Prescribing for OUD & AUD:

Treatment for Opioid and Alcohol Use Disorders

Content created by Prescribe Safe | montagehealth.org/prescribesafe

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Designation and accreditation

Community Hospital designates this online activity for a maximum of **CME 1.0 *AMA PRA Category 1 Credits*™**. Physicians should only claim credit commensurate with the extent of their participation in the online activity. This credit may also be applied to the CMA certification in continuing medical education. Provider number 4000941.

Cultural and linguistic competency

This online activity is in compliance with *California Assembly Bill 1195* that requires all CME activities comprising a patient care element to include curriculum addressing the topic of cultural and linguistic competency. The intent of this bill is to ensure that healthcare professionals are able to meet the cultural and linguistic concerns of a diverse patient population through effective and appropriate professional development. Cultural and linguistic competency was incorporated into the planning of this online activity.

Disclosure

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Welcome to the online activity

Thank you for joining the **Prescribing for OUD & AUD: Treatment for Opioid and Alcohol Use Disorders** online activity.

At the end of this module, you will have the opportunity to complete a quiz and evaluation questions. Successful completion will allow you to earn ***CME 1.0 AMA PRA Category 1 Credits™*** and receive a certificate of completion.

Let’s get started!

Dr. Reb Close and Dr. Casey Grover
Montage Health Prescribe Safe Medical Directors

Montage Health Prescribe Safe

Learning objectives

- Comprehend the diagnostic criteria for opioid use disorder and alcohol use disorder
- Identify how to use buprenorphine to treat opioid use disorder
- Identify how to use medications treat alcohol use disorder

Opioid dependence

- **Opioid dependence** refers to the fact that patients on chronic opioids will develop withdrawal when they stop
- **This can be from prescription medication** (even when medication is taken as prescribed) or illicit opioids
- **Approximately 2 weeks** of continuous opioid use will result in dependence

American Psychiatric Association, 2013

Opioid use disorder (OUD)

- OUD refers to **an *addiction* to opioids**
- OUD refers to **the psychological aspects of addiction** — craving the drug, using despite consequences, and compulsive behavior around getting/using the drug
- Most patients with OUD **also have opioid dependence** (patients will withdraw when chronic opioid use is stopped)
- In 2023, there were 105,007 drug overdose deaths in the U.S. and of these, 81,083 deaths involved opioids.

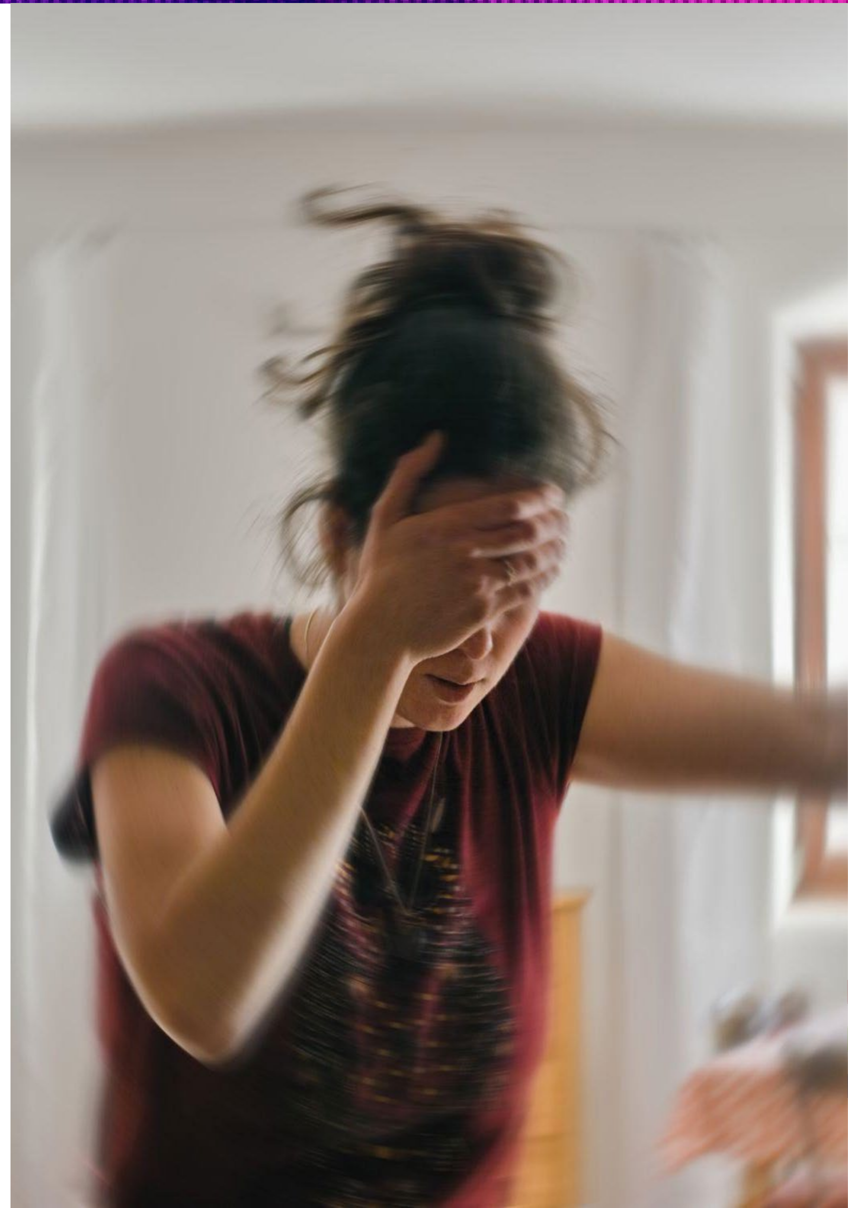
American Psychiatric Association, 2013
Centers for Disease Control and Prevention, 2023

Opioid dependence vs. OUD

Not all patients with opioid dependence have opioid use disorder

Example: A patient has a major surgery and takes hydrocodone 4 times per day for 15 days may develop dependence and withdrawal when the opioids are stopped. The patient does not demonstrate cravings or compulsive behavior and does not experience significant consequences from using the prescription.

American Psychiatric Association, 2013



Screening for OUD

There are 11 criteria for opioid use disorder

- 2-3 criteria = mild opioid use disorder
- 4-5 criteria = moderate opioid use disorder
- 6+ criteria = severe opioid use disorder

American Psychiatric Association, 2013
Krichbaum et al., 2023

Criteria for OUD

❶ Opioids are often taken in larger amounts or over a longer period than was intended.

❷ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

❸ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.

❹ Craving, or a strong desire or urge to use opioids.

❺ Recurrent opioid use results in failure to fulfill major role obligations at work, school, or home.

❻ Continued opioid use, despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

Criteria for OUD cont.

❼ Important social, occupational, or recreational activities are given up or reduced because of opioid use.

❽ Recurrent opioid use in situations in which it is physically hazardous.

❾ Continued opioid use, despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

❿ Tolerance

⓫ Withdrawal

American Psychiatric Association, 2013
Shulman et al., 2019

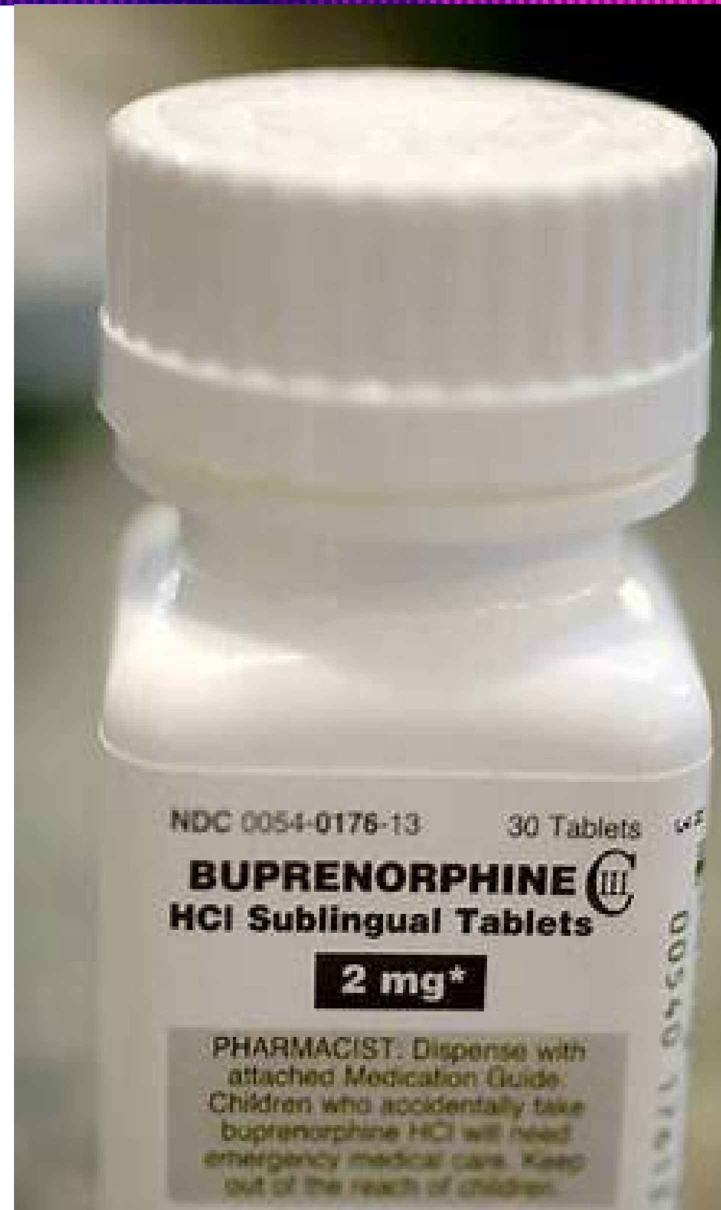
What is buprenorphine?

1

Partial mu opioid agonist and kappa/delta antagonist that binds with high affinity

- Out-competes other traditional opioids for the same receptors
- Can prevent withdrawal symptoms and cravings for those with addiction/dependence
- Provides pain relief with very little risk of respiratory depression
- Blocks other opioids from binding at the opioid receptor

Ahmadi et al., 2018
Snyder, 2023



What is buprenorphine?

2. **Schedule III medication**
3. **FDA approved for both opioid use disorder and pain**

Shulman et al., 2019

Buprenorphine

FOR OPIOID TREATMENT

Why buprenorphine?

Buprenorphine is a unique opioid that is useful for several reasons

- It has a lower risk of producing opioid induced hyperalgesia when used to treat pain as compared to other opioids
- It is a very effective treatment for Opioid Use Disorder (OUD) - buprenorphine reduces the risk of death from overdose by 70%!
- It blocks the effects of other opioids, and therefore is protective against severe overdose in the case of relapse
- It has a ceiling effect - it does not cause respiratory depression at high doses the way other opioids do
- As it is a partial agonist at the opioid receptor, it does not cause euphoria the way other opioids do

Poliwoda, 2022
Williams et al., 2019

NO…

- **X-DEA waivers** are no longer required
- If you have an **active DEA registration, you may prescribe buprenorphine** like any other controlled substance

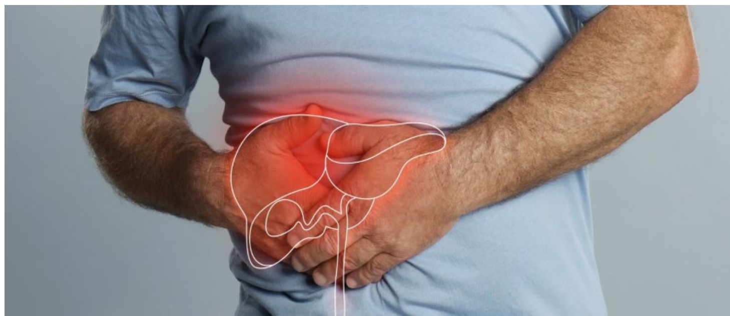
Do I need special licensure to prescribe?

Indications for Buprenorphine

- Opioid Use Disorder - **can be used to reduce** cravings, and prevents severe overdose in case of relapse
- Opioid Dependence - **can be used to treat** and stabilize opioid withdrawal
- Pain (acute or chronic)

Bridge to Treatment, n.d.

Contraindications



- Buprenorphine, like other opioids, **should not be combined** with benzodiazepines if possible.
- Buprenorphine is hepatically metabolized, and **cannot be used** with serious liver dysfunction, such as cirrhosis.
- **Should not be combined** with heavy alcohol use.

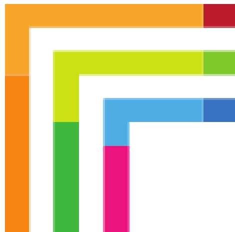
Buprenorphine dosing

- **Sublingual**
  - The first-pass effect is large - not effective when taken orally
  - Combined with naloxone (Suboxone, Zubzolv) to prevent misuse
  - Available as a single agent (Subutex) for patients who are intolerant of suboxone — often used in pregnancy
- **Transmucosal (Belbuca)** — generally used to treat pain
- **Transdermal (Butrans)** — generally used to treat pain
- Buprenorphine can be given in the **acute care setting IM or IV** for pain or opioid withdrawal (Buprenex)
- Buprenorphine is available as a **once-a-month injection** for opioid use disorder to improve compliance (Sublocade, Brixadi)

How is sublingual buprenorphine dosed?

- Most patients stabilize on a **dosage of 16–32 mg of buprenorphine daily** split into two to three doses
- Pain **responds better to divided dosing** (dosing for pain is often QID)
- Suboxone is a **combination of buprenorphine and naloxone** dosage in a 4:1 ratio, available in 2/0.5 mg, 4/1 mg, and 8/2 mg doses. The naloxone is not absorbed.
- Subutex is a **buprenorphine monoproduct**. It is available in 2 mg and 8 mg tablets

Shulman et al., 2019



How is sublingual buprenorphine dosed? cont.

- **Subutex and Suboxone dosing are equivalent** (8/2 Suboxone = 8 mg Subutex)
- Buprenorphine/naloxone is **available as sublingual strips or tablets**. Buprenorphine alone is only available as tablets
  - Reinforce with patients that these must be allowed to absorb in the mouth
  - Ineffective if swallowed
- 1 mg of SL buprenorphine is **approximately 30–40 MME**
  - Due to the ceiling effect of buprenorphine, the risk of overdose is lower than a full opioid agonist

Shulman et al., 2019

Screening prior to initiation

- Unless there are obvious signs of severe liver disease (e.g. jaundice), buprenorphine **may be started to stabilize a patient** with opioid use disorder or opioid dependence.
- Once stabilized on the dose, providers may **consider checking LFTs** every 6 to 12 months to monitor for any hepatic dysfunction as a side effect of buprenorphine.
- Discuss full **addiction history/use of other substances** with patient.

Shulman et al., 2019

Special populations

Pregnant person

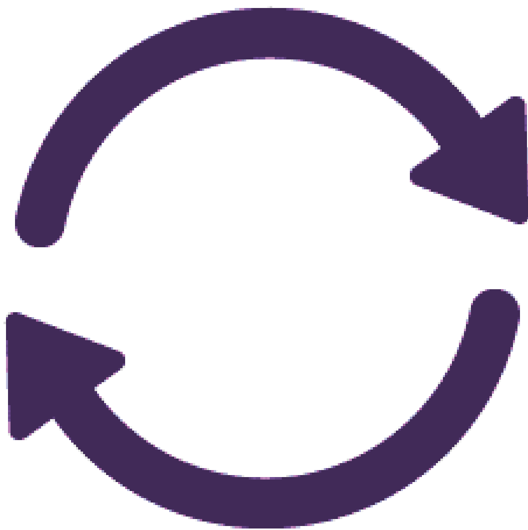
- Both SL buprenorphine and SL buprenorphine/naloxone may be used in pregnancy
- Slight dose increases may be needed later in the pregnancy due to increased volume of distribution
- Tapering during pregnancy should be avoided as withdrawal can precipitate preterm labor

Youth

- Buprenorphine can be used in children for both pain and opioid use disorder (OUD).
- Any patient 16 and older can consent to treatment with buprenorphine for OUD without parental consent.

Shulman et al., 2019

Common Side Effects



- Side effects of buprenorphine are **similar to those seen with other opioids**
  - Constipation
  - Nausea
  - Drowsiness

- Dental caries (from SL administration)

- Injection site reaction (from long-acting injection)

Initiating therapy

- For opioid naive patients, **buprenorphine can be started for pain** in the same fashion as any other analgesic:
  - Starting dose 1-2 mg TID to QID for pain
- For patients with opioid dependence, **patients must be in opioid withdrawal prior** to starting buprenorphine for pain or opioid dependence
  - This is because **buprenorphine has a high binding affinity at the opioid receptor** and is only a partial agonist at the opioid receptor, so using buprenorphine when other opioids are in a person's system displaces the other opioids currently bound to the receptors
- If initiating therapy, please **visit the CA Bridge resources page** regarding specifics to consider at samhsa.gov

Initiating therapy/continuing therapy

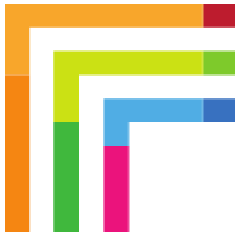
- Many **patients will initiate therapy in acute withdrawal** with the Emergency Department or in treatment for addiction and follow up with primary care physicians for continued therapy.
- Once the patient has stabilized on a **dose that manages their pain, withdrawal, and/or cravings** (e.g. 8 mg TID), that dose can be continued in a similar fashion to any other chronic medication.
- Primary care **physicians can help their patients** by taking over prescribing of buprenorphine when stable on the dose.

Monitoring

- Patients will **need to be seen at short intervals** during the first few weeks after initiation to ensure that the dose is correct.
  - Assess for symptoms (uncontrolled pain or withdrawal/cravings) and compliance with regimen.
- Once stabilized, patients may be **seen every few months**.
- As buprenorphine is a controlled substance, providers may consider doing **urine drug testing every 3–6 months**, or more frequently if there is concern for ongoing substance use or the patient is on a high-risk medication regimen.

Monitoring cont.

- Consider doing **liver function tests** at least annually.
- Patients and their families **should have Naloxone and know how to use it**.
  - Please share Prescribe Safe's Naloxone Training Video and the Naloxone Saves Lives page for more information and resources.
- For patients with OUD - encourage patients to **participate in addiction therapy**/support groups.



Important points

- **Buprenorphine is a life saving medication** for patients with opioid use disorder and can also be used to treat pain.
- Buprenorphine **can be prescribed by any physician**, NP, or PA with a valid DEA registration.
- Buprenorphine is a **mixed opioid agonist-antagonist with high binding affinity at the opioid receptor**, which requires caution during initiation but is protective in the case of relapse.

Sordo et al., 2017

Alcohol dependence

- **Alcohol dependence** refers to the development of withdrawal symptoms when a person with regular, prolonged alcohol use stops drinking or significantly reduces their intake.
- This can occur **in individuals drinking heavily over time**, and most those who drink daily.
- Dependence can develop **after sustained alcohol use**, and the risk increases with higher frequency and quantity of consumption.

American Psychiatric Association, 2013

Alcohol use disorder (AUD)

- AUD refers to **an *addiction* to alcohol**
- AUD includes **the psychological aspects of addiction** — craving alcohol, continued use despite negative consequences, and compulsive patterns of seeking and consuming alcohol.
- Most individuals with AUD **also have alcohol dependence** (patients will withdraw when chronic alcohol use is stopped)

American Psychiatric Association, 2013

Alcohol withdrawal

- Alcohol withdrawal symptoms typically occur in individuals with **alcohol use disorder** who abruptly stop or significantly reduce their alcohol intake. The **severity and onset of symptoms can vary** depending on the level and duration of alcohol use. However, it is **often difficult to predict the likelihood of withdrawal** based solely on the amount of alcohol consumed. The strongest predictor of alcohol withdrawal is a prior history of withdrawal episodes.

- Abruptly stopping alcohol in individuals with **heavy or prolonged use can lead to withdrawal symptoms**, which may range from mild to life-threatening. It is **essential for clinicians to assess the risk of withdrawal and initiate appropriate medical management**, including the use of medications such as gabapentin or benzodiazepines when indicated. This presentation will focus on the management of alcohol use disorder rather than alcohol dependence.

Schuckit, 2014

Screening for AUD

There are 11 criteria for alcohol use disorder

- 2-3 criteria = mild alcohol use disorder
- 4-5 criteria = moderate alcohol use disorder
- 6+ criteria = severe alcohol use disorder

American Psychiatric Association, 2013
Krichbaum et al., 2023

Criteria for AUD

❶ Consuming alcohol in larger amounts or over a longer period than intended.

❷ Persistent desire or unsuccessful efforts to cut down or control alcohol use.

❸ Spending a great deal of time obtaining, using, or recovering from alcohol.

❹ Craving or a strong desire or urge to use alcohol.

❺ Recurrent alcohol use resulting in failure to fulfill major role obligations at work, school, or home.

❻ Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by alcohol.

Criteria for AUD cont.

❼ Giving up or reducing important social, occupational, or recreational activities because of alcohol use.

❽ Recurrent alcohol use in situations where it is physically hazardous.

❾ Continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem likely caused or exacerbated by alcohol.

❿ Tolerance as needing more alcohol to feel the same effect or getting less effect from the same amount.

⓫ Withdrawal as experiencing withdrawal symptoms or drinking to avoid them.

American Psychiatric Association, 2013
National Institute on Alcohol Abuse and Alcoholism, n.d.
Shulman et al., 2019

Medications for AUD

- **Disulfiram** – Causes unpleasant effects when alcohol is consumed; deters drinking.
- **Naltrexone (PO/IM)** – Blocks opioid receptors; reduces alcohol and opioid cravings.
- **Acamprosate** – Helps restore brain balance; reduces alcohol cravings after quitting.
- *These medications do not treat alcohol dependence or withdrawal but help manage alcohol use disorder.*

Kranzler & Soyka, 2018

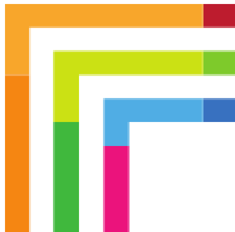
Disulfiram

- Mechanism – blocks acetaldehyde dehydrogenase
- Causes the “disulfiram reaction”
- Major side effects – drowsiness
- Contraindications – cardiovascular disease, active alcohol use, hepatic disease
- Dosing – 250 to 500 mg daily

How well does it work?

- It only works when patients are supervised in taking it, such as by a spouse (*NOT for alcohol harm reduction*)

Kranzler & Soyka, 2018



Naltrexone

- Mechanism – blocks opioid-mediated release of dopamine in reward centers from alcohol
- Major side effects – somnolence, GI upset, injection site reaction
- Contraindications – active opioid use, severe hepatic insufficiency
- Dosing options - can be taken daily, as needed, or a combination of both to reduce cravings and alcohol's rewarding effects.
  - Daily dosing: 50 mg PO daily – reduces cravings and alcohol consumption
  - Long-acting injectable – 380 mg IM monthly
  - Targeted dosing – taken before high-risk situations to reduce cravings
  - Combination dosing – daily dose plus extra as needed for high-risk situations.

Kranzler & Soyka, 2018

Naltrexone cont.

How well does it work (PO)?

- NNT to prevent return to drinking after abstinence = 20
- NNT to prevent one episode of binge drinking = 12

How well does it work (IM)?

- NNT to reduce binge drinking = 6

Kranzler & Soyka, 2018

Number Needed to Treat (NNT)

Acamprosate

- Mechanism – increases GABA activity, reduces glutamate activity
- Major side effects – diarrhea
- Contraindications – renal insufficiency
- Dosing – 666 mg TID (*can also be dosed BID if compliance is an issue*)

How well does it work?

- NNT to reduce return to drinking after abstinence = 12
- NNT to reduce any drinking = 9
- Recommended to start after 10-14 days of sobriety

Kranzler & Soyka, 2018

Number Needed to Treat (NNT)

Other medications

Other medications are commonly used off-label to manage alcohol use disorder, including:

- Topamax
- Baclofen
- Gabapentin
  - *10-14 days of sobriety*

Kranzler & Soyka, 2018

Important points

- **Disulfiram** – causes unpleasant physical reactions when alcohol is consumed and is most effective for highly motivated patients with strong supervision or support systems.
- **Naltrexone** – helps reduce cravings and the rewarding effects of alcohol and can be taken daily or as needed to support relapse prevention.
- **Acamprosate** – works by restoring balance to brain chemistry disrupted by chronic alcohol use and is best suited for patients who have already achieved abstinence.

Safety Tips for your Patients

- Be wary of **counterfeit pills**
- Assume that non-prescribed drugs contain fentanyl
- **Never use drugs alone** (friends can save your life)
- Always have naloxone (Narcan®) in case of overdose
- If using, **start low and go slow** (watch and wait before using more)
- Avoid **dangerous combos** (especially dangerous when mixed with benzos like Xanax and Klonopin, opiates such as heroin, Vicodin, or Oxycontin, and depressants including alcohol)

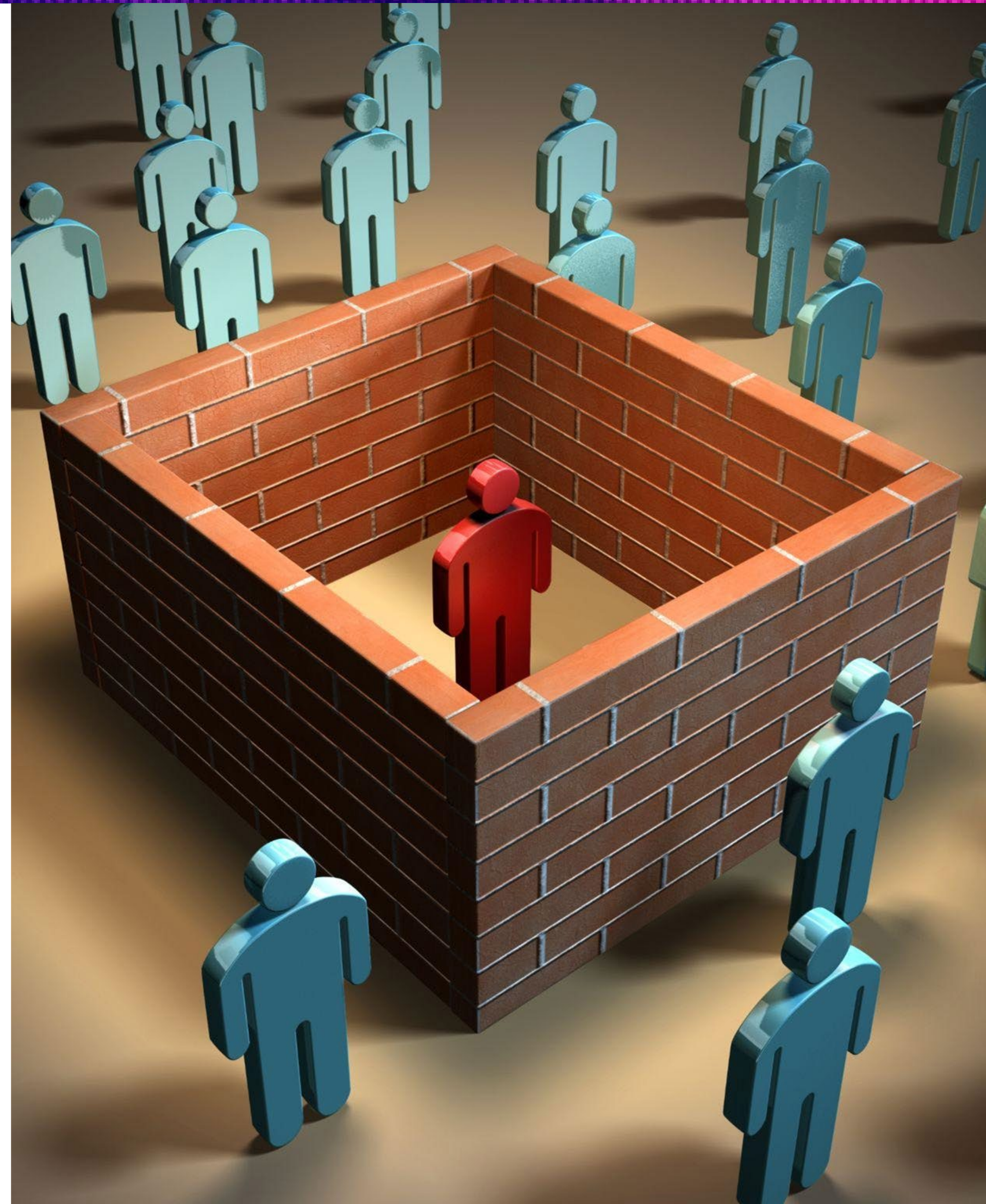
What is stigma?

An attribute considered to be undesirable and unpleasant by society and which differentiates the stigmatized person from other members of the community to which he or she should belong.

Hankir et al., 2014

Reducing Stigma

- Patients with pain, opioid dependence, and opioid use disorder **often feel judged for their conditions** by their healthcare providers
- **Avoid any terms** that confer judgement (such as “dirty urine” or “junkie”)
- Use **person-first language** and be objective - “this is a 35-year-old male with opioid use disorder”



What do we do about stigma?

- Start by identifying stigma
  - "In health facilities, the manifestations of stigma are widely documented, ranging from outright denial of care, provision of sub-standard care, **physical and verbal abuse**, to more subtle forms, such as making certain people wait longer or passing their care off to junior colleagues"

- And realize we are hurting ourselves too:
  - "Stigma also **impacts the well-being of the health workforce** because healthcare workers may also be living with stigmatized conditions"

Nyblade et al., 2019

Words matter

"Our language helps us understand and interpret the world around us. They convey meaning whether the effect is good or bad. **We can use our words to help decrease stigma.**"

Zwick et al., 2020

Use person-first language

Use **person-first, nonjudgmental language** to promote respect and support in all interactions—whether with patients or colleagues.

- “Patient with diabetes” vs. “diabetic”
- “Person with anorexia” vs. "anorexic"
- “Individual with obesity” vs. "fat person“
- “Person with alcohol use disorder” vs. “alcoholic”
- “Person with a mental illness” vs. "crazy" or "psycho“
- "Person experiencing homelessness" vs. "bum“
- “Person with substance use disorder” vs. “junkie” or "addict"
- “Abnormal urine toxicology screen” vs. “dirty urine”
- "Individual with a mental health condition" vs. "psycho“
- "Patient with a history of addiction" vs. "recovering addict“
- “That person has severe psychosis” vs. “that guy is crazy”

Language choice can reduce stigma

> “If you want to care for something, you call it a ‘flower’; if you want to kill something, you call it a ‘weed’”
>
> *Don Coyhis, n.d.*

Take-home points

- Addiction is killing Americans – we need to treat it!
- Buprenorphine is very effective in treating opioid use disorder
- There are several medication options to treat alcohol use disorder

Key Takeaways

- Effective medications are available for both opioid and alcohol use disorders and play a vital role in recovery and relapse prevention.
- Integrating medications with stigma-free care improves outcomes and helps individuals feel supported on their recovery journey.
- Using person-first language and reducing stigma creates a more inclusive, respectful healthcare environment that promotes healing and access to care.

Conclusion

By **prescribing medications for OUD and AUD**, you play a critical role in supporting recovery, reducing harm, and **saving lives**.

- **Effective** — Evidence-based medications for opioid and alcohol use disorders **treat the whole person, not just the symptoms**.
- **Protective** — Recognizing substance use as a medical disorder **reduces stigma and improves patient safety** and outcomes.
- **Supportive** — Centering care on the individual, not the label, **fosters trust, dignity, and lasting recovery** and saves lives.

Evaluation questions

1. What do you plan to do differently in your medical practice as a result of completing this module?
2. Did you feel that this presentation had a financial bias toward companies that produce, market, sell, or distribute healthcare products used on or by patients?
3. Did the presentation include relevant health disparity information relate to age, gender, race, socioeconomics, sexual orientation, religion, language, and/or ethnicity?

Thank you

Thank you for reviewing the **Prescribing for OUD & AUD: Treatment for Opioid and Alcohol Use Disorders** online module.

We appreciate your commitment to enhancing your knowledge and understanding of this important subject. By participating in this education, you are contributing to safer and more effective pain management strategies, supporting evidence-based practices, and playing a vital role in addressing the ongoing opioid crisis.

We appreciate the care you provide for our communities.

Dr. Reb Close and Dr. Casey Grover
Montage Health Prescribe Safe Medical Directors

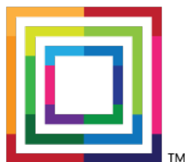
Montage Health Prescribe Safe

Acknowledgements

Prescribing for OUD & AUD: Treatment for Opioid and Alcohol Use Disorders was developed by ***Dr. Casey Grover*** and ***Dr. Reb Close*** to provide healthcare professionals with an in-depth understanding of medications' role in treating opioid and alcohol use disorders.

We hope this online educational resource enhances clinical practice and supports improved patient outcomes.

For questions or support, email **prescribesafe@montagehealth.org**



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Complete the quiz

To earn your credits:

- Please complete the quiz, evaluation questions, and attestation form.
- Once completed, you will earn **CME 1.0 AMA PRA Category 1 credit or CE credits** and receive a certificate of completion.

Click **LINK HERE** to complete the quiz and attestation. Your certificate of completion will be emailed to you after submission.

Explore our other online activity:

Changing Perspectives and Promoting Respect: Stigma Reduction and Person-First Language in Healthcare

This module offers **CME 0.5 AMA PRA Category 1 creditor CE credits** for those interested in enhancing their understanding of addressing stigma in healthcare.