Community Behavioral Health

Clinical Guidelines for Alcohol Use Disorder (AUD)

December 1, 2020

Table of Contents

1. BACKGROUND

Alcohol Use Disorder (AUD) is a common disorder, with lifetime prevalence of 29.1% in the United States (Appendix A; Grant et al 2015). It is well established that AUD leads to a large burden from public health, medical, financial, legal, and personal standpoints. While evidence-based treatments exist, including Medication-Assisted Treatment (MAT), these treatments are widely underutilized. Research estimates only 8-20% of patients with AUD receive any treatment, and far fewer receive evidence-based treatments (Appendix A; Grant et al 2015, Mark et al 2009, Hasin et al 2007). Low utilization of MAT for AUD is felt to be related to a patient's limited awareness of treatment options and prescriber unfamiliarity with medications, perceived in low demand, and low confidence in the medications (Appendix A; Hagedorn et al 2016).

Data from the Philadelphia Department Behavioral Health and Intellectual disAbility Services (DBHIDS) indicates that from 2016-2020, of the roughly 17,000 individuals diagnosed with substance use disorder at any given time, 15-20% had a primary diagnosis of AUD and another 4-7% had a secondary diagnosis of AUD. For 2019-2020, HEDIS initiation and engagement in treatment (IET) measures for CBH members with AUD showed that for members under 65 years old with AUD, 54.8% initiated treatment and 23.5% engaged in treatment. While both of these numbers are above the 2018 Medicaid average (Appendix A), there remains considerable room for improvement. Additionally, data suggest that utilization of MAT for AUD is low in Philadelphia, mirroring the findings discussed above.

Community Behavioral Health (CBH) has adopted clinical practice guidelines to outline best practices for the treatment of specific disorders or certain populations. These guidelines will be used by CBH to assess the quality of care provided to CBH members. As such, providers are advised to review and, where appropriate, implement these practices in their care. These guidelines apply to all clinical settings where members are seen with these disorders. These guidelines should be used in conjunction with any level-of-care-specific performance standards, as well as all other required CBH, NIAC, state, and federal regulations and standards.

2. PURPOSE

These AUD Clinical Practice Guidelines draw from the 2018 APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder, the 2015 SAMHSA Medication for the Treatment of Alcohol Use Disorder: A Brief Guide, and the 2020 ASAM Clinical Practice Guideline on Alcohol Withdrawal Management (see Appendix A) and describe expectations for quality of care. The aim is to articulate best practices and quality monitoring standards for providers of substance use treatment and to help providers design and monitor their services. These shall be maintained and updated collaboratively with providers and system stakeholders to reflect evolving evidence-based practice or changes in the APA, SAMHSA, or ASAM guidelines. Information on special populations as well as a listing of resources and referenced materials can be found in the appendices.

For assistance in accessing services, please contact CBH Member Services via phone at 888-545-2600. Additional information will be available in the AUD Access Toolkit in January 2021.

3. PRACTICE GUIDELINES

3.1. Screening and Referral

The first priority of screening is to assess safety and make appropriate referral(s) for any urgent or emergent medical or psychiatric problems. This includes assessment of imminent danger to self or others, acute intoxication, active withdrawal, or overdose. In cases of emergency, assessors should directly facilitate and ensure transfer to appropriate emergency medical or psychiatric services.

Validated screening tools should be used to assess for the presence and severity of alcohol and other substance use disorders. CBH recommends incorporation of brief, validated, structured screening instruments such as those outlined by SAMHSA's SBIRT (see Appendix A). Providers should consider utilization of measures, such as the HEDIS ® ASF (Unhealthy Alcohol Use Screening and Follow Up) measure to track progress related to AUD screening and follow up.

3.2. Withdrawal and Overdose Risk Assessment

Sequelae of alcohol dependence can include a life-threatening withdrawal syndrome which may require emergency, hospital, or other high acuity services. Initial assessment should assess for presence of withdrawal and withdrawal risk factors. Factors to consider include: duration, quantity, frequency, and time of last alcohol use, prior episodes of withdrawal, history of withdrawal seizures or Delirium Tremens (DTs), presence of high-risk medical conditions (TBI, epilepsy, recent illness/surgery, etc.), age over 65 years, autonomic hyperactivity, and physiologic dependence on GABAergic agents (benzodiazepines, barbiturates). Use of validated structured tools to assess for alcohol withdrawal is also recommended. Withdrawal risk assessment should inform recommendation for placement in specific Level of Care (LOC). Please refer to the 2020 American Society of Addiction Medicine (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management (Appendix A) for more information related to alcohol withdrawal.

Given the high comorbidity of alcohol and other substance use, priority should be given to assessing for any additional substance use disorders and overdose risk factors. Standardized instruments may be employed if available. At minimum, a detailed substance use history should be taken, including: amount and frequency of alcohol use and all other substances used (with particular attention to use of opioids, fentanyl, benzodiazepines and sedatives), history of prior overdose, and high-risk medical conditions should be documented.

3.3. Assessment

The ASAM Multidimensional Assessment should be completed and used to facilitate recommendation for a LOC. Assessors should be aware that members may not understand treatment terminology and may require education related to treatment process and recommended interventions. Initial assessment should include presenting complaint, current symptoms, complete medical and psychiatric history, medication list, detailed alcohol and substance use history (including recent and past use, assessment of current withdrawal risk, and history of any prior episodes of withdrawal), and family history. Individuals with AUD are at a heightened risk for medical complications, including hepatic disease, cirrhosis, cognitive impairment, gait/mobility difficulties or frequent falls, seizures, and nutritional/vitamin deficiencies. Providers should be mindful to assess for these conditions and attentive to the impact that they may have on a member's medical status and treatment. Collateral information from social supports or other treatment providers (with a signed release of information) should be obtained when possible. Assessment should also include determination of a member's goals and readiness for change, as well as identification of social and environmental factors that may facilitate or impede treatment. As part of the assessment process, providers should ensure a member has adequate understanding of MAT, and then clarify the member's interest in receiving MAT.

Comprehensive assessment should include a physical exam when possible. At minimum, the assessor should confirm the member's access to physical health care or provide appropriate referral. Collaboration with existing providers and/or supports is expected. Inability to immediately complete all aspects of the comprehensive assessment should not necessarily delay or preclude medically appropriate treatment.

3.4. Cultural and Social Determinants of Health

There is widespread evidence to support screening for various aspects of social risk within clinical care. As part of assessment and recovery planning, providers should identify relevant social determinants of health including housing and food insecurity, transportation challenges, vocational and educational history and opportunities, cultural and linguistic needs for engagement, disability status, and experiences with crime and violence (including physical and sexual trauma).

Additionally, there is increasing understanding that social, racial, ethnic, economic, and geographic disparities exist in healthcare, and must be addressed. Some groups known to have increased risks for AUD and it's complications include: Native Americans, Alaska Natives, Blacks/African Americans, men, and people ages 18 to 29 (Appendix A Grant et al 2015, Russo et al 2004).

Use of the DSM-5 Cultural Formulation Interview is a useful tool to aid in completing a culturally competent assessment of a member's condition (Appendix A). Any identified needs should be addressed by the provider, or through linkage to appropriate services.

3.5. Diagnosis

AUD diagnosis should be made in accordance with DSM-5 Criteria (see Appendix A). Documentation of diagnosis should follow any other pertinent state and federal regulations.

3.6. Laboratory Testing

Assessment should include obtaining or providing referral for laboratory testing. This may include physiological biomarkers to assess recent alcohol use (breathalyzer, serum ethanol, urine ethanol) and long term alcohol use (GGT, LFTs, and others). When appropriate, providers should also check urine/oral drug screen (instant and/or send out), pregnancy testing, CBC, LFTs, MCV and appropriate screening for infectious disease (hepatitis, HIV, TB, sexually transmitted infections). Inability to rapidly obtain laboratory testing should not necessarily delay or preclude medically appropriate treatment.

Monitoring of progress in recovery with urine/oral drug screen should follow CBH LOC performance standards, if available. At minimum, providers must have a protocol for collecting an alcohol/drug screen, determining frequency for alcohol/drug screening, and ensuring review of results. Random testing should be considered in lieu of routine testing. Results of alcohol/drug screens must be incorporated into treatment planning. Repeated positive results should be accompanied by a documented discussion of how they will be addressed, including consideration of a higher LOC. Additional recommendations can be found in the APA Guideline and ASAM Consensus Statement on Appropriate Use of Drug Testing in Clinical Addiction Medicine (see Appendix A).

3.7. Harm Reduction

When clinically appropriate, there should be discussion of risks of continued alcohol use (health risks, legal risks, occupational risks, financial risks, relationship risks) and as well as agreed-upon steps taken to reduce risk when possible. For individuals who may become pregnant, there should be discussions about Fetal Alcohol Spectrum Disorders (FASDs) and available options for family planning.

Given the frequent co-occurrence of multiple substance use disorders, as well as risks for impaired decision making when under the influence of substances, there are several harm reduction practices are recommended for all members with any substance use disorder:

- The epidemic of opioid related deaths continues to be an issue of high clinical priority. In addition to those with opioid use disorder, other illicit drugs (such as crack cocaine, etc.) can be laced with opioids, thus leading to unintentional consumption and high

overdose risk. Members should be educated on opioid overdose risk factors. All individuals at risk of witnessing or suffering an overdose should be assisted in obtaining a dose of Naloxone through either a written prescription or direct dispensation to the member. For additional details see CBH Opioid Use Disorder Guidelines and Provider Bulletin 16-04 and 17-10, "On-site Maintenance, Administration, and Prescription of Naloxone" (see Appendix B).

- Members should also be asked about nicotine use and provided with information about tobacco cessation, nicotine replacement therapies, and other forms of MAT for tobacco use disorder. Evidence-based MAT options for tobacco use disorder are underutilized despite the significant morbidity and mortality associated with tobacco use disorder. For additional information, please see Appendix B for CBH Tobacco Use Disorder Guidelines.

3.8. Treatment

Providers should utilize the ASAM Multidimensional Assessment and initial evaluation (including withdrawal risk assessment) to inform their recommendation for a specific LOC. CBH uses the ASAM LOC, which represent a continuum of services catered to an individual's needs. For more information see Appendix A. CBH recommends individualized, collaborative, evidence-based treatments.

3.8.1. Management of Withdrawal

A full discussion of treatment for alcohol withdrawal is beyond the scope of this guideline. Please refer to the 2020 American Society of Addiction Medicine (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management (Appendix A) for a more information. A brief collection of key points is included below:

- Withdrawal management can occur in a variety of treatment settings with different monitoring capability, ranging from ambulatory withdrawal management to treatment in medical hospital settings with ICU monitoring capabilities. The ASAM guidelines include specific recommendations for withdrawal management by LOC. Please also refer to CBH LOC specific Performance Standards for more information.

- Withdrawal can be associated with delirium and cognitive impairment; thus assessment of a member's decision-making capacity is important before any major decisions (such as leaving treatment AMA, or high risk intervention).

- Medications for withdrawal management include a variety of options that should be utilized dependent upon a member's individualized clinical situation and withdrawal severity. Benzodiazepines are the first line treatment, with alternative options including:

carbamazepine, gabapentin, phenobarbital. Additional adjunctive treatments are also mentioned in the ASAM guidelines.

- Symptom-triggered dosing of benzodiazepine is preferred when possible. Fixed dosing according to a scheduled taper may be appropriate if symptom-triggered dosing cannot be used.

- Prescribers should consider safety risks and diversion risks when prescribing these medications in an ambulatory setting. Efforts to mitigate these risks should occur and the minimum effective dose of benzodiazepine should be prescribed.

- Any benzodiazepine or phenobarbital used to treat alcohol withdrawal should be discontinued following treatment.

- Members who experience alcohol withdrawal should receive thiamine and folate supplementation to prevent Wernicke Encephalopathy. This can be done orally in ambulatory settings for mild withdrawal. In severe cases of alcohol withdrawal, suspected Wernicke's Encephalopathy, or if member has poor nutritional status/ malabsorption, then IV or IM administration of high-dose thiamine is recommended.

- Wernicke's Encephalopathy is underdiagnosed but is associated with substantial morbidity and mortality. Prompt aggressive treatment is critical.

- The period of alcohol withdrawal management should be used to engage patients with a comprehensive treatment program. This should include discussion of the evidence-based treatments, initiation of more long-term pharmacotherapy for AUD (MAT) if appropriate, and connection to services a warm hand off is ideal.

3.8.2. Medication-Assisted Treatment (MAT)

MAT for AUD should be offered to all members with moderate to severe AUD who seek to reduce or abstain from alcohol use and have no contraindications. The APA and SAMHSA Guidelines include extensive detail regarding use of MAT and should be used to help inform providers. The guidelines include details to assist with selection of a specific MAT type.

Complete evaluation of a member's medical, substance use, and mental health history as well as family history of alcohol use, pattern of use (daily vs binge drinking), presence/absence of cravings, and treatment goal (reduction vs abstinence) is critically important, as it is likely to influence selection of the most appropriate/beneficial MAT option. Prescriber should also review a member's complete medication list, PDMP query, and any available lab work. A full discussion of the MAT for AUD is beyond the scope of this guideline, however it should be noted that the APA 2018 guideline recommends naltrexone or acamprosate as first line agents (1B recommendation), and recommends disulfiram, topiramate, and gabapentin as a second

line (2C recommendation). While this prioritization is helpful, the guideline also emphasizes that patient preference and individual clinical situation should also guide prescribing decisions (See Appendix A).

All individuals diagnosed with AUD must receive information regarding all FDA approved MAT options. The information should be provided in an "informed-consent" structured discussion which should include discussion of benefits, risks, and alternatives and be documented in the medical record. Useful details related to informed consent for members with SUD are found in SAMHSA guideline pages 9-10 (See Appendix A). For individuals that have declined MAT, practitioners should continue to engage the person throughout treatment and indicate that MAT remains an option. If there is a reason that a member is not felt to be a candidate for MAT, the rationale for this should be documented in the chart. Individuals who elect to have MAT must be provided with MAT services on-site or should be promptly linked with another provider who can offer the desired MAT services.

For specific concerns related to prescription coverage, please see PA Medical Assistance Preferred Drug List (See Appendix A).

Members with AUD should not be prescribed benzodiazepines, with few exceptions. These exceptions include short-term use of benzodiazepines for management of acute alcohol withdrawal, or if there is another co-occurring medical or psychiatric disorder which requires short-term treatment with benzodiazepines. In these cases, benzodiazepine prescription should be accompanied by a plan to minimize benzodiazepine dose, duration, and to taper off the medication. Close monitoring strategies (PDMP query, laboratory monitoring, etc.) should be used in these circumstances. For information related to benzodiazepine prescribing and tapering, see CBH Clinical Practice Guidelines on these topics (see Appendix B).

3.8.3. Psychosocial Interventions

Evidence-based psychosocial treatments (including but not limited to Cognitive Behavioral Therapy (CBT), Motivational Enhancement Therapy (MET), and contingency management are recommended in conjunction with MAT (SAHMSA, APA Guideline, Ray et al 2020). APA and SAMHSA Guidelines also mention community-based peer support groups and mutual self-help groups are useful to many patients. Given the high incidence of trauma in this patient population, CBH encourages a trauma-informed approach. An individual's preference and unique clinical status should be considered in selecting a psychosocial intervention. However, a person's decision to decline psychosocial treatment should not delay or preclude appropriate medication management.

3.8.4. Recovery Planning

Treatment must be guided by a co-constructed recovery plan that adheres to DBHIDS NIC Standards for excellence (Domain 2, Standard C: Advancing Excellence in Resilience/Recovery Planning and Delivery of Services). Recovery plans must also adhere to the requirements detailed in DDAP licensing. A person's behavioral, physical, and substance use challenges should be considered in the development of the plan and all active issues should be addressed by a proposed intervention or referral to an appropriate service.

3.8.5. Duration

AUD is a chronic condition and some members may require medications for a long duration (SMHSA 2015 guidelines recommend *at least* six months to one year) or for multiple episodes.

3.9. Monitoring of Treatment

Progress in treatment should be regularly assessed. This should include reassessment of alcohol and other substance use (ex: ability to reduce use or abstain, any cravings, any relapses or increased use, problems related to use), clinical and functional status, and adherence to the treatment plan. Repeat administration of screening/structured tools maybe appropriate to monitor progress. Collateral information from social supports or other treatment providers (with a signed release of information) is also helpful in monitoring treatment progress.

Documentation of progress at each recovery plan update must include interventions to address any continued challenges and/or referral to higher LOC. Similarly, for members who are progressing in treatment and meeting treatment goals there should be consideration of reduction in intensity of services or discharge as clinically appropriate. All providers involved in the care should have a working knowledge of the recovery plan.

Treatment should occur with an understanding that relapse/disengagement is a common occurrence. Relapse reflects the natural history of substance use disorders and should be considered an opportunity for engagement between the member and the treatment team. Continued alcohol or substance use by the member is not necessarily a reason to discontinue MAT. However, continued use must be addressed clinically by the treatment team in an individualized way, taking into account possible triggers, need to adequately treat cravings/withdrawal symptoms, untreated medical or behavioral health symptoms, etc. Examples of appropriate response to continued substance use could include change in treatment plan, increased frequency of monitoring, change in medication type/dose, change in LOC, and development of a behavioral plan.

Monitoring of progress with alcohol/drug screening is discussed above in the laboratory section (3.7.).

Prescribers should have an ongoing awareness of the member's complete medication list. There should be monitoring for possible polypharmacy, drug-drug interactions, and any needed testing, including EKG, laboratory studies, or medication levels (see Appendix A).

MAT providers must review the PA Drug Monitoring Program (PDMP) as per state guidelines (see Appendix A) and it is advisable that query occurs on an ongoing basis. If a PDMP query shows concerning prescribing, the MAT provider should coordinate care with the other prescriber.

When members are absent from treatment, CBH requires that providers perform assertive outreach and document efforts to re-engage the member. Similarly, there should be efforts to reduce AWOL, AMA, and Administrative discharges for everyone receiving treatment.

3.10. Coordination of Care/Linkages

Providers must ensure members seeking services have access to and are quickly linked with evidence-based treatments, including MAT. Members should also receive appropriate referrals for underlying mental health needs, physical health needs, housing, case management, etc. Individuals with AUD frequently have medical comorbidity related to their alcohol use (for example: hepatic disease, cirrhosis, cognitive impairment, gait/mobility difficulties or frequent falls, seizures, nutritional deficiencies). This only underscores the importance of connection to appropriate medical monitoring and treatment.

Substance use providers should have a structure in place that supports integrated care and collaboration with other treatment providers, including, but not limited to, physical health and mental health providers, case management services, housing services, justice system services, etc. Integrated care is particularly important for individuals with any complex physical health or mental health needs.

Collaboration to coordinate care is expected between providers within an agency, as well as with any external providers. The purpose of this collaboration should be discussed with the member, including discussion of the benefits—as well as risks and possible consequences—of declining coordination. The medical record should include documentation of this discussion and any attempts to coordinate care.

Collaboration should occur regularly for ongoing care. Additionally, CBH requires evidence of real-time collaboration efforts in high risk circumstances, including, but not limited to, relapse, abnormal alcohol/drug screen result, concerning finding in PDMP query, referral to a higher LOC, or safety concerns.

3.11. Aftercare Planning/Discharge

The aftercare planning process should begin in the initial stages of treatment. Members should be involved in the aftercare planning, and the plan should reflect the individual's goals and preferences. Planning should include a clear and specific plan for follow up at the next recommended LOC. Whenever feasible, an appointment should be scheduled, and there should be a warm handoff. There should be a clearly stated plan regarding provision of medications

(including MAT) until the member is able to engage with the next provider. Discharge plans should always include a crisis and relapse prevention plan.

Unplanned discharges (including categories of Administrative, AMA, and AWOL discharge) have been linked to poorer treatment outcomes (see Appendix A). CBH expects providers to adopt a therapeutic, clinically based approach and strive to reduce these events. Attempts at outreach, engagement, and linkage should be documented in the medical record. For additional information please review the June 20, 2019 Provider Notice, CBH Provider Bulletin 18-13, and DDAP Bulletin 01-19 (Appendix B).

4. MONITORING

CBH providers are expected to follow the above guidelines for AUD. Adherence to the standards will be assessed through CBH monitoring and oversight, including Quality, Clinical, and Compliance Department protocols. Components may be reviewed as part of NIAC initial and recredentialling reviews. In addition, some standards will be assessed via quantifiable metrics, which are specified in the table below:

CPG Component Assessed	Metric	Data Source
Screening and Referral; Coordination of Care/Linkages	HEDIS® Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	TMG and CBH Data Informatics
Treatment	Percentage of members with AUD diagnosis who are receiving MAT & counseling.	CBH Data Informatics
Coordination of Care/Linkages; Aftercare Planning/Discharge	HEDIS® Follow Up After High-Intensity Care for Substance Use Disorder (FUI)	TMG and CBH Data Informatics

APPENDIX A: REFERENCES

- American Psychiatric Association (APA) Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder. 2018. https://doi.org/10.1176/appi.books.9781615371969

- Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute on Alcohol Abuse and Alcoholism, *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*. HHS Publication No. (SMA) 15-4907. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

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Website <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment> Accessed 9/30/20.

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- Jarvis, M. et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. ASAM Consensus Statement. J Addict Med. 2017 (11) 3: 163-173.

- Pennsylvania Medical Assistance Preferred Drug List.

- "Medications for Opioid Use Disorder Save Lives." The National Academies of Sciences, Engineering, and Medicine Consensus Study Report. March 2019. See highlights here.

- PDMP Resources
  - Registration
  - PA PDMP FAQ
  - 2014 PA Act 191: Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Enactment

- Li X, Sun H, Marsh DC, et al. Factors Associated with seeking readmission among clients admitted to medical withdrawal management. Subst Abus. 2008; 29:65-72.

- Substance Abuse and Mental Health Services Administration (SAMHSA): Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide. HHS Publication No. SMA-19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration, 2019.

APPENIDX B: PROVIDER BULLETINS, NOTICES, AND OTHER ADDENDA

1. Provider Bulletin 16-04 and 17-10: On-site Maintenance, Administration, and Prescription of Naloxone

2. Provider Bulletin 18-07: Requirement for All Crisis Response Centers (CRCs) and Drug and Alcohol Licensed Providers to Establish Protocols to Assist Individuals in Accessing Evidence-Based Treatment, Including Medication-Assisted Treatment

3. CBH Clinical Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications

4. CBH Clinical Guidelines for Tapering of Benzodiazepines

5. Provider Bulletin 18-13: Significant Incident Reporting

6. Provider Notice June 20, 2019: Administrative Discharges from Residential Drug and Alcohol Treatment Settings

7. DDAP Bulletin 01-19: Reminder to Alert Emergency Contacts When Patients Leave Against Advice

8. DBHIDS Practice Guidelines for Resiliency and Recovery-Oriented Treatment

9. Department of Behavioral Health and Intellectual Disability Services (DBHIDS), Network Inclusion Criteria (NIC) 3.0, 2019, (or most recent version)

10. CBH Tobacco Use Guidelines: https://cbhphilly.org/wp-content/uploads/2020/08/2020-08-06_clinical_guidelines_tobacco_use_disorder.pdf

11. CBH OUD CPG: https://cbhphilly.org/wp-content/uploads/2020/08/2020-08-06_clinical_guidelines_opioid_use_disorder_oud.pdf

APPENDIX C: SPECIAL POPULATION: CO-OCCURING PSYCHIATRIC DISORDERS

All individuals with AUD should have an evaluation of their mental health status as a part of their comprehensive assessment. In cases of emergency or acute safety concern, assessors should directly facilitate and ensure transfer to appropriate crisis services.

If a member needs mental health services in excess of what the substance use treatment provider can offer, then the member should be assisted in being linked to a provider who can offer these additional services. Collaboration between the substance use provider and the mental health provider is expected.

Individuals with psychiatric disorders or suicide risk factors should be asked about suicidal ideation/behaviors and should have closer monitoring for adherence to prescribed medications.

Assertive Community Treatment (ACT) should be considered for patients with serious and persistent mental illness, repeated hospitalization, or homelessness.

Please refer to the SAMHSA Guideline (Addressing Co-Occuring Disorders, pg. 11) details.

APPENDIX D: SPECIAL POPULATION: ADOLESCENTS

Special consideration should be given to treating adolescents with AUD. Clinicians should utilize ASAM Criteria and consider all available treatment options. This population may benefit from specialized adolescent addiction programs or other multidimensional treatment programs to address the member's unique needs.

As of the publication of this guideline, there is no FDA-approved MAT for adolescents with AUD, and validated research in this area is lacking. However, SAMHSA 2015 guideline notes that "in older adolescents and young adults, the limitations of available psychosocial interventions for youth and the demonstrated effectiveness of pharmacotherapy interventions in adults suggest that it may be reasonable to consider pharmacologic treatments for this age group." The guideline emphasizes that this may be particularly true in older adolescents who have severe AUD, have not achieved success with psychosocial treatments alone, or exhibit adult patterns of AUD.

Please refer to the SAMHSA Guideline (Treating Adolescents and Young Adults, pg. 12) for additional details.

APPENDIX E: SPECIAL POPULATION: PREGNANT INDIVIDUALS

The peripartum period is a critical time to screen for alcohol and other substance use disorders. Alcohol use disorder in pregnancy is known to increase risks of pregnancy complications, fetal abnormalities, and complications for the infant including fetal alcohol syndrome, cognitive problems, and other developmental difficulties. These risks, as well as the risks associated with any recommended treatments, should be discussed with individuals in an informed consent style discussion.

As of the publication of this guideline, there is limited research and evidence regarding ongoing use of MAT for AUD in pregnant or lactating individuals. The APA 2018 guideline does not recommend MAT for AUD in pregnant or breastfeeding individuals with AUD (with the exception of benzodiazepine use to treat acute alcohol withdrawal). The SAMHSA guidelines recommend that medication be used in this population only when the prescriber believes that the probable benefits outweigh the possible risks.

There are complex medical considerations in this population, including need for appropriate obstetrical and prenatal care and awareness of how pregnancy can affect pharmacokinetics of particular medications. Treatment of pregnant individuals with AUD should be co-managed by a clinician experienced in obstetrical care and a provider experienced in treating AUD.

Please refer to the APA Guideline (Statement 14, pg. 37), SAMHSA guideline (Treating Pregnant and Postpartum Women, pg. 12), ASAM guideline (Patients who are Pregnant, pg. 58) for additional details.

APPENDIX F: SPECIAL POPULATION: COURT-INVOLVED

For members involved with the criminal justice system, providers should adhere to SAMHSA's Principles of Community-Based Behavioral Health Services for Justice Involved Individuals (see Appendix A). Forensic goals should be assessed and included in recovery planning. All necessary consents for release of information should be obtained promptly to allow for providers to collaborate with any legal oversight (e.g. probation officers, defense attorney, district attorney). Collaboration should occur as needed or when requested by the member. All collaboration efforts should be documented in the medical record.

Practitioners should avoid a dual role whenever possible to avoid conflict of interest. For example, one practitioner could provide on-going treatment while another performs any court-stipulated assessment.

For additional details please refer to SAMHSA's Principles of Community-Based Behavioral Health Services for Justice Involved Individuals (see Appendix A).

APPENDIX G: MEDICATION ASSISTED TREATMENT FOR AUD, SUMMARY CHART

Note: The following table (adapted from 2015 SAMHSA guideline, pgs. 3-6). Please note that the table highlights some properties of the medications but does not provide complete information and is not intended to substitute for package inserts or other drug references. The information provided here is not a substitute for prescriber's clinical judgement. For information related to pregnancy and lactation, please see Appendix E.

Drug	Formulation and Frequency of Administration[2]	Mechanism of Action[2,3]	Clinical Uses/ Indications[2,3]	Warnings/Monitoring Recommendations[1-8]	Contraindications[1-8]
Naltrexone	Daily (oral) **Initiation:** 50mg daily **Alternative dosing**: 25mg 1 or 2 times daily with meals **Maintenance:** 50-100mg daily	Naltrexone is an opioid antagonist that blocks opiate receptors that are involved in the rewarding effects of drinking and craving for alcohol.	Oral naltrexone and extended-release injectable naltrexone are indicated for the treatment of alcohol use disorders.	Monitoring of liver function tests (LFTs) is recommended prior to the initiation of treatment, at 6 months, and then annually. Cases of hepatitis and liver dysfunction have been observed with some formulations. Discontinue use of naltrexone in the event of symptoms or signs of acute hepatitis. Caution in patients with elevated serum transaminase levels, consider consultation with medical providers. Caution in patients with hepatic impairment, renal impairment, suicidal risk, depression. Use naltrexone extended-release injection with caution in patients with injection site reaction, and for patients with thrombocytopenia or coagulation disorders. Patients should take no opioids for 7-14 days prior to starting naltrexone to avoid precipitating withdrawal. Patients should be warned that they may become more sensitive to opioids or analgesia. Failure to carefully titrate could increase risk of opioid intoxication or overdose.	Contraindicated in: • patients receiving opioids or opioid agonist therapy (including buprenorphine or methadone) • patients anticipating a need for opioids • patients currently dependent on opioids • patients in acute opioid withdrawal • patients who have failed the naloxone challenge test or whose urine tests positive for opioids • acute hepatitis or liver failure • sensitivity to naltrexone or ingredient
Naltrexone Extended Release injection	**Initiation & Maintenance:** 380mg IM every 4 weeks (extended-release injectable)	**Extended-release:** The monthly injection produces a more consistent and predictable blood level of the drug, because the depot injection bypasses 1st pass metabolism. Monthly dosing minimizes opportunities for nonadherence.	Extended-release injectable naltrexone is also indicated for the prevention of relapse to opioid dependence following detoxification.		

				Wallet card recommended for emergency situations.	
Acamprosate	**Initiation & Maintenance:** 666mg 3 times per day (oral)	Acamprosate is thought to counteracting the imbalance between the glutamatergic and GABAergic systems associated with chronic alcohol use. It has been linked to reduced alcohol use and reduced relapse.	Acamprosate is indicated for the treatment of Alcohol use disorders	Before initiating treatment with acamprosate, evaluate the patient's renal function through a standard panel for urea, electrolytes, and serum creatinine to rule out severe renal impairment. For patients with mild to moderate renal impairment (creatinine clearance of 30–50 mL/min), acamprosate should be used as a second line agent, and a reduced dose is recommended. Caution in patients with: suicide risk, depression	Contraindicated in: • patients with severe renal impairment • those who have a known hypersensitivity to the drug or its components.
Disulfiram	**Initiation:** 250mg daily (oral) **Maintenance:** 250-500mg daily (range 125-500mg)	Inhibits aldehyde dehydrogenase When taken in combination with alcohol, causes a significant physical reaction, involving nausea/vomiting, flushing, and heart palpitations. The knowledge that such reactions are likely if alcohol is consumed acts as a deterrent to drinking.	Disulfiram is indicated for patients dependent on alcohol who have completed alcohol withdrawal and have been abstinent from ingesting alcohol for the past 12 -24 hours. Patients should be committed to abstinence.	Liver function tests (taken at baseline and 14-30 days later) are suggested to detect any hepatic dysfunction that may result from disulfiram therapy. Additional monitoring of LFTs, blood counts, and serum chemistries should be considered on individualized basis as well. Severe and sometimes fatal hepatitis associated with disulfiram may develop after many months of therapy. Caution in patients with: hepatic impairment, heart disease, diabetes, hypothyroidism, cerebral injury, nephritis, age over 60 Not recommended for patient with epilepsy/ history of seizure. Counsel patients to avoid all forms of alcohol (mouthwash, various medications, alcohol-based hand sanitizer, etc.) and that reactions to alcohol can happen up to 14 days after taking disulfiram. Disulfiram has several important drug-drug interactions (see package insert for details).	Contraindicated in patients with: • severe myocardial disease or CAD • psychosis • pregnancy • in those with high levels of impulsivity • suicidality • hypersensitivity to disulfiram or component • patients who are taking or have recently taken metronidazole • alcohol use within 12 hours

				Wallet card recommended for emergency situations.	
Topiramate	**Initiation:** 25mg daily (oral), increase dose by 25-50mg/day divided twice daily at weekly intervals **Maintenance:** Maximum recommended dose 200mg/day divided doses Doses studied range between 75-300mg/day in divided doses	Topiramate decreases alcohol reinforcement and the propensity to drink by reducing craving for alcohol through antagonism of glutamate receptors and inhibition of dopamine release.	Topiramate is not Food and Drug Administration (FDA) approved for AUD but is sometimes used off-label. Topiramate may be a treatment consideration in patients who are unable to use other options or prefer gabapentin, or for augmentation.	Patients with renal impairment will require dose reduction. Cases of metabolic acidosis, nephrolithiasis, and precipitation of acute angle glaucoma have occurred. Caution in patients with: CNS depressant use, depression, suicide risk, alcohol use, status epilepticus, hepatic impairment, congenital metabolic disorders, renal impairment, hypokalemia, metabolic acidosis risk, nephrolithiasis, severe respiratory diseases, ketogenic diet, poor hydration status, cognitive dysfunction, anorexia, elderly, falls risk. Do not abruptly discontinue therapy; taper dosage gradually.	Contraindicated in: • metabolic acidosis with concomitant metformin use • hypersensitivity to topiramate or component
Gabapentin	**Initiation:** 300 mg oral at bedtime, may increase dose by 300mg/day daily, given in divided doses **Maintenance:** Target dose 1800mg/day in divided 3 doses	The effects of gabapentin likely occur through modulation of γ-aminobutyric acid (GABA) activity in the amygdala associated with AUD.	Gabapentin is not Food and Drug Administration (FDA) approved for AUD but is sometimes used off-label. Gabapentin may be a treatment consideration for patients with co-occurring neuropathic pain or in patients who are unable to use other options or prefer gabapentin, or for augmentation.	Monitor serum creatine periodically, particularly in patients with renal insufficiency. May require renal dose adjustment. Monitor for abuse/misuse, somnolence, dizziness, suicidal ideation. Caution in patients with: CrCl < 60, age > 60, depression, substance abuse, respiratory impairment, CNS depressant use, alcohol use. Do not abruptly discontinue therapy; taper dosage gradually	Contraindicated in: • hypersensitivity to gabapentin or component • CrCl < 30 (ER form)

References:

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5. Product Information: VIVITROL(R) intramuscular extended-release injection, naltrexone intramuscular extended-release injection. Alkermes Inc (per FDA), Waltham, MA, 2019.

6. Product Information: acamprosate calcium oral delayed-release tablets, acamprosate calcium oral delayed-release tablets. Mylan Pharmaceuticals Inc. (per DailyMed), Morgantown, WV, 2014.

7. Product Information: disulfiram oral tablets, disulfiram oral tablets. Roxane Laboratories, Inc (per DailyMed), Columbus, OH, 2014.

8. Product Information: Trokendi XR(TM) oral extended-release capsules, topiramate oral extended-release capsules. Supernus Pharmaceuticals (per manufacturer), Rockville, MD, 2013.

9. Product Information: Neurontin(R) oral capsules, tablets, solution, gabapentin oral capsules, tablets, solution. Parke-Davis, New York, NY, 2010.

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