



Identifying and Managing Opioid Use Disorder (OUD)

A VA Clinician's Guide

VA



U.S. Department of Veterans Affairs

Veterans Health Administration
PBM Academic Detailing Service

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Your Partner in Enhancing Veteran Health Outcomes

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Overview of OUD

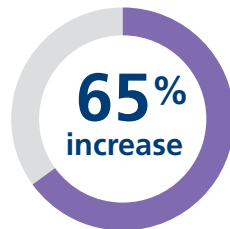
Opioid use disorder (OUD)* is a **brain disorder** that can develop after repeated opioid use.¹ Just like other chronic diseases (e.g., hypertension, diabetes), it typically requires **long-term management**.

Opioid misuse and OUD are associated with significant health risks

Opioid misuse is associated with increased morbidity and mortality



Between 2010-2016, Veterans had a 65% increase in all opioid overdose deaths²



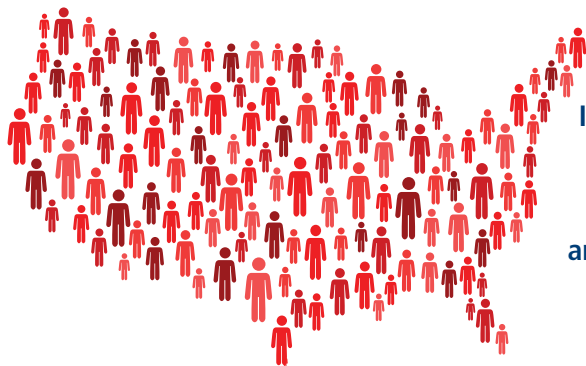
The risk of death by suicide is



13x

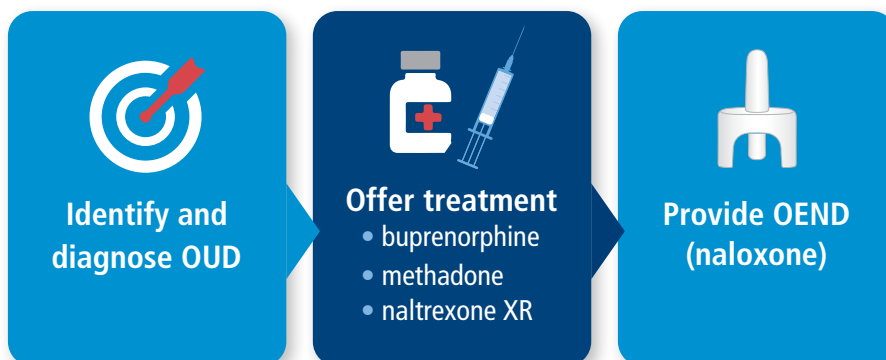
more likely in people with OUD than those without. In Veterans, this risk is even larger.³

For female Veterans with OUD, the risk is 14% greater than male Veterans.⁴



In the U.S. in 2018, **128** people died of an opioid overdose every day.⁵

Make a difference in the lives of Veterans



*OUD refers to both opioid use disorder and ICD-10 opioid dependence unless otherwise noted.
OEND = opioid overdose education and naloxone distribution

OUD facts: be in the know

Substance use disorders are highly stigmatized

Developing OUD is not a choice or moral weakness. It is a health condition that needs treatment.⁶ Healthcare professionals can play a vital role in **decreasing stigma** for their patients and the general public.



OUD can be identified and treated in many clinical settings

All providers, regardless of clinical setting, screen and manage patients with multiple medical conditions. OUD is no different.



Similarly, providers in many different settings can identify and offer maintenance treatment for OUD.⁷⁻⁹

OUD treatment is NOT simply replacing one opioid for another

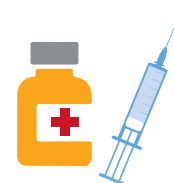
Buprenorphine and methadone (when used appropriately) can significantly lower the incidence of cravings and withdrawal symptoms associated with abstinence from heroin, morphine, hydromorphone, and other opioids.⁶



Naltrexone is a non-opioid option available as oral or extended release (XR) injection to treat OUD.

Patients with OUD can achieve recovery

Medications help patients manage OUD.^{7,10} Counseling and peer-support groups can provide another forum to support treatment but are not necessary for all patients to recover and should not create a barrier to beginning medication treatment.¹¹



OUD treatment saves lives

Patients engaged in OUD treatment with medication have **lower overdose mortality rates** compared to patients with OUD who were out of treatment.¹²



GOLD STANDARD

Medication is the gold-standard treatment for OUD.

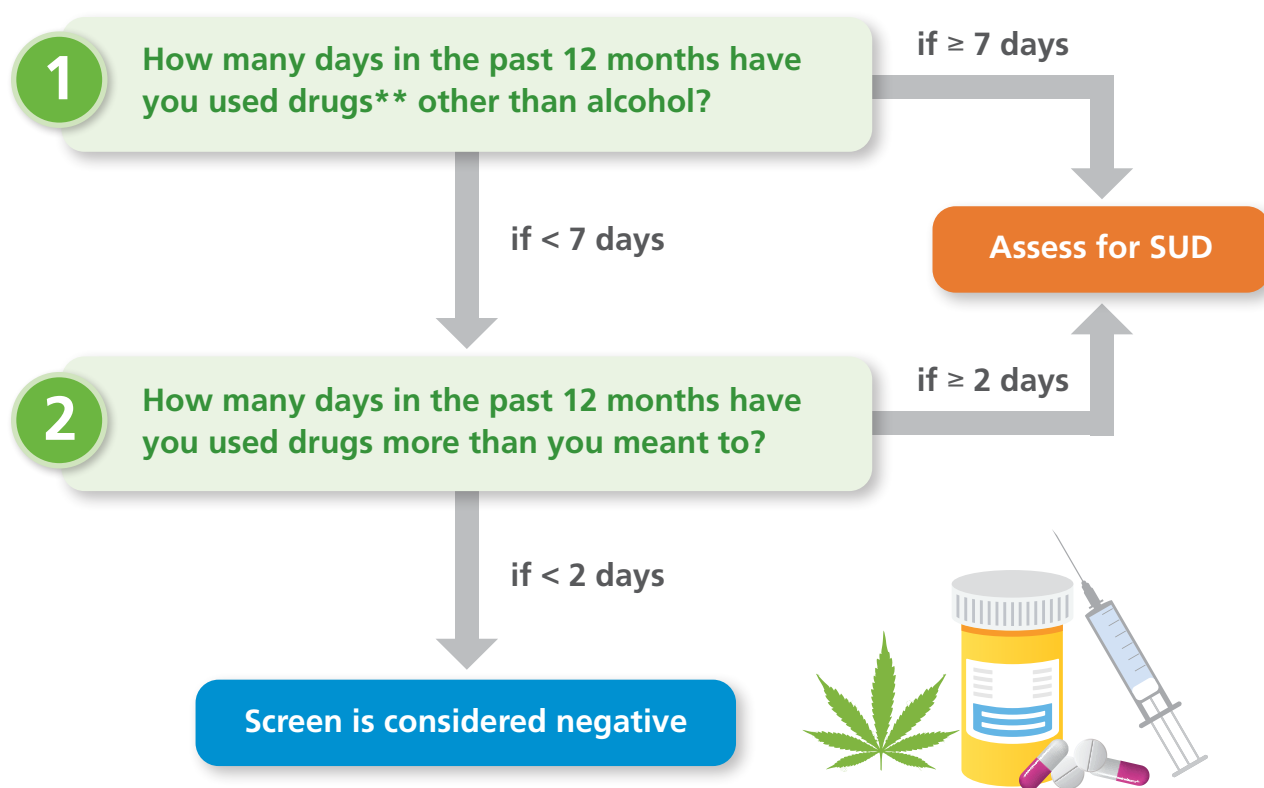
Identifying patients with OUD

Screening Veterans for substance use disorders using available screening tools is an important part of providing comprehensive care in any healthcare setting.^{6,13}

Every time a Veteran presents to VA, it is an opportunity to identify someone who may be suffering from a substance use disorder (SUD).^{7,8}



Figure 1: A two-item drug use disorder screener developed within VA^{*7,14}



If injection drug use is identified, offer pre-exposure prophylaxis (PrEP).

PrEP is the use of antiretroviral medication to prevent acquisition of HIV infection in appropriate persons (e.g., people who inject drugs). For more information, see the Quick Reference Guide for OUD (pages 22-23).

*There are various other screening tools available (e.g., NIDA quick screen, DAST-10, CAGE-AID, TAPS) that may be used based on clinical preference, work flow, and practice setting.⁶ **Drug refers to not only illicitly obtained substances but also any substance taken other than as prescribed or recommended for medical use (e.g., marijuana, tranquilizers, barbiturates, opioids).¹⁴

Making the diagnosis: clarifying the terminology

ICD-10 is the official diagnosis system used in VA medical records. The ICD-10 code “opioid dependence” is equivalent to the term “opioid use disorder” as defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*.

Table 1. Linking the diagnostic criteria with practical examples*

DSM-5 OUD (2-3 symptoms = mild; 4-5 = moderate; ≥ 6 = severe)	ICD-10 Opioid Dependence (3 or more criteria)	Example behaviors
1. Craving or a strong desire to use opioids	A. A strong desire to take the drug	Constantly thinking about the next dose
2. Using larger amounts of opioids over a longer period than initially intended	B. Difficulties in controlling opioid use	Taking a larger dose than prescribed
3. Persisting desire or unable to cut down on or control opioid use		Unable to control opioid use
4. Recurrent use in situations that are physically hazardous		Repeatedly driving under the influence
5. Continued use despite physical or psychological problems related to opioids	C. Persisting in opioid use despite harmful consequences	Request for more opioids after adverse effects (e.g., overdose, bowel obstruction, negative impact on mood or sleep)
6. Continued use despite persistent social or interpersonal problems related to opioids		Continued use despite poor work performance or family requests to stop using opioids
7. Spending a lot of time to obtain, use, or recover from opioids	D. Higher priority given to opioid use than to other activities and obligations	Spending a lot of time frequenting EDs or clinics with a goal of obtaining opioids
8. Failure to fulfill obligations at work, school, or home due to use		Progressive neglect of tasks (e.g., cleaning, poor work performance)
9. Activities are given up or reduced because of use		Stopping previously enjoyed activities (e.g., gardening, softball, card games)
10. Withdrawal**	E. A physiologic withdrawal state	Experiencing symptoms of withdrawal between use of opioids
11. Tolerance**	F. Tolerance	Requires larger doses for effect, whether a high or pain relief

ED = emergency department. *The criteria in Table 1 should be present at the same time within the prior 12 months in order to make the diagnosis. **Tolerance and withdrawal do not count for the DSM-5 diagnosis if taken as prescribed under medical supervision. Example: Veterans who have been taking opioids to manage pain will develop tolerance and withdrawal. However, they may not meet DSM-5 criteria for OUD.

Tips when making the diagnosis



You don't have to ask the patient about all the OUD diagnostic criteria to make a diagnosis.

Use open-ended questions and your knowledge of the patient to help you evaluate for OUD and determine the severity; determining the severity can help inform treatment decisions.

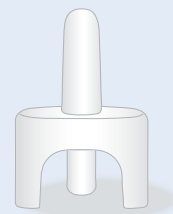


Consider using the VA Opioid Use Disorder Assessment template to complete your assessment.

This template was designed to facilitate documentation of assessments for OUD, be useful for providers from various disciplines, be flexible enough to be used in various settings, collect key measures for on-going monitoring, and inform next steps in the treatment of OUD with medications. Please check with your Clinical Applications Coordinator for more information about this national clinical note template.

Patients with OUD have a high risk of opioid overdose and should be offered opioid overdose education and naloxone distribution (OEND).

- The VA OEND Program aims to reduce harm and risk of life-threatening opioid-related overdose and deaths among Veterans.
- Key components of OEND include education and training on opioid overdose prevention, recognition, and rescue response, including offering naloxone.



? DID YOU KNOW

If you are interested in increasing your knowledge and skills in the prevention, identification, and treatment of OUD, training is available related to treating OUD with buprenorphine, which requires a special permit called an X-waiver. You can take the training without applying for an X-waiver.

Please see <https://pcssnow.org/medications-for-addiction-treatment> for more information.

Identify Veterans with OUD, make the diagnosis, and provide OEND.

Assessment

A comprehensive assessment is important for patient engagement and treatment planning and should be done early in the treatment process.

While a full assessment does not need to occur during the first visit, any urgent or emergent problems (e.g., risk of harm to self/others) should be identified, as should intoxication or withdrawal from other substances severe enough to require immediate medical attention.^{6,15}

Some key components of the comprehensive assessment, which can be completed by various healthcare team members, include:¹⁵

- Laboratory tests
- Medical history
- Mental health and substance use history
- Emotional, behavioral, or cognitive conditions or complications (barriers to treatment)
- Areas of strength; motivators for treatment
- Readiness for change



Prescription drug monitoring program (PDMP): Clinicians should check their state's PDMP before initiating OUD treatment to identify any other controlled substances the patient is receiving.¹⁵

- **Note:** methadone from an opioid treatment program (OTP) is not typically reported to the PDMP, but buprenorphine is.⁶



Pharmacotherapy for OUD can be started even if all assessments have not been completed in order to increase treatment use.

See the Quick Reference Guide for a more comprehensive listing and description of assessment components.

Engaging Veterans in treatment

Building a therapeutic alliance with Veterans is a key part of effective treatment for OUD.

Table 2. Tips to engage Veterans with OUD

<p>Use inclusive language</p>	<ul style="list-style-type: none"> • Use respectful, non-judgmental, and honest communication. • Choose language that is not stigmatizing (e.g., “a person with opioid use disorder” versus “addict”).
<p>Apply motivational interviewing techniques</p>	<p>Express empathy, elicit patient’s intrinsic motivation for change, and collaborate with and guide the patient to changes that align with motivation. Identify shared goals, summarize the patient’s plan, and encourage the patient’s belief in their ability to make changes.</p>
<p>Emphasize predictors of successful outcomes</p>	<ul style="list-style-type: none"> • Retention in formal treatment • Adherence to medications for OUD • Active involvement with community support for recovery
<p>Address concurrent problems</p>	<p>Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems.</p>
<p>Correct any misconceptions about medication treatment for SUD</p>	<p>Correct any misconceptions and offer to speak with family/significant others if their beliefs about treatment present a significant barrier to the Veteran engaging in treatment.</p>
<p>Respect patient preference</p>	<p>Consider the patient’s prior treatment experience and respect patient preference.</p>
<p>Emphasize that options will remain available</p>	<p>If unwillingness to initiate treatment remains:</p> <ul style="list-style-type: none"> • Maintain open communication. • Determine where medical/psychiatric problems are managed.* • Offer follow-up and continue to look for opportunities to engage. • Provide reassurance to support recovery. • Offer OEND and other harm reduction strategies (e.g., PrEP).

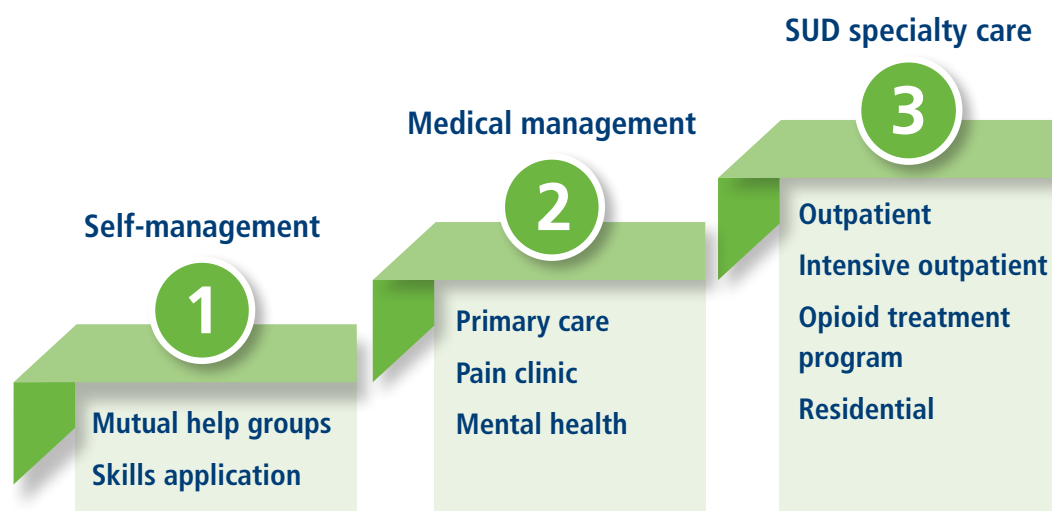
*Even when patients decline referral or are unable to participate in specialized addiction treatment, many are accepting of general medical or mental health care.

Inform the Veteran about the risks and benefits of the available treatment options. Select a treatment option that meets his or her needs.

Treating Veterans with OUD

Any VA provider who manages a patient with OUD should use the VA recommended stepped care model.

Figure 2. Offer a stepped approach to OUD treatment



Behavioral interventions are an important part of recovery for many Veterans, but take time to be effective—treating OUD with medications should not be delayed while behavioral treatments are arranged for or engaged in.¹⁵

1 Self-management

Self-management options include peer support or mutual help groups and skills application. While they are not a requirement to receive medication treatment, they are a helpful support for many patients.

➔ **Mutual help groups or peer support**, e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and SMART Recovery

- **AA and NA:** provide a network of people who understand the challenges of working toward and maintaining recovery, offering an opportunity to build new, non-substance using relationships.¹¹
- **SMART Recovery:** similar program that offers an alternative to the spiritual or religious basis of AA and NA.



Not all groups are accepting of medications to treat OUD. Veterans should be informed of the variable acceptance of medications to treat OUD by these groups.⁶

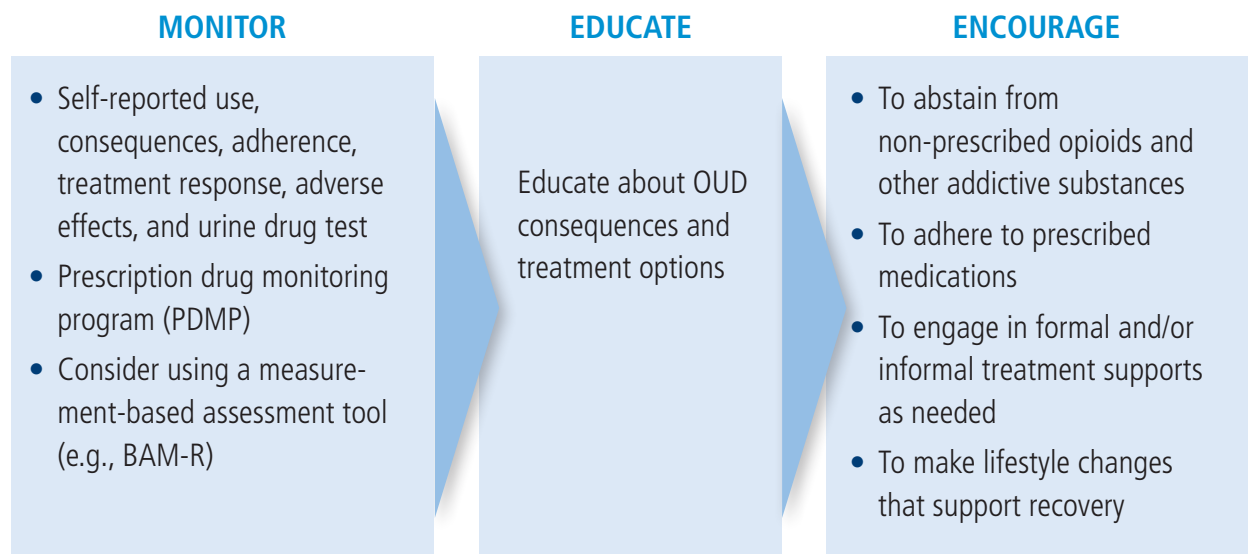
➔ **Skills application** helps patients with OUD create new daily structures or habits to help cope with cravings to resume opioid use and build new social relationships. Various methods and structures can assist the Veteran in achieving recovery:

- **Informal** (e.g., church, recreational activities, Veterans Service Organizations)
- **Formal** (e.g., therapy—individual, group, or psychotherapy educational groups). Individual or group psychotherapy can facilitate insights and improve interpersonal relationships. Psychoeducational groups are similar to SUD therapy groups but have a strong educational component.

2 Medical management

Medical management is a structured psychosocial intervention and can be delivered by a medical professional (e.g., physician, nurse, pharmacist, physician assistant) in many clinical settings.^{11,13}

Figure 3. Medical management*¹⁰



*Session structure varies according to the patient's substance use status and treatment adherence; BAM-R = brief addiction monitor-revised



Case management can assist in providing additional support for recovery, including housing support, food assistance, and links to mental health services and family therapy.⁶

3 SUD specialty care

Some Veterans may require SUD specialty care via intensive outpatient treatment, an opioid treatment program, or residential treatment program. Patients most likely to require higher levels of care include those **whose substance misuse has not responded to multiple episodes of outpatient treatment, are using or misusing another substance, and/or need enhanced support and monitoring.** Find out what options are available at your local facility.^{10,15}

- If patients are referred to SUD specialty care, continue to provide support and encouragement to sustain commitment to recovery and ensure access to opioid overdose education and naloxone distribution (OEND).

Medications for OUD: buprenorphine*, methadone, and naltrexone XR

Medications are the gold-standard treatment for patients with OUD.^{10,16-18} Each of these options has different availability, access, and logistical factors to consider when deciding which option is best for an individual Veteran.

- The most critical goal of medication for OUD is to prevent acute harm due to opioid use. In the long term, it also helps to reduce the associated negative medical, legal, and social consequences, including death from overdose.^{12,19-25} This allows the patient to focus more readily on recovery activities and positive change.

*Buprenorphine also refers to the combination buprenorphine/naloxone products.

Table 3. Summary of benefits of treatment by medication^{12,21,22,25-31}

	Buprenorphine	Methadone	Naltrexone XR
Reduced mortality (primarily by opioid overdose)	✓	✓	?
Treatment retention	✓	✓	✓
Reduced illicit opioid use	✓	✓	✓
Reduced opioid cravings	✓	✓	✓
Improved patient health and well-being	✓	✓	?

✓: benefit of treatment; ?: neutral or no effect

Table 4. Comparison of OUD treatment options

	Buprenorphine	Methadone	Naltrexone XR
Treatment setting	Office-based setting or an accredited opioid treatment program (OTP)	Accredited OTP	Office-based setting
Prescribing requirement	Need X-waiver	Accredited OTP	None
Mechanism of action	Partial opioid agonist	Opioid agonist	Opioid antagonist
Formulations	Oral (sublingual tablet or film, buccal film), injection, implant*	Oral liquid	Injection
Special requirements	Patient needs to be in mild to moderate withdrawal prior to initiation	Accredited OTP	Patient must be fully withdrawn from opioids prior to initiation
Cautions	Precipitated withdrawal can occur if symptoms of withdrawal are not severe enough prior to initiation	Monitor QT interval	Monitoring for depression/suicidal thinking in patients on naltrexone is recommended ¹⁸
REMS	Yes	No	Yes

REMS = risk evaluation and mitigation strategy. *Note: buprenorphine formulations such as transdermal buprenorphine (BuTrans[®]) and a buprenorphine-only buccal film (Belbuca[®]) are FDA approved for pain and not the treatment of OUD.



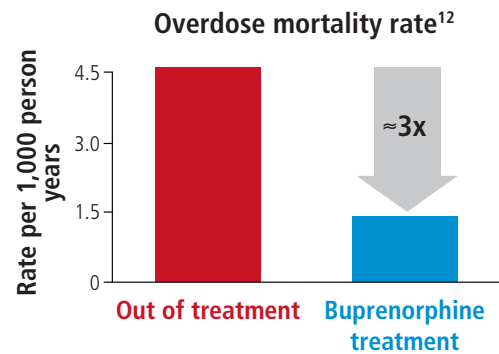
Medication treatment for OUD should be provided even when:

- **Co-occurring substance use disorders are identified.** Presence of other SUDs suggests need for intensified treatment.¹⁵
- **Patients decline participation in behavioral interventions.**¹⁵

Buprenorphine

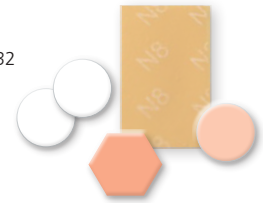
EFFICACY

- **Engages more patients in treatment** compared to placebo (75% vs. 0% in treatment at 1 year).²¹
- **Reduces overdose mortality rate nearly 3-fold** compared to those who were out of treatment.¹²



INITIATING BUPRENORPHINE

- **Treatment should start during or after the patient is in withdrawal.** Consider using an objective assessment tool such as the Clinical Opiate Withdrawal Scale (COWS). Initiation without sufficient withdrawal (COWS \geq 8) leads to precipitated withdrawal.¹⁵
- Initiation (typically done with buprenorphine/naloxone) can occur **at home or in the office.**¹⁵
- **Daily maintenance doses of the transmucosal tablet** generally range from 8-24 mg of buprenorphine, with a target dose of 16 mg.^{15,32}
 - For some forms of buprenorphine the dose will be lower. See Quick Reference Guide for dose comparisons.
- Side effects include nausea, headache, and constipation.^{32,33}
- **Long-acting injections or implants are available,** which some patients may prefer and which may improve adherence and reduce risk of diversion.



FOLLOW-UP AND MONITORING

Visit frequency varies during therapy.¹⁵

- Initial visits are frequent (e.g., every 1-3 days).³⁴
- As patients become stable, visits may become less frequent (e.g., every 4-8 weeks).³⁵
 - Stable patients include those who have maintained opioid abstinence, participated in psychosocial or other recovery activities, or have been able to demonstrate social or occupational functioning.

If you are a "qualifying practitioner" or "qualifying other practitioner" and are interested in increasing access to OUD care, get your X-waiver.

Who can get an X-waiver:

X-waiver qualifying practitioners

- Physicians

X-waiver qualifying other practitioners

- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists
- Certified Nurse Midwives

Obtaining an X-waiver:

- Qualifying practitioners need 8 hours of training while qualifying other practitioners need an additional 16 hours.
- For information on applying for an X-waiver, see [samhsa.gov/medication-assisted-treatment](https://www.samhsa.gov/medication-assisted-treatment)

Methadone

EFFICACY

- **Reduces illicit opioid use** compared to non-pharmacologic treatment in a meta-analysis of 11 trials.²⁶
- According to a study evaluating methadone treatment versus control (no methadone) after 2 years, participants receiving methadone were more likely to be drug free.²³

Methadone treatment



Control (no methadone)

PRESCRIBING CONSIDERATIONS

- **Can be used to treat OUD only via accredited opioid treatment programs (OTP).**

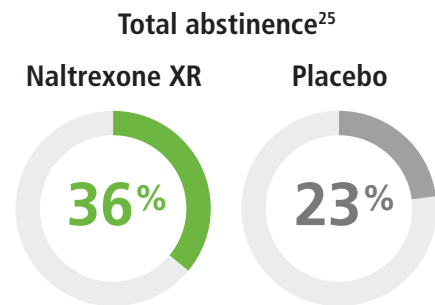
FOLLOW-UP AND MONITORING FOR PRIMARY CARE

- **Methadone increases the risk of respiratory depression**, especially when combined with other sedatives.¹⁰
 - Concurrent alcohol, benzodiazepine, or other sedative use with methadone increases the risk of overdose and death.⁶
 - Significant drug interactions occur with methadone, especially HIV medications and certain anticonvulsants. Interdisciplinary communication and collaboration is essential.¹⁰
- **Can cause QTc prolongation.** Consider an ECG if patient has risk factors (e.g., arrhythmia, QT prolonging medications).^{10,15}
- **Requires regular (at first, daily) attendance at the OTP to receive medication.** This can be disruptive for patients who do not require such intensive monitoring, but also very helpful for those patients who need structure and benefit from regular contact.

Naltrexone XR injection

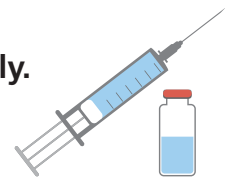
EFFICACY

- **Reduces illicit opioid use** compared to placebo. Total abstinence occurred in 36% of naltrexone XR patients vs. 23% of placebo patients.²⁵
- **Lowers craving scores** compared to placebo.²⁵
- Treats co-occurring **alcohol use disorder**.¹⁰
- **Oral naltrexone** has not been shown to be as effective as naltrexone XR for OUD.^{15,36}



INITIATING NALTREXONE XR

- **Patients must be fully withdrawn from opioids** prior to receiving naltrexone XR.
 - The length of time to full withdrawal depends on the opioid being used. Typically, 7-10 days is recommended, but for long-acting opioids (e.g., methadone, oxycodone extended-release) a longer duration may be required.
 - Consider a naloxone challenge to confirm abstinence. Administering naltrexone XR will precipitate withdrawal in patients who are not abstinent.³⁷
- **Administered as a 380 mg intramuscular gluteal injection monthly.**
 - More frequent administration (every 3 weeks) may be required in fast metabolizers of naltrexone.^{15,37}
- **Patients with acute trauma** on naltrexone can receive regional pain management or opioids while monitored (e.g., hospitalized).³⁸
- Serious **side effects** include high risk of overdose at end of dose interval, depression and suicidality, precipitated opioid withdrawal (if not already abstinent), injection site reactions (including tissue death), and hepatotoxicity.³⁸ Ensure the patient has been offered OEND.
- **Instruct patients to carry a wallet card or wear medical identification** to alert emergency care providers about naltrexone XR therapy.³⁹



FOLLOW-UP AND MONITORING

- Required appointments based on administration frequency (e.g., every 3 or 4 weeks).
- **Monitor for depression and suicide.**³⁷



What about detoxification only approaches?

Patients who underwent opioid detoxification but did not take medication for OUD had poorer outcomes. In two landmark trials for methadone and buprenorphine, nearly all patients who did not receive medication returned to drug use and 10-20% died.^{21,23}

- In patients with active OUD, **follow opioid withdrawal management with medications for OUD.**¹⁰
- **Do NOT provide withdrawal management alone** due to high risk of returning to use and overdose.

Offer medication as first-line treatment to Veterans with OUD.

Additional resources to support OUD treatment

Contact a Clinical Pharmacy Specialist provider

They can provide comprehensive medication management services, including ordering naltrexone when indicated or collaborating with opioid treatment programs or X-waivered providers.⁴⁰

Engage in virtual care

To learn more about telehealth options in VA, visit telehealth.va.gov.

Contact your local SCOUTT champion

Learn more about your local resources and team. For more information, go to: vaww.portal.va.gov/sites/OMHS/SUD/SCOUTT/default.aspx.

Access the National SUD Consultation Service

The National Telemental Health Center (NTMHC) provides consultation for the management of patients with complex SUD needs.



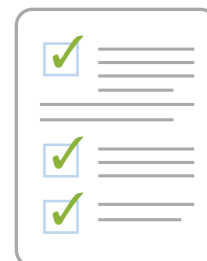
- **Ask the Expert** allows providers to ask any non-PHI question which is then triaged to subject matter experts nationally.
- **Direct Telehealth Videoconferencing** provides videoconferencing with Veterans for diagnostic clarification and treatment recommendations. Please note: The NTMHC does NOT assume the care of Veterans and does not provide direct treatment.
- **E-consult** allows expert clinicians from the NTMHC to review the Veteran's medical record and provide recommendations for care.

Email: AskTheExpert-SubstanceUseDisorder@va.gov (no PHI) or call: 203-479-8181.

Components of follow-up for patients receiving OUD treatment

Assess for use of opioids

- **Subjective:** Ask about opioid use and craving.
- **Objective:** Conduct urine drug testing (UDT) randomly throughout treatment as needed (frequency of drug testing is determined by the patient's level of care and treatment plan).



Address return to use

OUD symptom exacerbation does not mean treatment has failed.¹⁰



- Even “successful” OUD treatment commonly involves periodic episodes of symptom exacerbation.
- Do **NOT** stop OUD treatment for a Veteran because they have returned to use.
- A return to use is a signal that the current OUD treatment strategy needs to be adjusted, reinstated, or changed in order to move toward recovery.⁴²
- If the Veteran is using substances other than an opioid, consider increasing level of care or support (e.g., referring to SUD specialty care program for management, more frequent visits, etc.).

Monitor compliance with pharmacotherapy for OUD

Reviewing PDMP data can help assess treatment adherence based on prescription fill history and identify if any other controlled substances are being prescribed.¹⁵ Contingency management can be used to reinforce adherence to treatment, especially with an injection regimen.⁶



Training, coaching, and material support for contingency management is available in VA. Please see **Contingency Management SharePoint**.



Continuously assess risk of suicide in patients with OUD

Patients with OUD have a high risk for suicide.⁴³ Assessing mental health status in patients with OUD can assist in treatment planning and co-managing depression and other social determinants of health that may impact a patient's OUD treatment.¹⁵



Educate and train Veterans on how to prevent, recognize, and respond to an opioid overdose and offer naloxone (OEND)

Counsel patients that there are many factors that increase the risk of overdose, including increased risk at the end of the dosing interval (due to decreased tolerance), mixing with other substances, and discontinuing treatment.



Convey a message of hope, respect, and empowerment

Many patients with OUD have lived with many years of stigma from friends, family, providers, and the society around them.

Whether you do it directly or indirectly, conveying the message **“You matter, and we will stick with you through this”** can make a huge difference when someone is starting out in the difficult work of recovery.



The optimal duration of treatment for OUD has not been defined



Medication treatment should be continued as long as it is deemed necessary for recovery and not by predefined time schedules. Discontinuation should be a collaborative decision between the provider and patient based on an assessment of whether the patient will be able to maintain functional recovery without medications.



The intersection of chronic pain management and OUD

Whenever possible, use alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments to manage chronic pain in patients with OUD.⁴⁴

Figure 7. Recommendations when managing chronic pain in patients with OUD⁴⁵

<p>AVOID:</p> 	<ul style="list-style-type: none">• Opioid analgesics• Sedative-hypnotics• Muscle relaxants• Other medications with potential for addiction
<p>RECOMMEND:</p> 	<p>Nonpharmacological therapies</p> <ul style="list-style-type: none">• Cognitive behavioral therapy for pain• Pain school or behavioral groups• Support groups/Community support• Rehabilitation therapies (e.g., physical therapy and occupational therapy)• Specialty procedures (e.g., injections, nerve blocks)• Complementary and alternative therapies (e.g., acupuncture, massage, tai chi) <p>Non-opioid medications</p> <ul style="list-style-type: none">• Acetaminophen, NSAID• SNRI, TCA• Topicals (e.g., diclofenac, lidocaine, methyl salicylate, capsaicin) <p>Assessment for and treatment of co-morbid psychiatric conditions* (e.g., PTSD, insomnia, anxiety)</p> <p>Offer opioid overdose education and naloxone distribution (OEND)</p>

*Emotional and social distress in a patient with persistent pain and OUD greatly increases risk for opioid abuse and adverse events.⁴⁷ NSAID = non-steroidal anti-inflammatory; SNRI = serotonin norepinephrine reuptake inhibitor; TCA = tricyclic antidepressant; PTSD = post-traumatic stress disorder

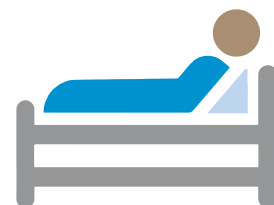


Please note: Adequate treatment of acute pain is needed to prevent return to use in patients with OUD. If pain management expertise is required, please contact your local pain management specialist.

Considerations for surgery and discharging from hospitalizations

For patients being treated for OUD who require surgical procedures:

- Institutions have varying protocols, but stopping buprenorphine is becoming less commonly required.⁴⁷
- Alternative methods for pain management include strategies such as regional anesthesia or other non-opioid options.
- Dividing buprenorphine to twice or three times daily can provide analgesia.^{47,48}



For patients being discharged after a hospitalization during which opioids were received:

- Discontinue the opioid or provide the lowest possible amount needed based on the clinical situation to minimize risk of returning to use.⁴⁷
- Ensure the patient has follow-up with their OUD treatment team.



ASK THE PHARMACIST

Engage your clinical pharmacy specialist provider to help manage medications and provide education to prevent any unnecessary treatment interruptions.

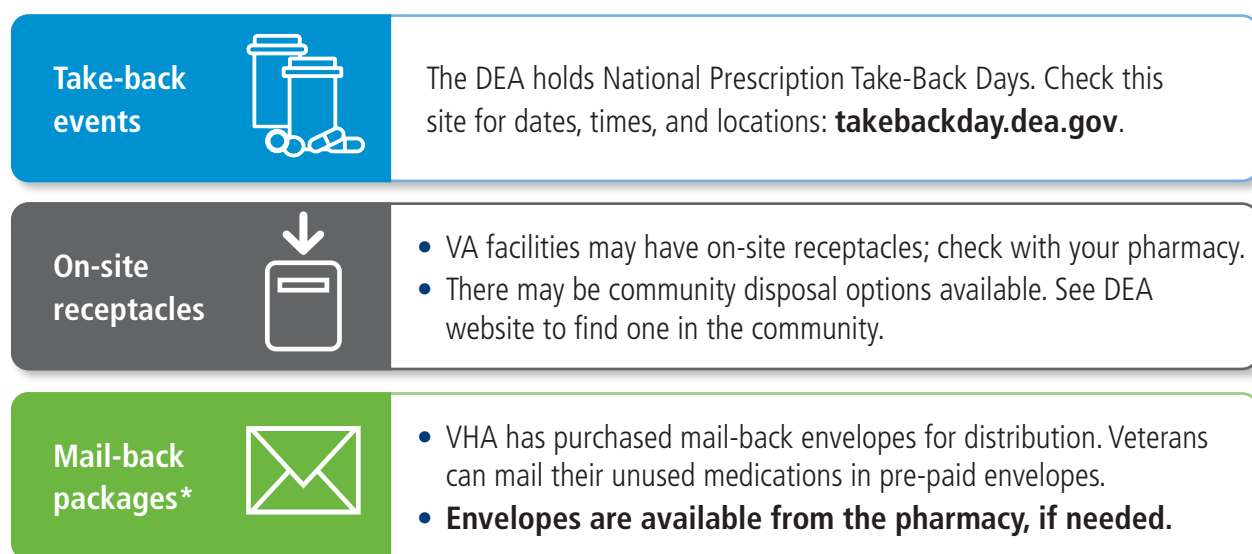
Medication storage and disposal

It is important to educate patients on how to safely store and dispose of unwanted or unneeded controlled medications to reduce potential misuse.

Assist patients with identifying a safe storage location for their medication.

Assess any specific risk factors in the home (e.g., children, family/friends with active addiction) and discuss risk mitigation strategies.⁶

Figure 9. Common options to safely dispose of medications



If none of these options are available, the FDA recommends flushing opioid medications down the toilet.⁴⁹

*Controlled and non-controlled medications may be co-mingled in the envelope; however, illicit drugs may not be placed in the envelope. The filled envelopes are sent to a facility where they are destroyed in an environmentally responsible manner.

Resources

- Management of Substance Use Disorder VA/DoD Clinical Practice Guidelines (2015): www.healthquality.va.gov/guidelines/mh/sud
- VA Treatment Programs for Substance Use Problems: www.mentalhealth.va.gov/substanceabuse.asp
- VA Substance Use Disorder Program Locator: va.gov/directory/guide/sud.asp
- Providers' Clinical Support System (PCSS): pcssnow.org
- Substance Abuse and Mental Health Services Administration (SAMHSA), TIP 63: Medications for OUD: samhsa.gov
- American Society of Addiction Medicine Focused Update: bit.ly/asam_update
- Narcotics Anonymous: na.org
- SMART Recovery: smartrecovery.org
- Prescribe to Prevent: prescribetoprevent.org

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U.S. Department of Veterans Affairs

Veterans Health Administration
PBM Academic Detailing Service

This reference guide was created to be used as a tool for VA providers and is available from the Academic Detailing SharePoint.

These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

VA PBM Academic Detailing Service Email Group:

PharmacyAcademicDetailingProgram@va.gov

VA PBM Academic Detailing Service SharePoint Site:

<https://vaww.portal2.va.gov/sites/ad>

VA PBM Academic Detailing Service Public Website:

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