

Treating Opioid Use Disorder

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DISCLOSURES

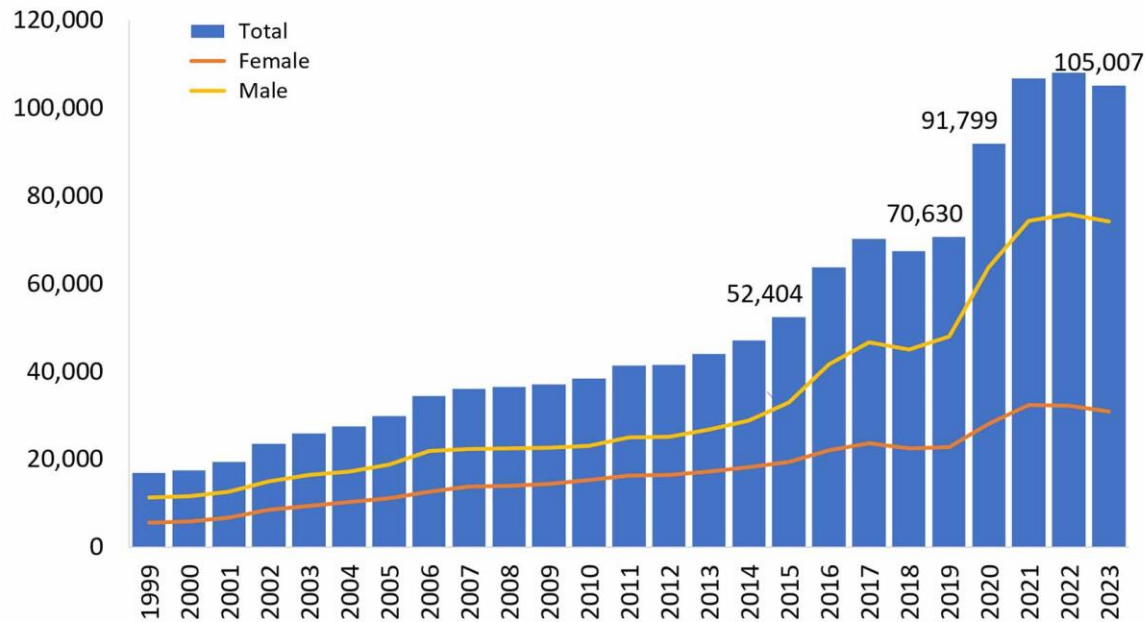
Objectives

Review	Epidemiology of the overdose crisis
Describe	The diagnosis of opioid use disorder and the components of evidence-based treatment
Detail	How to start treatment for opioid use disorder



The Overdose Crisis in the United States

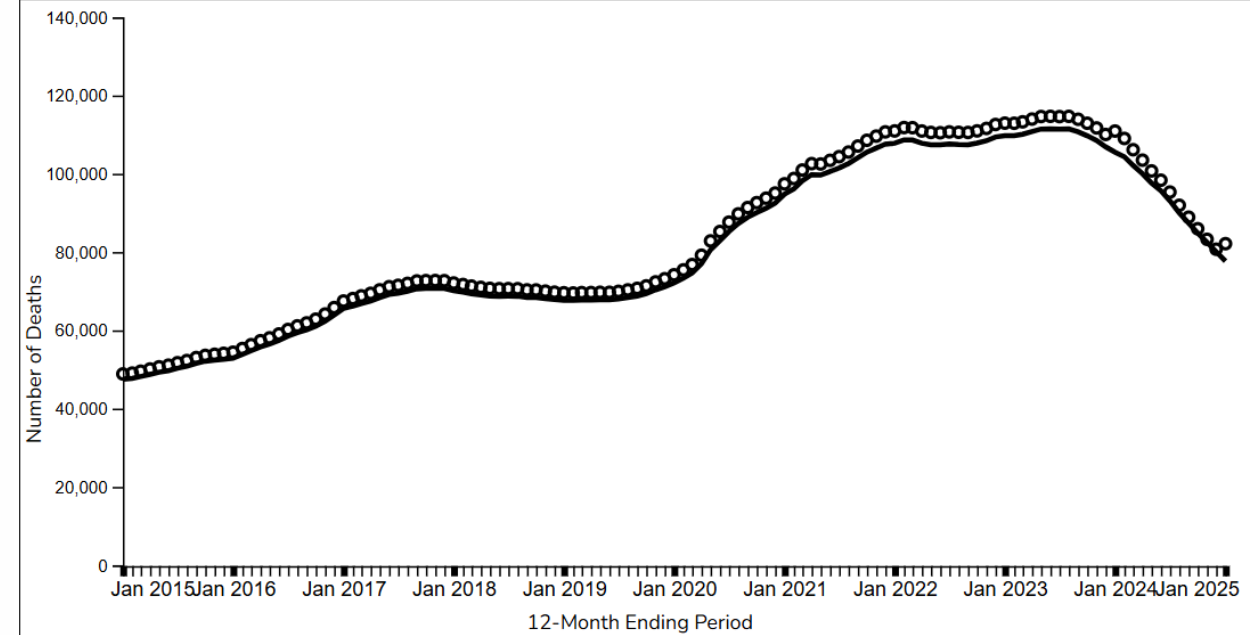
Figure 1. U.S. Overdose Deaths* by Sex, 1999-2023



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.

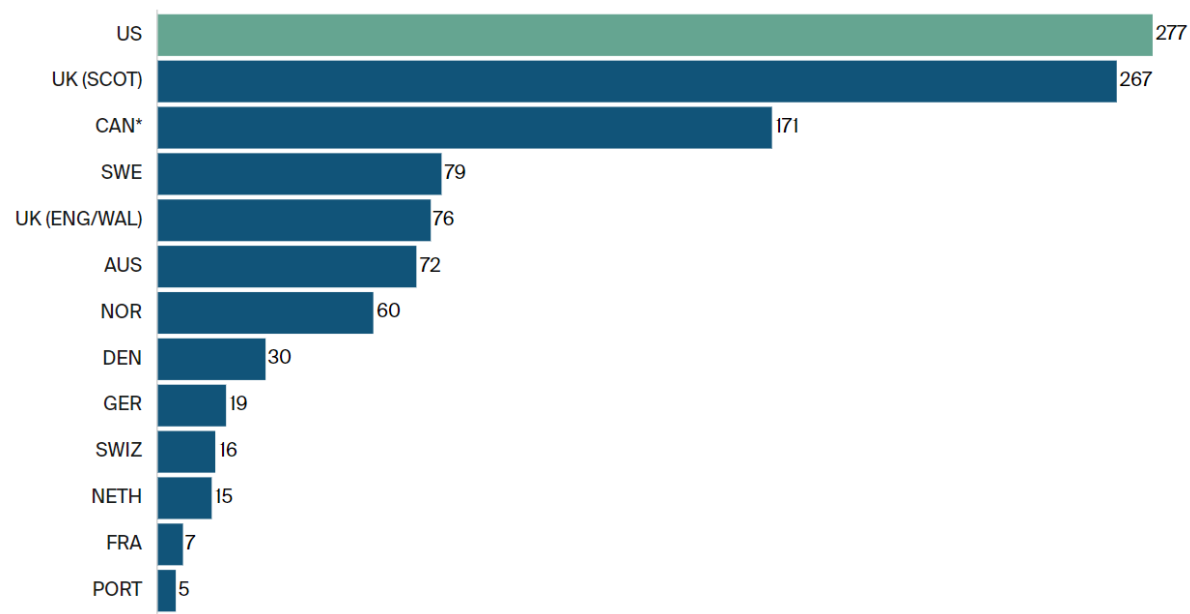
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2023 on CDC WONDER Online Database, released 1/2025.

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

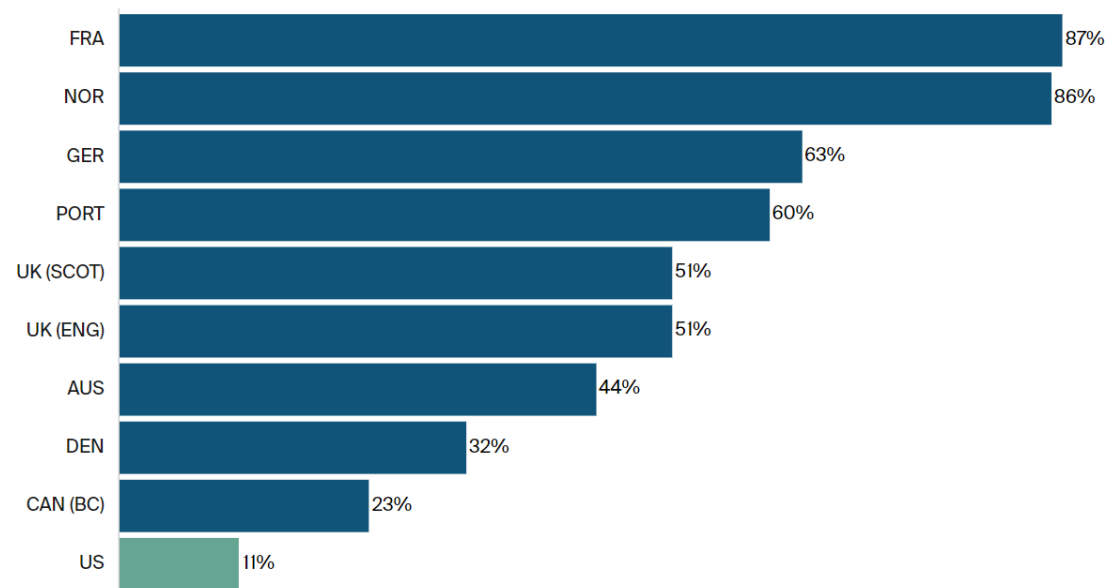


US leads the globe in overdose deaths, yet treatment gaps persist

Overdose or drug-related death rate per 1 million population (unadjusted), 2020 or latest year available



Percentage of people with high-risk opioid use or opioid use disorder (OUD) who received opioid-substitution treatment

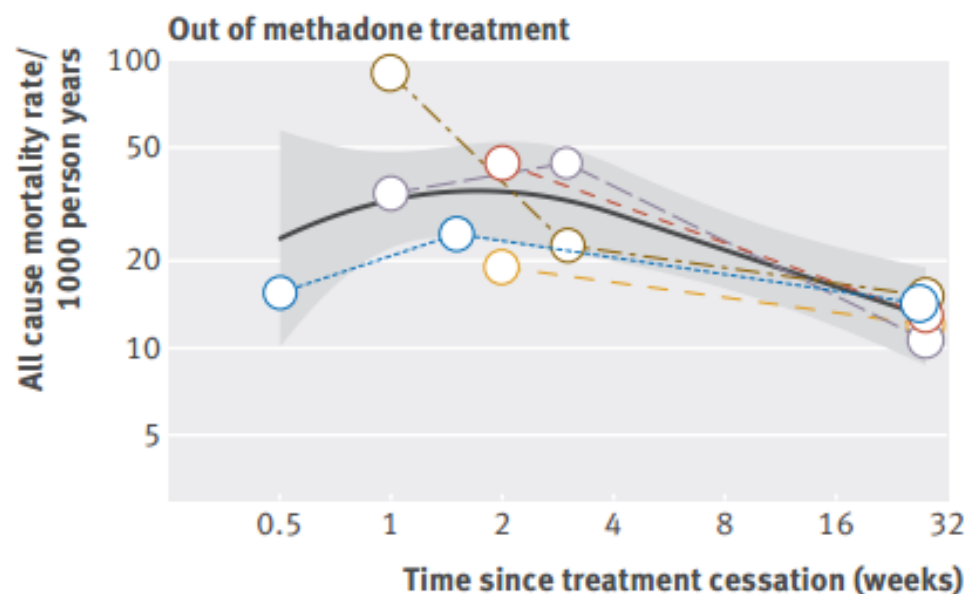
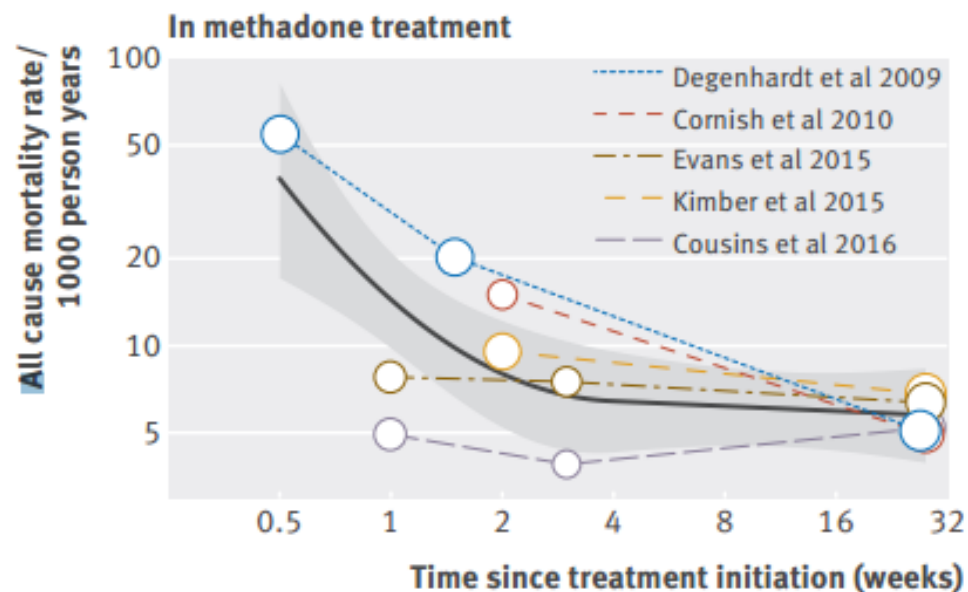


Treatment Is Effective: Putting Buprenorphine into Perspective

Intervention	Outcome	NNT
Anticoagulation for LE DVT	Prevent recurrent VTE	17
ASA after prior MI/CVA	Prevent: • subsequent MI • subsequent CVA • mortality	77 200 333
Buprenorphine (16mg+) ¹	Retention in treatment	2
Buprenorphine ²	Prevent 1 yr mortality	5



Methadone and buprenorphine reduce mortality



All cause mortality rates (per 1000 person years):

- In methadone treatment: 11.3
- Out of methadone treatment: 36.1

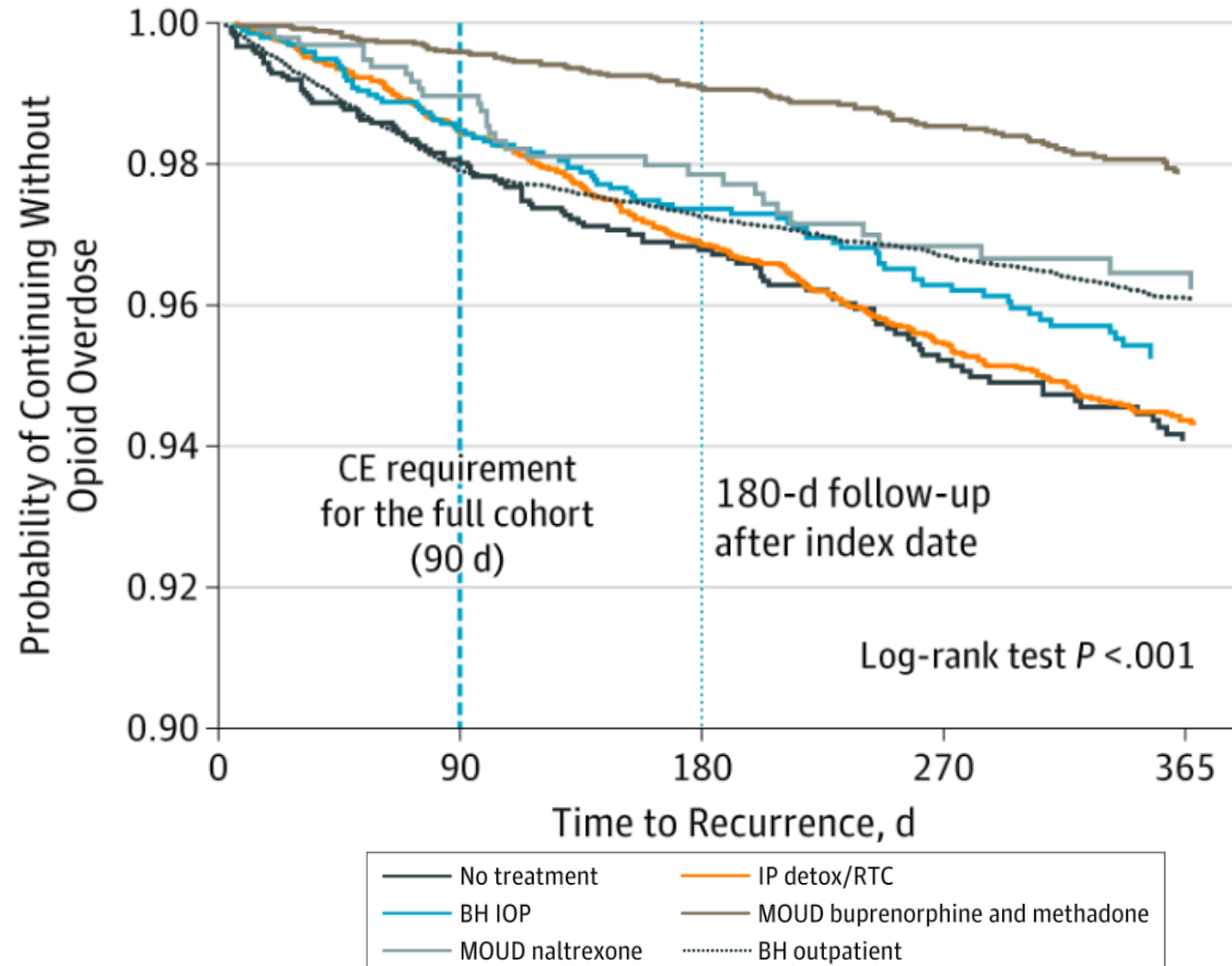
- In buprenorphine treatment: 4.3
- Out of buprenorphine treatment: 9.5

Overdose mortality rates:

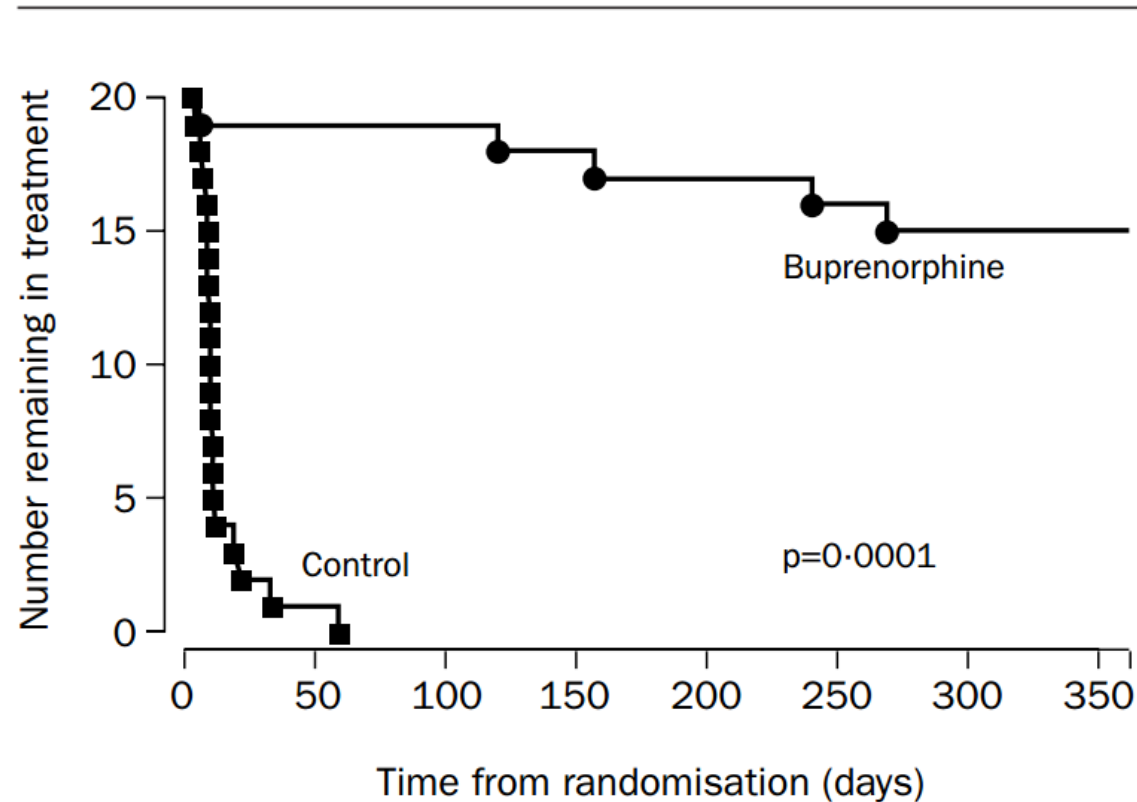
- In methadone treatment: 2.6
- Out of methadone treatment: 12.7

- In buprenorphine treatment: 1.4
- Out of buprenorphine treatment: 4.6

Methadone & buprenorphine associated w/ reduced OD



Buprenorphine treatment outcomes superior to withdrawal management plus psychosocial treatment



Kakko et al. The Lancet, Volume 361, Issue 9358, 2003, 662 - 668

Most treated patients achieve remission over time

Table 2.

Change in clinical characteristics from study entry to follow-up 18, 30, and 42 months later.

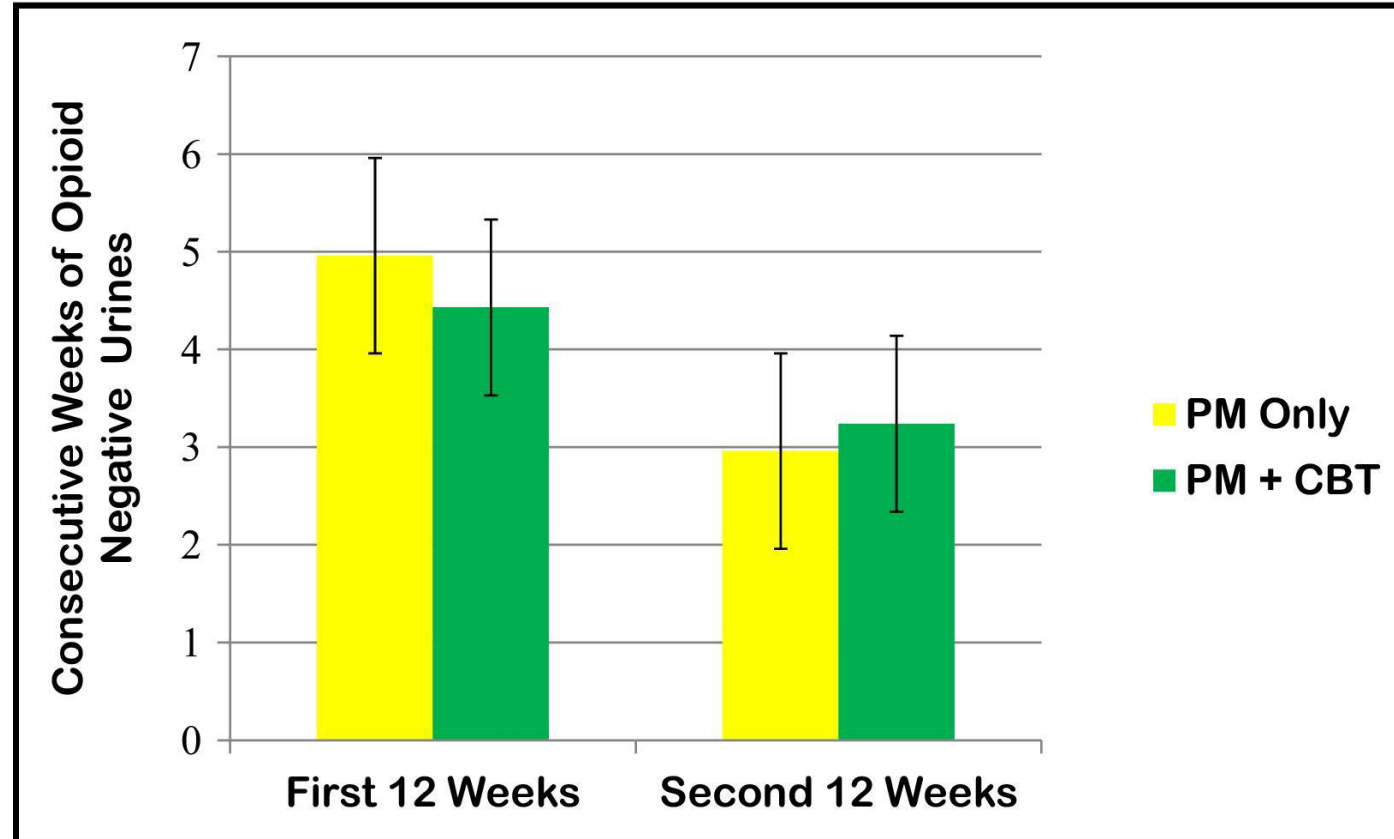
Participant characteristics	Month 0 ¹ (<i>n</i> = 338)	Month 18 (<i>n</i> = 252)	Month 30 (<i>n</i> = 312)	Month 42 (<i>n</i> = 306)
Substance use, past month				
Current opioid dependence ² , % ^{**}	100	16.3 ^a	11.5	7.8 ^b
Abstinent from illicit opioids ³ , % ^{***}	0	51.2 ^a	63.5 ^b	61.4 ^b
Opioid agonist treatment, %	0	31.8	38.1	36.9

Using healthcare touchpoints as reachable moments

- Initiating methadone in hospital:
 - 82% present for follow-up addiction care
- Initiating buprenorphine in hospital vs withdrawal management alone:
 - Buprenorphine: 72.2% enter treatment after discharge
 - Withdrawal management : 11.9% enter treatment after discharge
- Initiating buprenorphine in ED vs referral to treatment
 - 78% vs 37% engaged in buprenorphine treatment at 30 days
 - Fewer days of opioid use w/ buprenorphine tx



Treatment effective in primary care



No difference in opioid use, study completion, or cocaine use between the 2 groups



NASEM Consensus Report



Conclusion 6:

Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of U.S. Food and Drug Administration–approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.

Treatment with FDA-approved medications is clearly effective in a broader range of care settings (e.g., office-based care settings, acute care, and criminal justice settings) than is currently the norm. There is no scientific evidence that justifies withholding medications from OUD patients in any setting or denying social services (e.g., housing, income supports) to individuals on medication for OUD. Therefore, to withhold treatment or deny services under these circumstances is unethical.

Any DEA-registered Practitioner Can Prescribe!



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Removal of DATA Waiver (X-Waiver) Requirement

Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill), removes the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). With this provision, and effective immediately, SAMHSA will no longer be accepting NOIs (waiver applications).

All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law and SAMHSA encourages them to do so. SAMHSA and DEA are actively working on implementation of a separate provision of the Omnibus related to training requirements for DEA registration that becomes effective in June 2023. Please continue to check this webpage for further updates and guidance.



What does the care cascade look like?



Identify patients through
screening or acute
presentation



Make a diagnosis



Initiate treatment without
delay



Retain patients in treatment

Making a Diagnosis of OUD:

Problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period (mild =2-3; moderate = 4–5; severe = 6+)

1. Opioids taken in larger amounts or over a longer period of time than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time spent in activities to obtain, use, or recover from opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems.
7. Important social, occupational, or recreational activities are given up or reduced.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance.
10. Tolerance*
11. Withdrawal*

* Tolerance and withdrawal insufficient to make diagnosis if due to prescribed medication



Initiating effective treatment



Medication



Psychosocial interventions



Recovery supports

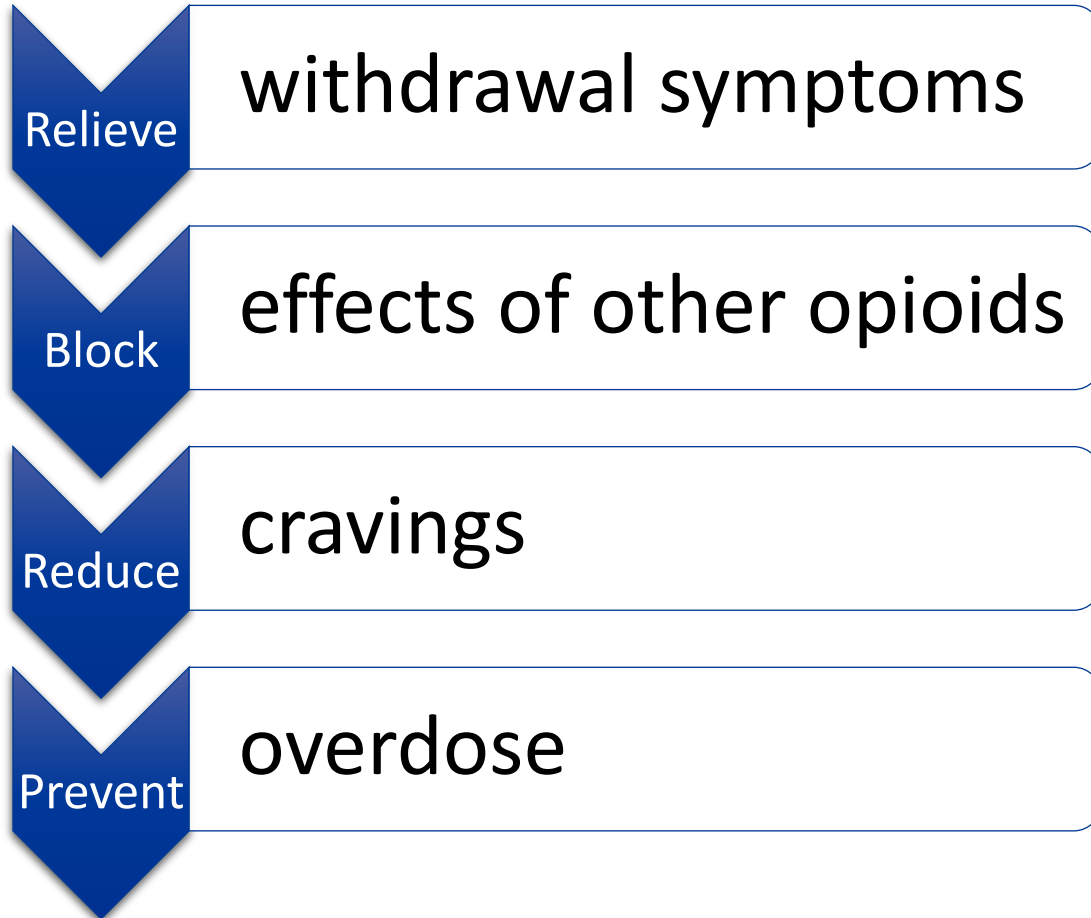


Harm reduction

**Similar to
Management of
Diabetes or HIV**

- Goal to prevent acute and chronic complications
- Patient-centered and directed treatment plans and goals
- Treatment includes:
 - Medication
 - Behavioral support
 - Lifestyle changes
 - Regular monitoring

Goal of medication for OUD: buprenorphine & methadone



Details of Treatment:

Buprenorphine and methadone first line, patient preference important.



Agonist treatment: daily methadone or buprenorphine

Stable level of opioid effect experienced as feeling normal
Methadone still must be dispensed by opioid treatment program (in US)



The aims of agonist treatment include:

Reduction or cessation of ongoing opioid use and associated risks
Improvement in health, quality of life, functional status

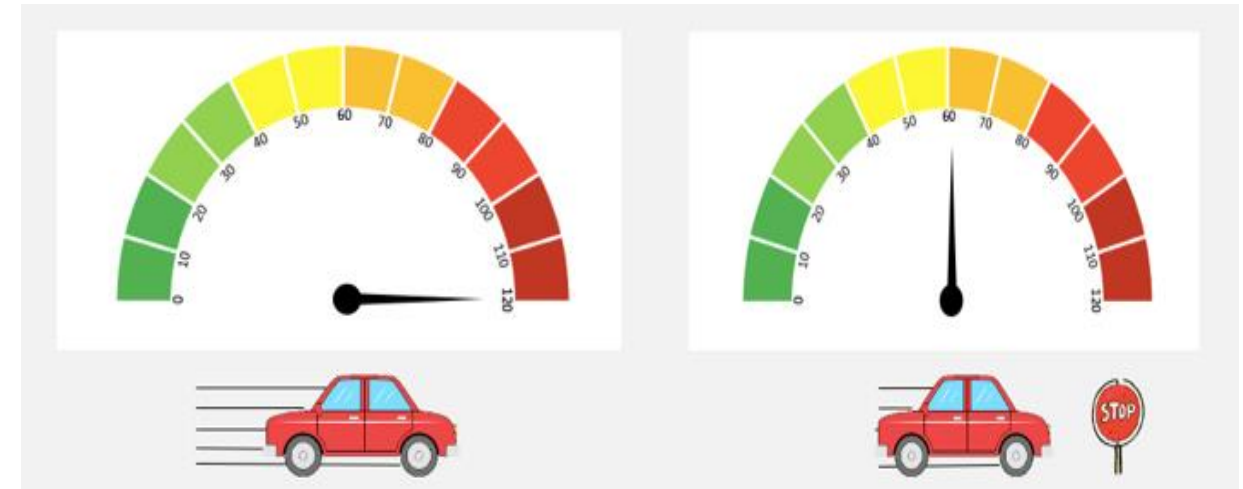
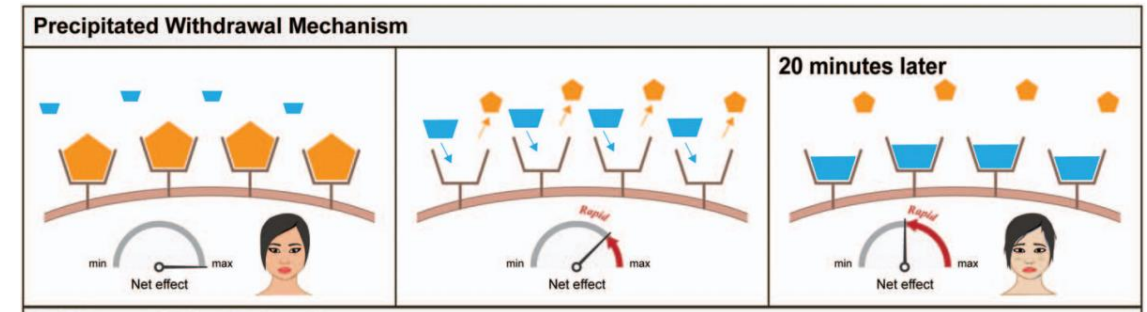


Antagonist treatment consists of once monthly injection

Second line treatment, relapse prevention

Understanding Buprenorphine

- Partial opioid agonist, ceiling effect for respiratory depression
- High affinity for opioid receptor, can displace full agonist opioids resulting in “precipitated withdrawal”
- Higher retention in treatment and abstinence rates seen w/ doses >16 mg
- To initiate, wait until person is in moderate withdrawal (COWS 8+) and start high dose or do low dose or direct-to-inject
- **For withdrawal, important that there are SIGNS not just symptoms**



Buprenorphine initiation dosing for a patient in moderate withdrawal



Day 1: Buprenorphine 8-16 mg Q 1H x 2 doses to a maximum of 32 mg on day 1



Day 2: Buprenorphine 16-24 mg daily



Counseling critical– must be objectively in withdrawal and not just anxious



Low dose initiation or XR-bupe are alternative approaches

Low dose initiation

- Some patients using fentanyl seem to experience precipitated withdrawal even after protracted wait times
- May be due to lipophilicity and range of fentanyl analogs
- Actual rates in clinical trials quite low
- If person not able to wait to be in objective withdrawal, currently taking full agonist opioids for pain and unable to stop, transitioning from methadone, or using fentanyl with a history of precipitated withdrawal, consider low dose initiation
- Uses 0.5 mg doses to gradually saturate receptor
- Can be done rapidly q3H or over days
- **Fear of precipitated withdrawal should not keep us from starting buprenorphine!**



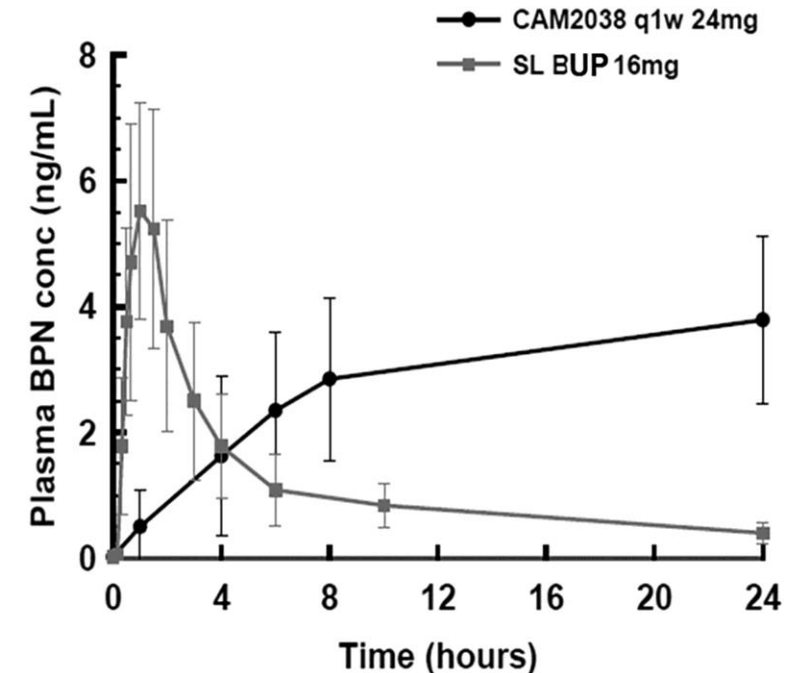
Start buprenorphine at 0.5 mg and increase dose as quickly as QID, or slower based on patient preference



Continue full agonist until patient gets to TDD of 8mg

What about direct to injection? Understanding pharmacokinetics of Brixadi

- SL buprenorphine has rapid absorption, but low oral bioavailability; reaches peak in 60 min
- Weekly injection → plasma concentrations therapeutic ~6-8 hours, peak level usually within 20 hours
- RCT started 24 mg weekly in patients with COWS 0-7 and found that 93% of patients tolerated initiation without precipitated withdrawal and 73% were engaged in OUD treatment after 7 days
- Retrospective studies have examined overlapping weekly Brixadi in patients still using full opioid agonists



What about methadone?

ED/Inpatient

- Generally, start at 40-50 mg x 1 and then additional 10 mg PRN for ongoing signs of opioid withdrawal
- Consolidate TDD next day, uptitrate by ~10 mg for ongoing cravings/withdrawal
- EKG prior to starting if prolonged QTc or risk factors; check EKG again at 100 mg and for dose increases beyond 100 mg

Outpatient (72-hour vs OTP)

- Under 72-hour rule allowed to administer/dispense but not prescribe methadone for up to 3 days
- Generally, start at 50 mg unless low tolerance and increase by 10-20 mg per day for up to max of 3 days of dosing
- Refer to OTP, generally they will start at 50 mg



Ongoing management of patients



Check in visits, frequently at first, space out as stabilize



Like any chronic care management:

evaluate symptoms (cravings, withdrawal, use)
benefits or challenges with medication
need for additional support
focus on patient identified goals



Patients don't fail treatment, but treatment can fail patients



If person not doing well, modify treatment

Increase dose
Increase supports
If persistent challenges, explore changing meds
Incorporate harm reduction

Take home points

Increased access to opioid use disorder treatment across healthcare settings is needed to address overdose crisis

Opioid use disorder is a treatable, good prognosis condition and prescribing buprenorphine is easy and fulfilling

Like other chronic conditions, it can be diagnosed, treated, and managed in general medical settings

Thank you!

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