Identifying and managing Opioid Use Disorder

Workers’ Compensation and Auto/No-Fault Continuing Education

May 25, 2017
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Objectives

• Discuss the recent rise in opioid use in the United States

• Describe opioid use disorder (OUD)

• Review the common indications, considerations, and strategies for opioid tapering and discontinuation

• Discuss opioid withdrawal and list common, non-opioid therapy options to treat withdrawal symptoms

• Review the Medication-Assisted Treatment (MAT) options used for the management of opioid withdrawal and opioid use disorder, considerations in their implementation, and additional supportive measures that are available
Opioid related deaths in the U.S.

Source: National Center for Health Statistics, CDC Wonder, Jan. 2017
U.S. drug overdose deaths involving opioid analgesics 2000-2015

- Any Opioid
- Commonly Prescribed Opioids (Natural & Semi-Synthetic Opioids and Methadone)
- Heroin
- Other Synthetic Opioids (e.g., fentanyl, tramadol)

Meet Anne
A case study

• Anne is a 45-year-old woman
• Injured lower back while moving heavy equipment at work
• Diagnosed with lumbar radiculopathy due to herniated disc
• Primary care provider (PCP) eventually prescribed OxyContin
• Anne’s pain was difficult to control, and she began taking more medication than prescribed
• In response, the PCP changed therapy by adding medications, which helped to lessen Anne’s pain but she starting experiencing side effects
What is Opioid Use Disorder (OUD)?
Opioid Use Disorder (OUD)

- Defined as a problematic pattern of opioid use leading to significant impairment or distress
- Diagnosis includes two criteria below in the past twelve months

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Impaired control       | • Opioids used in larger amounts or longer than intended  
                           • Unsuccessful efforts to cut back opioids or control use  
                           • Considerable time obtaining, using or recovering from opioids  
                           • Experience opioid cravings |
| Social impairment      | • Opioid use interferes with work, school, or obligations at home  
                           • Recurrent social or interpersonal problems aggravated by opioid use  
                           • Reduced or abandoned recreational, social, occupational activities |
| Unsafe behavior        | • Opioid use in physically hazardous situations  
                           • Continued opioid use despite knowledge of physical or psychological problem |
| Pharmacological properties | • Tolerance; increased amounts of opioids needed to achieve the desired effect  
                              • Withdrawal; demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal |

Source: Opioid Use Disorder: Update on Diagnosis and Treatment, Psychiatric Times, Apr. 2015
Centers for Disease Control and Prevention (CDC) reported that up to one in four patients suffering with chronic pain and currently are on opioid therapy may develop OUD. The risk of OUD increases with a higher Morphine Equivalence Dose (MED).

What does this mean?

- Increased hospitalizations
- Increased rates of admission to a recovery program
- Loss of workplace productivity
- Drug overdose is a leading cause of death in the US
Consequences of OUD

• Opioid overdose
  – Respiratory depression
  – Death

• Unhealthy lifestyle

• Increased risk for other substance abuse disorders

• Injection drug use (Blood-borne illness, including HIV and Hepatitis)

• Potential legal or criminal activity
Treatment of OUD

• Diagnosis of OUD should be referred to an appropriate pain or addiction specialist

• Provide non-pharmacological treatment strategies to reduce harm
  – Cognitive Behavioral Therapy
  – Exercise Therapy
  – Psychosocial needs assessment, supportive counseling, links to family supports
  – Referrals to community services (e.g. AA or NA)

• Medically supervised withdrawal or detoxification; treatment using Medication-Assisted Treatment (MAT)
Check in with Anne

• Claims professional observed ‘red flags’
• A peer-to-peer intervention was performed and tapering was suggested
Opioid tapering
Opioid tapering (weaning)

• **Gradual** reduction of opioids to the lowest effective dose

• Goals of opioid tapering:
  – When treatment with opioids have not effectively managed pain or improved function
  – Minimize adverse effects of opioid withdrawal
  – Manage risks associated with polypharmacy

• Tapering is generally recommended over abrupt discontinuation, especially with prolonged opioid utilization

• Opioid tapering may lead to complete discontinuation of opioids
Possible indications for tapering and discontinuing opioid therapy

- Serious adverse events
- Use of naloxone
- Lack of improvement in pain relief
- Unmanageable, severe side effects
- Request to discontinue therapy
- Non-adherence to treatment plan
- Use of medications or substances that a claimant has been advised to avoid

- Decreased level of pain or resolution of pain
- Illegal or unsafe behavior
- Unmet treatment goals
- Behavior that may suggest OUD
- Polypharmacy
- Unsafe MED level
Opioid tapering strategies

• No single universal opioid tapering exists
  - Guidelines vary on the percent dose reduction timeframe
  - The presence of multiple medications complicates the opioid cessation strategy and may require a step approach to tapering

• Comprehensive assessment of the claimant should be completed by a medical professional

• Prescriber and claimant must agree to a tapering/weaning plan (include a proposed rate at which medication doses will be decreased)

• Opioid rotation

• Adequate non-opioid pain management

• Claimants with opioid use disorder should be referred to an addiction or pain specialist
  - Managing opioid withdrawal side effects
  - If appropriate, detoxification through the use of Medication-Assisted Therapy (MAT)
Opioid withdrawal
Opioid withdrawal

• Opioid withdrawal may produce symptoms associated with discontinuing or abruptly stopping opioids

• Claimants with a chronic history of opioid use or receiving high opioid doses may be more likely to experience withdrawal symptoms

• Symptoms of opioid withdrawal can range from mild to severe

• Opioid withdrawal may be uncomfortable, but in most cases is not life threatening
Opioid withdrawal symptoms

- Body aches
- Diarrhea
- Increased heart rate
- Increased blood pressure
- Runny nose
- Sneezing
- Goose bumps
- Sweating
- Yawning

- Fever
- Nausea
- Vomiting
- Nervousness
- Restlessness
- Irritability
- Weakness
- Shivering or trembling
- Abdominal cramps
## Non-opioid treatment options for opioid withdrawal

<table>
<thead>
<tr>
<th>Medication class</th>
<th>Medication</th>
<th>Common target withdrawal symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihypertensives</td>
<td>Clonidine*</td>
<td>Nausea, vomiting, muscle cramps, diarrhea, sweating</td>
</tr>
<tr>
<td></td>
<td>Diphenhydramine</td>
<td>Insomnia, restlessness</td>
</tr>
<tr>
<td></td>
<td>Hydroxyzine</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Trazodone</td>
<td>Insomnia</td>
</tr>
<tr>
<td></td>
<td>Nortriptyline</td>
<td></td>
</tr>
<tr>
<td>Antiemetics</td>
<td>Promethazine</td>
<td>Nausea, vomiting</td>
</tr>
<tr>
<td></td>
<td>Metoclopramide</td>
<td></td>
</tr>
<tr>
<td>Antidiarrheal</td>
<td>Loperamide</td>
<td>Diarrhea</td>
</tr>
<tr>
<td></td>
<td>Pepto Bismol</td>
<td></td>
</tr>
<tr>
<td>Skeletal Muscle Relaxants</td>
<td>Methocarbamol</td>
<td>Muscle cramps</td>
</tr>
<tr>
<td></td>
<td>Tizanidine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cyclobenzaprine</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Gabapentin</td>
<td>Neuropathic (nerve) pain</td>
</tr>
<tr>
<td></td>
<td>Lyrica</td>
<td></td>
</tr>
</tbody>
</table>

*Clonidine is non-FDA approved for withdrawal symptoms*
Check in with Anne

• Anne began to experience significant withdrawal symptoms, and tapering had to be adjusted several times

• Taper unmasked signs and symptoms consistent with Opioid Use Disorder

• A pain specialist was brought into the case to determine an appropriate detoxification plan

• Based on Anne’s history and current situation, the specialist believed that Anne was a candidate for Medication-Assisted Treatment
Medication-Assisted Treatment (MAT)
FDA-approved medications for MAT

<table>
<thead>
<tr>
<th>Medication</th>
<th>Mechanism of action at opioid receptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>Agonist</td>
</tr>
<tr>
<td>Buprenorphine (and Buprenorphine/Naloxone)</td>
<td>Partial agonist</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Antagonist</td>
</tr>
</tbody>
</table>
Methadone mechanism

Long-acting opioid; binds tightly to the opioid receptor
Methadone mechanism

The long duration of action allows methadone to occupy opioid receptors and displace the other opioid (or heroin)
# Methadone

<table>
<thead>
<tr>
<th>Use</th>
<th>Drug interactions (select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opioid Use Disorder (detox)</td>
<td>• Antiarrythmic (heart rhythm)</td>
</tr>
<tr>
<td>• Chronic pain</td>
<td>• Antiretrovirals</td>
</tr>
<tr>
<td></td>
<td>• Antibiotics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formulations</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral tablet, suspension liquid, injection</td>
<td>ONLY through regulated Opioid Treatment Sites when used as part of a Opioid Use Disorder (detox) program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adverse effects (select)</th>
<th>Additional considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respiratory depression (breathing)</td>
<td>DEA Schedule II class drug</td>
</tr>
<tr>
<td>• Irregular heartbeat (cardiac risks)</td>
<td></td>
</tr>
<tr>
<td>• Sedation</td>
<td></td>
</tr>
<tr>
<td>• Constipation</td>
<td></td>
</tr>
<tr>
<td>• Death</td>
<td></td>
</tr>
</tbody>
</table>
Buprenorphine (and Buprenorphine/Naloxone)

Long-acting, mixed opioid agonist-antagonist binds to opioid receptor
Buprenorphine (and Buprenorphine/Naloxone)

Pharmacological and clinical effects plateau due to the “ceiling effect” of the agonist-antagonist properties
# Buprenorphine (and Buprenorphine/Naloxone)

<table>
<thead>
<tr>
<th>Use</th>
<th>Drug interactions (select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opioid Use Disorder (detox)</td>
<td>• Antifungals</td>
</tr>
<tr>
<td>• Chronic pain* (select formulations)</td>
<td>• Antiretrovirals</td>
</tr>
<tr>
<td></td>
<td>• Antiarrhythmics (heart rhythm)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formulations</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sublingual tablet, sublingual film,</td>
<td>DATA 2000 waiver required for</td>
</tr>
<tr>
<td>intradermal implant, buccal film</td>
<td>office-based treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adverse effects (select)</th>
<th>Additional considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nausea</td>
<td>DEA Schedule III class drug</td>
</tr>
<tr>
<td>• Vomiting</td>
<td></td>
</tr>
<tr>
<td>• Constipation</td>
<td></td>
</tr>
<tr>
<td>• Dizziness</td>
<td></td>
</tr>
<tr>
<td>• Headache</td>
<td></td>
</tr>
</tbody>
</table>

*Select formulations may be prescribed for chronic pain

• Permits physicians who meet qualifications under the Act to treat claimants with opioid addiction using Schedule III, IV and V narcotic medications
• Medications may be dispensed by “waived” physicians in office-based setting
• Nurse Practitioners (NP) and Physician Assistants (PA) may now apply for waiver to treat patients
• https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
Naltrexone

Antagonist that binds to receptors and blocks the effects of opioids (or heroin)
Naltrexone

Antagonist that binds to receptors and blocks the effects of opioids (or heroin)
## Naltrexone

<table>
<thead>
<tr>
<th>Use</th>
<th>Drug interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opioid Use Disorder (after detox to prevent relapse)</td>
<td>Opioid analgesic medications</td>
</tr>
<tr>
<td>• Ethanol dependence</td>
<td></td>
</tr>
<tr>
<td><strong>Formulations</strong></td>
<td><strong>Availability</strong></td>
</tr>
<tr>
<td>Oral tablet, injection</td>
<td>No restrictions</td>
</tr>
<tr>
<td><strong>Serious adverse effects (select)</strong></td>
<td><strong>Additional considerations</strong></td>
</tr>
<tr>
<td>Hepatotoxicity (liver damage)</td>
<td>• Non-scheduled medication</td>
</tr>
<tr>
<td></td>
<td>• Reserved for claimants NOT actively using opioid analgesics</td>
</tr>
</tbody>
</table>
Next steps
Questions to consider

• Assess the four As (Analgesia, Activities of daily living, Adverse events, Aberrant behavior)

• Are there any opioid ‘red flags’ or unusual patterns of behavior?
  – Signs of misuse, such as early refill requests for opioids
  – Are the opioid analgesics prescribed by different physicians?
  – Have there been any alerts or communications from your Pharmacy Benefit Manager (PBM)

• Has the claimant’s opioid medication regimen been changing often?

• Is tapering of opioids indicated?
  – Functional improvement, additional opioids, resolved pain, consistent increase in opioid MED?
  – Additional medications are prescribed to treat the side effects of initial medications

• Does the claimant have a history of abuse? Substance abuse? Illicit abuse?

• Are there any reservations noted by the prescriber about continuing or discontinuing therapy?

• Is the prescriber utilizing the Prescription Drug Monitoring Program (PDMP)?

• Has there been an inconsistent urine drug test?
What can you do?

- ASSESS and MONITOR your claimants who are prescribed opioid analgesics
- LOOK for risk factors of opioid use disorder
- ENGAGE the prescriber and/or your clinical resources for tapering and withdrawal
- COMMUNICATE with and EDUCATE your claimant to help ensure their safety
Thank you!

Questions?

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