

Naltrexone for Opioid Dependence

Dosage	50 mg/day	Indications for Use	Opioid dependence with: Ability to achieve at least 7-10 days of abstinence to rule out the need for opioid detoxification Note: Most effective when the patient is engaged in addiction-focused counseling with monitored administration (e.g., patients in criminal justice system or health care workers with employment-related monitoring).
Alternative Dosing Schedules	25 mg daily or twice a day (b.i.d.) with meals to reduce nausea, especially during the first week Observed administration improves compliance. Full opioid blockage is produced with a schedule of 100 mg on Monday and Wednesday and 150 mg on Friday	Contraindications for Use	Pregnancy Opioid withdrawal Opioid dependence, with use within past week Medical condition requiring opioid medication Severe hepatic dysfunction (i.e., transaminase levels > 3 times normal, or liver failure) Severe renal failure Allergy to naltrexone
Baseline Evaluation	Assure patient completed a naloxone challenge and/or has had at least 7 to 10 days of verified abstinence Transaminase levels Urine toxicology	Side Effects	Common: nausea (~10%) Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence
Patient Education	Discuss compliance-enhancing procedures. Negotiate commitment from the patient regarding monitored ingestion, if necessary. Provide patients with wallet cards that indicate use of naltrexone.	Drug Interactions	Opioid containing medications, including over-the-counter (OTC) preparations Thioridazine Oral hypoglycemics
Monitoring	Monitor for opioid use at least weekly during early recovery, via urine toxicology. Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter. Discontinue/reduce naltrexone, if transaminase levels rise significantly. Reevaluate patient compliance and progress at least every 3 months and adjust the treatment plan as necessary. Continue treatment for 12-24 months, if the patient maintains abstinence. Consider reinstating naltrexone if the patient relapses to opioid use after discontinuation of naltrexone.		

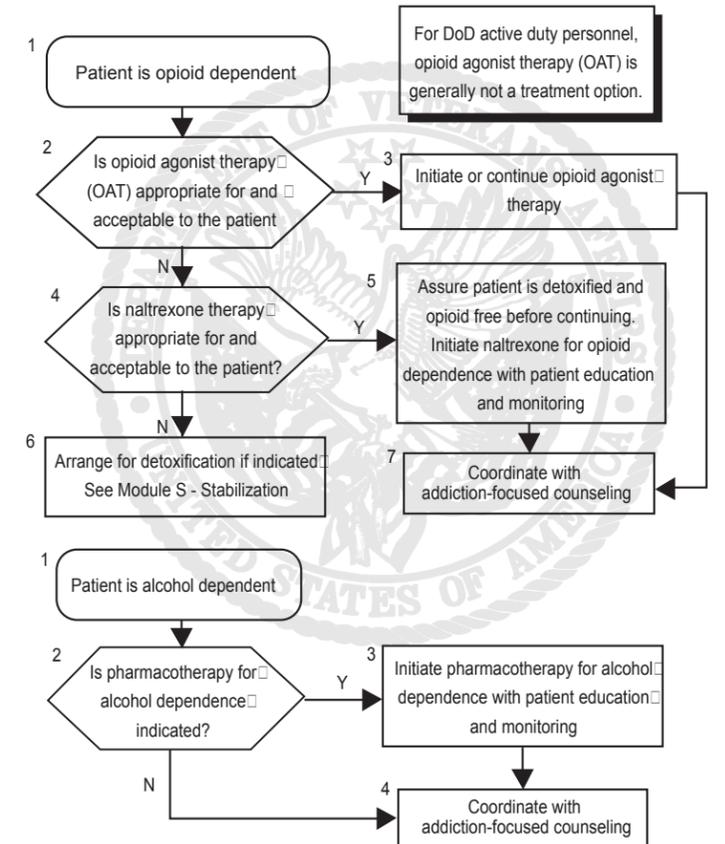
Agonist Therapy for Opioid Dependence

	Opioid Agonists: Methadone and LAAM
Indications	Opioid dependence \geq 1 year 2 or more unsuccessful opioid detoxification episodes within a 12-month period Relapse to opioid dependence within 2 years from OAT discharge
Contraindications	Allergy to agent Concurrent enrollment in another OAT Significant liver failure Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone) For LAAM, EKG with QT _c interval > 0.45 seconds
Side Effects	Common: constipation Less common: sexual dysfunction QT interval prolongation (LAAM)
Drug Interactions	Drugs that reduce serum methadone level: phenytoin, carbamazepine, rifampin, barbiturate sedative-hypnotics, anti-virals involving CYP3A4 activity (including interferon and HIV protease inhibitors), ascorbic acid, and chronic ethanol use Drugs that increase serum methadone level: cimetidine, ketoconazole, fluconazole, amitriptyline, diazepam, and fluvoxamine maleate

VA/DoD Clinical Practice Guideline Substance Use Disorders – Specialty Care Pharmacotherapy Pocket Guide

MANAGEMENT OF SUBSTANCE USE DISORDERS

Module P: Addiction-Focused Pharmacotherapy for Opioid and/or Alcohol Dependence



Pharmacotherapy for Alcohol Dependence

	Naltrexone	Disulfiram		Naltrexone	Disulfiram
Dosage	<ul style="list-style-type: none"> 50 mg/day up to 100 mg/day 	<ul style="list-style-type: none"> 250 mg/day 	Indications for Use	Alcohol dependence with: <ul style="list-style-type: none"> Ability to achieve at least 3-5 days of abstinence to rule out the need for detoxification Drinking within the past 30 days and/or reports of craving Note: Most effective when the patient is engaged in addiction-focused counseling	Alcohol dependence with: <ul style="list-style-type: none"> Abstinence > 24 hours and BAL equal to 0 Combined cocaine and alcohol dependence Failure of or contraindication to naltrexone Previous response to disulfiram Patient preference Capacity to appreciate risks and benefits and to consent to treatment Note: Most effective with monitored administration (e.g., in clinic or with spouse or probation officer.)
Alternative Dosing Schedules	<ul style="list-style-type: none"> 25 mg daily or b.i.d. with meals to reduce nausea, especially during the first week Full therapeutic effect is produced with a schedule of 100 mg on Monday and Wednesday and 150 mg on Friday 	<ul style="list-style-type: none"> Reduce dose to 125 mg to reduce side effects. For monitored administration, consider giving 500 mg on Monday, Wednesday, and Friday. If a patient taking 250 mg of disulfiram daily drinks alcohol and has no reaction, consider increasing dose to 500 mg daily. 	Contraindications for Use	<ul style="list-style-type: none"> Pregnancy Opioid withdrawal Opioid dependence with use within past week Medical condition requiring opioid medication Severe hepatic dysfunction (i.e., transaminase levels > 3 times normal, or in liver failure) Severe renal failure Allergy to naltrexone Need for alcohol detoxification 	<ul style="list-style-type: none"> Pregnancy Severe cardiovascular, respiratory, or renal disease Severe hepatic dysfunction (i.e., transaminase levels > 3 times upper limit of normal or in liver failure) Severe psychiatric disorders, especially psychotic and cognitive disorders and suicidal ideation Poor impulse control Previous disulfiram-ethanol reaction Metronidazole or ketoconazole therapy, which already induces a similar reaction to alcohol Allergy to disulfiram
Baseline Evaluation	<ul style="list-style-type: none"> Transaminase levels 	<ul style="list-style-type: none"> Transaminase levels Physical assessment Psychiatric assessment Electrocardiogram Verify abstinence with breath or blood alcohol level. 	Side Effects	<ul style="list-style-type: none"> Common: nausea (~10%) Other: headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence 	<ul style="list-style-type: none"> Common (usually mild and self-limiting): somnolence, metallic taste, and headache Less common, but more serious: Hepatotoxicity, peripheral neuropathy, psychosis, and delirium
Patient Education	<ul style="list-style-type: none"> Discuss compliance-enhancing procedures. If necessary, negotiate commitment from the patient regarding monitored ingestion. Provide wallet cards that indicate the use of naltrexone. Note that side effects, if any, tend to occur early in treatment and can typically be resolved within 1-2 weeks with dose adjustment 	<ul style="list-style-type: none"> Instruct patients to avoid alcohol in food, beverages, and medications. Provide wallet cards that indicate the use of disulfiram. Because of the risk of significant toxicity and limited evidence of effectiveness: <ul style="list-style-type: none"> Give careful consideration to risks and benefits. Document informed consent discussion with the patient. Obtain written informed consent for VA patients. 	Drug Interactions	<ul style="list-style-type: none"> Opioid containing medications, including OTC preparations Thioridazine Oral hypoglycemics Note: Does not alter ethanol absorption or metabolism or have major effects when combined.	<ul style="list-style-type: none"> Alcohol containing medications, including OTC preparations Severity of disulfiram-ethanol reaction varies considerably among patients and is generally dose-related, causing vasodilatation, flushing, hypotension, nausea, vomiting, dizziness, tachycardia, cardiac arrhythmias, myocardial infarction/stroke in susceptible patients, and even death from cardiac complications in older patients. Drug-drug interactions may occur with phenytoin, warfarin, isoniazid, rifampin, diazepam, chlordiazepoxide, imipramine, desipramine, and oral hypoglycemic agents.
Monitoring	<ul style="list-style-type: none"> Repeat transaminase levels monthly for the first 3 months and then every 3 months thereafter, and discontinue if levels significantly rise. Continue treatment 3-12 months if the patient is making satisfactory progress towards treatment goals. Consider reinstating naltrexone, if the patient relapses to harmful alcohol use after discontinuation of naltrexone. 	<ul style="list-style-type: none"> Repeat transaminase levels monthly for the first 3 months and every 3 months thereafter. Discontinue disulfiram if transaminase levels significantly rise. Reevaluate the need for disulfiram at least every 3 months and discontinue use once stable abstinence is achieved or if patient adherence cannot be safely maintained. 			