for SUDs and a CLIA Waived Point of Care (POC) toxicology screen for drugs of use performed on site. A breathalyzer will be used to determine alcohol levels. Vital signs are taken and recorded.
- A medical, psychiatric and substance use history is obtained (drugs of use and treatment history). Risks of self-harm/suicide and violence are screened prior to admission by trained admission staff and again by the admitting RN after admission to the program. Patients at a potentially elevated risk will be referred to a higher level of care or to the on-site psychiatrist/psychiatric Nurse Practitioner for further assessment if available prior to admission. Once admitted, psychiatric evaluations and assessments, including medication management from a psychiatrist or psychiatric NP are provided on-site. Medications will be prescribed as needed to stabilize a patient or the patient can be referred out to a higher level of care.
- The LOCATR 3.0 is performed upon admission and that the concurrent review module of the LOCATR is performed at least once during the program admission, with the frequency and timing of subsequent concurrent review modules determined as clinically appropriate given the care setting.
- The patient has a routine history and physical performed by a licensed medical provider within 24 hours of admission to the Medically Supervised Withdrawal and Stabilization service. The patient is carefully assessed for complicated and/or serious withdrawal on admission and throughout the admission. The domains of assessment include but are not limited to the length and amount of recent use, poly-substance use including opioids and benzodiazepines, a history of serious withdrawal complications (e.g., intensive care admissions, delirium tremens, seizures, suicidal ideation, self-harming or violent behaviors). Unstable co-morbid medical and psychiatric conditions will be referred to a higher more appropriate level of care. The determination of the appropriate level of care and patient centered individualized protocols will be made by the medical provider.

- Routine admission laboratory testing includes urinalysis, a complete blood count (CBC), a complete metabolic panel with liver functions tests, screening for tuberculosis (utilizing the TB Quantiferon test) and syphilis. Screening for HIV, hepatitis BsAG and hepatitis C AB (with reflex viral load testing if HCV AB is positive) is offered, patients may opt out. A PT and INR and other tests may be ordered as indicated. Patients who are readmitted within 6 months may have the laboratory tests reviewed with the Medical Provider instead of repeated if no changes are reported at the discretion of the medical provider.
- Patients with **tobacco use disorder** or nicotine dependence will be offered nicotine replacement therapy to prevent nicotine withdrawals while they are at the program and unable to use tobacco products, even if they are not willing to consider tobacco cessation.
- Patients with co-occurring **opioid use disorder (OUD)** and withdrawal symptoms or the expectation of withdrawal will be offered Medication Assisted Treatment or a withdrawal protocol with either methadone or oral buprenorphine if the patient refuses MAT. A detoxification protocol can be halted and switched to a dose stabilization and induction model with the informed consent of the patient to start medication assisted treatment. Patients admitted on MAT for OUD will be allowed to continue their maintenance medications while receiving medications for alcohol withdrawal. They will be carefully monitored with the CIWA – Ar and vital signs by the nurses who will notify the medical provider to assess the patient if any signs of sedation are noted because of the co-administration of benzodiazepines for alcohol withdrawal.
- Patients with **alcohol use disorder** and withdrawal symptoms or the expectation of withdrawal symptoms will be offered a detoxification protocol utilizing benzodiazepine medications and symptomatic treatments in addition to the opioid withdrawal or induction protocol if they have a diagnosis of OUD. If patients are medically stable after the last dose of medication or after a 24 hours observation period as clinically indicated, the patient may receive the 1<sup>st</sup> dose of Vivitrol after consents are signed and labs reviewed (ideally a PT and INR are ordered on admission) if the patient does not have co-occurring OUD (see Vivitrol for OUD policy).
- Patients with **alcohol use disorder (AUD)** and withdrawal symptoms or the expectation of withdrawal symptoms will be offered a withdrawal protocol utilizing benzodiazepine medications and symptomatic treatments. In addition, an opioid withdrawal or induction protocol will be offered if they have a diagnosis of OUD.
- A patient with a history of AUD will be assessed with a validated and objective tool, the CIWA- Ar (Appendix G) on admission. The prevention of acute withdrawal emphasizes

the need to start beginning medication treatment at mild-to-moderate levels of withdrawal (CIWA-Ar 8-10).

- All admitted patients with a diagnosis of AUD on a withdrawal protocol will have vital signs and a CIWA-Ar administered by nursing staff q6h x 48 hours and as indicated thereafter. A CIWA-Ar score greater than 15 will require notifying the physician/NP/on-call medical provider and transferring the patient to a higher level of care by calling 911 and transporting the patient by ambulance.
- The patient will be closely observed during the withdrawal protocol for the appearance of any withdrawal symptoms/syndromes and/or medical/ neurological complications with the potential for life threatening complications, in which case the physician or licensed provider (PA, NP) will be notified and the patient will be transferred to the hospital emergency room.
- The medical provider will be notified of unstable vital signs: tachycardia or bradycardia, hypertension or hypotension, and fever; when acute medical problems or adverse drug effects are suspected, when withdrawal severity is increasing despite treatment (even if mild –to – moderate), and when withdrawal severity is assessed to be high-moderate (CIWA –Ar 13 or greater, COWS if 20 or greater).
- Librium, Valium or Ativan will be utilized for alcohol withdrawal detoxification depending on clinical presentation and patient preference (see protocols below). Any protocol may be individualized to meet the needs of the patient.
- Medications will be held for sedation and the medical provider on call notified. Protocols can be shortened or decreased based on clinical presentation or medical necessity at the discretion of the medical provider to provide individualized patient centered care.
- Patients will be given Folic Acid 1mg, Thiamine 100mg and a Multivitamin preparation daily to compensate for any possible nutritional deficiencies and to prevent Wernicke’s encephalopathy
- Ancillary medications will be available as needed for the symptomatic treatment of withdrawal. These include but are not limited to: Colace (100MG capsules 1 PO QHS for patients started on MAT), Melatonin 5MG tablets 1 PO QHS, for sleep scheduled, vital signs must be taken prior to administration, Baclofen 10mg tablets PO TID prn for muscle spasms/pain. Tylenol up to a max daily dose of 3g or less for patients with liver disease and ibuprofen, with magnesium containing antacids

as well. Other medications will be ordered as indicated. See policy for ancillary withdrawal medications.

- On each day of protocol, the patient is highly encouraged to participate in the therapeutic groups if he/she is physically capable of participation.
- **Overdose prevention:** education and a naloxone kit (or a prescription for naloxone) will be provided to all patients prior to discharge from the program,

**Protocols:** while the risk of intoxication and side effects from the withdrawal management medications must be carefully balanced with the risk of acute withdrawal, prevention of withdrawal is a priority and protocols should begin at mild to moderate levels of withdrawal (i.e. CIWA –Ar 8-10). If the withdrawal severity increases despite treatment (e.g.; CIWA – Ar rises from 6-9) the medical provider should be notified, treatment modified and prn medications if available utilized until the patient is stabilized.

**Librium Taper for Alcohol:** Librium 25mg doses PO prn will be available as needed

Day 1 Give 25mg Librium if CIWA-Ar >8

then between 50- 200mg total daily dose based on signs and symptoms of withdrawal.

Day 2 Range 100 – 200mg daily.

Day 3 Range 75-125mg daily

Day 4 Range 25- 50 mg daily

Day 5 Range 0-25mg daily

**Ativan Taper for Alcohol:** Ativan 0.5mg doses PO prn will be available as needed

Day 1 Give 1 mg Ativan if CIWA-Ar >8

then between 3 -8 mg total daily dose based on signs and symptoms of withdrawal.

Day 2 Range 3 -5 mg

Day 3 Range 2-4 mg

Day 4 Range 1-3 mg

Day 5 Range 0.5 -1.5 mg

**Valium Taper for Alcohol:** Valium 10mg doses PO prn will be available as needed

Day 1 Give 10mg Valium if CIWA-Ar >8

then between 40 – 60 mg total daily dose based on signs and symptoms of withdrawal.

Day 2 Range 30 – 50 mg daily.

Day 3 Range 20 – 40 mg daily.

Day 4 Range 10 - 20 mg daily.

Day 5 Range 5-10 mg daily.

## C. BENZODIAZEPINES/SEDATIVE WITHDRAWAL PROTOCOLS

**Policy:** Benzodiazepine or sedative withdrawal may result in seizures, delirium and is potentially life-threatening. Patients with symptoms of benzodiazepine withdrawal require non-pharmacological and pharmacological interventions. Clinical judgement is necessary to assess a patient's degree of benzodiazepine tolerance in the context of their symptoms, signs and history of use. Our goal is to provide a safe and effective withdrawal from benzodiazepine with the minimization of the multiple harmful impacts of benzodiazepine withdrawal and to improve treatment outcomes. Patients stable on MAT (either methadone or buprenorphine) will be able to continue while undergoing benzodiazepine/sedative withdrawal.

### Inclusion Criteria:

- Diagnosis of a benzodiazepine use disorder.
- Moderate withdrawal symptoms or expected moderate withdrawal symptoms based on history.

The following conditions are not exclusion criteria:

- Repeated episodes of relapse after withdrawal.
- Stable comorbid medical and psychiatric illness.
- Older age
- Co-occurring alcohol use disorder and polysubstance use.
- Elevated vital signs
- Controlled epilepsy on medication brought to facility by patient.

### Exclusion Criteria:

- A history of a DT type syndrome in past with comparable benzodiazepine consumption.
- Recent history of seizures, including withdrawal seizures (past 6 months)
- Unstable acute medical or psychiatric comorbidity.
- Current Suicidal ideation or suicide risk based on history (no one with a history of suicide attempt within the last 6 months).
- Pregnancy
- Cognitive deficits
- Severe unstable liver disease with ascites and/or encephalopathy.
- Uncontrolled epilepsy not on medication.
- Anyone with a communicable illness as per facility policy.
- A CIWA >18 on admission assessment should be referred to a higher level of care.

Patients not eligible for admission or developing complications during their admission will be transferred to a higher level of care or the nearest hospital. Staff will be directed to notify the medical provider and call 911 to transport the patient by ambulance. Referral and reasons for referral will be documented in the case record.

**Procedure:**

- The preadmission assessment will include the following:
  - An assessment of the patient's substance use disorder (SUD) and other drugs of use.
  - A brief mental status exam
  - An assessment of communicable infectious disease transmitted by casual contact, pulmonary, liver, and cardiac abnormalities, dermatological and neurological sequela; and possible concurrent surgical problems.
  - Point of Care Urine toxicology screening (with confirmatory quantitative analysis if indicated), and alcohol levels obtained utilizing a breathalyzer will be administered. Routine labs sent, including a CBC, a comprehensive metabolic profile with liver function tests, HIV and hepatitis screening for B and C, an RPR, and TB screening utilizing the TB Quantiferon test will be sent on admission unless the patient can present recent evidence of testing (within 3 months or history of positive results). For women of child-bearing age, a pregnancy test will be performed, an EKG and CXR will be ordered as clinically indicated.
- A complete history and physical will be completed by a licensed medical provider within 24 hours of admission, if the examination is conducted by a qualified health professional who is not a physician, the result of the examination and any recommendations arising from the examination will be reviewed by the medical director (or physician designee) prior to implementation.
- Patients who are readmitted within 3 months may have the physical exam and laboratory tests reviewed instead of repeated if no changes are reported at the discretion of the medical provider.
- All patient with a history of benzodiazepine use disorder will be assessed with a CIWA-Ar (Appendix G) on admission. All admitted patients with a diagnosis of benzodiazepine use disorder on a detoxification protocol will have vital signs and a CIWA-Ar administered by nursing staff q6h x 48 hours and as indicated thereafter.
- Clonazepam, Valium or Ativan will be utilized for benzodiazepine withdrawal/detoxification depending on clinical presentation and patient preference (see protocols below). Any protocol may be individualized to meet the needs of the patient.
- Patients will be given Folic Acid 1mg, Thiamine 100mg and a Multivitamin preparation daily to compensate for any possible nutritional deficiencies and to prevent Wernicke's encephalopathy.

- PRN medications will be available for the symptomatic treatment of withdrawal. These include but are not limited to: Colace 100mg up to 300mg daily, Senna 2 tablets up to three times a day, Melatonin 5MG tablets 1 PO QHS, for sleep scheduled, Baclofen 10mg tablets PO TID prn for muscle spasms/pain. Flexeril 5-10mg may be used if baclofen ineffective. Tylenol up to a max daily dose of 3g or less for patients with liver disease, ibuprofen, and magnesium containing antacids as well. Other medications will be ordered as indicated. See policy for symptomatic medication.
- The patient will be closely observed during detoxification for the appearance of any withdrawal symptoms/syndromes and/or medical/ neurological complications with the potential for life threatening complications, in which case the physician or license provider (PA, NP) will be notified and the patient will be transferred to the hospital emergency room.
- Medications will be held for sedation and the medical provider on call notified. Protocols can be shortened or decreased based on clinical presentation or medical necessity at the discretion of the medical provider to provide individualized patient centered care.
- On each day of protocol, the patient is highly encouraged to participate in the therapeutic groups if he/she is physically capable of participation.

### **Valium Taper for Benzodiazepines:**

Day 1 Give 30-60mg PO total daily dose based on signs/symptoms of withdrawal and usage history.

Day 2 Range 30 – 60 mg PO daily based on signs and symptoms of withdrawal.

Day 3 Range 30 – 40 mg PO total daily dose based on signs and symptoms of withdrawal.

Day 4 Range 20-30 mg PO total daily dose based on signs and symptoms of withdrawal

Day 5 Range 10-20 mg PO total daily dose based on signs and symptoms of withdrawal.

Day 6 Range 5- 10mg PO qAM

**Ativan Taper for Benzodiazepines:**

Day 1 Give 3-8mg PO total daily dose based on signs and symptoms of withdrawal and usage history.

Day 2 Range 3 -5 mg PO total daily dose based on signs and symptoms of withdrawal.

Day 3 Range 3- 5 mg PO total daily dose based on signs and symptoms of withdrawal.

Day 4 Range 2 -4 mg PO total daily dose based on signs and symptoms of withdrawal.

Day 5 Range 1-3 mg PO total daily dose based on signs and symptoms of withdrawal.

Day 6 Range 0.5mg - 1mg PO qAM.

**Clonazepam Taper for Benzodiazepines**

Day 1 Give 1-3mg PO total daily dose based on signs and symptoms of withdrawal and usage history.

Day 2 Range 1-3mg PO total daily dose based on signs and symptoms of withdrawal.

Day 3 Range 1-3mg PO total daily dose based on signs and symptoms of withdrawal.

Day 4 Range 0.5 - 2mg PO total daily dose based on signs and symptoms of withdrawal.

Day 5 Range 0.5-1mg PO total daily dose based on signs and symptoms of withdrawal.

Day 6 Range 0.5mg-1mg PO qAM.

## Ancillary Medications for Withdrawal Management

Date: September 2019

**Policy:** Cessation of alcohol, sedative/benzodiazepine and/or opioid use in a patient with physiological dependence may result in many withdrawal signs and/or symptoms resulting in clinically significant distress and functional impairment. Ample use of ancillary medications will be utilized for withdrawal management.

### Procedure:

1. **Nutritional deficiency** - Daily vitamin supplementation with thiamine 100mg, Folic Acid 1mg and a MVI preparation will be ordered for all patients to address any possible nutritional deficiencies from substance misuse. Special diets can be ordered to meet patients nutritional requirements.
2. **Insomnia** – Remeron 15mg po qHS or trazadone 50mg will be ordered prn for all patients unless contraindicated. Patients on a withdrawal protocol will have scheduled melatonin 5mg qHS. Patient on an opioid withdrawal protocol utilizing buprenorphine or methadone will have valium 10mg qHS scheduled prn as well as the melatonin.
3. **Anxiety** – clonidine 0.1-0.2mg PO prn, with a maximum daily dose of 1.2 mg (with cut off parameters for heart rate and blood pressure), will be ordered for patients on an opioid detoxification or induction and stabilization MAT protocol utilizing buprenorphine or methadone. Neurontin 100mg every 8 hours prn may be ordered in addition for all patients. Hydroxyzine can be used up to a total daily dose of 150mg. This medication can be titrated upward to a max dose of 1200mg tid if no sedation is noted. The judicious use of benzodiazepines for opioid withdrawal with appropriate and careful monitoring for sedation when used in combination with opioid medications. Plans to discontinue the benzodiazepines are started prior to discharge.
4. **Nausea and Vomiting** – Zofran 0.4mg q8h ODT prn, dose may be increased based on patient need and considering risk of prolonged QTc and torsade's.
5. **Muscle pain or spasm** – Patients on a detoxification or medication induction and stabilization protocol with buprenorphine/methadone will have Flexeril 5-10 mg tid prn or baclofen 10mg q8h prn will be ordered.
6. **Chronic pain** - is best treated with around the clock medications. Depending on the etiology of the pain multiple medications may be utilized in addition to Tylenol and NSAIDS. Tylenol 650mg q6h will be ordered prn as a first line medication after assessment by nurse. Ibuprofen 200-400mg q6h prn will be offered as a second line medication or by patient preference. Nursing staff may alternate using the 2 medications to improve pain management. Other effective pain management ancillary medications include the judicious use of Neurontin (titrated to a maximum dose 1200mg

every 8 hours), baclofen 10mg every 8 hours, naproxen 500mg bid and Flexeril 10mg up to tid, and Elavil 50mg at night for neuropathic pain.

7. **Nasal congestion** - actified/sudafed1 tablet prn tid will be ordered.
8. **Dry eyes** – artificial tears bid prn will be ordered.
9. **Fever** – Tylenol 650mg q6h will be ordered prn as a first line medication after assessment by nurse. Ibuprofen 200-400mg q6h prn will be offered as a second line medication or by patient preference.
10. **Indigestion/GERD/Heartburn** – Mylanta, a magnesium containing medication, will be ordered 30ml po q6h prn. Pepto Bismal will also be available, unless the patient has renal failure, magnesium containing preparations will be initially utilized. Proton pump inhibitors and other medications can be prescribed.
11. **Constipation** – Milk of Magnesia (MOM), another magnesium containing medication will be ordered as first line medication, Senna 2 tablets bid prn and Citroma 300mg po q48 will also be ordered if MOM not effective. All patient started on MAT induction and stabilization protocol with buprenorphine will have Colace 100 - 300mg qHS scheduled.
12. **Diarrhea** – Pepto Bismal 30ml po q6h prn will be ordered. Loperamide 2mg po q2h if Pepto Bismal not effective (or patient preference) will also be available.
13. **Sore Throat** – Cepastat Lozenge 1 tablet q6h prn

Appendix A (next page):

## DSM-5 Criteria for Diagnosis of Opioid Use Disorder

### Diagnostic Criteria\*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

**Total Number Boxes Checked:** \_\_\_\_\_

**Severity: Mild:** 2-3 symptoms. **Moderate:** 4-5 symptoms. **Severe:** 6 or more symptoms

\*Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, . Washington, DC, American Psychiatric Association page 541.

## Appendix B

**Name:**

**DOB:**

### Informed Consent for Treatment with Buprenorphine/Naloxone

I understand that buprenorphine (also known as Suboxone) is a medication to treat opioid use disorder (addiction to heroin or prescription opioids such as oxycodone, hydrocodone, etc).

Suboxone contains the opioid pain medication, buprenorphine, and the opioid antagonist drug, naloxone. The naloxone is present to prevent abuse of this medication.

Yes No 1. I agree to keep appointments and let staff know if I will be unable to show up.

Yes No 2. I agree to report my history and my symptoms to my physician, nurses, and counselors. I will inform staff of all other physicians/dentists I am seeing; of prescription/non-prescription drugs I am taking; of any alcohol or street drugs I have recently been used; or if I have developed hepatitis.

Yes No 3. I agree to cooperate with toxicology screening whenever requested by clinic staff.

Yes No 4. Buprenorphine is an opioid pain medication, and thus it can produce sedation and/or euphoria particularly when starting treatment or if my dose is increased; I know that taking buprenorphine can lead to physical dependence and if I were to abruptly stop taking buprenorphine after a period of regular use, I could experience symptoms of opioid withdrawal. Buprenorphine combined with a benzodiazepine, sedative or tranquilizing medication has been associated with adverse events and even death. I understand that alcohol used could possibly interact with buprenorphine to produce medical adverse events such as reduced breathing or impaired thinking. My doctor may end my treatment with buprenorphine if I am unable to follow the terms of this treatment agreement and I cannot safely take the medication.

Yes No 5. I have been informed that buprenorphine is to be placed under the tongue for it to dissolve and be absorbed, and that it should never be injected. Injecting buprenorphine could lead to sudden and severe opioid withdrawal, as can taking sublingual buprenorphine.

Yes No 6. I have been informed that buprenorphine is a powerful drug and that supplies of it must be protected from theft or unauthorized use, since persons who want to use it or who want to sell it for profit, may be motivated to steal my take-home prescription buprenorphine.

Yes No 7. I have a means to store take-home prescription supplies of buprenorphine safely, where it cannot be taken accidentally by children or pets or stolen by unauthorized users. If my buprenorphine medication is swallowed by anyone besides me, I will call 911 or Poison Control at 1-800-222-1222 immediately and I will take the person to the doctor or a hospital.

Yes No 8. I will be careful with my take-home prescription supplies of buprenorphine. If I report that my supplies have been lost or stolen, my doctors will not be expected to provide me with make-up supplies. If I run out of my medication supplies it could result in my experiencing symptoms of opioid withdrawal. If there has been a theft of my medications, I will report this to the police and will bring a copy of the police report to my next visit.

Yes No 9. I agree to bring my buprenorphine in with me for every outpatient clinic appointment with my doctor so that remaining supplies can be counted. On the day of my clinic visit I will plan to take my medication in front of the clinic staff to assess effect.

Yes No 10. I agree to take my buprenorphine as prescribed, to not skip doses, and not adjust the dose without talking with my doctor.

Yes No 11. I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking buprenorphine or after a dosage increase, or after initiating other sedating medication to make sure that I can tolerate it without side effects (sleepy or clumsy).

Yes No 12. I understand that I may not be able to drive a car or operate any form of heavy machinery during the induction phase with buprenorphine because of possible psychomotor impairment that I may have during this induction phase. I will assume all responsibility for determining the method of my transportation to and from the treatment facility during my first days of taking buprenorphine.

Yes No 13. I have been informed that buprenorphine, as found in Suboxone, is a treatment for opioid use disorder (addiction) only, it will not treat addiction to other drugs/alcohol.

Yes No 19. I will be asked for consent, allow telephone, email, or other contact, as appropriate, between my treatment team, and outside parties when the staff has decided that communication is necessary to coordinate care to safely receive medication.

Yes No 20. I will inform staff about cravings, the potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred

Yes No 21. I have been given a copy of clinic procedures, hours of operation, clinic phone number, and responsibilities as a recipient of buprenorphine and other treatment services.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix D:

### **INFORMED CONSENT TO OPIOID (METHADONE) MAINTENANCE TREATMENT**

I understand that I have been diagnosed as suffering from opioid dependence (*i.e.* that I am or have been addicted to an opiate drug, such as heroin or oxycodone) and that it has further been determined that an appropriate treatment is opioid maintenance therapy, which involves the daily use of medication (methadone), along with medical and rehabilitative (counseling) services, to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. The overall goal of opioid maintenance therapy is improved quality of life and freedom from illicit drugs.

I understand that methadone does not cure addiction, and is itself an opioid drug, which is addictive and can have serious, even fatal, side effects. The most commonly reported side effects are constipation and sweating/flushing. It may also cause dizziness, especially after sitting or lying down; drowsiness; mood changes; vision problems; difficulty falling or staying asleep; and sexual side effects. Serious and sometimes fatal side effects include seizures; severe allergic reaction; slowed or difficult breathing; and irregular heartbeat, especially in patients with certain existing heart conditions (known as prolonged QT interval).

I understand that mixing methadone with other depressants (such as alcohol or benzodiazepines) is especially dangerous and will refrain from doing so. I agree to take methadone only as prescribed, and to inform other healthcare providers that I take methadone to avoid potentially harmful interactions. Until I know how methadone will affect me, I will use caution when driving or operating machinery. I have made the Medical Director aware of all medical conditions I have and medications (prescription, over-the-counter, or illicit) I take, and will keep this information current throughout treatment.

I understand that methadone maintenance therapy generally takes place over an extended period of time, but that I am free to discontinue treatment at any time. I understand that if I stop taking methadone suddenly that it may produce severe withdrawal symptoms. I understand that at periodic intervals, and with my full consultation, the Program will discuss my present level of functioning, my course of treatment, and my future goals.

I understand that all medical decisions, including, but not limited to, diagnosis and treatment, are made by the Medical Director, or his designee.

While information contained in drug and alcohol abuse patient records is generally confidential under Federal law, reports of suspected child abuse or neglect are NOT protected and MUST be reported to the appropriate authorities.

I understand that other treatments are available, including, but not limited to, inpatient treatment, detoxification programs, buprenorphine treatment, and abstinence programs.

**FOR WOMEN WHO ARE OR MAY BECOME PREGNANT:** While methadone is approved by the FDA for medication-assisted treatment for opioid addiction in pregnant patients, there are no conclusive data regarding the safety of methadone in human pregnancy and it may be harmful to unborn babies. Tell your doctor and the Program's Medical Director if you are pregnant or plan to become pregnant. After delivery, babies may experience withdrawal symptoms. A small amount of methadone is transmitted through breast-milk; therefore, discuss breastfeeding with your doctor.

**Understanding the risks and benefits associated with methadone maintenance therapy, as well as alternatives to it, I hereby give my informed and voluntary consent to receive methadone maintenance therapy.**

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witness' Printed Name

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date