C·B·H

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CLINICAL PRACTICE GUIDELINES

Opioid Use Disorder (OUD)

Updated September 11, 2026

Community Behavioral Health

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TABLE OF CONTENTS

1. BACKGROUND

The City of Philadelphia, like much of the United States, faces a crisis in opioid use disorder (OUD) and fatal opioid overdose deaths. Community Behavioral Health (CBH) is keenly aware of the unprecedented changes and numerous challenges our communities in Philadelphia have faced in recent years. In efforts to address the opioid epidemic in Philadelphia, there have been robust, multidisciplinary efforts, including the use of evidence-based treatment, medication-assisted treatment, harm reduction, public health education, and policy changes. In 2017, Mayor Jim Kenney's ***Task Force to Combat the Opioid Epidemic in Philadelphia*** released its final report and recommendations, which have informed much of the work that CBH and its provider network have done to improve access to and quality of OUD treatment. A multimethod research project, **Mapping the Opioid Use Disorder Crisis in Philadelphia, PA**, can assess the status and capacity of the current treatment system to ensure equitable access and offer insights into the factors that contribute to engagement, early exit, and retention.

Thankfully, according to the **Philadelphia Department of Public Health (PDPH),** accidental overdose deaths have been declining since 2023. Unintentional death by drug overdose decreased by 18% from 2023 to 2024. In 2024, there were over 1,069 drug overdose deaths recorded in Philadelphia, a 24% decrease from the all-time peak in 2022.

Despite these improvements, contamination of the illicit drug supply continues to complicate the response to the opioid epidemic in Philadelphia. Xylazine, also known as "tranq," is a non-opioid sedative or tranquilizer intended for use in animals. In 2021, 91% of purported heroin or fentanyl samples from Philadelphia also contained xylazine[1]. According to a Drug Enforcement Administration (DEA) **public safety alert**, xylazine, when mixed with fentanyl, places users at a higher risk of suffering a fatal drug overdose. PDPH indicates that of overdose deaths in 2023, fentanyl and/or fentanyl analogs were present in 97% of opioid overdose cases, stimulants were detected in more than 70% of cases with or without opioids, and xylazine was present in 38% of all overdose death cases.[2] Furthermore, xylazine contributes to severe wounds in the opioid-dependent population, leading to pain and prolonging treatment times.

In 2024, Medetomidine, another, more potent veterinary sedative, was detected in Philadelphia's drug supply. Medetomidine is 100-200 times more potent than xylazine. It significantly complicates the withdrawal and treatment process as it causes prolonged sedation, low heart rate, and complex withdrawal, which can require treatment from higher levels of care. Therefore, standard withdrawal rating scales provide less reliable support for treatment decisions.[3] Since the initiation of medetomidine testing by **Philadelphia's Medical Examiner's Office** in May 2024, it was found in 9% in overdose deaths in 2024 (data for 2025 are not yet available).

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[1] ***PDPH Health Alert: Risks of Xylazine Use and Withdrawal in People Who Use Drugs in Philadelphia; March 16, 2022***.

[2] *Philadelphia Department of Public Health:* ***PhilaStats***.

[3] ***DDAP Technical Assistance Webinars: Emerging Drug Trends: Medetomidine and Clinical Considerations for Treatment Providers***.

The Food and Drug Administration (FDA) issued a warning in 2019 about its respiratory depressive function, especially when used together with opioids or other central nervous system depressants like opioids.[4] Therefore, providers need to be aware of updates and warnings related to the use of other medications for members with opioid use, as gabapentinoids, such as gabapentin, are commonly prescribed for a variety of FDA-approved and off-label indications, including anxiety, pain, and alcohol use disorder (AUD). (Please refer to **Section 3.7: Treatment** for further details, and a full summary of best practices for gabapentinoid prescribing.)

2. PURPOSE

CBH has adopted clinical practice guidelines (CPGs) to outline best practices for treating specific disorders or particular populations. CBH uses these guidelines to assess the quality of care provided to CBH members. As such, providers are advised to review and, where appropriate, implement as many of these practices as possible in delivering care. These guidelines apply to all clinical settings where members are treated for these disorders. These guidelines should be used with any level-of-care-specific performance standards, and all other required CBH, state, and federal regulations and standards. Recommendations from this CPG may be used in quality management, provider performance evaluations, and other incentive programs, such as value-based payment.

These guidelines draw on the **American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of OUD, 2020 Focused Update**, and describe expectations for quality of care. The aim is to articulate best practices and quality-monitoring standards for substance use disorder (SUD) treatment providers and to help them 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 ASAM national guidelines. In addition, all CBH providers offering OUD treatment should be familiar with the **Substance Abuse and Mental Health Services Administration (SAMHSA)** regulations under the Code of Federal Regulations **42 CFR Part 8** (Medications for the Treatment of Opioid Use Disorder), including regulations that guide opioid treatment programs. These regulations were revised, and the final rule was released in February 2024 by the U.S. Department of Health and Human Services through SAMHSA.

While designed for the CBH network, CPGs are intended to be used/accessed by other Philadelphia Medicaid providers, including physical health providers, to facilitate high-quality, evidence-based care for CBH members across all treatment settings. Information on special populations and a list of resources and references can be found in the appendices. For assistance in accessing services, please contact CBH Member Services at 888-545-2600.

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[4] *U.S. Food and Drud Administration (FDA): **Neurontin, Gralise, Horizant (gabapentin) and Lyrica, Lyrica CR (pregabalin): Drug Safety Communication - Serious Breathing Problems**.*

3. PRACTICE GUIDELINES

3.1. Screening and Referral

The first priority of screening is to assess safety and make appropriate referrals for any urgent or emergent medical or psychiatric problems. This includes assessment of imminent danger to self or others, substance intoxication, withdrawal, or overdose. CBH requires the use of an evidence-based tool to screen for suicide risk, and strongly recommends the **Columbia Suicide Severity Rating Scale (C-SSRS)**. In cases of emergency, assessors should directly facilitate and ensure transfer to appropriate emergency medical or psychiatric services. Awareness and knowledge of slang terms and code words for drugs may be relevant in screening and assessment stages.[5]

Validated, standardized, and structured screening should be used to assess the presence and severity of SUDs. CBH recommends incorporating screening instruments, such as those outlined in SAMHSA's **Screening, Brief Intervention, and Referral to Treatment** (SBIRT) and the National Institutes of Health's **Screening and Assessment Tools Chart**.

3.1.1. Overdose Risk Assessment

Given the high risk of overdose death in individuals with OUD, priority should be given to assessing for overdose risk factors. Standardized instruments may be employed if available. At a minimum, a history of prior overdose, amount and type of opioid used (including fentanyl), concurrent substances used (particularly respiratory depressants), and high-risk medical conditions should be documented.

CBH recommends that providers sign up for the **Philadelphia Department of Public Health (PDPH) Opioid Overdose Notification Network**, a notification system establishing a coordinated rapid response to "outbreaks" or opioid overdose surges in Philadelphia. Providers are encouraged to stay informed of local news and follow **PDPH news** for identification of risk of overdose and new drugs of abuse. PDPH publishes annual reports on unintentional drug overdose fatalities in Philadelphia that include recommendations for health care providers.[1] These and other reports can be subscribed to via the **PDPH CHART**. Furthermore, providers can refer to the **DEA's public safety alerts**.

3.2. Assessment

The **ASAM Multidimensional Assessment** should be completed and used to facilitate recommendations for a level of care (LOC). Assessors should be aware that members may not understand treatment terminology and may require education about the treatment process and recommended interventions. Initial assessment should include presenting complaint, current symptoms, complete medical and psychiatric history, and detailed substance use history. This includes assessing readiness for change, interest in medication-assisted treatment (MAT), and social and environmental factors to identify facilitators and barriers to treatment in both medical settings and communities. A comprehensive assessment should include a physical exam aligned

[5] *DEA Intelligence Report: Slang Terms and Code Words: A Reference for Law Enforcement Personnel; July 2018*

with the LOC per the ASAM Criteria, when possible. At a minimum, the assessor should confirm the patient's access to physical health care or provide an appropriate referral. Collaboration with existing providers and/or supports is expected. The inability to immediately complete all aspects of the comprehensive assessment should not necessarily delay or preclude medically appropriate treatment.

Members with SUDs have high comorbidity for other mental health conditions, as well as heightened risk of suicide. As part of the intake process, members should be screened for suicide risk using an evidence-based tool. CBH strongly recommends using the C-SSRS. Members should also be screened for depression using the **Patient Health Questionnaire (PHQ-9)** (or other evidence-based tool) and health-related social needs (HRSN) using the **CBH Health Level Seven (HL-7) Submission Guide**.

After the treatment team has developed and implemented an initial treatment plan, the team should conduct periodic reassessments to monitor the patient's progress and inform clinical decision-making. Reassessments and treatment plan reviews should also be conducted in response to significant events or changes in the patient's condition or circumstances that may influence the treatment plan or recovery process. Assessment and treatment should align with **The ASAM Criteria, 3rd Edition**.

3.3. Health-Related Social Needs (HRSN)

There is widespread evidence supporting screening for various aspects of adverse HRSN in clinical care. Recent studies have demonstrated that reduced economic opportunity has been associated with heightened opioid overdose mortality.[6] The PDPH finds there to be a disproportionate increase in the number of overdose deaths among non-Hispanic Black individuals compared to other racial/ethnic groups in Philadelphia in recent years. Between 2018 and 2022, the number of overdose fatalities increased 87% and 43% among non-Hispanic Black individuals and Hispanic individuals, respectively, and decreased 12% among non-Hispanic white individuals.[1] The recent data show that overdose deaths decreased 27% among non-Hispanic Black individuals and 26% among Hispanic individuals from 2023 to 2024. While trends in overdose mortality are decreasing, communities of color continue to be the most impacted.

As part of assessment and recovery planning, providers should identify relevant HRSN, 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). Providers should utilize a structured screening tool, such as the **HL-7 Submission Guide**.

Modifiable factors should be noted, and efforts should be made to support or connect members with resources to address them as part of a comprehensive treatment plan. When feasible, efforts should be made to reduce barriers to engagement (e.g., transportation difficulties). For more information, please refer to Section 4.2 of the **CBH Clinical Performance Standards for Opioid Centers of Excellence** (located under the *Clinical Performance Standards* tab) and resources available through the **Department of Behavioral Health and Intellectual Disability Services (DBHIDS)**.

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[6] ***Screening for Social Determinants of Health in Clinical Care: Moving from the Margins to the Mainstream***

3.4. Diagnosis

OUD diagnosis should be made in accordance with **DSM-5-TR** criteria. Before initiating any MAT, this diagnosis should be confirmed and documented by the MAT prescriber. Documentation of diagnosis should follow any other pertinent state and federal regulations.

3.5. Laboratory Testing and Drug Screening

Assessment of SUDs should include obtaining or providing a referral for laboratory testing, regardless of a patient's self-report regarding use. ASAM recommends "smarter" drug testing that includes reliance on random testing over scheduled testing. Urine and drug screens are highly recommended; however, other matrices (saliva, blood) may be more appropriate for certain populations or persons who have experienced traumatic events. It is imperative for care, especially for the management of withdrawal symptoms, to obtain drug screening results.

Members should be educated on the need for drug screening as a public and patient safety measure, as there are widespread contaminations of multiple illicit, deadly substances mixed with their substance of choice, often without their knowledge. It is important to include informed consent on drug screens during the admission process. Not only as best practice, but to involve the person in decision making of their interventions, explain program policies, and to build a therapeutic alliance and obtain the patient's preferences (if any, i.e., gender of staff) on drug testing procedures.

The presence of xylazine in drug testing results may inform treatment decisions. Xylazine withdrawal syndrome and evidence-based treatment are distinct from MAT for OUD.[1] At this point, no approved point-of-care drug screen for medetomidine is available for wider use. Please refer to **Section 3.7.1. Medication-Assisted Treatment** for further details surrounding the management of xylazine and medetomidine withdrawal.

The education and process of obtaining drug screening should be approached cautiously so as not to seem punitive and stigmatizing. It should be explained that drug testing can inform not only the assessment of an SUD but can also aid in supporting one's recovery and monitoring how effective the current treatment plan is in achieving the patient's goals. It is a tool for supporting one's recovery and can provide positive feedback when discussed in a non-punitive manner. If a patient refuses a drug test, the refusal should be addressed in the treatment plan. The inability to rapidly obtain drug screening should not necessarily delay or preclude medically appropriate treatment, especially at higher acuity LOC.

Additional laboratory testing may also include pregnancy testing, CBC, LFTs, and appropriate screening for infectious diseases (e.g., hepatitis, HIV, TB, sexually transmitted infections) with patient-informed consent. The inability to rapidly obtain laboratory testing should not necessarily delay or preclude medically appropriate treatment.

If possible, monitoring progress in recovery with a urine drug screen (UDS) should follow CBH LOC performance standards. See the **CBH Clinical Performance Standards: Opioid Centers of Excellence** (located under the *Clinical Performance Standards* tab) where applicable. At a minimum, providers must have a protocol for collecting drug screens, determining the frequency of screening, and ensuring that results are reviewed. Random unannounced testing is recommended over scheduled testing. The results of 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 for all LOCs, including selecting an appropriate testing panel and collaborating with a national laboratory, can be found in the ***ASAM Consensus Statement on Appropriate Use of Drug Testing in Clinical Addiction Medicine*** (which includes a pocket guide and an app). ASAM also provides educational materials to educate patients.

3.6. Harm Reduction

Given the harmful sequelae of OUD, this disorder benefits from a variety of harm reduction practices. Members should be educated on interventions related to intravenous drug use (syringe exchange if available, etc.) and overdose. All individuals receiving SUD treatment, particularly those with OUD, should be provided with education about and access to naloxone.[7] The DEA has published a **public safety alert** detailing that while naloxone does not reverse the effects of xylazine, which is making fentanyl even more deadly, it is still recommended to administer naloxone if someone may be suffering from an opioid overdose. The same is true concerning the newer adulterant, medetomidine.

In Philadelphia, naloxone can be accessed via the Pennsylvania Naloxone Standing Order, individualized prescriptions from providers, mail order through NEXT Distro, or direct dispensing by a provider agency or community-based organization.[7] Members with OUD should be asked regularly throughout the course of treatment about their access to naloxone. This is particularly important for individuals who are known to have relapsed or be using illicit substances. Direct support should be provided in obtaining naloxone when needed. For additional details, see CBH Provider Bulletins **16-04** and **17-10**. PDPH maintains **resource hubs** that offer free naloxone, HIV test kits, and test strips for fentanyl and xylazine. Medetomidine test strips are available by request through **SUPHR.** Philadelphians are strongly encouraged to obtain and receive training on how to use naloxone to prevent opioid overdose deaths.[5] Above all, the wide availability of naloxone should become a universal tenet within our system, as its rapid use can save lives from overdose. Please refer to **Appendix H: Resources for Members**.

There should be a discussion of the risks of continued opioid use (e.g., serious health, legal, occupational, financial, and relationship risks) and agreed-upon steps taken to reduce risk when possible. For individuals who may become pregnant, there should be discussions about the impact of OUD on pregnancy, neonatal opioid withdrawal syndrome, and available options for family planning.

Given the frequent co-occurrence of multiple SUDs, members should be asked about the use of other substances, as mentioned in **Section 3.2: Assessment**. Members should be offered available MAT for any comorbid conditions, particularly alcohol use disorder (AUD) or tobacco use disorder (TUD). For more information, please see **CBH CPGs** for these conditions. Providers should also educate members on the potential for contamination of the illicit drug supply. Specific to xylazine, providers should inform members of potential side effects, such as atypical wounds and increased risk for overdose, as well as harm reduction strategies.[1] Specific features of medetomidine withdrawal should also be explained. In addition, PDPH recommends encouraging patients who use street drugs to test their drugs using fentanyl, xylazine, and

[7] ***Learn how to get and use naloxone (Narcan®), City of Philadelphia Mental & Physical Health Services***

medetomidine test strips and providing sterile syringes to patients who inject drugs to reduce the spread of HIV and hepatitis.[Error! Bookmark not defined.]

3.7. Treatment

Providers should utilize the **ASAM Multidimensional Assessment** and initial evaluation to inform their recommendation for a specific LOC. CBH uses the **ASAM Criteria LOC**, representing a continuum of services catered to an individual's needs. Pennsylvania maintains a **1115 Waiver** approved by the Centers for Medicare & Medicaid Services (CMS) that is valid through September 30, 2027. A key requirement of the waiver is that care must be consistent with ***The ASAM Criteria, 3rd Edition,*** at the residential and inpatient LOCs.

CBH recommends individualized, collaborative, evidence-based treatments. Providers should utilize non-stigmatizing language as much as possible when discussing substance use with patients[8].

3.7.1. Gabapentinoid Prescribing for Members with OUD

It is also important for providers to be aware of updates and warnings related to the use of other medications for members with opioid use. Gabapentinoids, such as gabapentin, are commonly prescribed for a variety of FDA-approved and off-label indications, including anxiety, pain, and AUD.

While legitimate uses for these medications exist, prescribers need to be mindful of their use in certain high-risk populations, such as individuals using opioids or with OUD. The FDA issued a warning in 2019 about its respiratory depressive function, especially when used together with opioids or other central nervous system depressants like opioids.[9]

Please see **Appendix C** for a full summary of best practices for gabapentinoid prescribing.

3.7.2. Medication-Assisted Treatment (MAT)

MAT is recommended as a first-line treatment per the **ASAM National Practice Guidelines** and **SAMHSA TIP 63: Medications for OUD** and has been correlated with better long-term outcomes for individuals with OUD. The ASAM guidelines include extensive details on MAT, which should help inform providers.

All individuals diagnosed with OUD must receive information regarding all FDA-approved MAT options. The information should be provided in an informed-consent structured discussion, including a discussion of benefits, potential risks, and alternatives, and documented for each patient within the medical record. Given the associated risks, documentation for a medication-free treatment for OUD must include a discussion of the member's preferences, even after appropriate education about available treatment options. For individuals who elect to undergo withdrawal management (formerly referred to as detoxification) without MAT, informed consent should be obtained regarding the medical, psychological, and social risks of medication-

[8] ***Division of Substance Use Prevention and Harm Reduction (SUPHR) Guidance: Language Matters***

[9] *FDA:* ***Neurontin, Gralise, Horizant (gabapentin) and Lyrica, Lyrica CR (pregabalin): Drug Safety Communication - Serious Breathing Problems***

free treatment, and practitioners should continue to engage the person throughout the withdrawal management episode of care, indicating that MAT remains an option.

Individuals who elect to undergo MAT must be provided with on-site MAT services or promptly linked to another provider who can offer the desired MAT services. In hospital-based settings where members cannot leave to connect to MAT through another provider, there should be the ability to provide MAT on-site, including both induction and maintenance. For additional information, see CBH Provider Bulletins **18-07** and **20-33**.

A full discussion of withdrawal management for OUD is beyond the scope of this guideline. However, individuals must be offered MAT induction as a part of withdrawal management if clinically appropriate.

The following are useful resources related to adulterants:

- Xylazine withdrawal
  - Penn Medicine Center for Addiction Medicine and Policy: **Xylazine Withdrawal and Overdose**
- Medetomidine withdrawal in the outpatient setting
  - PDPH Health Information Portal: **Medetomidine Withdrawal in the Outpatient Setting**
  - PDPH Health Information Portal: **Responding to overdose and withdrawal involving medetomidine**
  - **Substance Use Philly: Medetomidine: What you need to know**
  - **ASAM Printable Resource Guides - Medetomidine** (see medetomidine)

For specific concerns related to prescription coverage, please see the **Statewide Preferred Drug List (PDL)**.

3.7.3. Psychosocial Treatments

Psychosocial treatments, including individual and/or group therapies, are recommended in conjunction with MAT. The ASAM guidelines provide information on evidence-based psychosocial treatments. Given the high incidence of trauma in this patient population, CBH encourages trauma screening as well as a trauma-informed approach. An individual's preference should be considered when selecting a psychosocial intervention. However, a person's decision to decline psychosocial treatment should not delay or preclude appropriate medication management. **The National Academies of Sciences, Engineering, and Medicine 2019 Consensus Study** concluded that "withholding or failing to have available all classes of FDA-approved medication for the treatment of OUD in any care setting is denying appropriate medical treatment."

3.7.4. Recovery Planning

Treatment must be guided by a co-constructed recovery plan that adheres to the requirements detailed in **DDAP licensing**. A person's behavioral, physical, and SUD challenges should be considered when

developing the plan, and all active issues should be addressed through a proposed intervention or referral to an appropriate service. Personalized goal-setting and coping strategies are essential parts of a recovery plan. As addiction is a chronic relapsing disorder, accountability and steady daily routines are key elements for a positive long-term outcome.[2]

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

3.7.5. Duration

OUD is a chronic condition, and some members may require treatment for a long duration or multiple episodes following relapse. There is no recommended time limit for MAT use. Research is limited, but it has been suggested that longer treatment duration may be associated with better outcomes. Members who relapse following discontinuation of MAT should be encouraged to resume treatment with MAT. Additional details related to discontinuing MAT or transitioning from one form of MAT to another are available in the ASAM guidelines.

3.8. Monitoring of Treatment

Treatment should occur with an understanding that relapse/disengagement is a common occurrence. Return to substance use reflects the natural history of OUD and should be considered an opportunity for heightened engagement between the member and the treatment team. Continued substance use by the member is not necessarily a reason to discontinue MAT. However, continued substance use must be addressed clinically by the treatment team in an individualized way, considering possible triggers, the need to adequately treat cravings/withdrawal symptoms, inadequately treated behavioral health symptoms, etc. Examples of appropriate responses to continued substance use could include a change in the treatment plan, a change in medication type/dose, a change in LOC, and the development of a behavioral plan. Monitoring progress with drug screening is discussed in **Section 3.5: Laboratory Testing and Drug Screening**.

MAT providers must regularly review the **PA Prescription Drug Monitoring Program (PDMP)** for each member, in accordance with state guidelines. If a PDMP query shows that a member is currently receiving controlled substances from an outside prescriber, the MAT provider should coordinate care with the other prescriber. Providers are encouraged to use the **PMP Interconnect Search** to locate their patients in bordering states.

Prescribers should be aware of the member's complete medication list. They should monitor for possible polypharmacy, drug-drug interactions, and any needed testing, including EKG, laboratory studies, or medication levels (see **Appendix A**). Some medications, particularly benzodiazepines and gabapentinoids, pose elevated safety risks when used in combination with some types of MAT. In most cases, benzodiazepines should not be used in combination with MAT. For additional information related to benzodiazepine prescribing and tapering, see **CBH CPGs** on these topics. For a full summary of best practices for gabapentinoid prescribing, see **Appendix C**.

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

3.9. Coordination of Care/Linkages

Providers must ensure that members seeking services have access to, and are quickly linked to, evidence-based treatments, particularly MAT. For details, please refer to **CBH Provider Bulletin 18-07**. Members should also receive appropriate referrals for underlying mental and physical health needs, such as comorbid Hepatitis C and HIV, major depressive disorder, case management, etc.

SUD providers should have a structure in place that supports integrated care and collaboration with other treatment providers, including but not limited to physical and mental health providers, case management services, housing services, and justice system services. Integrated care is particularly important for individuals with complex physical health or mental health needs. In alignment with the **American Medical Association's Medication Reconciliation policy**, care coordination systems and provider collaboration (internal and external) are also expected to ensure medication reconciliation, support continuity of care, reduce medical errors, and enhance patient safety and quality of care.

Collaboration to coordinate care is expected among providers within an agency, as well as with external providers, methadone maintenance centers, and entities that provide members' care. The purpose of this collaboration should be discussed with the member, including the benefits—as well as the risks and possible consequences—of declining to coordinate. The medical record should include documentation of this discussion and any attempts to coordinate care.

Specifically, staff at care management agencies and outpatient care managers working with members with SUD should familiarize themselves with relevant **CBH CPGs.** Whether or not the case management agencies provide clinical services, the staff at any LOC management services should facilitate harm reduction practices, including helping members access naloxone and educating them on its use, collaborating on treatment planning, helping obtain UDS, and other relevant activities in the CPGs.

Collaboration should occur for ongoing care at least every three months. CBH requires evidence of real-time collaboration efforts in high-risk circumstances, including but not limited to medical and psychiatric hospitalization, relapse, referral to a higher LOC, safety concerns, or any other significant events that could impact the member's treatment and recovery process. For example, staff can host meetings with external psychiatric providers involved in a member's care to facilitate care coordination and revisions to a treatment plan at any point during a psychiatric or medical hospitalization. All staff should be aware that they can call CBH to ask about services provided to members and to help locate members in real time, such as when a member is hospitalized.

3.10. Aftercare Planning/Discharge

The aftercare planning process should begin in the initial stages of treatment. Members should be involved in aftercare planning, and the plan should reflect their goals and preferences. Planning should include a clear and specific plan for follow-up at the next recommended LOC. An appointment should be scheduled, and a warm handoff should be provided whenever feasible. There should be a clearly stated plan regarding the

provision of medications (including MAT) until the member can engage with the next provider. Discharge plans should always include a crisis and relapse prevention plan.

Unplanned discharges (including administrative, AMA, and AWOL discharge categories) have been linked to poorer treatment outcomes (see **Appendix A**). CBH expects providers to adopt a therapeutic, clinically based approach and to recommend alternative treatment modalities to individuals slated for administrative discharge. Attempts at outreach, engagement, and linkage should be documented in the medical record. For additional information, please review **CBH's significant incident reporting (SIR) process**.

4. MONITORING

CBH providers are expected to follow the above guidelines for OUD. CBH monitoring and oversight will assess adherence to the standards, including protocols from the Quality, Clinical, and Compliance Departments. Components may be reviewed as part of initial and re-credentialing reviews. In addition, some standards will be assessed via quantifiable metrics, which are specified in the table below:

CPG Component Assessed	Metric	Data Source
Treatment	MAT-OUD: Percentage of members with OUD who receive both MAT and counseling	CBH Data Informatics
Coordination of Care/Linkages; Aftercare Planning/Discharge	HEDIS® FUI - Follow-up after high-intensity care for SUD assessing inpatient, residential treatment and detoxification visits or discharges among patients 13+ that resulted in follow-up care within 7 and 30 days	TMG

APPENDIX A: REFERENCES

- **The Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia: Final Report and Recommendations.** May 19, 2017. Mayor James F. Kenney.
- **The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.**
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- **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.
- McCance-Katz E et al. **Drug Interactions of Clinical Importance among the Opioids, Methadone and Buprenorphine, and Other Frequently Prescribed Medications: A Review.** Am J Addict. 2010; 19(1): 4–16. doi:10.1111/j.1521-0391.2009.00005.x.
- 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.
- American Medical Association. ***Medication Reconciliation to Improve Patient Safety D-120.965***. American Medical Association, Policy Finder.
- Substance Abuse and Mental Health Services Administration. **Criminal and Juvenile Justice**.
- Penn Medicine Center for Addiction Policy and Medicine. ***Xylazine withdrawal and overdose***.
- Philadelphia Department of Public Health Division of Substance Use Prevention and Harm Reduction. ***Emerging practices for managing medetomidine withdrawal in the outpatient setting***. City of Philadelphia, Department of Public Health - Health Information Portal (HIP).
- American Society of Addiction Medicine. ***Education & Training: Printable Resource Guides***. ASAM - American Society of Addiction Medicine.

APPENDIX B: PROVIDER BULLETINS, NOTICES, AND OTHER ADDENDA

- CBH Provider Bulletin 16-04 and 17-10: On-site Maintenance, Administration, and Prescription of Naloxone
- CBH 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
- CBH Provider Bulletin 20-33: Requirement for all Hospital-Based Psychiatry Providers to Have Capability to Provide Medications for Opioid Use Disorder (MOUD) to Individuals with OUD who Require Hospital-Based Care.
- CBH Clinical Practice Guidelines for the Prescribing and Monitoring of Benzodiazepines and Related Medications
- CBH Clinical Practice Guidelines for Tobacco Use Disorder
- CBH Clinical Practice Guidelines for Alcohol Use Disorder
- CBH Provider Bulletin 18-13: Significant Incident Reporting
- DDAP Bulletin 19-01: Reminder to Alert Emergency Contacts When Patients Leave Against Advice
- DBHIDS Practice Guidelines for Resiliency and Recovery-Oriented Treatment
- SUPHR Trainings and Toolkits
- SUPHR: Opioid and Overdose Basics

APPENDIX C: GABAPENTINOID PRESCRIBING FOR MEMBERS WITH OUD

Gabapentinoids, such as gabapentin, are commonly prescribed for a variety of FDA-approved and off-label indications, including anxiety, pain, and alcohol use disorder (AUD). While legitimate uses for these medications exist, prescribers need to be mindful about their use in certain high-risk populations, such as individuals using opioids or with opioid use disorder (OUD).

In 2019, the Food and Drug Administration (FDA) released a drug safety communication regarding the risk of respiratory depression with gabapentinoids, especially in combination with other CNS depressants like opioids.[10] Due to the high comorbidity of pain disorders, substance use disorders, including OUD and AUD, anxiety, and trauma, gabapentinoids are frequently prescribed and used by individuals who are also prescribed or taking opioids. One study estimates that in 2023, 58.7% of individuals on long-term opioid therapy were also prescribed a gabapentinoid.[11] Furthermore, gabapentin was detected in almost 10% of all drug overdose deaths nationally.[12]

To help support safe gabapentinoid prescribing, CBH is sharing the best practice recommendations below for members who are prescribed gabapentinoids.

Best Practices

Prescribing

- Prescribing decisions should be made in collaboration with the member, other providers involved in the member's care, and other supports.
- As clinically feasible, avoid use of gabapentinoids in individuals who are:
  - Actively using illicit substances, with particular emphasis on those with known OUD
  - Prescribed or taking opioids (including prescription opioids or medications for OUD)
  - Using other sedating substances (e.g., benzodiazepines, barbiturates)
  - Elderly

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[10] *Department of Health and Human Services (US), Food and Drug Administration. **Neurontin, Gralise, Horizant (gabapentin) and Lyrica, Lyrica CR (pregabalin): Drug Safety Communication - Serious Breathing Problems** [Internet]. Silver Spring (MD): Food and Drug Administration; 2019 Dec 19 (accessed 2026 Apr 27).*

[11] *Nguyen TD, Chua KP, Jiao A, Bicket MC, Bohnert A, Lagisetty P. **US Trends in Long-Term Opioid Therapy**. JAMA. 2026 Apr 8:e263241.*

[12] *Mattson CL, Chowdhury F, Gilson TP. **Notes from the Field: Trends in Gabapentin Detection and Involvement in Drug Overdose Deaths - 23 States and the District of Columbia, 2019-2020**. MMWR Morb Mortal Wkly Rep. 2022 May 13;71(19):664-666. doi: 10.15585/mmwr.mm7119a3. Erratum in: MMWR Morb Mortal Wkly Rep. 2024 Apr 04;73(13):292.*

- Have medical conditions that reduce lung function (e.g., chronic obstructive pulmonary disease [COPD])

- Provide education to members about the potential risks associated with gabapentinoids, including:
  - Sedation and respiratory depression
  - Overdose, especially when used with other depressants (e.g., opioids, benzodiazepines)
  - Misuse, dependence, and tolerance
- When a gabapentinoid is being prescribed, the prescriber should periodically evaluate effectiveness and screen for side effects and misuse of the medication or other substances.
- When prescribing gabapentinoids, use the lowest possible effective dose.
- Conduct an overdose risk assessment at initiation and at regular intervals.
  - Tools, such as the **Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)**, can help to guide clinical decision-making.
- Members at risk for an opioid overdose should be provided with education on and access to naloxone. All providers are required to maintain a policy regarding the on-site maintenance, administration, and prescription of naloxone.

Management of Comorbidities

- Engaging in OUD treatment decreases the risk for overdose. Please refer to the **CBH Clinical Practice Guidelines for OUD** to align treatment policies and practices as necessary.
  - For members with comorbid AUD, please also refer to the **CBH Clinical Practice Guidelines for AUD**.
- Members with comorbid pain should receive multimodal, multidisciplinary care to address physical health and behavioral health needs.
  - Guidance on pain management can be found in the **CDC Clinical Practice Guideline for Prescribing Opioids for Pain**.

Tapering/Deprescribing

- Decisions to stop or change medication therapy should involve collaboration with the member and their supports.
  - Tapering or discontinuation should be considered especially for members at an increased risk for overdose (e.g., active substance use, use of other sedating substances)
  - The reasoning behind treatment decisions should be clearly communicated to the member and, as appropriate, their supports.
  - Resources on shared decision-making are available on the **CBH Pharmacy Resources for Providers** page.
- If a decision is made to taper or discontinue a gabapentinoid, the dose of the gabapentinoid should be reduced gradually.

- The **US Deprescribing Research Network** lists resources for providers on deprescribing medications.

Additional Resources

- **Pennsylvania Medical Assistance Preferred Drug List (PDL)**: Provides coverage information for medications for individuals with Pennsylvania Medicaid
- **Pennsylvania Statewide PDL Prior Authorization Guidelines**: Provides information on when a medication prescribed to an individual with Pennsylvania Medicaid requires a prior authorization and details the documentation for medical necessity

APPENDIX D: SPECIAL POPULATION – CO-OCCURRING PSYCHIATRIC DISORDERS

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

If a member needs mental health services beyond what the SUD provider can offer, the member should be assisted in linking to a provider who can provide these additional services. Collaboration between the SUD provider and the mental health provider is expected.

Individuals with psychiatric disorders or suicide risk factors should be screened with an evidence-based screening tool at the onset of treatment, and then on an ongoing basis during the course of treatment. CBH strongly recommends the C-SSRS. These individuals should be monitored more closely for adherence to prescribed medications. Members who are known to be at risk should have a safety plan developed and updated regularly. For additional information, please see the CBH Suicide Prevention Clinical Practice Guidelines.

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

Please refer to the **ASAM National Practice Guidelines** (Part 11) for additional details.

APPENDIX E: SPECIAL POPULATION – ADOLESCENTS

Special consideration should be given to treating adolescents with OUD. Clinicians should utilize ASAM criteria and consider all available treatment options, including pharmacotherapy for OUD and psychosocial interventions. This population may benefit from specialized multidimensional treatment programs to address the members' unique needs. Please refer to the **ASAM National Practice Guidelines** (Part 10) for additional details.

APPENDIX F: SPECIAL POPULATION – PREGNANT INDIVIDUALS

ASAM guidelines recommend that pregnant individuals who are "physically dependent on opioids should receive treatment with methadone or buprenorphine rather than withdrawal management or psychosocial interventions alone." Furthermore, guidelines highlight that methadone or buprenorphine should be started as early as possible during pregnancy. It is important to plan a pregnant patient's treatment in conjunction with their obstetrical care.

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

Additionally, it is recommended that these members be screened for depression with the **Edinburgh Postnatal Depression Scale (EPDS).** Further details can be found on the **CBH Screening Programs webpage.**

Please refer to the **ASAM National Practice Guidelines** (Part 8) for additional details.

APPENDIX G: SPECIAL POPULATION – COURT-INVOLVED

For members involved with the criminal justice system, providers should adhere to **SAMHSA's Criminal and Juvenile Justice resources.** Forensic goals should be assessed and included in recovery planning. All necessary patient consent for the release of information should be obtained promptly to allow providers to collaborate with any legal oversight (e.g., probation officers, defense attorneys, district attorneys). Collaboration should occur as needed or when requested by the member. All collaboration efforts should be documented in the medical record. Forensic goals should be assessed and included in recovery planning. All necessary patient consent for the release of information should be obtained promptly to allow providers to collaborate with any legal oversight (e.g., probation officers, defense attorneys, district attorneys). 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 a conflict of interest. For example, one practitioner could provide ongoing treatment while another performs any court-stipulated assessment.

ASAM specifies that the "risk for relapse and overdose is particularly high in the weeks immediately following release from prisons and jails" and recommends continuation of OUD treatment, including pharmacotherapy for OUD.

Please refer to the **ASAM National Practice Guidelines** (Part 12) for additional details.

APPENDIX H: RESOURCES FOR MEMBERS

- SUD Treatment
  - Behavioral Health Services Initiative (Uninsured): 1-215-546-1200
  - Community Behavioral Health (Medicaid): 1-888-545-2600
  - CareConnect Warmline: 484-278-1679
  - CBH: **Opioid Use Disorder and Medication-Assisted Treatment**
  - SAMHSA National Helpline: 800-662-HELP (4357)
- City of Philadelphia, Mental and Physical Health Services: **Learn how to get and use naloxone (Narcan®)**
- **SUPHR: Party Smarter This Summer - Substance Use Prevention and Harm Reduction**
  Resources for different kinds of substance use, some strategies for keeping yourself and people around you safe, and what to do if you or a friend has gone too far
- **SUPHR: Opioid and Overdose Basics**
  Resources for members regarding where to obtain and how to utilize naloxone and test trips, in addition to resources and trainings outlining how to recognize and reverse an overdose and how to utilize universal precautions to prevent overdose (Trainings also available in Spanish)
- **Prevention Point**
  Harm reduction resources, including syringe exchange