The Pharmacists Role in Increasing Treatment Access for Patients with Opioid Use Disorder

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Learning Objectives

1. Review the chronic, relapsing nature of opioid use disorder (OUD) and its impact on choice, reward, and motivation
2. Compare and contrast pharmacotherapy for OUD with an emphasis on harm reduction, and how pharmacists can increase treatment access
3. Discuss the clinical pearls and anticipated treatment challenges of Sublocade®, the newest FDA-approved medication for OUD
Part I: Opioid Use Disorder

Review the chronic, relapsing nature of opioid use disorder (OUD) and its impact on choice, reward, and motivation.
## Understanding the Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Misuse</td>
<td>Use of a medication (for a medical purpose) other than as directed or indicated, whether willful or unintentional, and whether harm results or not</td>
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<tr>
<td>Abuse</td>
<td>Any use of an illegal drug or the intentional self-administration of a medication for a non-medical purpose such as altering one’s state of consciousness, for example, getting high</td>
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<tr>
<td>Addiction</td>
<td>A primary, chronic disease involving brain reward, motivation, memory, and related circuitry that can lead to relapse and progressive development, and that is potentially fatal if left untreated; markers include craving and continued use despite adverse outcomes</td>
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<tr>
<td>Tolerance</td>
<td>A state of adaptation in which exposure to the drug results in the diminution of its effects over time</td>
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<tr>
<td>Physical dependence</td>
<td>Engenders abstinence syndrome when the drug is abruptly stopped</td>
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Brain Chemistry

- Brain becomes accustomed to exogenous stimuli
- Starts to alter its normal production of neurotransmitters
- Physically does not have the same ability to produce neurotransmitters
- Can last for months into abstinence
DSM-5 Criteria for OUD

Severity: Mild: 2-3 symptoms | Moderate: 4-5 symptoms | Severe: 6 or more symptoms

1. Opioids are often taken in larger amounts or over a longer period of time than intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain and/or use the opioid, or recover from its effects.
4. Craving, or a strong desire to use opioids.
5. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
10. Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
11. Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

SBIRT

Screening, Brief Intervention, and Referral to Treatment

1. Brief Screening ➔ In the past 12 months, have you used opioids other than those required for medical reasons?

2. (+) on Brief Screening ➔ Use assessment instruments like DAST-10 (adult) or CRAFFT (adolescent); or conduct interview following DSM-5 criteria

3. Brief Intervention ➔ Educate re: health risks, possible DDIs, hazards of using (esp. during pregnancy); recommend making a change; assess willingness to make a change

4. Referral to Treatment ➔ Assist with change behavior, setting goals, developing a plan; start and/or refer to treatment

How Can the Pharmacist Help?

**Hospital**
- SBIRT
- Education to HCP and patients re: chronic disease, need for mOUD
- Decrease stigma

**Community**
- SBIRT
- Education to HCP and patients re: chronic disease, need for mOUD
- Decrease stigma

**Office-based**
- SBIRT
- Education to HCP and patients re: chronic disease, need for mOUD
- Decrease stigma
Part II: Pharmacotherapy

Compare and contrast pharmacotherapy for OUD with an emphasis on harm reduction, and how pharmacists can increase treatment access
Detoxification

- Some patients request detox based on past experience
- Some patients may require detox based on past intolerance
- Preferred: agonist/partial agonist +/- comfort medications
- Alternative: comfort medications only
Detoxification – lasts approximately 3-5 days, may be longer depending on half-life of opioid

- Not full treatment, only a component of treatment
- The detoxification process consists of three essential components, which should be available to all people seeking treatment:
  - Evaluation
  - Stabilization
  - Fostering patient readiness for and entry into treatment

**Treatment compromises:** Detoxification, Psychotherapy, Medical Treatment for Addiction, Medical Treatment of Psychiatric/Medical Illnesses, Referral for help with other associated problems (social, legal, child care, vocational, spiritual, etc.)
Pharmacotherapy for OUD

• No “one size fits all” treatment option

• Three FDA approved treatments with multiple approaches:
  1. Reduce or eliminate withdrawal symptoms: methadone, buprenorphine
  2. Blunt/block the effects of other opioids: methadone, buprenorphine, naltrexone
  3. Reduce or eliminate cravings to use opioids: methadone, buprenorphine, naltrexone

• Methadone and buprenorphine have been associated with reduced risk of overdose death
Methadone

Review:
- Full agonist at mu opioid receptor (MOR)
- Dispensed from Opioid Treatment Program (OTP)
- Similar ADEs to opioids (note: QTc prolongation)
- Multiple CYP involvement; metabolism, substrate
- Long-acting ($t_{1/2} = 8$-59 hours)

Advantages:
- Tx during withdrawal
- Analgesic

Considerations:
- OTP structure/ability to adhere
- Polypharmacy = DDIs
- Age-related heart, kidney, liver, or lung problems decreases safety
- Rapid metabolizer (2D6)
- QTc; respiratory depression
Buprenorphine

Review:
- Partial agonist at MOR
- Sublingual, buccal, long-acting implant, long-acting SC injection
- Need DATA waivered clinician
- Similar ADEs to other opioids
  - Reduced intensity
- CYP3A4
- Long-acting ($t_{1/2}=24-60$ hours)

Advantages:
- Ceiling effect
- Tx during withdrawal
- Analgesic

Considerations:
- DATA waivered clinician
- Polypharmacy = DDIs
- Age-related heart, kidney, liver, or lung problems decreases safety
- Dose multiple times per day?
Naltrexone IM

Review:
• Antagonist at MOR
• Oral, long-acting IM injection
• Not a control substance/opioid
• Must be opioid free for 7-10 days
• ADEs = injection-site rxn, headache
• Hepatic metabolism
• Long-acting (t<sub>1/2</sub>=5-10 days)

Advantages:
• IM formulation
• Non-opioid

Considerations:
• Concomitant anticoagulation
• Liver toxicity; elevated liver enzymes
• Complicates situations in which analgesia is required (i.e. EMS)
• Does not provide analgesia
• Increased risk of OD
How Can the Pharmacist Help?

**Hospital**
- Inpatient:
- Detox vs. induction
- Discharge:
- mOUD supply & connection to SUDs clinic

**Community**
- Detox vs. induction
- Education re: mOUD, options, formulations, effectiveness
- mOUD (CPA?)
- Connection to SUDs clinic

**Office-based**
- Detox vs. induction
- Education re: mOUD, options, formulations, effectiveness
- mOUD (CPA?)
- Connection to SUDs clinic
Part III: Harm Reduction

Compare and contrast pharmacotherapy for OUD with an emphasis on harm reduction
Opioid Crisis

First wave: 1999-2010
- Prescription opioid overdose deaths

Second wave: 2010-2013
- Heroin overdose deaths

Third wave: 2013-present
- Synthetic opioid overdose deaths (i.e. fentanyl, carfentanil)

What does this mean?
We have to shift our focus to combating the opioid crisis as it relates to synthetic opioids (i.e. intravenous drug use)

CDC. Understanding the Epidemic. 2018.
Harm Reduction

• In addition to ensuring appropriate opioid prescribing and increasing access to medications for opioid use disorder, we have to engage in harm reduction to have the most positive impact on the opioid crisis.

• What is Harm Reduction?
  • Public health approach to reduce impact in communities

• I’ve never heard of Harm Reduction before…
  • Yes you have!

Seatbelts  Birth Control  Condoms  PEP/PrEP

PEP = post-exposure prophylaxis
PrEP = pre-exposure prophylaxis
Impact of OUD

Harm Reduction:
(1) Overdose Prevention & Response
- Access to medications for opioid use disorder (mOUD)
- Safer use education
- Naloxone access
- Point-of-care testing
- Good Samaritan laws

(2) Infection Identification & Management
- Point-of-care (POC) testing
- PEP and PrEP
- Self-management of soft tissue infections & use of wound care products

© 2018 CPNP. Harm Reduction Strategies for People Who Inject Drugs: Considerations for Pharmacists.
(1) Overdose Prevention & Response

A. Medications for OUD
   • Increased didactic/field training re: effectiveness & utilization of medications for OUD
   • Pharmacist waiver eligibility for collaborative practice agreements
   • X the X waiver

B. Safer use/injection practices (OD related)
   - Use with others/notify someone pre-use
   - Don’t mix with other CNS depressants
   - Have naloxone nearby/visible during use
   - May consider using via other route (i.e. snorting, sniffing)
   - Utilize test shots (tolerance, potency) and take turns
   - Have a safety plan
(1) Overdose Prevention & Response (cont.)

C. Naloxone access
   • Stock in your pharmacy
   • Offer to all persons (esp. those receiving opioid rx’s or if suspected need)
   • Counsel on importance of carrying at all times & proper use
   • Advocate for OTC naloxone

D. Point-of-care testing
   • Fentanyl test strips
   • Carfentanil test strips?
E. Good Samaritan Law

What the Good Samaritan Law does do:

- Empowers witnesses to call 911 during an overdose by protecting people from prosecution for possession of a controlled substance.
- Provides legal protection for medical professionals who rx naloxone, or people who possess and/or administer naloxone to someone appearing to suffer an opioid-related overdose.
- Saves lives & gives people who use opioids a chance to seek recovery and treatment services.

What the Good Samaritan Law does not do:

- Does not interfere with law enforcement securing the scene.
- Does not prevent prosecution for drug trafficking or weapons charges.
- Does not prevent prosecution for outstanding warrants.

http://opioidoverdoseprevention.org/bmoocp/good-samaritan-law/
A. Access programs

- Syringes at a minimum
- Safe injection kit preferred
1. Clean bottle for mixing water and bleach
2. Bleach to disinfect used syringes if sterile one isn’t available
3. Bandages to help avoid infection after injecting
4. Sterile water to mix the drug with
5. Tourniquet to “tie off” above the injection site
6. Bottle cap for mixing water with the drug before it’s drawn up into the syringe (commonly called “cooker”)
7. Cotton balls to trap dirt and debris as the drug, mixed in water, is pulled into the syringe
8. Sterile syringes
9. Step-by-step injection instructions
10. Alcohol swabs to clean injection site

B. Safe syringe disposal
## C. Safer use/injection practices (ID related)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterile syringes/supplies every time if possible</td>
<td>Sterile; decreases infection risk</td>
</tr>
<tr>
<td>Bleach if needed (flush with water x3, bleach x3, water x3)</td>
<td>Sterilization; decreases infection risk</td>
</tr>
<tr>
<td>Filters – Q-tips or cotton balls, maybe tampons or filter paper; avoid cigarette filters; avoid cotton shots</td>
<td>Cigarette filters have glass, impurities; used cotton is a breeding ground for bacteria</td>
</tr>
<tr>
<td>Water – sterile &gt; boiled x10 min &gt; bottled &gt; tap</td>
<td>Natural bacteria</td>
</tr>
<tr>
<td>Tourniquets – stockings &gt; neckties &gt; lubricated condoms</td>
<td>Easier release; slip-knot tie</td>
</tr>
<tr>
<td>Acidifiers – vitamin C power preferred; avoid lemon juice/vinegar</td>
<td>Lemon juice/vinegar more damaging to veins; lemon juice has bacteria</td>
</tr>
</tbody>
</table>
## C. Safer use/injection practices (ID related, cont.)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arms are the safest, then back of hands; avoid injecting in legs, avoid injecting in groin/neck</td>
<td>Increased risk of clots/leg swelling; proximity to important nerves and arteries</td>
</tr>
<tr>
<td>Rotate injection sites (at least 1 inch away from last injection)</td>
<td>Allows for healing</td>
</tr>
<tr>
<td>Use tourniquets</td>
<td>Allows to see veins more easily, reduces damage</td>
</tr>
<tr>
<td>Avoid reusing/sharpening needle</td>
<td>Needles may be dull – local damage or vein collapse</td>
</tr>
<tr>
<td>Sterile practice (wash/sanitize hands, alcohol swab, injection, band aid)</td>
<td>Decreases risk of infection</td>
</tr>
<tr>
<td>Avoid licking needles</td>
<td>Decreases risk of infection</td>
</tr>
<tr>
<td>Avoid needlesticks (never re-cap someone else’s needle, proper disposal)</td>
<td>Decreases risk of infection</td>
</tr>
<tr>
<td>Education re: PEP/PrEP</td>
<td>Decreases risk of infection</td>
</tr>
</tbody>
</table>
(3) Infection Identification and Management

A. POC testing
- HCV/HIV screening
- Pre/Post-test counseling for positive results
- CDTM?

B. PEP/PrEP
- Education
  - Pre-exposure prophylaxis (PrEP) – for people who are ongoing very high risk of HIV infection
  - Post-exposure prophylaxis (PEP) – for someone who thinks they’ve recently been exposed to HIV during sex or through sharing needles/works
- CDTM?

C. Self-management of soft tissue infections & use of wound care products
- Recommend OTC wound care products for self-management
- Identify when wound requires referral for more intensive medical care
4x more likely to need healthcare for a chronic condition but less likely to seek preventative care

More likely to utilize EDs, generating ~$1,000 per person per year in excess service utilization

Hospital admissions for IDU-related SSTI lead to significantly increased length of stays

High rates of criminalization contribute to societal and economic burden

For every $1 spent on treatment & harm reduction, $2 to $18 is saved in criminal justice and healthcare costs
Spotlight on Portugal

What did they do?
- Decriminalized all drugs (marijuana, heroin, etc.) if less than 10 day supply
- Widespread access to addiction treatment and needle exchange programs

What did the world think would happen?
- Drug use will sky rocket; diversion of mOUD will increase

What actually happened?
- Users feel less stigmatized, were more likely to seek care
- 50% reduction in OUD from 100,000 people in 2001 to 50,000 people in 2016
- 80% reduction in overdose-related deaths from 80 in 2001 to 16 in 2012 (compare to 14,000 in the U.S. that year)
- 95% reduction in HIV cases from 1,016 cases in 2001 to 56 in 2012

"I think harm reduction is not giving up on people, I think it is respecting their timing and assuming that even if someone is still using drugs, that person deserves the investment of the state in order to have a better and longer life." – Dr. João Goulão, Drug Policy Coordinator, Portugal

http://www.emcdda.europa.eu/country-data/harm-reduction/Portugal#drid
The Future of Harm Reduction?

- **Supervised Consumption Sites/Overdose Prevention Sites**
  - Safe, hygienic space to self-administer drugs they obtained elsewhere with access to safe injection education and naloxone

- **Law Enforcement Assisted Diversion Programs (LEAD)**
  - Alternative to punitive approach toward individuals who commit “low-level” drug-related acts
  - Instead, redirects people into community-based support services such as housing, health care, drug treatment, and mental health services

- **Drug Legalization/Decriminalization**
  - Eliminates many negative consequences of drug criminalization for ‘low level’ drug users including stigmatization, incarceration, separation of families, barriers to housing and jobs post sentencing, and infection
Resource

• The majority of the harm reduction content was adapted from this excellent resource:

• CPNP Toolkit: Harm Reduction Strategies for People Who Inject Drugs: Considerations for Pharmacists
  • Available at: https://cpnp.org/guideline/harmreduction
How Can the Pharmacist Help?

**Hospital**
- **Inpatient:** Appropriate opioid Rxing/start mOUD
- **PEP/PrEP**
- **Discharge:** mOUD, Naloxone, Safer injection practices, Syringe/Clean Works, PEP/PrEP

**Community**
- **Appropriate opioid Rxing**
- **mOUD (CPA?)**
- **PEP/PrEP (CPA?)**
- **Naloxone (OTC?)**
- **POC Testing**
- **Safer injection practices**
- **Syringe/Clean Works**
- **Wound care**

**Office-based**
- **mOUD (CPA?)**
- **PEP/PrEP (CPA?)**
- **Naloxone**
- **POC Testing**
- **Safer injection practices**
- **Syringe/Clean Works**
Part III: Sublocade

Discuss the clinical pearls and anticipated treatment challenges of Sublocade®, the newest FDA-approved medication for OUD
## Indication, Induction, Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Moderate to severe opioid use disorder</th>
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<tbody>
<tr>
<td>Induction</td>
<td>Must have initiated treatment on a sublingual buprenorphine product delivering the equivalent of 8 to 24 mg of buprenorphine daily for 7 days</td>
</tr>
<tr>
<td>Administration</td>
<td>Administered subcutaneously (SQ) only by healthcare professional only within 26-30 days of last injection</td>
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</table>
Dose Adjustments

May increase maintenance dose to 300mg SQ injection if 100mg/0.5mL did not provide adequate response (i.e. continued opioid use, cravings, positive toxicology, etc.)

Pharmacokinetics

43-60 days $\rightarrow$ Half life
4-6 months $\rightarrow$ Steady state
Pharmacokinetics of SL vs. XR

Note: ≥2-3 ng/mL is required to block subjective drug-liking of exogenous opioid

![Table 6. Comparison of Buprenorphine Mean Pharmacokinetic Parameters Between SUBUTEX and SUBLOCADE](image)

## Alternative Dosing Regimen?

<table>
<thead>
<tr>
<th>Design</th>
<th>Multicenter, randomized, double-blind, placebo-controlled phase 3 trial</th>
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<tbody>
<tr>
<td>Population</td>
<td>504 adult patients with moderate-severe OUD (defined by the DSM-5)</td>
</tr>
<tr>
<td>Intervention</td>
<td>Initial treatment with buprenorphine-naloxone for up to 2 weeks.</td>
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<tr>
<td></td>
<td>Group 1 (n = 201): BUP-XR 300 mg/300 mg</td>
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<tr>
<td></td>
<td>Group 2 (n = 203): BUP-XR 300 mg/100 mg</td>
</tr>
<tr>
<td></td>
<td>Group 3 (n = 100): volume-matched placebo</td>
</tr>
<tr>
<td></td>
<td>Treatment duration – 6 months</td>
</tr>
<tr>
<td>Primary Endpoint</td>
<td>Participant’s % abstinence from opioid use from weeks 5-24</td>
</tr>
<tr>
<td>Results</td>
<td>BUP-XR 300 mg/300 mg: 41.3%</td>
</tr>
<tr>
<td></td>
<td>BUP-XR 300 mg/100 mg: 42.7%</td>
</tr>
<tr>
<td></td>
<td>Volume-matched placebo: 5.0%</td>
</tr>
<tr>
<td>Conclusion</td>
<td>BUP-XR demonstrated a significantly higher % abstinence compared to placebo (p&lt;0.0001). Both BUP-XR dosage regimens are comparable to each other. BUP-XR 300/300 may be considered for patients who require higher drug exposure based on previous opioid use.</td>
</tr>
</tbody>
</table>
Unpublished Data

Study 1

• Open-label induction
• Randomized, double-blind 24-week study of 6 monthly doses
  • RBP-6000 300mg x6
  • RBP-6000 300/100 x2, 4
  • Placebo volume-matched

Study 2

• Completers from Study 1 and de novo participants who received up to 12 monthly open-label RBP-6000 doses
  • All received flexible dosing of RBP-6000 300mg x1, following by either 100mg or 300mg based on medical judgement

Primary endpoint: % abstinence during weeks 10-25; major comparisons were persons who inject drugs (PWIDs) vs. those who do not (sniffing, oral, etc.); and daily use vs. non-daily use
Results

• Higher mean % abstinence observed among persons who inject drugs (PWIDs) in the 300mg maintenance group
  • PWID = 14.9% vs. non = -9%
• Above result persisted after risk-adjustment
  • PWID = 14.8% vs. non = -7.4%

Conclusion?

• Suggests that PWIDs may benefit from 300mg maintenance dose
Side Effects

- Constipation
- Headache
- Nausea
- Vomiting
- Injection site pruritus
- Injection site pain
- Increased hepatic enzymes
- Fatigue

Serious Harm/Death

- When Sublocade comes in contact with bodily fluids, it immediately forms a solid mass (i.e. depot)
- Intravenous injection of Sublocade may result in occlusion, local tissue damage, and thrombo-embolic events such as PE
- Sublocade should never be administered intravenously
REMS Program

• **Purpose**: To ensure Sublocade is always distributed through a restricted distribution program, **never** directly to a patient

• **Goal**: Prevent intravenous self-administration of Sublocade due to risk of serious harm or death

• An authorized representative of the dispensing location will be designated to ensure that dispensing location meetings REMS requirements to purchase, receive, and dispense Sublocade

• The REMS program does not require action from the provider on behalf of the patient (i.e. no laboratory or other additional testing is required)
Medication Preparation

1. Pull medication out of refrigerator and allow at least 15 minutes to come to room temperature. Remove foil pouch and safety needle from carton and open syringe.

2. Verify that medication in the syringe is liquid, free of particles, and either colorless, yellow, or amber.

3. Remove the cap from the syringe and remove safety needle from sterile packaging.

4. Twist the needle clockwise until it is tight and firmly attached, but do not remove the plastic cover from needle.
Injection Site Preparation

5. It is recommended to place the patient in a supine position.

6. Choose a site between transpyloric and transtubercular planes with adequate SQ tissue.

7. Ensure site is free of nodules, lesions, excessive pigmentation, irritation, redness, bruising, infection, or scarred.

8. Clean the injection site with an alcohol swab.
Injection Technique

9. Hold syringe upright, allow air bubbles to rise (this may take several seconds as the injection is viscous)

10. Remove needle cover and slowly depress plunger to remove excess air from syringe

11. Pinch enough skin at the injection site to accommodate the needle (19 gauge, 5/8 inch) and to lift from underlying muscle

12. Insert needle fully into the abdominal SQ tissue and use a slow, steady push to inject all of the medication in the syringe
Post-Injection Procedure

13. Withdraw the needle at the same angle and release the pinched skin.

14. If there is bleeding, apply gauze or bandage with minimal pressure.

15. Lock the needle guard by pushing it against a hard surface such as a table. Dispose of all components in a sharps container.

16. Tell the patient they may have a small lump for several weeks that will decrease over time, and tell them not to rub the site or place belts/waistbands directly over injection site.
Additional Considerations

**Depot Caveats**

- In the event the depot must be removed, it can be surgically removed under local anesthesia within 14 days of injection
- Prior to each injection, examine the injection site for signs of injection, evidence of tampering, or attempts to remove the depot

**Patient Counseling**

- Long duration of action
  - If treatment is discontinued, withdrawal may not occur for weeks to months
- Risk of serious harm/death if injected intravenously
- Risk of withdrawal if depot is tampered with or removed
Anticipated Treatment Challenges

• What do I do if my patient missed a dose?
  • Give the next dose as soon as possible. Delays of up to 14 days are unlikely to have an impact.

• How soon can I give a subsequent dose?
  • No less than 26 days after the previous dose.

• What is the equivalent dose for SL buprenorphine?
  • The 300 mg per month dose has a higher serum concentration at steady state than 24 mg per day of sublingual buprenorphine.

• What do I do if my patient is having cravings or ongoing use?
  • If the patient is on 100 mg monthly, increase back to 300 mg monthly.
  • Keep in mind emerging evidence to empirically keep those with IVDU on 300mg monthly.

• Is there evidence to support the use of supplemental SL doses?
  • The clinical trial evaluating Sublocade did not use supplemental sublingual doses, but this would be reasonable to try for safety.
Anticipated Treatment Challenges

• What is recommended if a patient requires pain management?
  • Treat with a non-opioid analgesic whenever possible. Patients requiring opioid therapy for analgesia may be treated with a high-affinity full opioid analgesic, with particular attention to respiratory function. Higher doses may be required for analgesic effect. Therefore, a higher potential for toxicity exists with opioid administration.
  • Common opioid affinities at mu receptor are provided below, keeping in mind that the LOWER the Ki the HIGHER the affinity
How Can the Pharmacist Help?

Hospital
- Administrative:
  - P&T
  - Train HCPs on Sublocade administration
- Inpatient:
  - Evaluation of tx challenges (adherence, homelessness, diversion)
- Discharge:
  - Sublocade?

Community
- Evaluation of tx challenges (adherence, homelessness, diversion)
- Assist/advocate during PA process
- Advocacy around pharmacist administration of Sublocade

Office-based
- Train HCPs on Sublocade administration
- Evaluation of tx challenges (adherence, homelessness, diversion)
- Assist/advocate during PA process
- Advocacy around pharmacist administration of Sublocade
Summary

• Understand brain chemistry involvement in OUD as increased education helps to reduce stigma and increase treatment success
• Screen patients for OUD and assist in treatment planning
• Advocate for agonist/partial agonist induction, unless there is a need for detoxification
• Assist in selecting most appropriate mOUD given patient case
• Implement harm reduction interventions whenever possible to maximize safety and decrease healthcare costs
• Identify patients who may be more successful on Sublocade
Questions?

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