Medications for Opioid Use Disorder Quick Guide

SURGICAL COLLABORATIVE OF WISCONSIN

Medication	Perioperative Management	Discharge Considerations

Naltrexone (NTX)
Opioid antagonist
 	
Available as:
PO tab
IM injection (q3-4 weeks)
	For planned intervention:
	• Communicate with NTX provider group
	  ◦ Hold PO NTX for 24 hours preop
	  ◦ Hold IM NTX for 4 weeks - consider transition to PO NTX with plan to hold PO NTX for 24 hours preop
	For emergent intervention/pain:
	• Hold PO NTX
	• Higher doses of opioids may be needed for pain control initially
	  ◦ Only ≈24 hours if on PO NTX
	• Consider more potent opioids (hydromorphone), particularly if on IM NTX
	• Optimize non-opioid medications (acetaminophen, NSAIDs, gabapentin)
		• Coordinate with NTX provider for pain management
		• Educate patient that resuming historical opioid use increases risk for overdose when off NTX
		• Discharge with naloxone prescription

Methadone
Full opioid antagonist
	• Confirm date and dose of last methadone intake
	  ◦ Call OTP to confirm and alert of admission in AM *(odd hours are common)*
	  ◦ If less than or equal to 3 days missed, no need to adjust dose
	• Continue methadone while inpatient - OTP may offer dosing help
	• Daily dose will be inadequate for acute pain relief
	  ◦ May split daily dose as TID or QID to offer consistent analgesia
	• Offer additional opioids for acute pain
	• Optimize non-opioid medications (acetaminophen, NSAIDs, gabapentin)
	• Avoid buprenorphine as it may precipitate withdrawal
		• Provide dose on AM of discharge, customary dosing will resume at OTP on following day
		• Do NOT prescribe methadone on discharge
		• Discharge with MAR and documentation of any opioid prescription for OTP

Buprenorphine Partial opioid antagonist Available as: Sublingual Subcutaneous injection	• Continue buprenorphine through operative period • Daily dose will be inadequate for acute pain relief ◦ May split daily dose as TID or QID to offer consistent analgesia • Consider higher potency opioid for breakthrough (hydromorphone, fentanyl) • May require 2-5x as much opioid for pain relief • Optimize non-opioid medications (acetaminophen, NSAIDs, gabapentin)	• If daily dose was split, resume customary dosing once pain is mild-moderate or weaning additional opioids

NTX, naltrexone; PO, per os; IM, intramuscular; NSAIDS, non-steroidal anti-inflammatory drugs; OTP, opioid treatment program; TID, three times daily; QID, four times daily; MAR, medication administration record

Turn over for more information

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Addiction Consultation Line:

University of Wisconsin Addiction Consultation Line offers on-call help to providers who seek support and direction to manage patients with substance-abuse problems. The Consultation Line is available weekdays from 8 a.m. to 5 p.m.

Call the UW Health Access Center at 608-263-3260 for assistance.
Outside Madison should call toll-free: 800-472-0111.

References:

1. Harrison TK, Kornfeld H, Aggarwal AK, Lembke A. Perioperative considerations for the patient with opioid use disorder on buprenorphine, methadone, or naltrexone maintenance therapy. *Anesthesiol Clin.* 2018 Sep;36(3):345-359.
2. Kapur BM, Hutson JR, Chibber T, Luk A, Selby P. Methadone: a review of drug-drug and pathophysiological interactions. *Crit Rev Clin Lab Sci.* 2011 Jul-Aug;48(4):171-95.
3. Walsh SL, Preston KL, Stitzer ML, Cone EJ, Bigelow GE. Clinical pharmacology of buprenorphine: ceiling effects at high doses. *Clin Pharmacol Ther.* 1994 May;55(5):569-80.
4. Ward EN, Quaye AN, Wilens TE. Opioid use disorders: perioperative management of a special population. *Anesth Analg.* 2018 Aug;127(2):539-547.