Prescribing Naloxone to Patients for Overdose Reversal

Module Author:
Julie Kmiec, DO
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine
Addiction Psychiatry - Western Psychiatric Institute & Clinic, Pittsburgh, PA

Content review completed by:
Stephen A. Wyatt, DO, FAOAAM
American Osteopathic Academy of Addiction Medicine
Disclosures

• Julie Kmiec, DO, has no financial relationships to disclose.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
Stephen A. Wyatt, DO
Disclosures

- Stephen A. Wyatt, DO, has no financial relationships to disclose.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that it is their responsibility to disclose this information.
AOAAM aims to provide educational information that is balanced, independent, objective and free of bias and based on evidence. In order to resolve any identified Conflicts of Interest, disclosure information from all planners, faculty and anyone in the position to control content is provided during the planning process to ensure resolution of any identified conflicts. This disclosure information is listed below:

The following developers and planning committee members have reported that they have no commercial relationships relevant to the content of this module to disclose. PCSSMAT contributors: PCSS-MAT AOAAM Clinical Expert Lead and CME content review completed by: Stephen A. Wyatt, DO; Module author: Julie Kmiec, DO and AOAAM Staff: Nina Albano Vidmer and Lara Renucci.

All faculty have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis. Speakers must inform the learners if their presentation will include discussion of unlabeled/investigational use of commercial products.
Accreditation and Designation Statement

• The AOAAM is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians.

• The American Osteopathic Academy of Addiction Medicine (AOAAM) designates this educational activity for a maximum of 1 (one) Category 2B Credit by the AOA CCME and will report CME and specialty credits commensurate with the extent of the physician’s participation in this activity.
In order to complete this online module you will need Adobe Reader. To install for free click the link below:

Target Audience

• The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

At the conclusion of this activity participants should be able to:

- Discuss how the opioid prescribing epidemic is associated with the overdose epidemic
- Discuss opioid overdose risk factors
- Describe the basic pharmacology of naloxone
- Describe studies demonstrating the efficacy of naloxone in bystander overdose
- Name the four different forms of naloxone available for bystander reversal of overdose and discuss to prescribe it
Overview

• Opioid epidemic
• Overdose epidemic
• Overdose risk factors
• Naloxone
• Opioid overdose prevention programs
• How you can prescribe naloxone
OPIOID EPIDEMIC
Opioid Epidemic

• From 1999 to 2008, the number of opioids prescribed in the US quadrupled (CDC, 2011)
  ▪ Consensus statement from American Pain society and American Academy of Pain Medicine in 1997
    – Little risk of addiction and overdose in pain patients
    – Less than 1% of patients become addicted to opioids
  ▪ Greater emphasis in assessing and treating pain (TJC; Berry & Dahl, 2000), 5th vital sign (APS, VHA)
Opioid Prescribing

Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.

Number of painkiller prescriptions per 100 people

Lowest

AZ 82
NE 79
WA 77
ND 75
TX 74
IA 73
CT 72
CO 71
WY 70
VT 67
AK 65
NJ 63
NY 60
HI 52

Average

SC 102
NC 97
NV 94
DE 91
RI 90
PA 88
DC 86
ME 85
MS 120
AR 116
MI 107
AL 143

Highest

OH 100
MO 95
KS 94
GA 91
UT 86
ID 86
LA 118
IN 109

Heroin Use

Heroin Use Has INCREASED Among Most Demographic Groups

<table>
<thead>
<tr>
<th>Category</th>
<th>2002-2004*</th>
<th>2011-2013*</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEX</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
</tr>
<tr>
<td><strong>AGE, YEARS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-17</td>
<td>1.8</td>
<td>1.6</td>
<td>--</td>
</tr>
<tr>
<td>18-25</td>
<td>3.5</td>
<td>7.3</td>
<td>109%</td>
</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>58%</td>
</tr>
<tr>
<td><strong>RACE/ETHNICITY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>1.4</td>
<td>3</td>
<td>114%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td>--</td>
</tr>
<tr>
<td><strong>ANNUAL HOUSEHOLD INCOME</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $20,000</td>
<td>3.4</td>
<td>5.5</td>
<td>62%</td>
</tr>
<tr>
<td>$20,000-$49,999</td>
<td>1.3</td>
<td>2.3</td>
<td>77%</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>1</td>
<td>1.6</td>
<td>60%</td>
</tr>
<tr>
<td><strong>HEALTH INSURANCE COVERAGE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4.2</td>
<td>6.7</td>
<td>60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.3</td>
<td>4.7</td>
<td>--</td>
</tr>
<tr>
<td>Private or other</td>
<td>0.8</td>
<td>1.3</td>
<td>63%</td>
</tr>
</tbody>
</table>

Heroin Addiction and Overdose Deaths are Climbing

http://www.cdc.gov/drugoverdose/data/heroin.html
OVERDOSE EPIDEMIC
### 6 Leading Causes of Unintentional Injury Deaths, United States
#### 1999, All Races, Both Sexes

<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional Suffocation</td>
<td>472</td>
<td>Unintentional MV Traffic</td>
<td>564</td>
<td>Unintentional MV Traffic</td>
<td>751</td>
<td>Unintentional MV Traffic</td>
<td>9,893</td>
<td>Unintentional MV Traffic</td>
<td>6,602</td>
<td>Unintentional MV Traffic</td>
</tr>
<tr>
<td>2</td>
<td>Unintentional MV Traffic</td>
<td>179</td>
<td>Unintentional Drowning</td>
<td>490</td>
<td>Unintentional Drowning</td>
<td>192</td>
<td>Unintentional Drowning</td>
<td>177</td>
<td>Poisoning</td>
<td>964</td>
<td>Poisoning</td>
</tr>
<tr>
<td>3</td>
<td>Unintentional Drowning</td>
<td>68</td>
<td>Unintentional Fire/burn</td>
<td>308</td>
<td>Unintentional Fire/burn</td>
<td>171</td>
<td>Unintentional Drowning</td>
<td>647</td>
<td>Poisoning</td>
<td>647</td>
<td>Poisoning</td>
</tr>
<tr>
<td>4</td>
<td>Unintentional Fire/burn</td>
<td>44</td>
<td>Unintentional Suffocation</td>
<td>162</td>
<td>Unintentional Suffocation</td>
<td>54</td>
<td>Unintentional Suffocation</td>
<td>78</td>
<td>Unintentional Suffocation</td>
<td>386</td>
<td>Unintentional Other Land Transport</td>
</tr>
<tr>
<td>5</td>
<td>Unintentional Other Land Transport</td>
<td>100</td>
<td>Unintentional Natural/Environment</td>
<td>49</td>
<td>Unintentional Natural/Environment</td>
<td>49</td>
<td>Unintentional Natural/Environment</td>
<td>26</td>
<td>Unintentional Natural/Environment</td>
<td>14</td>
<td>Unintentional Natural/Environment</td>
</tr>
<tr>
<td>6</td>
<td>Unintentional Natural/Environment</td>
<td>55</td>
<td>Unintentional Fall</td>
<td>242</td>
<td>Unintentional Fall</td>
<td>242</td>
<td>Unintentional Fall</td>
<td>279</td>
<td>Unintentional Fall</td>
<td>279</td>
<td>Unintentional Fall</td>
</tr>
</tbody>
</table>

**WISQARS™** Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

CDC WISQARS
http://www.cdc.gov/injury/wisqars/leading_causes_death.html
### 6 Leading Causes of Unintentional Injury Deaths, United States
#### 2014, All Races, Both Sexes

<table>
<thead>
<tr>
<th>Rank</th>
<th>All Ages</th>
<th>Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;1</td>
</tr>
<tr>
<td>1</td>
<td>Unintentional Suffocation 991</td>
<td>Unintentional Drowning 388</td>
</tr>
<tr>
<td>2</td>
<td>Unintentional MV Traffic 61</td>
<td>Unintentional Drowning 125</td>
</tr>
<tr>
<td>3</td>
<td>Unintentional Suffocation 29</td>
<td>Unintentional Drowning 120</td>
</tr>
<tr>
<td>4</td>
<td>Unintentional Natural/Environment 17</td>
<td>Unintentional Fire/burn 117</td>
</tr>
<tr>
<td>5</td>
<td>Unintentional Fire/burn 15</td>
<td>Unintentional Drowning 20</td>
</tr>
<tr>
<td>6</td>
<td>Unintentional Unspecified 12</td>
<td>Unintentional Struck by or Against 38</td>
</tr>
</tbody>
</table>

**WISQARS™** Produced By: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

CDC WISQARS http://www.cdc.gov/injury/wisqars/leading-causes_death.html
Overdose Deaths

• Since 2000, there has been a 200% increase in deaths involving opioids

• In 2014, there were approximately 1.5x more drug overdose deaths than deaths from motor vehicle crashes

Rudd et al., 2016
Prescription Opioid Overdoses

- Every day 46 people die from prescription opioid overdose

National Overdose Deaths
Number of Deaths from Rx Opioid Pain Relievers

Source: National Center for Health Statistics, CDC Wonder

National Overdose Deaths
Number of Deaths from Heroin

Source: National Center for Health Statistics, CDC Wonder

US Pharmaceutical OD Deaths

- *JAMA* research letter (Jones et al., 2013)
- In 2010, there were 38,329 drug overdose deaths, 22,134 (57.7%) involved pharmaceuticals
- Of the pharmaceutical deaths
  - 74.3% were unintentional
  - 17.1% were suicides
  - 8.4% were undetermined intent
Drugs Involved in OD Deaths in 2010

<table>
<thead>
<tr>
<th>Drug or Drug Class</th>
<th>Drug Involvement in Pharmaceutical Overdose Deaths</th>
<th>Specific Drug Involvement in Opioid Analgesics-Related Overdose Deaths</th>
<th>Opioid Analgesics Involvement in Deaths for Specific Drugs, No./Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All pharmaceuticals (T36-T39, T40.2-T40.4, T41-T43.5, T43.8-T50.8)</td>
<td>22,134 (100.0)</td>
<td>NA</td>
<td>16,651/22,134 (75.2)</td>
</tr>
<tr>
<td>Opioid analgesics (T40.2-T40.4)</td>
<td>16,651 (75.2)</td>
<td>14,333 (86.9)</td>
<td>16,651/16,651 (100.0)</td>
</tr>
<tr>
<td>Benzodiazepines (T142.4)</td>
<td>649 (29.4)</td>
<td>5017 (30.1)</td>
<td>5017/6497 (77.2)</td>
</tr>
<tr>
<td>Antidepressants (T43.0-T43.2)</td>
<td>3869 (17.6)</td>
<td>2239 (13.4)</td>
<td>2239/3869 (57.8)</td>
</tr>
<tr>
<td>Antiepileptic and antiparkinsonism drugs (T42.0-T42.2, T42.5-T42.8)</td>
<td>1717 (7.8)</td>
<td>1125 (6.8)</td>
<td>1125/1717 (65.5)</td>
</tr>
<tr>
<td>Systemic and hematological drugs (T45)</td>
<td>1591 (7.2)</td>
<td>699 (4.2)</td>
<td>699/1591 (43.9)</td>
</tr>
<tr>
<td>Antipsychotic and neuroleptic drugs (T43.3-T43.5)</td>
<td>1351 (6.1)</td>
<td>783 (4.7)</td>
<td>783/1351 (58.0)</td>
</tr>
<tr>
<td>Acetaminophen (T39.1)</td>
<td>881 (4.0)</td>
<td>405 (2.4)</td>
<td>405/881 (46.0)</td>
</tr>
<tr>
<td>Respiratory drugs (T48.3-T48.7)</td>
<td>487 (2.2)</td>
<td>143 (0.9)</td>
<td>143/487 (29.4)</td>
</tr>
<tr>
<td>Cardiovascular drugs (T46)</td>
<td>354 (1.6)</td>
<td>57 (0.3)</td>
<td>57/354 (16.1)</td>
</tr>
<tr>
<td>Barbiturates (T42.3)</td>
<td>296 (1.3)</td>
<td>148 (0.9)</td>
<td>148/296 (50.0)</td>
</tr>
<tr>
<td>Autonomic nervous system drugs (T44)</td>
<td>263 (1.2)</td>
<td>110 (0.7)</td>
<td>110/263 (41.8)</td>
</tr>
<tr>
<td>Nonsteroidal anti-inflammatory drugs (T39.0, T39.2, T39.3)</td>
<td>228 (1.0)</td>
<td>53 (0.3)</td>
<td>53/228 (23.2)</td>
</tr>
<tr>
<td>Anesthetics and therapeutic gases (T41)</td>
<td>195 (0.9)</td>
<td>49 (0.3)</td>
<td>49/195 (25.1)</td>
</tr>
<tr>
<td>Hormones, insulins, glucocorticoids (T38)</td>
<td>147 (0.7)</td>
<td>10 (0.1)</td>
<td>10/147 (6.8)</td>
</tr>
<tr>
<td>Anti-infectives (T38-T37)</td>
<td>114 (0.5)</td>
<td>44 (0.3)</td>
<td>44/114 (38.6)</td>
</tr>
<tr>
<td>Diuretics and other drugs, medicaments, and biological substances (T50.0-T50.8)</td>
<td>56 (0.3)</td>
<td>27 (0.2)</td>
<td>27/56 (48.2)</td>
</tr>
<tr>
<td>Topical drugs (T49)</td>
<td>34 (0.2)</td>
<td>6 (0.04)</td>
<td>6/34 (17.8)</td>
</tr>
<tr>
<td>Other psychotrophic drugs (T43.8, T43.9)</td>
<td>24 (0.1)</td>
<td>13 (0.1)</td>
<td>13/24 (54.2)</td>
</tr>
<tr>
<td>Muscle relaxants (T48.0-T48.2)</td>
<td>24 (0.1)</td>
<td>4 (0.02)</td>
<td>4/24 (16.7)</td>
</tr>
<tr>
<td>Other analgesics, antipyretics, antirheumatics (T39.4, T39.8, T39.9)</td>
<td>23 (0.1)</td>
<td>13 (0.1)</td>
<td>13/23 (56.5)</td>
</tr>
<tr>
<td>Gastrointestinal drugs (T47)</td>
<td>6 (0.03)</td>
<td>2 (0.01)</td>
<td>2/6 (33.3)</td>
</tr>
</tbody>
</table>

Abbreviation: NA, data not applicable.
*Deaths are not mutually exclusive. Deaths involving more than 1 drug or drug class are counted multiple times.*

Jones et al., 2013
OD Deaths in 2010 Involving a Single Class of Drug

Jones et al., 2013
OVERDOSE RISK FACTORS
Overdose Risk Factors

• Using more than 100 mg of oral morphine equivalents daily (Bohnert et al., 2011; Dunn et al., 2010)
• Recent release from controlled environment
  – Incarceration (Binswanger et al., 2013; Binswanger et al., 2007)
  – Treatment (Strang et al., 2003)
• Mixing opioids with benzos, alcohol, other drugs (Powis et al., 1999)
• Medical conditions (renal, hepatic, pulmonary diseases, HIV)
Opioid Overdose

- Opioids bind to mu receptors in the brain causing respiratory depression
  - Less than 12 breaths per min
- Decreased oxygenation of brain and heart leads to
  - Unresponsiveness
  - Anoxia, cyanosis
  - Death
- Respiratory depression can last 1-3 hours, is reversible with naloxone

Boyer, 2012
Possible Complications of Non-fatal Overdoses

- Anoxic brain injury
- Pulmonary edema
- Acute respiratory distress syndrome
- Hypothermia
- Renal failure
- Compartment syndrome
- Liver failure
- Seizures (depending on substance ingested)

Boyer, 2012
Case of Steve

- Steve is a 50 year old SWM with a history of heroin addiction
- MH: chronic pain, migraine headaches, depression, tobacco use disorder, h/o suicide attempt by OD on heroin
- Meds: sertraline 200 mg daily; quetiapine 300 mg qhs; propranolol ER 80 mg daily; buprenorphine/naloxone 8/2 mg BID
Case of Steve (2)

- Steve has been on buprenorphine/naloxone for >5 years. He attends all of his appointments and urine drug testing indicates he is taking buprenorphine and not using other substances
- He denies use of all other substances
- Does Steve need naloxone?
NALOXONE
Naloxone

• Naloxone is opioid antagonist
  ▪ High affinity for mu receptor
  ▪ Displaces bound agonist
  ▪ Prevents other agonists from binding
  ▪ Works within minutes
  ▪ Lasts 20-90 mins
  ▪ FDA approved for IV, SC, IM use
    – Recent FDA approved intranasal naloxone; also off-label intranasal use of naloxone for injection
• Naloxone has been used for opioid reversal for 40 years in hospitals
• Naloxone has been used for overdose in ED and by paramedics for years
• Since mid-1990s, provision for use outside medical setting for people at risk of overdose

Boyer, 2012
Possible Adverse Effects of Naloxone

- If administered to someone not using opioids, there is no adverse effect
- Tachycardia
- Hypertension
- Hypotension
- Seizure – due to anoxia
- Nausea, vomiting
- Diaphoresis
- Other opioid withdrawal symptoms
- Severe symptoms listed in prescribing info were seen in post-op reversals

Naloxone prescribing information
Naloxone IM vs. IN (1)

- Kelly et al. (2005), prospective randomized trial comparing naloxone 2 mg IM to naloxone 2 mg/5 mL given IN with MAD
- 182 patients enrolled, 155 had evaluable data
- IM group had faster time to >10 respirations (p=0.006)
  - 6 mins for IM
  - 8 mins for IN
- Needed rescue naloxone (p=0.0558)
  - 13% for IM
  - 26% for IN
- This was dilute naloxone – should not use more than 1 mL per nostril; it was the only preparation done at time of study
Naloxone IM vs IN (2)

- Kerr et al. (2009)
- Concentrated naloxone 2 mg/1 mL IM vs. IN randomized, controlled, open-label trial
- 172 patients with suspected overdose treated by EMS
  - 83 received 1 mg/0.5 mL in each nostril
  - 89 received 2 mg/1 mL IM
- 129 had adequate response within 10 mins (95% CI -18.2, 7.7%)
  - 60 in IN group (72.3%)
  - 69 in IM group (77.5%)
- Adverse events were similar between groups
- Mean response time was similar between groups, about 8 mins
Refusing Medical Treatment After Naloxone

- Retrospective review of San Diego EMS database and medical examiner’s database
- Looked at paramedic data, who received naloxone and who signed AMA form (n = 998)
- Looked at ME data, who died of heroin OD (n=601)
- Cross-referenced lists, no one released AMA had died of OD within 12 hours

Vilke et al., 2003
OPIOID OVERDOSE PREVENTION PROGRAMS
Opioid Overdose Prevention Programs (OOPP)

- Started 1996, first program in Chicago
- Started in harm prevention programs
- OOPP train people at risk for overdose how to prevent overdose as well as how to recognize and respond to overdose
- Participants are trained to seek help (call 911), rescue breath, administer naloxone IN or IM, and stay with the person who has overdosed
## OOPP Providing Naloxone, 2014

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2014</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sites</td>
<td>188</td>
<td>644</td>
<td>243%</td>
</tr>
<tr>
<td>providing naloxone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of persons</td>
<td>53,032</td>
<td>152,283</td>
<td>187%</td>
</tr>
<tr>
<td>provided kits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of reversals</td>
<td>10,171</td>
<td>26,463</td>
<td>160%</td>
</tr>
<tr>
<td>reported</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of states</td>
<td>16</td>
<td>30</td>
<td>94%</td>
</tr>
<tr>
<td>with OOPP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wheeler et al., 2015
FIGURE 2. Number* and location of local drug overdose prevention programs providing naloxone to laypersons, as of June 2014, and age-adjusted rates† of drug overdose deaths§ in 2013 — United States

* Total N = 644; numbers on map indicate the total number of programs within each state.
† Per 100,000 population.
§ CDC, National Center for Health Statistics; Compressed Mortality File 1999–2013 on CDC WONDER Online Database, released January 2015.

Wheeler et al., 2015
Implementation of OOPP in MA

• Between 2006-2009, 4857 people were enrolled in OOPP programs and 545 naloxone rescue attempts reported
  ▪ Of the 19 communities meeting study criteria, 2912 were enrolled and 327 rescue attempts made
  ▪ 327 rescue attempts were made by 212 individuals
  ▪ 87% were by people who used opioids
  ▪ Most rescue attempts occurred in private settings
  ▪ Rescuer and person who overdosed were usually friends

Walley et al., 2013
Implementation of OOPP in MA

- Naloxone was successful in 98% (150/153) of rescue attempts
  - The remaining 3 people received care by medical system and survived
- Reduced death rates in communities that implemented OOPP
  - Low implementers (1-100 enrollments per 100,000) had 27% decrease
  - High implementers (>100 enrollments per 100,000) had 46% decrease

Walley et al., 2013
Naloxone Laws

- Controlled substance/paraphernalia protection
- Criminal & civil protection for lay administration
- Prescriber immune from criminal & civil liability
- Third party prescription authorized

Source: Office of National Drug Control Policy (ONDCP) website of state legislative information. 
From the following website, please check the information on the chart, and some states vary from state to state.

Naloxone for bystander administration

- Intramuscular
  - Traditional
  - Auto-injector
- Intranasal
  - With MAD (off-label)
  - NARCAN nasal spray
What’s in a Rescue Kit?

• Two doses of naloxone or devices
• Two syringes or mucosal atomizing devices (MAD)
• Instructions on use
• May also include
  ▪ Alcohol swabs
  ▪ Face shields
  ▪ Gloves
HOW TO PRESCRIBE NALOXONE TO PATIENTS
Talk to Patients about Overdose

• Have you ever had an accidental overdose?
  ▪ What were the circumstances, what happened, how did you survive?
• Have you ever witnessed an overdose?
  ▪ What did you do?
• What do you do to protect yourself from overdose?
• What are some risk factors for overdose?
• Have you heard about naloxone/Narcan for reversal of overdose?
Patient Selection (1)

- History of opioid overdose (Silva et al., 2013, Wines et al., 2007)
- Emergency treatment for opioid overdose or intoxication (SAMHSA, 2014)
- Suspected or known heroin or nonmedical opioid use (SAMHSA, 2014)
- Buprenorphine or methadone maintenance (Paulozzi et al., 2012; Britton et al., 2010)
- Receiving >100 morphine equivalents of opioid per day (Bohnert et al., 2011; Dunn et al., 2010)
- Changing from one opioid to another (incomplete cross-tolerance; SAMHSA, 2014)
- Living in remote location or difficulty accessing EMS
- Request from patient or concerned significant other
Patient Selection (2)

- Patient receiving opioid prescription and:
  - Smoking, COPD, asthma, sleep apnea, respiratory infection, other respiratory illness (Warner-Smith et al., 2001; Darke et al., 2006)
  - Renal disease, liver disease, cardiac disease, HIV/AIDS (Warner-Smith et al., 2001; Darke et al., 2006; Green et al., 2012)
  - Known or suspected heavy alcohol use (UNODC/WHO, 2013; Häkkinen et al., 2011)
  - Concurrent benzodiazepine or other sedative prescription (Paulozzi et al., 2012; Silva et al., 2013)
  - Concurrent antidepressant prescription (Darke & Ross, 2000)
  - Recently released from incarceration, detoxification, mandatory abstinence program (SAMHSA, 2014)
Case of Steve (3)

- Is Steve an appropriate candidate for naloxone?
  - Buprenorphine maintenance >5 years
  - Appears to be taking as prescribed, urine is positive for bup/norbup, neg for other substances
  - Denies substance use
  - Has depression, smokes, h/o OD
Case of Steve (4)

- Steve is an appropriate candidate for naloxone based on
  - h/o heroin addiction
  - Buprenorphine maintenance
  - Smoking
  - Antidepressant prescription
  - h/o overdose
Educational Videos for Patients

- Chicago Recovery Alliance (~13 mins)
  - https://www.youtube.com/watch?v=U1frPJoWtkw&feature=player_embedded
- Prescribetoprevent.org
  - http://prescribetoprevent.org/patient-education/videos/
- Getnaloxonenow.org (~20 mins, interactive)

- Study showed first time recipients of naloxone receiving 5-10 minute education on overdose education and naloxone demonstrated high level of knowledge on Brief Overdose Recognition and Response Assessment (Behar et al., 2015)
Writing a Prescription for IM Naloxone

Naloxone HCl 0.4 mg/mL (Narcan)
1 x 10 mL as one flip-top vial (NDC 0409-1219-01) OR
2 x 1 mL single dose vials (NDC 0409-1215-01)

Refills: _____

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: _____ Refills: _____

Sig: For suspected opioid overdose,
inject 1 mL IM in shoulder or thigh.
Repeat after 3 minutes if no or minimal response.

Writing a Prescription for IN Naloxone

Naloxone HCl 1 mg/mL
2 x 2 mL as pre-filled Luer-Lock needless syringe
(NDC 76329-3369-1)

Refills: _____

2 x Intranasal Mucosal Atomizing Device (MAD 300)

Refills: _____

For suspected opioid overdose, spray 1mL in each nostril.
Repeat after 3 minutes if no or minimal response.

Pharmacist: Call 1-800-788-7999 to order MAD 300.

Writing a Prescription for Auto-injector

• Naloxone Auto-Injector 0.4mg/0.4 mL
  ▪ Disp #1 twin pack
  ▪ Use 1 auto-injector upon signs of opioid overdose. Repeat after 3 minutes if minimal or no response.
  ▪ Refills _____
Writing Prescription for NARCAN nasal spray

• Narcan nasal spray 4 mg/0.1 mL (1 box, pack of 2)
  ▪ Sig: For suspected overdose, spray in one nostril. May repeat in 3 mins if minimal or no response.
  ▪ Disp: #1 (pack of two)
  ▪ Refills _____
Common Issues

• Covered by commercial insurance, Medicaid, Medicare
• Cost of naloxone has gone up in recent years due to increased demand
• MAD may not be covered, typically $4-8/each
• NARCAN nasal spray may cost $130, covered by insurance, including Medicaid, may need prior auth
• Auto-injector may cost $3750, covered by some insurances and Medicaid with prior auth
• Stocked by more and more commercial pharmacies; if not, see if pharmacist will order
• Shelf life 12-24 months
Standing Orders

lawaltas.org/preview?dataset=laws-regulating-administration-of-naloxone
Collaborative Pharmacy Practice Agreements (CPA)

- CPA permit pharmacists to work in collaboration with a prescriber on drug therapy management
  - 48 states allow CPA to manage pharmaceutical care under agreement
  - 21 states permit pharmacists to initiate medication under agreement

Green et al., 2015
Monday, March 7, 2016

WOONSOCKET, R.I., March 7, 2016 /PRNewswire/ -- CVS Health (NYSE: CVS) announced today that it will expand access to the opioid overdose-reversal medication naloxone at the end of March at its CVS Pharmacy locations in eight new states: Connecticut, Kentucky, Maryland, North Carolina, New Hampshire, Ohio, Virginia and Vermont. Under a physician-approved protocol permitted by the state, CVS Pharmacy will be able to dispense naloxone to patients in these states without the need for an individual prescription.

"Naloxone is a safe and effective antidote to opioid overdose and by expanding availability of this medication, we can save lives and give more people a chance to get the help they need for recovery," said Tom Davis, RPh, Vice President of Pharmacy Professional Practices at CVS Pharmacy. "By establishing a physician-approved protocol that allows our pharmacies to dispense naloxone to patients without an individual prescription, we strengthen our commitment to help the communities we serve by preventing drug abuse."

Naloxone is already available without a prescription at CVS Pharmacy locations through standing order or collaborative practice agreements in 15 states: Arkansas, California, Indiana, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah and Wisconsin. The company has said it will add a total of 20 states to its naloxone program in 2016 and expects to announce additional states throughout the remainder of the year.

References

References


References

References

PCSS-MAT Listserv

Have a clinical question? Please click the box below!

Ask a Colleague
A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now
PCSS-MAT Mentoring Program

- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

- PCSS-MAT Mentors comprise a national network of trained providers with expertise in medication-assisted treatment, addictions and clinical education.

- Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

- The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit: pcssmat.org/mentoring
PCSSMAT is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society of Addiction Medicine (ASAM) and Association for Medical Education and Research in Substance Abuse (AMERSA).

For More Information: www.pcssmat.org

Twitter: @PCSSProjects

Funding for this initiative was made possible (in part) by Providers’ Clinical Support System for Medication Assisted Treatment (5U79TI024697) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Please Click the Link Below to Access the Post Test for this Online Module

Click here to take the Module Post Test

Upon completion of the Post Test:

• If you pass the Post Test with a grade of 70% or higher, you will be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

• If you received a grade of 69% or lower on the Post Test, you will be instructed to review the Online Module once more and retake the Post Test. You will then be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

• After successfully passing, you will receive an email detailing correct answers, explanations and references for each question of the Post Test.