Appendix A: Opioid Use Disorder Diagnosis and Management Pathway

Addiction Medicine Consult
Contact local specialist
or RACE line: 604-682-2344
Toll-free 1-877-696-2131
www.raceconnect.ca

* For detailed guidance refer to *Guideline for the Clinical Management of Opioid Use Disorder*

Screening
"How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"

More than zero for opioids?

Diagnosis of Opioid Use Disorder
DSM-5 Diagnostic croteria

NO

Ongoing high-risk drug use?
- Discuss risks and harm reduction (naloxone kit, drug checking, safe injection, harm reduction supplies, overdose prevention), and follow up

If no opioid use, screen for other substance use disorders using DSM-5 criteria
- e.g. alcohol, stimulants, benzodiazepines
- contact RACE line and refer to bccsu.ca

YES

everyone at risk should have a naloxone kit

*Lack of access to counselling **should not be considered a barrier** to beginning treatment for opioid use disorder.*

Discuss pros/cons of Common Treatment Options

1. Buprenorphine/naloxone (bup/nlx)
- Good safety profile: less risk of overdose
- Milder side effects
- Easier to progress to take-home doses; generally can progress to take-home doses immediately at the discretion of the treating clinician once clinically stable and can safely store medication.
- Induction can be challenging and requires focussed care
  - Time required to complete induction
  - Risk of precipitated withdrawal

2. Methadone
- May be preferred treatment for unstable individuals
- Consider when buprenorphine/naloxone is contraindicated or not-preferred.
- Requires daily witnessed ingestion
- Higher risk of overdose
- Requires education and training to prescribe – via the Provincial Opioid Addiction Treatment Support Program, available at bccsu.ca

1 Recommended 1st line treatment
Buprenorphine/Naloxone (Suboxone®) Opioid Agonist Treatment

Assessment and Investigations

Preparing for Induction
- Treating opioid use disorder benefits from a supportive, empathetic, open-door approach.
- Assess addiction history and co-morbidities.
- Assess concurrent medications (review Pharmanet).

If concurrent alcohol, benzodiazepines, sedatives–consult RACE line.
- Review contraindications.

Allergy to drug components, severe liver dysfunction, severe respiratory distress, *delirium tremens*, acute alcohol intoxication.
- Offer an office-based urine pregnancy test.

If positive, consult RACE line.
- Complete the following within the first week if not already.
  - Targeted physical and mental health assessment.
  - Laboratory tests.
  - Urine drug test, include test for fentanyl.
- Provide education and discuss the following with the patient and caregiver (if appropriate).
  - How bup/nlx works.
  - Home and office induction.
  - Precipitated withdrawal and how it can be avoided by being in withdrawal for 1st dose on Day 1.
  - Withdrawal assessment tools: COWS (office) and SOWS (home).
  - Review treatment plan.

Induction: Patient must be in withdrawal for 1st dose on Day 1 (COWS ≥ 12) or (SOWS ≥ 17)

- **Office Based Induction**
  - Ask patient to come to office, in withdrawal. Patient will stay and/or check-in several times throughout Day 1. Doses are witnessed in office unless practitioner determines it is appropriate for patient to take-home.
- **Home Induction (if appropriate)**
  - Provide contact info where patient/caregiver can reach you including after-hours advice if needed
  - Provide instructions about timing and doses
  - Patient self-assesses withdrawal using SOWS and takes dose at home. Youth require supervision by a responsible adult.
  - Ask patient to call after they have taken 1st dose.

Day 1 - Document in office (or at home by patient).

1. 1st dose (note doses are mg/mg buprenorphine/naloxone (bup/nlx) and sublingual)
- Confirm withdrawal using COWS or SOWS.
- If COWS 12-23 (SOWS ≥17): Common starting dose is 4 mg/1 mg bup/nlx.
- Adjust dose if severe withdrawal (COWS≥24) or if abstinent.
- For youth, use an individualized and step-wise approach to dosing, consider call to RACE line.

2. Check-in after 30-60 min
- If patient (office or home) feels terrible/worse, manage symptoms of precipitated withdrawal and encourage continuing with induction – if they choose to continue, give second dose and follow with additional doses every 1–2 hours to max total of 12mg/3 mg bup/nlx.

3. Schedule visit or call to check-in after 1-3 hrs
- If patient feels good, no additional Day 1 doses (consider a take-home dose if concerned may be needed to manage withdrawal symptoms later)
- If withdrawal symptoms persist, provide additional doses of one or two 2 mg/0.5 mg bup/nlx tablets every1–3 hours, if needed, to a **max total of 12 mg /3 mg bup/nlx on Day 1.**

Remainder of first week

Day 2 max total: 16 mg/4mg bup/nlx.
Ongoing max total: 24 mg/6mg bup/nlx.
- Aim to reach dose of 12mg/3mg-16mg/4mg bup/nlx. This range is recommended for effective treatment.
- Goal is 24-hour dosing interval with no withdrawal symptoms, medication-related intoxication or sedation.

Day 2 onwards (symptoms managed)
- Repeat previous total dose + one to two 2 mg/0.5 mg bup/nlx tablets – taken once daily.

Day 2 onwards (feeling withdrawal)
- Repeat previous day total dose + one to two 2 mg/0.5 mg bup/nlx tablets.
- Titrate as needed (by one to two 2 mg/0.5 mg bup/nlx tablets every 1–3 hours to recommended daily max.

Day 2 onwards (feeling sedated)
- Decrease dose as needed.

Long-term Maintenance

- **Schedule follow-up visits**
  - Initially every 1–2 weeks or as needed, with longer intervals once stabilized.
  - Review effectiveness and side effects.
  - Patients are often clinically stable within 7-10 days.
  - Consider take-homes once clinically stable and can safely store medications.
- **Urine Drug Testing**
  - 4 random tests recommended for the first year for patients prescribed take-home doses
  - Test for bup/nlx to assess adherence to treatment, test for fentanyl, opioids, and substances that may affect safety.
- Opioid use disorder is a chronic relapsing disease. If patient relapses, reassess treatment plan and continue treatment.

2

If buprenorphine/naloxone is challenging or not indicated

Methadone opioid agonist treatment or alternative higher intensity treatment options (slow-release oral morphine and injectable opioid agonist treatment)

- Consider taking provincial Provincial Opioid Addiction Treatment Support Program (bccsu.ca) to be able prescribe methadone.
- The *Guideline for the Clinical Management of Opioid Use Disorder* outlines detailed methadone management strategies.
- Alternative, higher intensity treatment options are also available in BC for individuals who do not benefit from first- and second-line opioid agonist treatments, such as slow-release oral morphine and injectable opioid agonist treatment (refer to *Guidance Document for Injectable Opioid Agonist Treatment*), which can be prescribed by experienced addiction medicine practitioners.

3

Proceed with caution: Outpatient Withdrawal Management with concurrent long-term addiction treatment

CAUTION: *"Withdrawal management" (commonly known as detox) alone without long-term opioid agonist treatment or linkage to continuing care is not recommended. Dangers associated with withdrawal management alone include elevated rates of relapse, HIV and HCV infection and overdose death after discharge if there is no linkage to comprehensive and continuing addiction care*

The terms "withdrawal management", "withdrawal management alone" and "detox" can have multiple meanings for the general public and experts, which can lead to confusion. In this guideline, the term "withdrawal management" refers to a short-term detox or opioid agonist taper that takes place over days (not months). "Withdrawal management alone" refers to situations where short-term detox or opioid agonist taper is administered without a plan for long-term opioid agonist treatment.

- Dangers associated with "withdrawal management alone" include elevated rates of relapse, HIV and HCV infection and overdose death after discharge if there is no linkage to comprehensive, continuing care.
- Risk of overdose and death increases after a reduction or the cessation of opioids because of lower tolerance to opioids.
- The safest and most effective treatment option is long-term opioid agonist treatment.
- If patient request withdrawal management, slow (months, not days), outpatient withdrawal management with supporting long-term addiction and recovery-oriented treatment is recommended after discussion of risks. This can be done in the primary care setting as an outpatient. The primary care setting offers less risk of loss to follow-up, continuity of care, and a supportive patient-practitioner relationship. Refer to the provincial *Guideline for the Clinical Management of Opioid Use Disorder*, *Associated Document: Withdrawal Management Safety Bulletin*, and consult RACE line as needed.