PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Naltrexone FAQs and Answers

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Question 1. How does the effectiveness of XR-naltrexone compare to the effectiveness of other treatments for opioid dependence?

Answer. A traditional model of treatment for opioid dependence involves detoxification followed by outpatient psychosocial treatment without medications to prevent relapse. This **"drug-free"** approach can be effective for a small subgroup of stable patients with high motivation. However, the majority of patients, perhaps as many as 90% of those who are detoxified, will resume opioid use within the first 1-2 months.

Buprenorphine retains 40% to 50% of patients over 3 to 6 months of treatment, suppressing opioid use. Higher doses of buprenorphine (16 mg/d or more) are more effective than lower doses. However, as many as 30-50% of patients treated with buprenorphine in an office-based setting continue to use illicit opioids.

Methadone, when used at optimal doses (60 mg/day or more) retains 60% or more of patients in long-term treatment, suppresses illicit opioid use, and reduces mortality, other drug use, drug-related HIV risk behavior, and criminal activity. Comparative trials using optimal dosing suggest it is more effective than buprenorphine at retaining patients in treatment.

Clinical trials of **XR-naltrexone** have shown retention rates of 50-70% at 6 months similar to those observed with buprenorphine, with little or no concomitant opioid use. However transitioning patients through detoxification onto naltrexone remains a hurdle, as 30-40% of patients are not able to complete a rapid week-long detoxification-induction process. Success rates are higher if the naltrexone treatment initiation is done 1-2 weeks following detoxification, a strategy best accomplished in the residential treatment setting.

There have been, as yet, no direct, controlled comparisons of XR-naltrexone with buprenorphine or methadone.

Question 2. I am interested introducing XR-naltrexone to my practice. Which patients should start with?

Answer. XR-naltrexone can be started without difficulties in patients completing treatment at a residential program, detoxified and with 3-4 weeks from the last dose of opioids. In this case, after confirming that a urine sample is negative for opioid metabolites (including synthetic opioids), injection of XR-naltrexone can be given at the outset. For a more conservative approach, to make sure that there is no adverse reaction to naltrexone, the first dose can be given orally 12.5 mg (1/4 of the tablet) followed by the injection of the XR preparation the next day. Patients who receive XR-naltrexone after 3-4 weeks of abstinence should have minimal, if any, protracted withdrawal. The next dose should be scheduled within 3-4 weeks after the first injection, with the interval between injections extended to every 4 weeks after the first 2-4 injections. The risk of dropping out of treatment is greatest in the first 1-3 months of treatment, and the full compliance with XR-naltrexone is essential at this stage.

Question 3. Which patients are more likely to have a good response to naltrexone?

Answer. There are several groups of patients that seem to have a better response to naltrexone including: 1) Highly motivated patients who are committed to complete abstinence, 2) Patients who have external contingencies to remain abstinent such as professionals in the monitoring programs, probationers, and young adults living with parents, 3) Older patients with a long history of use, multiple relapses, failures of other treatments, and 4) Patients with long periods of abstinence between relapses.

Question 4. What to do if the patient who received XR-naltrexone returns to the office with urine newly positive for opioids?

Answer. Many, approximately 30-50% of patients, will "test" the blockade -- whether intentionally to see if indeed they are blocked, because they are unable to resist urge to use, or in attempt to self-medicate protracted withdrawal. Usually doses of opioids are low, the blockade is complete, and in the majority of cases this is an isolated incident. The fact that the patient is using 1-2 times while fully blocked is by itself not a reason to change treatment plan, actually there is some indication that those patients may do better overall as they are reassured that the blockade works and they are "protected. " However repeated, persistent use, unblocked use, or use with large amounts with attempts to override blockade are reasons for concern and revision of the treatment plan to increase monitoring, intensify treatment, or transition onto agonist. In patients maintained on naltrexone who are using opioids, it is important to make sure that they receive a full blocking dose of naltrexone with no possibility of limited blockade. To accomplish that, XR-naltrexone can be given at shorter intervals than 28 days or supplemented with oral preparation.

Question 5. Can patient be transitioned from methadone maintenance onto naltrexone?

Answer. Generally this is a difficult task that may take several months, and not all patients will be able to accomplish it. Patients who stop methadone and try to start naltrexone usually do poorly so this strategy is not recommended. The first step would be to gradually lower the dose of methadone to 40 mg and induct onto buprenorphine. After stabilization, the dose of buprenorphine is gradually reduced to 2 mg, and after the patient is stable on 2 mg for 1 month, buprenorphine is stopped and naltrexone is gradually introduced after 2-3 days of washout, starting at the 1-3 mg dose while withdrawal symptoms are treated with adjunctive medications. After 3-4 days on the low doses of naltrexone, an injection of XR-naltrexone can be given. The final step of this procedure can be done inpatient to increase chances of success as higher dose of adjunctive medications can be given with close monitoring.

Question 6. How long the patient should remain on XR-naltrexone?

Answer. For the majority of patients, opioid dependence is a chronic and often a relapsing disease. To match the nature of the disease, treatment is most effective when it is long–term, more intensive during treatment initiation and during periods of exacerbation, and consists of less frequent but regular monitoring during periods of remission. XR-naltrexone is most important during early phases of treatment and its advantages are less noticeable as the duration of treatment becomes longer. The longer the patient stays on medication, the less likely he or she is to relapse after the medication is stopped, but certainly there will be patients who will relapse after treatment discontinuation. The absolute minimum recommended duration of treatment would be 6 months, with the optimal duration of approximately 12-18 months, provided that the patient remains in complete abstinence from all substances he or she was abusing prior to treatment. Subsequently, the patient should be monitored off medication but have the option of taking oral naltrexone as needed during periods of increased risk, with an option of resuming XR-naltrexone in case of increased cravings. It is not known if there is a critical duration of antagonist treatment that would permanently reverse the course of the disease.