MAT

Medication-Assisted Treatment for Opioid Use Disorder

A Printable Pocket Guide

Created in partnership with AHCCCS and the ASU Medical Advisory Board

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AHCCCS
Arizona Health Care Cost Containment System

Overdose Reversal

All patients with an opioid use disorder should be co-prescribed naloxone.

Consider prescribing naloxone for patients prescribed an opioid medication, particularly those patients at high risk for respiratory depression. Per Arizona Revised Statutes 32-3248, patients must be co-prescribed naloxone when prescribed more than 90 morphine milligram equivalents (MME) per day. As a patient experiencing an overdose cannot self-administer naloxone, friends and family members of those with opioid use disorders should have naloxone readily available and be trained to administer the medication. For more information on obtaining and administering naloxone, opioid users and friends/family of opioid users can visit **getnaloxonenow.org.**

Medications: naloxone (Narcan®, Evzio®).

Administration: injection, auto injection, intramuscular, or intranasal spray.

Mechanism: Reverses opioid overdose by removing opioids from receptor. Only effective at reversing overdose for 20-90 minutes. Patients should be taken for medical attention after naloxone is administered.

Medication-Assisted Treatment (MAT)

combines **behavioral therapy** ***and*** **medication** to treat substance use disorders for the purposes of promoting and maintaining recovery.

The Evidence

Research on MAT shows:

- Half of patients participating in treatment with behavioral therapies alone will be lost to attrition.
- Treatment that combines medication with behavioral therapies has been shown to be more effective than treatment with behavioral therapies alone.
- MAT has been found to improve treatment retention, reduce illicit opiate use, decrease cravings, and improve occupational functioning.
- MAT has demonstrated a 75% reduction in mortality and premature death.
- MAT has been found to reduce healthcare costs, primarily in the form of fewer and shorter inpatient admissions. When considering the costs of drug-related crime, criminal justice costs, and total healthcare expenses, every dollar invested in addiction treatment programs yields twelve-fold savings.

Frequently Asked Questions

How do I know if my patient needs MAT?

If you suspect your patient has an opioid use disorder, they may be an appropriate candidate for MAT. Patients who have struggled to maintain abstinence from opioids through traditional forms of treatment alone may benefit from the addition of pharmacotherapy to behavioral therapies.

Isn't treating my patient's opioid use disorder with medication just replacing one addiction for another?

Addiction differs from physical dependence, in that addiction involves using a substance compulsively, using a substance despite negative consequences, and using it to reach a state of euphoria. With medications to treat substance use, a patient may become physiologically dependent on the substance, but the medication is used to feel and stay well, not to achieve euphoria or a "high." Medications, such as methadone, actually have greater chemical similarities to the brain's natural hormones (e.g. endorphins), than do other opioids.

How long should my patient remain on MAT?

MAT, like other forms of pharmacological treatment, is individualized. Some patients may utilize MAT to stabilize in their recovery for a period of time, while others may remain on these medications for their lifetime. Research suggests brief courses of MAT may not be sufficient and a minimum of 12-month courses or longer may be optimal.

My patient is currently abstaining from opioids, do they really need MAT?

Patients who are currently abstinent, but at risk for relapse, may be good candidates for MAT. Patients are most at risk for overdose when they have a reduced tolerance for opioids, which may occur after a period of abstinence, incarceration, or detoxification services. This may be a critical time to consider medication-assisted treatment.

Aren't methadone overdoses common? Would I be putting my patient at risk?

A federal panel of national experts, through an extensive review of the research literature and national data, determined the majority of methadone overdoses occur when methadone is used as an analgesic, *not* when methadone is dispensed in Opioid Treatment Programs (OTPs). Methadone and other forms of MAT are some of the most heavily regulated and monitored forms of medication in the healthcare system.

Is one form of medication better than another?

The best medication is the one that works for the patient. A patient's response to a medication is primarily based on genetic markers, though the patient's history and the treatment setting are also factors that can be used in deciding the most appropriate medication.

I work with pregnant women, what are the standards of care for this population?

Due to the risk of miscarriage with untreated opioid withdrawal, the American College of Obstetricians and Gynecologists endorses methadone and buprenorphine (mono-product), accompanied by behavioral therapy, as the standard of care for pregnant women with opioid use disorders and dependence.

Arizona Opioid Assistance & Referral Line

This free 24/7 hotline, gives providers information about safe prescribing limits, potentially dangerous drug combinations, chronic pain treatment options, and caring for patients who are suffering from opioid-use disorder.

1-888-688-4222

Patients at Risk for Overdose:

- **Individuals receiving rotating opioid medication regimens**
- **Individuals who inject opioids**
- **Individuals with reduced tolerance who have:**
  - Recently been released from incarceration and are a past user of opioids
  - Recently been released from emergency medical care following opioid intoxication or poisoning
  - Completed opioid detoxification or have been abstinent for a period of time

Opioid Withdrawal Symptoms

If your patient experiences withdrawal symptoms when they attempt to stop their opioid use, they may be a good candidate for MAT. Opioid withdrawal symptoms include:

- Anxiety
- Dilated pupils
- Watery eyes
- Diarrhea
- Vomiting
- Sweating
- Cramping/abdominal pain
- Rapid heart rate
- Excessive yawning
- Nausea
- Restlessness
- Insomnia
- Tremors
- "Goose bumps"

As a healthcare provider, YOU can help your community address this epidemic:

Interested in obtaining a waiver to prescribe buprenorphine?

SAMHSA Information and Training

https://www.samhsa.gov/medication-assisted-treatment

Need to refer your patient for MAT services?

Buprenorphine Treatment Practitioner Locator

www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

To locate an Opioid Treatment Program (OTP)

Opioid Treatment Program Directory

www.samhsa.gov/medication-assisted-treatment

Reminder: MAT = Pharmacotherapy + Behavioral Therapies

You can locate psychosocial substance abuse treatment services in your area using the Arizona Substance Abuse Treatment Provider Locator: http://substanceabuse.az.gov/

Evidence-Based Practices
used by Substance Abuse Counselors

Treatment Modality	Motivation Enhancement/ Motivational Interviewing	Cognitive Behavioral Therapy	Contingency Management
Psychological Mechanism	Enhance internal motivation through a strong working alliance/therapeutic alliance and eliciting "change talk" from the patient	Patient changes maladaptive thinking and behaviors through structured exercises and activities	Reinforces desired behaviors through an incentive-based system
Treatment Frequency and Duration	Can be utilized for brief interventions or longer interactions; useful for initial treatment engagement	Short to long term therapy (approximately 10-20 sessions)	Several months (8-16 weeks), 1-2 times weekly
Considerations	Patient must have a clearly identifiable and measurable target behavior	Patients may require a high level of cognitive functioning and ability to work independently to participate in this treatment	Should be used to augment other forms of treatment the patient is receiving, not the sole treatment

Consult with a licensed substance abuse treatment provider, as not one behavioral treatment is right for everyone.
For an overview of substance abuse treatment best practices, see: National Institute on Drug Abuse (2018, January 17). *Principles of Drug Addiction Treatment: A Research-Based Guide* (3rd ed.). Washington, D.C.

MAT Medications

	methadone (Methadose®, Dolophine®) FDA Approval: 1964	buprenorphine/ naloxone (Suboxone®) FDA Approval: 2002	naltrexone (Vivitrol®, Revia®, or Depade®) FDA Approval: 1984
Pharmacologic Mechanism	Full Agonist - Activates opioid receptors	Partial Agonist - Acts on and blocks opioid receptors	Antagonist - Blocks opioid receptors
Administration Route	Liquid or oral tablet	Sublingual tablet or film	Take-home daily oral medication or long term injectable
Administration Frequency	Daily administration; take home doses for stable patients	Take home doses permitted; initial weekly visits, then monthly	Weekly visits or once monthly injection
Prescriber Requirements	Must be administered at an Opioid Treatment Program (OTP)	SAMHSA waiver required for MD, DO, NP, or PA	Any licensed prescriber
Pros	Economical/ low cost Long half-life (24-36 hours allows for daily dose in clinic) Good control of cravings and withdrawal symptoms Acts an analgesic for pain patients 50-80% 1-year retention rates No abstinence required prior to commencing treatment	Improved safety profile compared to methadone Patient convenience (take home dosing available) Naloxone combination prevents misuse Acts an analgesic for pain patients 40-50% 1-year retention rates	Does not cause physical dependence Injectable, can prevent diversion and noncompliance
Cons	Risk for respiratory depression when combined with opioids, alcohol, benzodiazepines Less accessible than other forms of MAT due to in-clinic dosing	May provide poor craving control in long-term opioid users due to ceiling effect Often administered without accompanying psychosocial interventions Abstinence of approximately 24 hours required prior to commencing treatment	Poor control of cravings due to antagonist properties Higher cost Extended abstinence (10-14 days) required prior to commencing treatment
Patient Considerations	May provide better control of withdrawal symptoms and cravings for long term opioid users FDA-approved for pregnant women	Patients with high motivation towards compliance and strong social supports may best suit-ed for this treatment Not currently FDA-approved to treat pregnant women with OUD, but often prescribed off-label; consider risks and benefits when prescribing off-label	May be most appropriate for patients with shorter term or less severe addiction histories

Effective treatment for Opioid Use Disorder includes medication prescribed in conjunction with behavioral therapies.