Drugs for Opioid Use Disorder

Opioid use disorder is a chronic, relapsing disease with both physical and psychiatric components. It is associated with economic hardship, social isolation, incarceration, increased rates of blood-borne infections such as HIV and viral hepatitis, adverse pregnancy outcomes, and increased mortality. According to the CDC, there were 33,091 deaths related to opioid overdose in the US in 2015, more than in any previous year.1 Several guidelines on the management of opioid use disorder have recently been published.2-5

MAINTENANCE TREATMENT

METHADONE — Methadone was the first successful treatment for opioid addiction; it is a synthetic mu-opioid receptor agonist with a slow onset of action and a long, variable elimination half-life. At high doses, methadone induces cross-tolerance with other opioid agonists. Patients tolerant to other opioid agonists, however, may have only an incomplete cross-tolerance to methadone.6

Availability — Methadone is classified as a schedule II controlled substance (highest potential for abuse; recognized medical use). In the US, methadone maintenance treatment is only available through government-licensed opioid treatment programs which offer supervised administration of the drug. The drug is available in oral tablets, tablets for oral suspension, an oral solution, and an oral concentrate. To reduce the risk of drug diversion, treatment programs usually do not dispense the tablet formulation.7

Efficacy — Methadone maintenance therapy can improve treatment retention, productivity, and social engagement, and decrease crime rates, heroin use, injection risk behaviors, mortality rates, and the spread of blood-borne infections such as hepatitis C and HIV.8-11 Use of higher doses of methadone (≥100 mg/day) in patients with opioid use disorder and HIV infection has been associated with increased adherence to antiretroviral therapy, lower viral loads, and higher CD4 cell counts.12

Safety — The risk of methadone-associated mortality is highest in the first weeks after starting or stopping treatment.13 The drug accumulates during induction; it takes 4-7 days to achieve a stable dose. In overdosage, or if the dose is increased too rapidly during initiation of therapy, methadone can cause sedation and respiratory depression. The respiratory depressant effect of methadone peaks later and lasts longer than that of buprenorphine and other opioid agonists, and it persists longer than the analgesic effect of the drug.

Methadone can prolong the QT interval and cause arrhythmias such as torsades de pointes, particularly in patients taking other QT interval-prolonging drugs14 and in those with congenital long QT syndrome or a history of QT-interval prolongation.15

Drug Interactions — Methadone is a substrate of CYP3A4 and CYP2B6; inhibitors of these isozymes can increase serum concentrations of methadone, and inducers can reduce them.16 Concurrent use of methadone and other QT interval-prolonging drugs should be avoided if possible.14 As with any opioid, concomitant use of methadone with selective
serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, or other serotonergic drugs could result in serotonin syndrome. Concurrent use of methadone and benzodiazepines or other sedating drugs can result in additive CNS effects.

Dosage and Administration – Because methadone has a long half-life, initial titration of the drug should be performed slowly. Federal law prohibits administration of an initial methadone dose >30 mg or a total first daily dose >40 mg. For most patients, a maintenance dose of 60-120 mg/day can suppress cravings and block the euphoric effects of other opioid agonists.

**BUPRENORPHINE** – Buprenorphine is a mu-opioid receptor partial agonist and kappa-opioid receptor antagonist. It is available alone and in combination with the opioid antagonist naloxone. Taken orally, naloxone is poorly absorbed and generally has no clinical effects; combining it with buprenorphine in sublingual or buccal formulations is intended to counteract intravenous or intranasal abuse.

Availability – Buprenorphine is classified as a schedule III controlled substance (less potential for abuse than schedule II; recognized medical use). In the US, prescribers who complete a training course and obtain a special DEA number can treat a limited number of patients for opioid use disorder with buprenorphine in an outpatient setting; current laws relating to outpatient prescription of buprenorphine are available at the website for the Substance Abuse and Mental Health Services Administration.

**Efficacy** – Buprenorphine significantly improves treatment retention and reduces illicit opioid use compared to placebo. It appears to be at least as effective as methadone in reducing mortality. Office-based buprenorphine/naloxone maintenance therapy has been shown to improve abstinence rates, occupational stability, and psychosocial outcomes.

**Safety** – Even without naloxone, buprenorphine is safer than methadone because it has a ceiling on its respiratory depressant effect. As a partial agonist, it also has a lower abuse potential than methadone; the presence of naloxone may further reduce the abuse potential of buprenorphine products.
QT-interval prolongation, ventricular arrhythmia, or cardiac arrest.26

In a retrospective study in the United Kingdom of about 20 million prescriptions for methadone or buprenorphine over a 6-year period, prescriptions for methadone were 6.23 times more likely to be associated with a subsequent overdose death than prescriptions for buprenorphine with or without naloxone.27

Hepatic impairment reduces naloxone clearance to a greater extent than it does buprenorphine clearance. Use of fixed-dose buprenorphine/naloxone combinations in patients with severe hepatic impairment can lead to withdrawal symptoms when treatment is started and may decrease the efficacy of buprenorphine maintenance treatment.

Buprenorphine subdermal implants, like other drug-eluting implants, can cause adverse effects such as pain, pruritus, and erythema at the insertion site, and insertion and removal of implants have been associated with nerve injury and implant migration and extrusion. Healthcare providers must complete a live training session and become certified through a Risk Evaluation and Mitigation Strategy (REMS) program before they can prescribe, insert, or remove buprenorphine implants.22

**Drug Interactions** – Buprenorphine is metabolized primarily by CYP3A4; concomitant use with a CYP3A4 inducer can decrease serum concentrations of buprenorphine and use with a 3A4 inhibitor can increase them.16 As with methadone or any other opioid, use of buprenorphine with selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, or other serotonergic drugs may result in serotonin syndrome, and use of benzodiazepines or other sedating drugs with buprenorphine can have additive effects.

Buprenorphine may interfere with the analgesic efficacy of full opioid agonists. It should generally be discontinued 24-36 hours before elective surgery (except Cesarean section; stopping buprenorphine could cause fetal withdrawal).

**Dosage and Administration** – Buprenorphine has a greater affinity for opioid receptors than full opioid agonists such as heroin and can displace them, causing opioid withdrawal. The risk of withdrawal can be reduced by not starting treatment until the patient is already experiencing mild-to-moderate opioid withdrawal (Clinical Opiate Withdrawal Scale score ~11-12)28 and by using a low initial dose of buprenorphine (2-4 mg of Suboxone, or equivalent). The daily dose should then be uptitrated, usually to at least 8 mg; most patients can readily achieve their target dose within 2-3 days. Higher doses (12-16 mg/day) should be considered if opioid misuse or abuse persists. Data supporting increased efficacy with doses >16 mg/day up to the maximum recommended dose of 24 mg/day are limited.

**NALTREXONE** – The mu-opioid receptor antagonist naltrexone is available as a once-daily oral tablet (Revia, and generics) and as a once-monthly extended-release (ER) microsphere suspension given by intramuscular (IM) injection (Vivitrol). It is not addictive or readily abused, and tolerance to its effects does not develop with long-term use. Both oral and extended-release IM naltrexone are also approved for treatment of alcohol use disorder.29

**Availability** – Naltrexone is not a controlled substance, and there are no special restrictions on its prescription.

**Efficacy** – Adherence and outcomes have been better with extended-release IM naltrexone than with the oral formulation, though neither formulation

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**Table 2. Recommendations for Switching Treatments for Opioid Use Disorder**

<table>
<thead>
<tr>
<th>Method</th>
<th>Instructions</th>
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| Methadone to Buprenorphine |  - Use buprenorphine without naloxone when initially switching therapies  
- Tapering to 30-40 mg/day of methadone before transition can reduce patient discomfort  
- Administer first dose (2-4 mg of Suboxone, or equivalent) ≥ 24 hours after last dose of methadone  
- Observe patient for 1 hour after first dose  
- If withdrawal symptoms improve, dispense 2 additional doses (2-4 mg) to be taken as needed later in the day |
| Methadone or Buprenorphine to Naltrexone |  - Patient must be completely withdrawn from methadone or buprenorphine before starting naltrexone (may take up to 14 days)  
- Consider naloxone challenge (0.4-0.8 mg) to confirm absence of physiological dependence, except in pregnant women |
| Buprenorphine to Methadone |  - No special time delay or precautions required  
- Naltrexone to Buprenorphine or Methadone  
- Use of naltrexone can reduce tolerance to opioids  
- Administer first dose of methadone or buprenorphine about 1 day after last dose of oral naltrexone or 30 days after last dose of IM naltrexone |

has been conclusively shown to have a mortality benefit. In a randomized, double-blind, placebo-controlled, 24-week trial in 250 patients with opioid dependence, addition of injectable naltrexone to biweekly counseling was found to significantly increase the likelihood of abstinence from opioid use, improve retention in the treatment program, and reduce cravings and relapse to physiological opioid dependence, compared to addition of placebo. In an open-label, randomized, 24-week trial in 308 patients with a history of opioid dependence who were abstinent from opioids at the time of randomization, those who received extended-release IM naltrexone had a significantly longer median time to relapse (10.5 vs 5.0 weeks) and significantly lower rates of relapse (43% vs 64%) than those who received usual care, which consisted of brief counseling and referral to community treatment programs.

Safety — Naltrexone is generally well tolerated. Adverse effects reported in opioid-dependent patients given IM naltrexone have included injection-site reactions, nasopharyngitis, insomnia, headache, nausea, and toothache. Depressed mood and suicidality have occurred rarely; a cause-and-effect relationship has not been established. Hepatic enzyme elevations and toxicity have been reported with use of naltrexone, but these findings occur frequently in opioid- and alcohol-dependent patients. Use of naltrexone can reduce tolerance to opioids; patients who relapse after receiving naltrexone may be at greater risk of a serious, potentially fatal opioid overdose.

Drug Interactions — Naltrexone blocks the effects of usual doses of opioids, including opioid-derivative antidiarrheals and antitussives. It should not be used in patients taking an opioid for treatment of pain. Oral naltrexone should be discontinued 72 hours before and IM naltrexone 30 days before elective surgery.

Dosage and Administration — Administration of naltrexone to a patient with physiological opioid dependence can precipitate a severe opioid withdrawal syndrome; patients should be free of dependence for at least 7 days before naltrexone is initiated. A naloxone challenge can be used to confirm the absence of physiological opioid dependence, but it is contraindicated in pregnant women because it can induce preterm labor or fetal distress.

Vivitrol is supplied in single-use cartons containing a vial of microspheres, a diluent for suspension, needles, and a syringe. It should be given as a 380-mg IM gluteal injection in alternating buttocks every 4 weeks or once monthly. The dose pack should be stored in the refrigerator; if left unrefrigerated, it may be used for up to 7 days as long as it is not exposed to temperatures >77°F (25°C).

Patients starting treatment with oral naltrexone should receive an initial dose of 25 mg. If withdrawal symptoms do not occur, they can then be given a maintenance dosage of 50 mg once daily.

ALTERNATIVES — Limited data suggest that 24-hour extended-release oral morphine may be effective for maintenance treatment of opioid use disorder. Morphine may be better tolerated and more effective than methadone in some patients; it has less of an effect on the QT interval, but it may have a greater risk of opioid-related adverse effects. In a 22-week, randomized, open-label, crossover study in 157 patients being treated in methadone maintenance clinics, 24-hour oral morphine was noninferior to methadone in preventing positive urine tests for heroin. Adverse effects were similar in the two groups.

Addition of supervised heroin injections to flexible-dose methadone therapy has been shown to improve treatment retention and may also reduce criminal activity, incarceration rates, and social functioning, but it also increases the risk of adverse events.

In a 12-week, randomized, double-blind trial in 196 opioid-dependent patients, addition of the antitus- sive dextromethorphan 60 mg/day to methadone maintenance therapy significantly improved treatment retention and decreased plasma morphine levels compared to placebo, but addition of dextromethorphan 120 mg/day did not.

In a 24-week randomized trial in 141 opioid-dependent patients, addition of cognitive behavioral therapy to primary care-based maintenance treatment with buprenorphine did not improve self-reported opioid use or opioid abstinence.

PREGNANCY — Opioid use during pregnancy is associated with an increased risk of complications
such as preeclampsia, miscarriage, reduced fetal growth, fetal death, and premature delivery. Pregnant women who are physically dependent on opioids or are likely to resume opioid misuse should receive opioid agonist maintenance therapy; it is safer than detoxification alone.

Methadone has a long history of use in pregnancy and is generally considered the standard of care for maintenance treatment of pregnant women with opioid use disorder. More recently, buprenorphine (without naloxone) has been used as an effective and safe alternative. In a randomized, double-blind, double-dummy trial in 175 opioid-dependent pregnant women, neonates whose mothers were treated with buprenorphine during pregnancy required less morphine and had shorter durations of treatment for neonatal abstinence syndrome and hospital stays than those whose mothers received methadone, but treatment retention was significantly greater among women taking methadone.

Combination buprenorphine/naloxone products are considered safe for use during pregnancy, but data on their efficacy in pregnant women are limited. Buprenorphine without naloxone is preferred.

Data on the safety and efficacy of naltrexone use in pregnancy are limited. In general, women taking naltrexone who become pregnant and are at high risk for relapse can continue treatment.

LACTATION — Use of methadone or buprenorphine monotherapy by breastfeeding women is generally considered safe. Women taking naltrexone should not breastfeed because the drug and its major metabolite can pass into breast milk to a clinically significant extent.

**TREATMENT OF OPIOID OVERDOSE**

**NALOXONE** — Naloxone is the drug of choice for emergency treatment of opioid overdose. It is available in various dosage forms for intravenous (IV), intramuscular (IM), subcutaneous (SC), or intranasal administration (see Table 3).

**Availability** — A number of jurisdictions now have naloxone access laws that make the drug available to first responders and to relatives and close friends of persons using heroin or taking prescription opioids. These laws may also grant civil and criminal immunity to laypeople who carry or administer naloxone, to healthcare professionals who prescribe or dispense the drug to laypeople, and to persons who call emergency medical services in good faith to reverse an overdose.

A regularly updated database of state naloxone access laws is available (http://lawatlas.org/datasets/laws-regulating-administration-of-naloxone).

**Pharmacology** — Naloxone is a competitive mu-opioid receptor antagonist and has no opioid agonist effects. In opioid overdose, naloxone begins to reverse sedation, respiratory depression, and hypotension within 1–2 minutes after IV administration, 2–5 minutes after IM or SC administration, and 8–13 minutes after intranasal administration.

The half-life of naloxone is much shorter than that of most opioids and repeated administration may be necessary, especially for overdose with a long-acting opioid agonist such as methadone or a sustained-release formulation of a short-acting agonist such as oxycodone. Pure heroin has a shorter half-life than naloxone (2–6 minutes), but heroin is a prodrug that is rapidly metabolized to 6-acetylmorphine and morphine. The risk of respiratory depression is related to those active metabolites, and it may persist well

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### Table 3. Some Naloxone Formulations

<table>
<thead>
<tr>
<th>Drug Formulations</th>
<th>Usual Dosage</th>
<th>Cost1</th>
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<tbody>
<tr>
<td><strong>Parenteral</strong></td>
<td></td>
<td></td>
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<tr>
<td>generic</td>
<td>0.4 mg/mL vials and syringes; 1 mg/mL syringes</td>
<td>0.4-2 mg IV, IM, or SC</td>
</tr>
<tr>
<td><strong>Evzio (Kaleo)</strong></td>
<td>0.4, 2 mg/0.4 mL prefilled auto-injectors</td>
<td>0.4 or 2 mg IM or SC</td>
</tr>
<tr>
<td><strong>Intranasal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcan nasal spray (Adapt)</td>
<td>4 mg/0.1 mL nasal spray</td>
<td>4 mg intranasally</td>
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</table>

1. Approximate WAC for a single dose at the lowest usual dosage. WAC = wholesaler acquisition cost or manufacturer’s published price to wholesale; WAC represents a published catalogue or list price and may not represent an actual transactional price. Source: AnalySource® Monthly. May 5, 2017. Reprinted with permission by First Databank, Inc. All rights reserved. ©2017. www.fdbhealth.com/policies/drug-pricing-policy.
2. Dose can be repeated every 2–3 minutes up to a total of 10 mg.
3. Cost for a 1-mL vial.
4. Dose can be repeated every 2–3 minutes until the patient responds or emergency medical personnel arrive.
5. Manufacturer’s list price for insurers for one 0.4-mg auto-injector, but it is supplied in packages containing 2 auto-injectors. The list price for one 2-mg auto-injector is $2050. Insurers and pharmacy benefit managers may negotiate with the manufacturer for a lower price or decide not to pay for Evzio at all. According to the manufacturer, the out-of-pocket cost is $0 for all commercially insured patients, whether or not their insurer covers the device. The cash price for patients without government or commercial insurance is $360 for those with a household income <$100,000/year and $0 for those with a household income ≥$100,000/year.
6. A 2 mg/0.1 mL formulation of Narcan nasal spray has been approved by the FDA, but is not yet available.
7. Cost for one nasal spray device, but supplied in cartons containing two nasal spray devices.
8. Available from the manufacturer at a discounted price of $37.50 per 4-mg nasal spray device to law enforcement, firefighters, first responders, departments of health, local school districts, colleges and universities, and community-based organizations.
beyond the clearance of heroin from the blood. Other drugs used to “cut” heroin may have longer half-lives.46 If not already present, emergency medical services should always be called immediately after administration of naloxone.

Adverse Effects — Whether naloxone itself has any toxicity is unclear, but it can precipitate acute withdrawal symptoms in opioid-dependent patients. Acute opioid withdrawal is associated with anxiety, piloerection, yawning, sneezing, rhinorrhea, nausea, vomiting, diarrhea, and abdominal or muscle cramps, which are uncomfortable but generally not life-threatening, except in neonates. In a pharmacokinetic study of intranasal naloxone (Narcan), the most common adverse effects were increased blood pressure, constipation, toothache, muscle spasms, musculoskeletal pain, headache, rhinalgia, xeroderma, and intranasal effects including dryness, edema, congestion, and inflammation.

Pregnancy — No embryotoxic or teratogenic effects were observed in pregnant mice and rats treated with large doses of naloxone. Naloxone does cross the placenta, however, and may cause fetal opioid withdrawal or induce preterm labor.

Additional Content Available Online
Some Drugs for Maintenance Treatment of Opioid Use Disorder
http://medicalletter.org/TML-article-1522c

30. E Krupitsky et al. Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled,