Medication Assisted Treatment of Opioid Dependence (MATOD)

Disclaimer

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About medication assisted treatment of opioid dependence (MATOD)

➢ Also known as pharmacotherapy or opioid replacement therapy (ORT)
➢ An effective, evidence-based treatment for opioid dependence.
➢ Benefits of MATOD include:
  o Reduced:
    ▪ opioid drug use.
    ▪ drug-seeking and drug crimes.
    ▪ risk of over-dose deaths and long-term morbidity.
    ▪ injecting and risk of transmission of blood-borne infections.
  o Improved:
    ▪ physical and social health outcomes.
    ▪ stability and ability to engage in recovery journey.
➢ Provided in a structured system that manages risk as an ongoing supervised daily supply of:
  o Methadone – a potent synthetic opioid agonist which is well absorbed orally with a long, variable plasma half-life.
  o Buprenorphine – a partial agonist at the mu receptor which has a higher affinity for the mu receptor than methadone and other oral opioids. It is available in tablets or films and can be combined with naloxone (Suboxone).

Practice Point

• In Victoria, all medical practitioners can prescribe Suboxone (buprenorphine/naloxone) for ≤ 5 patients without the need to undergo additional training.
• The highest risk of overdose or toxicity occurs during the first few days of initiating MATOD treatment when there is greater risk of concurrent poly-drug use.

Before prescribing

1. Ensure to complete accreditation training to become authorised to prescribe:

Accreditation training

Medication Assisted Treatment for Opioid Dependence (MATOD) – provided free by RACGP Victoria:

➢ Module 1: Safer Opioid Prescribing: provided online
➢ Module 2: provided as a 1-day face-to-face workshop

• Methadone for any patient.
• Suboxone (buprenorphine/naloxone) for > 5 patients.
• Subutex (buprenorphine) for > 5 patients.
For policy information and forms, see clinical resources.

Clinical resources

- Australian Prescriber – Opioid Treatment of Opioid Addiction
- Faculty of Pain Medicine, ANZCA – Opioid Calculator
- Victorian Department of Health:
  - A Brief Guide to Prescribing Buprenorphine/Naloxone
  - Pharmacotherapy Policy in Victoria
  - Pharmacotherapy: Forms, Applications and Pharmacotherapy Networks
  - Pharmacotherapy Termination

1. Confirm opioid dependence based on risk categorisation and complexity factor:

Complexity factors

<table>
<thead>
<tr>
<th>Complexity factor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor mental health</td>
<td>- Kessler Psychological Distress Score (K10) ≥ 30, or</td>
</tr>
<tr>
<td></td>
<td>- presence of serious mental health diagnoses e.g., bipolar disorder,</td>
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<tr>
<td></td>
<td>schizophrenia, borderline personality disorder</td>
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<tr>
<td>Lack of meaningful activity</td>
<td>Unemployed and not studying or performing home duties</td>
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<tr>
<td>Housing insecurity</td>
<td>Homeless or at risk of eviction</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Pregnant</td>
</tr>
<tr>
<td>Serious criminal justice involvement</td>
<td>E.g. on a court order or on parole</td>
</tr>
<tr>
<td>Multiple previous AOD treatment episodes</td>
<td>&gt; 5 AOD treatment episodes (lifetime)</td>
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<tr>
<td>Children potentially unsafe</td>
<td>Clinician concern about parenting capacity</td>
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<tr>
<td>Significant or serious physical health issue</td>
<td>Serious physical illness (e.g. liver, cardiovascular, respiratory,</td>
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<tr>
<td></td>
<td>neurological disease) that significantly impacts on wellbeing</td>
</tr>
<tr>
<td></td>
<td>and functioning</td>
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Opioid dependence

Opioid dependence is a chronic disorder characterised by:

- evidence of opioid tolerance and withdrawal
- associated adverse effects on behaviour, social and psychological functioning
- significant associated morbidity and mortality.

See also DSM-5 Criteria for Diagnosis of Opioid Use Disorder
**Low risk**

*Intermittent user or using opioids long term but not opioid dependent.*

**Moderate risk**

*Opioid dependent with low to moderate mental health concerns but uncomplicated health issues.*

**High risk**

*Opioid dependent with moderate to high mental health issues and/or complicated health issues e.g., concurrent alcohol abuse or pregnancy.*

3. Identify *complicated presentations*, seek expert advice from **DACAS**, and refer as appropriate:

**Drug and Alcohol Clinical Advisory Service (DACAS)**

*Free 24-hour addiction medicine specialist advice line for healthcare professionals*

- Phone: **1800-812-804**
- Website

**Complicated presentations**

- Pregnancy
- Acute pain, in an opioid dependent patient
- Severe multiple drug use e.g., alcohol or benzodiazepine dependence
- Psychiatric co-morbidity
- Severe co-morbidity e.g., significant liver or renal failure

*For advice or referral, see Referral section.*

- If pregnancy, refer to the **Women’s Alcohol and Drug Service (WADS)**
- Contact **DACAS** for specialist advice if:
  - acute pain, in an opioid dependent patient.
  - severe multiple drug use e.g., alcohol or benzodiazepine dependence.
  - severe co-morbidity e.g., significant liver or renal failure.

4. Review **pharmacotherapy policy**, if unfamiliar.
5. Obtain proof of identity from patient. Attach patient’s photograph to the permit.
6. Establish and document evidence of opioid use and dependence criteria, including results of urine drug screen, history, and examination.

**Prescribing**

1. Select **opioid agent**. If accreditation training has not been completed, only prescribe Suboxone for \( \leq 5 \) patients.

**Opioid agents**

*Methadone and buprenorphine/naloxone have:*
➢ been used to treat opioid dependence, both in detoxification from opioids, and maintenance treatment.
➢ proven effective in reducing dependence on heroin and pharmaceutical opioids.

<table>
<thead>
<tr>
<th>Agent</th>
<th>Description</th>
<th>Dosing</th>
</tr>
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| **Buprenorphine/naloxone (Suboxone)** | • Partial agonist opioid with naloxone as 2 mg/0.5 mg and 8 mg/2 mg sublingual film  
➢ Best safety profile  
➢ Minimal drug-drug pharmacokinetic interactions | • Usually once daily  
• Starting dose between 4 to 8 mg on first day  
• Consider increased dose of 8 to 16 mg on day 2  
• Continue to assess and adjust dose accordingly, typically patients stabilize between 12 to 16 mg per day  
• Induction to therapeutic dose is rapid  
• Usually takes 1 to 2 weeks to achieve stable dose  
➢ Doses up to 32 mg per day may be used |
| **Methadone solution (Biodone Forte, methadone syrup)** | • Full agonist opioid in 5 mg/mL solution  
➢ A number of drug-drug interactions to be aware of | • Starting dose usually around 30 mg per day  
• Usually a once daily dose, titrated up gradually with therapeutic doses usually in the range of 60 to 100 mg  
➢ May take many weeks to achieve stable dose |
| **Buprenorphine (Subutex)** | • Partial agonist opioid as 0.4 mg, 2 mg and 8 mg sublingual tablet  
➢ Reserved for special cases e.g., pregnancy, documented allergy | • Usually once daily  
• Starting dose between 4 to 8 mg on first day  
• Consider increased dose of 8 to 16 mg on day 2  
• Continue to assess and adjust dose accordingly, typically patients stabilize between 12 to 16 mg per day  
• Induction to therapeutic dose is rapid  
• Usually takes 1 to 2 weeks to achieve stable dose  
➢ Doses up to 32 mg per day may be used |

2. Obtain:
   • informed verbal consent before prescribing. If general practitioner assesses the patient to be capable of informed consent, there is no legislated age limit for prescribing pharmacotherapy.
   • mandatory **permit** before commencing treatment.
Permit

➢ Apply for a permit to treat an opioid dependent person with methadone, buprenorphine/naloxone. This is to reduce the risk of sourcing MATOD from multiple providers and potential overdose.

➢ Phone Drugs and Poisons Regulation on 1300-364-545 for information on a patient's previous prescriber. This will be required for the permit application, and to permit clinical handover.

Information on a patient's previous prescriber

Questions to ask:

- Does another general practitioner currently have a permit to prescribe methadone, buprenorphine, or Suboxone?
- Has the Drugs and Poisons Unit (DPU) received notification of dosing in the hospital or correctional facility in the preceding weeks or months?
- Who is the general practitioner with the current permit?
- If there is no current permit, has a pharmacotherapy permit ever been issued? When was the first time? Last time?
- Has the Department of Health and Human Services (DHHS) received notifications of a drug dependency, drug seeking behaviour, or request for S8 permit for oral opioids?

➢ To view past prescribing history, complete Authority to Release Personal Medicare Pharmaceutical Benefits Scheme Claims Information to a Third Party form.

3. Help patient to choose a pharmacy to receive supervised dosing. This is mandatory for the permit to be accepted.
   - If the patient has an identified pharmacy, call the pharmacy to confirm that is the case.
   - If no pharmacy is identified by the patient, phone DirectLine on 1800-888-236 to confirm the availability of a dosing pharmacy suitable and accessible to the patient.
   - Discuss pharmacy location, opening hours, and the dosing fee charged by the pharmacy.

Dosing fees

➢ Fees are determined by each individual pharmacy for dispensing pharmacotherapies. There is no Pharmaceutical Benefits Scheme (PBS) subsidy.

➢ The Department of Health and Human Services (DHHS) pays a dispensing fee for patients:
   - aged ≤ 18 years.
   - on Youth Justice community orders.

➢ The Department of Justice pays dispensing fees for patients for up to 30 days after their release from prison.

- Provide patient information.

4. Complete the prescription process and pharmacotherapy agreement. Provide patient with a takeaway policy.
Prescription process

1. Handwrite or annotate the printed prescription, using words and figures.
2. Include:
   - the dispensing pharmacy.
   - instructions for takeaway, if any.
   - the prescription date of first dose and date of last dose.
   - an endorsed current photo of the patient for the first prescription e.g., an enlarged photocopy of the patient’s driver’s licence. This ensures that the patient who presents at the pharmacy is the same person who consulted you. On the back of the photo, write:
     - your signature as the prescriber.
     - the date.
     - the patient’s name.

Prescription Examples

- Methadone Syrup, 60 sixty mg daily, dispense from Smith’s Pharmacy, takeaways for Sundays and public holidays. Dose from: 2nd November 2018. Last dose: 28th December 2018.
- Suboxone, 8 eight mg, dispense from Jones’s Pharmacy, takeaways for 5 five days per week in divided doses. Extra 3 three Takeaways to cover trip to Tasmania. Script from 02/06/2018 to 01/08/2018.

2. Check drug interactions for MATOD.

5. If prescribing Suboxone, wait for signs and symptoms of mild-moderate withdrawal before administering the first dose:

   Signs and symptoms of withdrawal or precipitated withdrawal

   Signs:
   - Dilated pupils
   - Rhinorrhoea
   - Perspiration
   - Piloerection
   - Muscle twitching, especially legs
   - Yawning
   - Vomiting
   - Diarrhoea
   - Restlessness

   Symptoms:
   - Opioid craving
   - Hot and cold flushes
   - Cramps
   - Bone, joint, and muscle pain
   - Anorexia, nausea
   - Abdominal pain
   - Insomnia
Onset and duration of symptoms depend on the drug being taken. Protracted low grade symptoms may last for several weeks after precipitated withdrawal.

- Typically start 1 to 4 hours after the first dose. They are generally mild to moderate in severity, but may be severe in some cases, depending on the opioid tolerance that a patient may have already developed, and last for up to 12 hours.
- Consider completing the Clinical Opiate Withdrawal Scale (COWS) form to avoid a precipitated withdrawal.

**Precipitated withdrawal**

- Precipitated withdrawal occurs when buprenorphine, a partial antagonist, displaces agonist opioids from the mu receptors, without activating the receptor to an equivalent degree. This results in a net decrease in agonist effect, thus precipitating a withdrawal syndrome.
- Precipitated withdrawal is the main risk of starting buprenorphine/naloxone pharmacotherapy.
- It may be so unpleasant that the patient avoids further involvement in treatment.
- To avoid a precipitated withdrawal, patient must no longer be experiencing the agonist effects of an opioid. At induction, ask the patient what their first few signs and symptoms of withdrawal have been in the past. Look for these before administering the first dose to ensure the patient is in opiate mild to moderate withdrawal. This is usually between 12 to 48 hours after their last illicit, over-the-counter, or prescribed dose. Long-acting opioids will require a longer period of abstinence than short-acting opioids.

Treatment of precipitated withdrawal is to administer additional 2 to 4 mg doses of buprenorphine hourly until symptoms dissipate.

6. **Prescribe naloxone**, for use in an unintended overdose emergency, and provide or arrange training to avoid risk of overdose.

7. For advice around MATOD prescribing contact **Pharmacotherapy Network**.

**Pharmacotherapy Networks**

**North and West Metropolitan Pharmacotherapy Network**

- **Service provides:**
  - general practitioner peer mentoring, education, training, and community of practice for treatment providers.
  - addiction medicine specialist support including specialist assessment and secondary consultation.

- **For information, contact Grant Liptrot on:**
  - Phone: *(03) 9448 5511*
  - Fax: *(03) 7000 1822*
  - Email: pharmacotherapy@cohealth.org.au
South and Eastern Metropolitan Pharmacotherapy Network

- Service provides:
  - addiction medicine specialist support to clients including secondary consultation.
  - liaison support to general practitioners and pharmacists, education, training and community of practice support.
- For information, contact Jana Dostal on:
  - Phone: (03) 8514 6600
  - Fax: (03) 8514 6699
  - Email: A4PN@semphn.org.au

8. Inform patient of patient-accessed advice services:

   - **Pharmacotherapy Advocacy, Mediation, and Support (PAMS)**
     - Statewide telephone service available to pharmacotherapy patients, prescribers, or pharmacists to help resolve conflicts between patient and provider.
     - Available Monday to Friday, 10.00 am to 6.00 pm.
       - Phone: 1800 443 844
   
   See Harm Reduction Victoria – [About PAMS](#)

   - **Community Overdose Prevention and Education (COPE).**
     This is a community-based opioid overdose prevention initiative funded by the Victorian Government. COPE provides training and support to primary health and community organisation staff. These trained staff will provide education to individuals who may be opioid users or potential overdose witnesses, such as a family member or friend.

     Contact via:
     - Phone: (03) 8514 6600
     - Fax: (03) 8514 6699
     - [Website](#)

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**Follow-up**

1. Review patient at **recommended frequency**.

**Recommended patient reviews**

- The day of, or the day after, the first dose of buprenorphine/naloxone. This enables the prescriber to identify the onset of any precipitated withdrawal and the general adequacy of the first dose.
- Every 2 to 4 days until **stabilisation of dose**.
### Stabilisation of dose

**Dose too low**

If patient experiencing early withdrawal symptoms prior to next dose:

- increase dose by 2 to 4 mg per day.
- review in 3 to 4 days.

**Dose too high**

If patient experiencing nausea or drowsiness 1 to 2 hours after dosing:

- reduce dose by 2 to 4 mg per day.
- review in 3 to 4 days.

- Every week during the following 4 to 6 weeks – permitting further assessment, longer term goal setting, follow-up of initial investigations and provision of support with or without relevant referrals.
- Every 2 weeks during the following 6 to 8 weeks – reviewing progress, goal review and coordination of any necessary psychosocial rehabilitation.
- Monthly reviews thereafter, but consider extending reviews up to 3 months for stable patients.

- If in withdrawal, review dosing and compliance. Also consider withdrawal symptoms from other classes of drugs. For further advice, discuss with Emergency Department admitting officer, or Drug and Alcohol Clinical Advisory Service (DACAS).
- If vomiting on:
  - methadone, consider **interval** between ingestion and vomiting.

### Methadone

Consider the interval between ingestion and vomiting:

- If vomiting occurs > 20 minutes after ingestion, the dose is likely to be absorbed.
- If vomiting occurs < 20 minutes of ingestion of dose, **review patient**.

### Review patient

- If reviewed within 4 to 6 hours, plasma levels will be at their peak. Assess for withdrawal.
- If withdrawal symptoms present, consider supplementing with half of the patient’s usual dose.
- If the patient is pregnant, seek specialist advice (phone DACAS on 1800-812-804), as withdrawal can cause foetal distress.
Suboxone (buprenorphine/naloxone), this does not reduce clinical effect as it is absorbed sublingually within minutes. No further action is necessary.

2. Communicate with the pharmacist regularly regarding attendance, appearance, and for any identified issues.

3. Once stabilised:
   - provide ongoing monitoring, including medication use.
   - check adherence to plan.
   - address other health issues e.g., smoking, mental health, gastrointestinal symptoms, hepatitis B and C monitoring, contraception, blood pressure monitoring.
   - provide usual medical care. provide reassurance and support.
   - provide reassurance and support.
   - consider supports.

Supports

- Housing
- Social support
- Employment and training
- Financial situation
- Counselling and group treatment supports

4. If 4 consecutive days have elapsed since the last methadone or buprenorphine dose (alternate day dosing of buprenorphine: 2 doses equates to 4 missed days), assess for signs of withdrawal and refer to clinical guidelines on re-dosing schedule.

Takeaway doses

Takeaway doses are dispensed for use at a later time.

- There are many risks e.g., diversion, hoarding, and deliberate overdose, accidental overdose, and poor compliance with plan.
- Can lessen the constraints on stable patients who are attempting to normalise their lives.
- Could be used as an incentive for rewarding patient stability.

See requirements for takeaway doses.

Requirements for takeaway doses

- There is a need for takeaway dosing e.g., travel distance, work arrangements.
- The patient is assessed to be clinically, psychologically, and socially stable. See Victorian Health Department – Checklist for Assessing Appropriateness of Take-away Doses
- Patient has been on the MATOD program for a certain period of time:
  - Buprenorphine – no takeaway doses in the first 2 continuous weeks.
  - Methadone – no takeaway doses in the first 3 months.
• Takeaway doses can only be authorised by the prescriber. Pharmacists can refuse to give takeaway doses on a given day if the patient presents as intoxicated.
• Patient has signed a take-away agreement:
  • Methadone
  • Buprenorphine/Naloxone
• Follow-up by contacting the patient’s pharmacist to confirm recent behaviour and dose collection has been regular and stable.

Transfers

• Consider the patient’s suitability for transfer to another pharmacy or prescriber, before making arrangements.
• **Requirements for takeaway doses** also apply to patients seeking transfer.
• For advice on the locations of approved prescribers and pharmacies, phone DirectLine on 1800-888-236.

Medication assisted treatment of opioid dependence in prison

• Where safe and clinically appropriate, patients receiving pharmacotherapy before entering prison may continue treatment while in prison.
• On release from prison, the prison medical officer completes a [Notification of Release From Prison of a Patient Treated with Methadone or Buprenorphine for Opioid Dependence](#) form.

Termination

• When the patient ceases treatment, terminate the permit as per requirements. See Department of Health and Human Services – [Pharmacotherapy Termination](#).
• Consider writing a discharge letter to notify the patient.

Information

For health professionals

• Australian Prescriber – [Opioid Treatment of Opioid Addiction](#)
• Faculty of Pain Medicine, ANZCA – [Opioid Calculator](#)
• Victorian Department of Health:
  • [A Brief Guide to Prescribing Buprenorphine/Naloxone](#)
  • [Pharmacotherapy Policy in Victoria](#)
For patients

- Alcohol and Drug Foundation
- Department of Health and Human Services Victoria:
  - Methadone Treatment in Victoria: User Information Booklet
  - Starting Methadone or Buprenorphine

Sources

References
1. The Royal Australian College of General Practitioners. [place unknown]: The Royal Australian College of General Practitioners; Updates from the RACGP Victoria Drug and Alcohol Committee, 2016.

Disclaimer