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Medication Assisted Treatment Protocol

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ABSTRACT

This article describes a protocol to be able to utilize medication assisted treatment options for patients dependent on opioids. The first step is using a 15-day Klonopin taper for effect detox of acute opioid withdrawal. Once detoxed, the patient can be started on low dose methadone or low dose Buprenorphine. Titration above 40 mg of Methadone, or 8 mg of buprenorphine will usually not be needed. Buprenorphine is utilized as the mono product, Subutex. Avoiding Suboxone eliminates the risk of reemergence of acute opioid withdrawal symptoms.

A description of how to transition to Naltrexone is provided. There are some differences between Methadone and Buprenorphine in the transition to Naltrexone. Once the patient is transitioned to Naltrexone, the stage is set for the patient to be able to get off medication assisted treatment.

KEYWORDS: Naltrexone; Buprenorphine; Protocol; Medication; Treatment

INTRODUCTION

This article describes a protocol to utilize medication assisted treatment options for patients dependent on opioids. The protocol is designed to provide the patients ability to smoothly transition from one medication to another. The ultimate goal is to provide patients the ability to eventually come off of medication assisted treatments entirely. The key factor is the implementation of an effective detox for acute opioid withdrawal.

METHADONE MAINTENANCE

Use of Methadone for opioid maintenance is currently allowed only in federally licensed clinics. The well-established protocols, utilized in Methadone clinics, start the transition to Methadone only when the patient exhibits signs of acute withdrawal. This requires a need to quickly titrate the Methadone dose upwards. The recommended first day dose of Methadone is 30 mg or less. Typically, the maintenance doses utilizing this strategy are at least 60 mgs and range as high as doses well above 100 mgs.

However, if Methadone clinics were to provide an effective detox for acute withdrawal, much lower maintenance doses could be utilized. Under these conditions, the starting dose of Methadone can be 10 mg or less. A slow gradual taper lasting one to four weeks can be utilized to reach a maintenance dose. Typically, the maintenance dose will be 40 mgs or less.

Usually, prescribers will not be able to use Methadone for maintenance as their patients will not be in a federally licensed Methadone clinic. Providing effective detox for acute opioid withdrawal allows the use of much lower maintenance doses of Methadone.

BUPRENORPHINE MAINTENANCE

Advantages

Partial mu opioid agonist.

Prescribers with waivers can utilize Buprenorphine for maintenance.

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Recommended Protocol

1. To use long acting formulations of buprenorphine for protection of drug diversion.
    - Step 1 - Treat acute opioid withdrawal using a 15-day Klonopin taper.
    - Step 2 - Once detox is complete start 2 mg Buprenorphine daily for one week.
    - Step 3 - Start a long acting version of Buprenorphine, for example 100 mg Sublocade subcutaneously.
    - Step 4 - Maintenance dose of 100 mg Sublocade subcutaneously once a month.
2. Guideline regarding Drug testing.
    A. UDS at initial visit to verify patient is using opioids daily.
    B. UDS at the end of the two week Klonopin taper.
    C. UDS at the completion of the 7 day oral induction of Buprenorphine.
    D. UDS at the monthly subcutaneous injections of Sublocade.
    E. Patients informed that evidence of Benzodiazepine use will result in discontinuing use of Buprenorphine-patient may need to be offered a 15 day Klonopin taper for detox at that time.
    F. Evidence of use of Cannabis or Stimulants or other abused drugs on UDS is a risk and could lead to a decision to stop maintenance Buprenorphine.
3. Review of State Pharmacy Prescription monitoring sites.
    A. Review prescription monitoring website at every visit in the induction/ stabilization phase including the first 3 to 6 months of use of long acting formulations of Buprenorphine, then periodically every 3 to 6 months.
4. Maintenance dose goal- the lower the maintenance dose, the easier transition to using Naltrexone, or to stop use of maintenance use of medications completely.
5. Summary clarification- these additions to the protocol provides a comprehensive safe induction/stablization guideline for Buprenorphine maintenance.

Typical maintenance dose

Maximum of 8 mg per day Buprenorphine dose.

Klonopin Detox Protocol

Klonopin 0.5 mg po three times daily for 5 days, then decreases to, Klonopin 0.5 mg twice a day for 5 days, then decrease to Klonopin 0.5 mg once a day for 5 days, then stop. Consider using Klonopin 1 mg 15-day taper for anticipated severe withdrawal such as:

- History of several pervious withdrawal episodes requiring detox.
- History of withdrawal seizures or delirium.
- Patients over the age of 40 with current acute medical conditions such as pneumonia, acute pancreatitis, cancer, and delirium.
- History of recently using high doses of Xanax, IV opiate, or IV methamphetamines.
- Klonopin 1 mg 15 day 30 pills, Klonopin 1 mg three times daily for 5 days, then decrease Klonopin to 1 mg bid for 5 days, then decrease to Klonopin 1 mg daily for 5 days.

SUMMARY

1st Step – Provide effective detox for acute opioid withdrawal-15-day Klonopin taper.

2nd Step – Start Buprenorphine 2 mg daily.

3rd Step – Titrate Buprenorphine dose upward once weekly by 2 mgs per day for one to four weeks.

4th Step – Utilize maintenance dose of Buprenorphine of 8 mgs per day or less.

5th Step – When the patient is ready transition to Naltrexone.

6th Step – When the patient is ready discontinue Naltrexone. At this time medication assisted treatment ends.

ETHICAL STATEMENT

Hereby, I David Michael Mathis DO consciously assures that for the manuscript, MAT Treatment Protocol, the following is fulfilled:

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This material is the authors' own original work, which has been previously published in September 2019 by Population Health Network: https://www.managedhealthcareconnect.com/content/medication-assisted-treatment-protocol

1. The paper is not currently being considered for publication elsewhere.
2. The paper reflects the authors' own research and analysis in a truthful and complete manner.
3. The paper properly credits the meaningful contributions of co-authors and co-researchers.
4. The results are appropriately placed in the context of prior and existing research.
5. All sources used are properly disclosed.
6. All authors have been personally and actively involved in substantial work leading to the paper and will take public responsibility for its content.

CONFLICTS OF INTEREST STATEMENT

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