POSITION STATEMENT

MEDICATIONS FOR OPIOID USE DISORDER DURING TRANSITIONS OF CARE

POSITION

The American Society of Consultant Pharmacists (ASCP) advocates that pharmacists use their pharmacotherapy expertise to ensure that medications for opioid use disorder (OUD) are available to patients as they transition between different levels of care. Patients transitioning into long-term care facilities should be continued on their current medications for opioid use disorder (MOUD) when possible and non-clinical barriers should be readily addressed.

PREAMBLE/BACKGROUND

In the United States in 2020, among those 12 years of age and older, approximately 1% of individuals (2.7 million individuals) had OUD.1 Opioid use disorder among older adults tripled from 2013 to 2018 with approximately 1 million adults over the age of 65 having OUD.2, 3 In 2019, over 10,000 patients 55 years and older died from an opioid overdose, and emergency department visits for opioid misuse rose 220% between 2006 and 2014 in patients 65 years and older.4-5 From 2019 to 2020, the rate of overdose deaths from synthetic opioids increased by over 50% among patients 65 years and older.6 Opioid use disorder is defined as a pattern of opioid use, resulting in negative medical, social, and psychological consequences. Symptoms may include taking opioids in greater amounts than intended, a desire or unsuccessful attempts to reduce use, and strong cravings for opioids.7 Substance misuse in older adults is often overlooked and undertreated, possibly due to incorrect beliefs that this population does not develop, or require treatment for, OUD.8 Opioid use disorder treatment should consist of MOUD, previously known as medication-assisted treatment, in combination with counseling and behavioral therapies.8

ARGUMENTS

According to the American Society of Health-System Pharmacists statement of the pharmacist’s role in substance prevention and education, pharmacists “have responsibilities regarding substance abuse prevention, education, and assistance including providing pharmaceutical care to patients being treated for substance use disorder (SUD) and collaborating with outpatient and ambulatory care providers to prevent substance use after discharge.”9
Medications are an important component of OUD treatment in older adults.8, 10 Methadone, buprenorphine, and naltrexone have been approved by the U.S Food and Drug Administration for OUD treatment in adult patients.11 Methadone is a full agonist at mu-opioid receptors, buprenorphine is a partial mu-opioid receptor agonist, and naltrexone is a mu-opioid receptor antagonist.11 Methadone and buprenorphine can reduce and eliminate opioid withdrawal symptoms, whereas methadone, buprenorphine, and naltrexone can blunt the effects of illicit opioids and reduce opioid cravings.8 Naltrexone should only be used after a minimum opioid-free period of 7-10 days to avoid precipitating opioid withdrawal.11 Oral, injectable and extended-release formulations of MOUD are available to allow for individualized patient-centered treatment plans.11

Medications for opioid use disorder can be provided to patients as either medically supervised withdrawal (i.e., detoxification, or tapering the medication to assist patients in discontinuing opioids) or maintenance therapy.8 In general, longer term maintenance therapy is recommended for the treatment of OUD.5 Current guidelines for OUD treatment recommend a combination of pharmacologic and nonpharmacologic interventions. However, if a patient declines psychosocial treatment, or such treatment is unavailable, it should not prevent or delay the use of MOUD.12 Opioid agonist therapy is recommended for the treatment of OUD in older adults. Buprenorphine is preferred over methadone because of advantages in its safety profile and broader accessibility in the community setting.2 Older adults require additional consideration when choosing pharmacotherapy because of age-related comorbidities.3 Methadone has greater effects on QT interval prolongation and requires more cautious dose titration, resulting in more adverse effects and increased risk of overdose. A recent literature review suggests buprenorphine and naltrexone have fewer medication interactions and serious adverse effects in older adults than methadone.3 The goal of OUD treatment is recovery, and behavioral strategies and MOUD are needed to help patients reach this goal.8

Medications have been shown to be effective, especially when used for long-term maintenance therapy of OUD. The literature describes the following benefits of maintenance therapy with either methadone or buprenorphine: reduced illicit opioid use, increased treatment retention, reduced risk of death by overdose, reduced risk of human immunodeficiency virus infection, reduced risk of hepatitis C infection, reduced rates of cellulitis, and reduced rates of criminal behavior.13-18 Methadone and buprenorphine are associated with reduced overdose mortality and overall mortality while patients are receiving treatment but not after treatment has ceased.18, 19 Naltrexone has been found to have comparable effectiveness to buprenorphine in the prevention of relapse.20

Despite the large number of patients with OUD and the significant benefits of MOUD, only an estimated 21.5% of patients receive treatment.8 The need for MOUD continues to outpace availability. Medications should be available at transitions of care, and transitions of care programs can increase access to MOUD. Pharmacists should educate patients and their caregivers about the proper use of naloxone. Several studies of pharmacists participating in transitions of care programs have shown benefits with regard to clinical outcomes and medication errors.21, 22 When using a pharmacist-led SUD transition of care telephone clinic, patients continued MOUD treatment post hospital discharge at significantly higher rates.23 Another study investigated nurses in the hospital setting who identified patients not currently receiving treatment for OUD. Nurses were able to link the majority of these patients with a transitional opioid treatment program following discharge from the hospital.24
Until recently, various laws have allowed physicians, nurse practitioners, physician assistants, and other qualified, licensed healthcare professionals to obtain waivers to prescribe buprenorphine for OUD in the office-based setting. Section 1262 of the 2023 Consolidated Appropriations Act removes the federal requirement for practitioners to submit a Notice of Intent (and have a waiver) to prescribe medications, like buprenorphine, for the treatment of OUD. All practitioners who have a current Drug Enforcement Administration registration that includes schedule III authority may now prescribe buprenorphine for OUD in their practice if permitted by applicable state law.

According to guidance from the Centers for Disease Control and Prevention (CDC), healthcare professionals have a responsibility to coordinate care for patients, including patients with OUD. The CDC states that clinicians should not abandon patients because patient abandonment has contributed to patient harm, including suicidal ideation and harmful behavior.

**SUMMATION**

ASCP supports easily accessible MOUD (i.e., methadone, buprenorphine, naltrexone) during transitions of care across healthcare settings to provide patients with the benefits of treatment and to support the goal of recovery in adults with OUD. Pharmacists should continue to advocate for ready access and the removal of barriers to care. This document will be updated as changes in regulations occur in the future.

**REFERENCES**


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