Buprenorphine/naloxone Tapering

* Upon abrupt discontinuation, withdrawal syndrome may occur.
* Subjective withdrawal symptoms begin within the first 3 days, peak between 3 and 5 days, and return to baseline usually within 10 to 14 days (may be longer).
* Autonomic withdrawal signs (lacrimation, rhinorrhea, tremors, chills, gooseflesh).
* General complaints include: restless leg, insomnia, anxiety, abdominal distress.
* Protracted abstinence syndrome can occur and persist for months or years following discontinuation of the medication. It is important to respond to patient’s protracted withdrawal symptoms (anxiety, insomnia, depression) to support their recovery process and avoid relapse.
* Buprenorphine/naloxone should be tapered over days, weeks, or months, depending on patient’s tolerance of symptoms.
* Some patients may choose to taper off of buprenorphine/naloxone. These patients will continue to be supported by the OBAT team and receive assistance with dose decreases, and management of withdrawal symptoms. The taper duration is individualized to the patient and should be continually adjusted to meet the patient’s needs.
* Tapering/discharge from program or initiation of intensive treatment plan should be considered for the following cases:  
  + Ongoing opioid use or use of other illicit drugs: three or more positive urine toxicology results in a row for opioids or other illicit drugs and the risk of continuing treatment outweighs the benefit.
  + Negative buprenorphine screens.
  + Patient presents to OBAT clinic impaired, incidence of overdose, or hospitalization related to substance use.
* If treatment is intensified to include increased visit frequency, counseling, IOP, meeting attendance, and patient continues “regular” use of opioids or other illicit drugs, then the treatment team may discontinue buprenorphine/naloxone treatment and refer the patient to a higher level of care.
* If patient complies with the intensive treatment plan and has had some improvement in drug use, team will restructure treatment as needed and continue treatment with buprenorphine/naloxone.
* Patients who are referred to a higher level of care or discharged, will be reconsidered for future treatment in OBAT.
* Multiple missed appointments or inability to contact patient:  
  + Address with treatment team and document in electronic medical record. If unable to reach patient prescription refills should be canceled in hopes this will bring the patient back in to care.

Naltrexone Discontinuation

* There is no withdrawal syndrome associated with naltrexone discontinuation.
* Some patients may choose to discontinue naltrexone. These patients may continue to be supported by the OBAT team and receive assistance with their recovery in terms of monitoring and clinical management. Patients choosing to discontinue naltrexone should be encouraged to continue psychosocial therapies and mutual-help groups.
* Some patients may stop naltrexone due to side-effects or adverse reactions. In this case, alternative treatment strategies should be discussed.
* Naltrexone discontinuation/discharge from program or initiation of intensive treatment plan should be considered for the following cases:  
  + *Opioid use:* Two to three recent positive urine toxicology results for opioids and the risk of continuing treatment outweighs the benefit. Consider discontinuing naltrexone treatment sooner if opioid use is occurring towards the end of the extended-release naltrexone dosing interval as this places the patient at increased risk for fatal overdose.
  + *Alcohol use:* Patients presenting to clinic smelling of alcohol, positive Breathalyzer, provides reports of ongoing ETOH use, or noted ED admissions for ETOH use.
  + *Ongoing use of other illicit drugs:* three or more positive urine toxicology results in a row for illicit drugs (cocaine, amphetamines, benzodiazepines, gabapentin, or other central nervous system depressant) and the risk of continuing treatment outweighs the benefit.
  + Patient presents to OBAT clinic impaired or reports of impairment, incidence of overdose, or hospitalization related to substance use.
* If treatment is intensified to include increased visit frequency, counseling, IOP, meeting attendance, and patient continues use of opioids or other illicit substances, then the treatment team may discontinue naltrexone treatment and refer the patient to a higher level of care.
* Patients who are referred to a higher level of care or discharged, will be reconsidered for future treatment in OBAT.
* If patient complies with the intensive treatment plan and has had some improvement in substance use, team will restructure treatment as needed and continue treatment naltrexone and resume extended-release naltrexone injections.
* Multiple missed appointments or inability to contact patient:  
  + Initially if a patient misses an extended-release naltrexone injection, he/she should be instructed to receive the next injection as soon as possible. Reassess patient status prior to administering medication. Naloxone/naltrexone challenge if suspected opioid use or if injection has lapsed for an extended period of time. Augment treatment plan as needed.
  + Consider a temporary change to weekly naltrexone tablet prescriptions rather than continue with extended-release injectable naltrexone until patient is able to adhere to treatment plan.
  + Multiple missed appointments should be addressed with the patient and the treatment team. Risk may outweigh benefits of continuing naltrexone treatment; document in electronic medical record.

Discharge

* If a patient is discharged from the program they are welcome to re-engage, except if there are administrative or safety concerns connected with the discharge.
  + Examples of administrative and safety issues: violence or criminal activity on hospital grounds, police report or other documentation of patient selling prescribed medication, inappropriate behavior in a clinic setting, threatening safety of staff or other patients.