Opioid Use in Older Adults: The Double-Edged Sword

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Mental Health and Aging Training Initiative: Live Webinar Series
Getting to know the audience

In which area do you primarily practice?

- Hospital
- Long-term care
- Outpatient specialty
- Outpatient internal/family medicine
- Other
Objectives

1. Describe **physiological changes** in older adults as they impact choices in opioid therapy

2. Select appropriate **opioid therapy** for older adults

3. Describe **opioid misuse and management of opioid use disorder** in older adults
DISCLAIMER:

When possible, chronic non-cancer related pain in older adults should be managed by non-pharmacologic methods in combination with non-opioid analgesics.
Challenges of Chronic Pain Management in Older Adults

• Acetaminophen
  – Efficacy
  – Toxicity

• NSAIDs
  – Toxicities: GI, renal, CV

• Topicals
  – Less effective

• Adjuvant therapies
  – TCAs: Toxicities
  – SNRIs
  – Antiepileptics
  – Muscle relaxants: Falls

Older adults are often excluded from clinical trials

What do we do if moderate-severe pain persists?
Opioids in Medicare Part D

Exhibit 1: Opioid Utilization in Part D, 2017

- Nearly 1 in 3 Part D beneficiaries received at least 1 prescription opioid
- Part D paid for 76 million opioid prescriptions
- 1 in 10 Part D beneficiaries received opioids for 3 or more months

Exhibit 2: Overall spending for opioids in Part D decreased in 2017, but remained more than $3 billion.


Decreased spending driven by lower prices not lower prescribing rates
Physiological Changes of Older Adults

- Gastrointestinal
- Hepatic Metabolism
- Renal Excretion
- Distribution
- Pharmacodynamic
## Physiological Changes: Gastrointestinal

<table>
<thead>
<tr>
<th>Change with normal aging</th>
<th>Clinical consequence of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed gastric emptying; reduced peristalsis</td>
<td>Alteration of drug absorption has little clinical effect</td>
</tr>
<tr>
<td>Reduced blood flow to GI tract</td>
<td>Increased risk of GI-related side effects, especially opioid-related gut mobility disturbance</td>
</tr>
</tbody>
</table>

Age and Ageing 2013; 42: i1–i57 doi: 10.1093/ageing/afs200
### Physiological Changes: Hepatic Metabolism

<table>
<thead>
<tr>
<th>Change with normal aging</th>
<th>Clinical consequence of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased hepatic blood flow</td>
<td>Reduced first-pass metabolism</td>
</tr>
<tr>
<td>Reduced liver mass and functioning liver cells</td>
<td>• Oxidative reactions (Phase I) may be reduced resulting in prolonged half-life</td>
</tr>
<tr>
<td></td>
<td>• CYP450 and MAO are Phase I enzymes</td>
</tr>
<tr>
<td></td>
<td>• Conjugation (Phase II) is usually preserved</td>
</tr>
<tr>
<td></td>
<td>• Difficult to predict precise effect in individual</td>
</tr>
</tbody>
</table>

*Age and Ageing 2013; 42: i1–i57 doi: 10.1093/ageing/afs200*
## Physiological Changes: Renal Excretion

<table>
<thead>
<tr>
<th>Change with normal aging</th>
<th>Clinical consequence of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced renal blood flow</td>
<td>Reduced excretion of drugs and metabolites eliminated by kidney leads to accumulation and prolonged effects.</td>
</tr>
<tr>
<td>Reduced glomerular filtration rate</td>
<td></td>
</tr>
<tr>
<td>Reduced tubular secretion</td>
<td></td>
</tr>
</tbody>
</table>
Physiological Changes: Distribution

<table>
<thead>
<tr>
<th>Change with normal aging</th>
<th>Clinical consequence of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased body water</td>
<td>Reduced distribution of water soluble drugs</td>
</tr>
<tr>
<td></td>
<td>• Morphine</td>
</tr>
<tr>
<td>Increased body fat; lipid soluble drugs accumulate in reservoirs</td>
<td>Lipid soluble drugs have longer effective half-life</td>
</tr>
<tr>
<td></td>
<td>• Fentanyl</td>
</tr>
<tr>
<td>Lower concentration of plasma proteins; increased free fraction of highly protein-bound drugs</td>
<td>Increased potential for drug-drug interactions with other highly protein bound drugs</td>
</tr>
</tbody>
</table>
Physiological Changes: Pharmacodynamic

<table>
<thead>
<tr>
<th>Change with normal aging</th>
<th>Clinical consequence of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased receptor density</td>
<td>Increased sensitivity to therapeutic and side effects</td>
</tr>
<tr>
<td>Increased receptor affinity</td>
<td></td>
</tr>
</tbody>
</table>
Obtain history of use of opioids for dental or surgical procedures and beneficial or adverse responses to guide initial choice.

Start at 25-50% of typical adult dose

“Start low and go slow”

Extended interval for short-acting agents when initiating therapy
• Every 6 hours instead of 4 hours at initiation
Side Effects in Older Adults

CNS effects: INCREASE incidence of falls and fractures.
- Resolves after 2-3 days

Cognitive function:
- Unaffected once dose is stable
- Impaired up to 7 days after dose increase

Constipation:
- Be proactive! Recommend a bowel regimen

Hormonal suppression:
- Decreased testosterone

Urinary retention:
- Enlarged prostate
Getting to know the audience

What is your “go to” opioid for an older patient with chronic pain?

- Hydromorphone
- Morphine
- Oxycodone
- Fentanyl
- Whatever their insurance will pay for
Choosing an Appropriate Opioid

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>CAUTIOUS CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oxycodone</strong></td>
<td>• Morphine</td>
</tr>
<tr>
<td>• Flexibility in dosing</td>
<td>• Active/toxic metabolites renally eliminated</td>
</tr>
<tr>
<td><strong>Hydromorphone</strong></td>
<td>• <strong>Methadone</strong></td>
</tr>
<tr>
<td>• Inactive metabolites</td>
<td>• CYP450 substrate (3A4, 2D6, 1A2)</td>
</tr>
<tr>
<td>• Preferred in renal disease</td>
<td>• P-glycoprotein substrate</td>
</tr>
<tr>
<td><strong>Fentanyl</strong></td>
<td>• Half-life (15-60 hours) exceeds duration of analgesia (8-12 hours)</td>
</tr>
<tr>
<td>• Better tolerated than oxycodone</td>
<td>• Prolongs Qtc interval</td>
</tr>
<tr>
<td>• Preferred in renal and/or hepatic disease</td>
<td>• Sequesters in fat tissue</td>
</tr>
<tr>
<td>• Not for opioid naïve</td>
<td></td>
</tr>
</tbody>
</table>
LESS FREQUENTLY USED OPIOIDS
**Mechanism of action**
- NMDA receptor antagonist
- Mu and kappa opioid receptor agonist
- Inhibits reuptake of serotonin and norepinephrine

**Pharmacokinetics**
- Half-life of drug is longer than duration of analgesia.
- Typically dosed every 6-8 hours
- Do not adjust dose more frequently than every 4 days

**Efficacy**
- Neuropathic pain
- General pain syndrome

**Compared to methadone:**
- No cardiac toxicity
- No CYP450 metabolism
- Not a p-gp substrate
Buprenorphine Transdermal

**Mechanism of action**
- Partial mu receptor agonist
- Delta and kappa receptor antagonist
- High affinity and robust binding make it nearly impossible to displace, even with naloxone

**Pharmacokinetics**
- Highly lipophilic
- Long half-life (up to 32 hours)
- Transdermal formulation changed every 7 days

**Efficacy**
- Osteoarthritis
- Low back pain
# Tapentadol

## Mechanism of action
- Mu opioid receptor agonist
- Norepinephrine reuptake inhibitor

## Pharmacokinetics
- No major drug-drug interactions
- No active metabolites
- Metabolism: glucuronidation, CYP2C9/19 substrate

## Efficacy
- Neuropathic pain
- Osteoarthritis
- Low back pain

## Compared to tramadol:
- Not a prodrug
- No Qtc prolongation
- No serotonin reuptake inhibition
Getting to know the audience

Which of the following have you seen prescribed for older patients with pain?

a. Buprenorphine transdermal
b. Levorphanol
c. Tapentadol
d. 2 of the above
e. All of the above
Safe Opioid Use

Discuss with patient safe and secure storage of opioids to reduce risk of diversion

Consider periodic urine drug screening to monitor adherence to therapy

Frequent contact via phone or email to assess for and manage adverse effects
CMS Policies Effective January 1, 2019

• 7-day supply limit for opioid naïve patients
• Opioid care coordination alert when cumulative MMED reaches or exceeds 90MMED
  – Pharmacy calls prescriber to confirm medical need
• Patient-specific point of sale claim edit
• Pharmacy limitation ("lock-in")
• Prescriber limitation ("lock-in")
I HOPE THESE MAKE YOU FEEL BETTER, BECAUSE THEY'RE ALL YOU'RE GETTING.
Opioids: The Double-Edged Sword

Effective for Pain Management

Risk of Abuse, Misuse and Dependence
Pointed out:

- More prescriptions, more abuse
  - In 2008 at 13% of the population, they were receiving 33% of all medications
  - Medicare Part D expansion will result in increased prescribing
  - Baby-boomers are aging who have a greater lifetime rate of using drugs than previous generations might result in **increased numbers of older drug users in 15 to 20 years**
  - Predicted use of psychotherapeutics without medical directions in adults > 50 years old will increase to 2.7 million by 2020
- Discussed doctor and pharmacy “shopping”, borrowing medications from friends and family; obtaining medications via the internet; “hoarding” old or unused medications just in case…
- Additional concerns **including overlooking substance abuse as the cause**
  - changes in behavior like memory impairment may be attributed to dementia; balance or incoordination attributed to Parkinson’s disease
<table>
<thead>
<tr>
<th>Factor</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Hx of Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Personal Hx of Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Age</td>
<td>16-45 years</td>
<td>1</td>
</tr>
<tr>
<td>Hx of preadolescent sexual abuse</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD, OCD, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
## Opioid Risk Tool

The Opioid Risk Tool is a tool developed in 2005 to assess the risk of future opioid abuse. It considers various factors such as history of substance abuse, personal history of substance abuse, age, history of preadolescent sexual abuse, and psychiatric disease. The tool assigns points based on these factors, and the total score is used to determine the risk level:

- **≤3:** Low risk
- **4-7:** Moderate risk
- **≥ 8:** High risk

The tool is adapted from [https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf](https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf)


### Risk Factors with Points Assigned

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<tr>
<th>Risk Factor</th>
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<tr>
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<td>4</td>
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<td>3</td>
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</tr>
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<td>Alcohol</td>
<td></td>
<td></td>
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<td>Prescription drugs</td>
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<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td></td>
</tr>
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</table>

### Scoring – Risk of future opioid abuse:

- **≤3:** Low risk
- **4-7:** Moderate risk
- **≥ 8:** High risk
In adults aged ≥ 65 years old:

- 750,529 drug-related emergency dept (ED) visits
- 2,056 drug-related ED visits on an average day
- 290 of which were related to illegal drugs, alcohol with drugs, or nonmedical use of pharmaceuticals
- Of the 118 pain relievers; 80 were related to narcotic pain relievers

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, Drug Abuse Warning Network (DAWN), 2011.

First Time Admissions in Adults ≥ 55 years old

Fig. 2. Left: percent of older adults (55 and older) presenting to treatment for the first time with opioid use disorder using heroin as their primary drug of choice. Right: percent of older adults presenting to treatment for the first time with opioid use disorder using prescription opioids as their primary drug of choice. Both graphs show the relative proportion (in black) of older adults where opioid maintenance therapy (OMT) was planned as part of treatment for opioid use disorder (OUD). RX = prescription.

https://www.cdc.gov/nchs/products/databriefs/db294.htm
When to Recommend Naloxone?

Naloxone an opioid antagonist is available for reversal of opioid overdose

In Virginia, as of 2017 – Prescribers of opioids for chronic pain – if morphine milligram equivalents (MME) > 120 mg or are prescribed an opioid in combination with a benzodiazepine – must prescribe naloxone.

In general, anyone in an opioid treatment program (OTP) or office-based opioid treatment (OBOT) program

History of past overdose

Virginia’s Legislative Information System at http://lis.virginia.gov/cgi-bin/legp604.exe?151+sum+HB1458
Poll: Case Study Mr. J

Mr. J a 72-year-old male with a history benign prostatic hypertrophy, hypertension, and osteoporosis. He was recently discharged after undergoing hip replacement surgery.

At discharge he was prescribed oxycodone/acetaminophen 1-2 tablets every 6 hours as needed for pain #56 (a 7-day supply). He calls the orthopedic clinic after 5 days asking for a “refill”. Upon questioning he reported that the medication was wearing off after 3-4 hours, so he started taking it 5 to 6 times per day (which he looked up on the internet that it can be prescribed every 4 hours).

How would you describe his use of oxycodone/acetaminophen?

- Legitimate medical use
- Abuse
- Misuse
- Diversion
- Dependence
Ms. Z is a 68-year-old female with a history of osteoarthritis, breast cancer, and diabetes recently started complaining of right knee pain. She reports acetaminophen and ibuprofen “just were not cutting it.”

A neighbor offered her some oxycodone/acetaminophen that they had left over from a recent surgery. She has been using the oxycodone/acetaminophen 2 to 3 times daily with significant pain relief. She denies any history of substance use disorder.

How would you describe her use of oxycodone/acetaminophen?

- Legitimate medical use
- Abuse
- Misuse
- Diversion
- Dependence
Definitions

**Abuse**
One of the following over the last 12 months (*DSM-IV term*)
- Recurrent use resulting in failure to fulfill obligations (home, work); in physically hazardous situations; linked to legal problems; continued use despite social or interpersonal problems
- Purposely take medications for uses other than prescribed, doses greater than prescribed

**Misuse**
An Rx medication is taken incorrectly – too often, wrong dose, too long, or incorrect indication

**Diversion**
Transfer of a legally rx’d controlled medication to another individual

**Dependence**
*DSM-IV term*
Traditionally linked to physical dependence resulting in withdrawal when the medication is discontinued

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DSM-IV-Tr, APA 2000
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Poll: Case Study Ms. Z

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A neighbor offered her some oxycodone/acetaminophen that they had left over from a recent surgery. She has been using the oxycodone/acetaminophen 2 to 3 times daily with significant pain relief. She denies any history of substance use disorder.

How would you describe his use of oxycodone/acetaminophen?

- Legitimate medical use
- Abuse – Ms. Z
- Misuse
- Diversion – neighbor
- Dependence
Access and Diversion

Many older adults are prescribed opioids by doctors

Senior-living communities
  • Sharing their prescriptions

Family members

Purchase on the internet

Those in the hospital or long-term care facility
  • Diversion by staff

DSM-IV to DSM-5 Changes in Terminology

**DSM-IV**

- **Abuse** – 4 of the current combined “use” disorder criteria
- **Dependence** – 7 of the current combined “use” disorder criteria including tolerance and withdrawal

**DSM-5**

- DSM-5 refers to all as a substance “use” disorder

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DSM-IV-Tr, APA 2003; DSM-5, APA 2013
Screening for an Opioid Use Disorder

Patient Scenario...
Screening for an Opioid Use Disorder

Mrs. P is a 67-year-old female with a past medical history of ankylosing spondylitis, COPD, and chronic pain.

Medications include: Methadone 10 mg – 2 tablets 3 times daily; oxycodone 10 mg every 3 hours PRN

In the past 4 months has requested fills early, so provider has switched to 7 and 14-day supplies UDS: + methadone, + morphine, + oxycodone

Interview between provider and patient to screen for an opioid use disorder; as you listen PLEASE NOTE how many questions the patient answers positively
Severity of Opioid Use Disorder

- **Mild**: 2-3 criteria
- **Moderate**: 4-5 criteria
- **Severe**: ≥ 6 criteria

DSM-5
Based on how the patient answered the screening questions, how would you classify the severity of their Opioid Use Disorder?

- Mild
- Moderate
- Severe
Who Makes up the Older OUD Population?

- Early-onset
- Late-onset

Elderly with OUD

Carew Drug Alcohol Dep 2018; 48-57.
Older adults (>55 yo) were more likely to be male, AA or Hispanic than <55yo

Case Scenario

Mr MA is a 62-year-old male with a history of benign prostatic hypertrophy, hypertension, and chronic pain. He has a history of cocaine use disorder back in his 20s-30s. He has been in “recovery” from cocaine use for over 25 years.

- In 2002 he had a work-related injury and experienced lower back pain
- For 15 years he was prescribed oxycodone/acetaminophen. He reports he only ever took the oxycodone/acetaminophen exactly as prescribed.
- In Nov 2017 his prescriber informed him he would no longer be prescribing him oxycodone/acetaminophen. No attempts to taper were made.
- Mr. MA found himself purchasing prescription opioids from neighbors and off the street. He switched to heroin (intranasal) in March 2018 because it helped with pain and was much cheaper.
In May 2018 Mr. MA presents to the Substance Use Disorder Clinic because he is “Too old to mess with this stuff.” He reports he had no idea that he could become “addicted to his pain medications”

- Had he been screened with the opioid risk tool – He would have scored a 4 (moderate risk to develop future opioid abuse or an opioid use disorder)

What treatment options can we offer him?
Opioid Use Disorder Medication Assisted Therapy

Treatment Options

Goal is abstinence from Opioid Use

- Buprenorphine/Naloxone
- Naltrexone
- Methadone (OTP)
- Non-pharmacologic therapy: Psychosocial Treatment

MAT = Medication Assisted Therapy

Goal is abstinence from Opioid Use
Methadone

<table>
<thead>
<tr>
<th>MOA</th>
<th>Full opioid agonist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Via Opioid Treatment Program (OTP) licensed facilities</td>
</tr>
<tr>
<td>Cost</td>
<td>Daily fee</td>
</tr>
<tr>
<td>Dosing</td>
<td>Day 1: 5-10 mg every 4 hours up to 40 mg OR 10-30 mg, followed by 10 mg 3-4 hours later. Dose is titrated over 2 weeks</td>
</tr>
<tr>
<td>Usual range</td>
<td>60-120 mg per day</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Urine drug screens, QTc prolongation, drug interactions</td>
</tr>
</tbody>
</table>

1970 – *first Methadone clinic*  

<table>
<thead>
<tr>
<th>MOA</th>
<th>Partial opioid agonist/opioid antagonist (as an abuse deterrent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Outpatient by DATA waived providers only</td>
</tr>
<tr>
<td>Cost</td>
<td>Each prescription – 3/7/14/21/28 day supply</td>
</tr>
<tr>
<td>Dosing</td>
<td>Day 1: 2 to 8 mg of buprenorphine (max 8 mg)</td>
</tr>
<tr>
<td></td>
<td>Day 2: day 1 dose + additional (max 16 mg)</td>
</tr>
<tr>
<td>Usual range</td>
<td>8-16 of buprenorphine daily [max usually 24 mg daily]</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Urine Drug Screens, LFTs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOA</th>
<th>Opioid antagonist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>No restrictions on prescribing or dispensing</td>
</tr>
<tr>
<td>Cost</td>
<td>Each prescription/monthly</td>
</tr>
</tbody>
</table>
| Dosing    | Must be opioid free for 7-14 days prior to initiation  
Induction: 12.5-25 mg test dose; 25 mg 4 hours later  
Maintenance: 50 mg daily or can consider using 100 mg  
on Mondays and Wednesdays, and 150 mg on Fridays if  
the patient is abstinent from opioids and cooperative |
| Usual range | 350 mg/week |
| Monitoring | Urine Drug Screens, LFTs |

## Geriatric Considerations with MAT Options

<table>
<thead>
<tr>
<th>Drug</th>
<th>Renal or Hepatic Dosage Adjustments</th>
<th>Drug Interactions</th>
<th>Other considerations</th>
</tr>
</thead>
</table>
| **Naltrexone** | No specific adjustments  
Metabolite is renally excreted;  
AUC is increased in 5-10 times in hepatic cirrhosis; not recommend in acute hepatitis or hepatic failure | Opioids |  |
| **Buprenorphine/Naloxone** | No specific recommendations | Opioids, CNS depressants, Benzodiazepines, QTc prolongation |  |
| **Methadone** | If renal function CrCl < 10 mL/min administer 50-75% of dose  
No hepatic adjustments; start lower, titrate slower | QTc prolongation, CYP3A4 inducers/inhibitors, benzodiazepines | QTc prolongation  
Long half-life  
Central sleep apnea |
# MAT Comparison

<table>
<thead>
<tr>
<th>Medication</th>
<th>% opioid free on active medication</th>
<th>% opioid free on placebo</th>
<th>Citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone ER</td>
<td>36</td>
<td>23</td>
<td>Krupitsky et al. 2011</td>
</tr>
<tr>
<td>Buprenorphine/Naloxone</td>
<td>60</td>
<td>20</td>
<td>Woody et al. 2008</td>
</tr>
<tr>
<td>Methadone</td>
<td>60</td>
<td>30</td>
<td>Mattick 3t al. 2009</td>
</tr>
</tbody>
</table>

## Long-acting Options

<table>
<thead>
<tr>
<th>Medication</th>
<th>Route of Administration</th>
<th>Frequency</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine</td>
<td>Subcutaneous</td>
<td>Every 4 weeks</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Implant</td>
<td>Every 6 months</td>
<td>Must be on ≤ 8 mg of buprenorphine daily</td>
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<tr>
<td>Naltrexone</td>
<td>Intramuscular</td>
<td>Every 4 weeks</td>
<td></td>
</tr>
</tbody>
</table>

Mr. MA met the criteria for OUD - severe

Decision is made to start him on Buprenorphine/naloxone

To initiate, he must be in moderate opioid withdrawal; his Clinical Opioid Withdrawal Scale (COWS) today is 14

- Received 4 mg/1 mg of buprenorphine/naloxone with minor improvement
- Received a second dose 4 mg/1 mg of buprenorphine/naloxone
- Day 2 of induction dose was increased to 8 mg/2 mg buprenorphine/naloxone 2 films SL daily

Scoring:
- Mild: 5-12
- Moderate: 13-24
- Mod/Severe: 25-36
- Severe: >36

COWS screens for:

1. Pulse rate
2. Sweating
3. Restlessness
4. Pupil size
5. Bone/joint aches
6. Runny nose or tearing
7. GI upset
8. Tremor
9. Yawning
10. Anxiety/Irritability
11. Gooseflesh Skin
Back to Mr. MA

• Has been maintained on 16 mg of buprenorphine (as combo product) for over 5 months
• Attends narcotics anonymous weekly at his local church and one group per week at our clinic.
• Urine drug screens (UDS) consistently negative for any opioids or morphine metabolites
• Occasionally UDS positive for marijuana (states it helps with his pain)
Physiological changes in older adults impact opioid prescribing.

If indicated, preferred opioids in older adults include oxycodone, fentanyl and hydromorphone.

Older adults are at risk for opioid misuse and opioid use disorders and may be candidates for medication-assisted treatment.

Take Home Points