State of Alaska
Department of Corrections
Division of Health and Rehabilitation Services
*February 11, 2024*

# Medication Assisted Treatment

## *Clinical Care Guide*

## Purpose

HARS provides Medication Assisted Treatment to qualifying patients as essential care for the treatment of opioid abuse using evidence based practices and a multidisciplinary approach.

**NOTE:** MAT is used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medications operate to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug.

## Alerts

- **Patients with signs of withdrawal will be referred to medically managed withdrawal (detoxification)**
- **Pregnant patients who use opiates are immediately referred to facility medical provider for evaluation**
- **Pregnant pateints with SUD/OUD require consultation and co -management with OB-GYN**
- **Inmates with SUD/OUD leaving prison are at high risk for overdose-related harms, inmates may be offered naloxone upon release**

## Definitions

**Bridging**—the process of continuing legally prescribed medication for a patient in the institutional setting.

**Buprenorphine (Subutex)**—an opioid partial agonist that relieves opiate withdrawal and cravings.

**Medication Assisted Treatment (MAT)**—Medication-assisted treatment is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a whole -patient approach to the treatment of substance use disorders.

**MATR**—Medication Assisted Treatment at Release. A program which provides DOC patients with access to MAT at the time of release from custody in conjunction with screening, brief intervention and referral to treatment.

**Methadone**—a synthetic opioid agonist that is similar to morphine in its effects but longer acting, used as a substitute drug in the treatment of morphine and heroin addiction.

**Naloxone**—A full opioid antagonist used in emergency situations during suspected overdose of opioids, not to be confused with Naltrexone used in MAT.

**Naltrexone**—a synthetic opioid antagonist which blocks opiate receptors in the nervous system and is used chiefly in the treatment of heroin addiction. A short-acting naltrexone challenge is given prior to the naltrexone ER (Vivitrol) injection.

**Opioid Agonist** —a drug that activates opioid receptors in the brain. Full agonist opioids activate the opioid receptors in the brain resulting in the full opioid effect (i.e. methadone).

**Opioid Antagonist** —a drug that blocks opioid receptors. Antagonists cause no opioid effect and block or reverse full agonist opioids (naltrexone is an example). Antagonists precipitate withdrawal in opioid dependent individuals with recent opioid use.

**Opioid Partial-agonist** —a partial-agonist is a drug that activates opioid receptors in the brain, but unlike a full agonist, only results in a limited opioid effect (buprenorphine is an example).

**Opioid Treatment Program (OTP)**—a licensed clinic that provides medication (typically methadone or buprenorphine) and non-pharmacological services for the treatment of opioid dependence.

**Opioid Use Disorder (OUD)**—A substance use disorder involving opioids.

**Precipitated withdrawal**—a condition that occurs when an opioid agonist (i.e. fentanyl or methadone) is displaced from the opioid receptors by an antagonist (i.e. naloxone) or partial agonist (i.e. buprenorphine) in an opioid dependent individual.

**Recovery**—A process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in substance use disorder (SUD). The goal is abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Individuals can be “in recovery” and receiving MAT.

**Relapse**—A process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors.

**Sobriety**—The quality of being engaged in recovery and treatment and focused on one's well-being. It does not simply mean abstinence from drugs or alcohol. One person's definition of sobriety may not be the same as another's, and there are no definitive guidelines for how sobriety is achieved.

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# MEDICATION ASSISTED TREATMENT (MAT) IN CUSTODY

## PURPOSE

Alaska Department of Corrections (AKDOC) Health and Rehabilitative Services (HARS) provides MAT as essential care for the treatment of OUD using evidence-based practices and a multidisciplinary approach. The goals of MAT include: reducing SUD-related morbidity and mortality; equipping patients with tools, techniques, and treatments necessary to successfully manage their addiction; and ensuring continuity of care when booked into a correctional facility and when reentering the community.

The AKDOC MAT program currently has five distinct yet overlapping components:

1. Risk assessment for opioid dependence at intake;
2. Medical management of withdrawals;
3. Bridging for inmates receiving legally dispensed and administered MAT in the community;
4. Continuation of MAT for inmates demonstrating adherence during incarceration whose duration of incarceration exceeds the bridging period; and
5. Initiation of MAT for pregnant inmates with an OUD

## SCREENING ASSESSMENT & TREATMENT

**BOOKING.**

At booking, Identify inmates **at risk** of serious withdrawal symptoms from OPIATES. See Medically Supervised Withdrawal Clinical Care Guide for management of withdrawals.

**OBSERVATION/WITHDRAWAL MANAGEMENT**

For persons determined to be **at risk** of withdrawal either due to being established on MAT or due to a reported use of non-prescription opiates (heroin, fentanyl, oxycodone, etc.):

1. Place in a lower bunk in a cell with a 24 hour post and follow according to management of withdrawal procedures (see Medically Supervised Withdrawal Clinical Care Guide).
2. Provide bridging MAT at the dose verified from the community treatment facility. See bridging guidelines page 4.
   - If on methadone, confirm dose and treatment history with local OTP
   - If on buprenorphine, verify active buprenorphine prescriptions through Alaska's PDMP
3. Patients on CIWA/COWS monitoring are automatically placed in the MHC queue.

**SCREENING and ASSESSMENT**

1. Refer all patients treated for OUD or opiate withdrawals to the substance use disorder (SUD) program for assessment.
2. For persons established on MAT prior to incarceration, medical health practitioners will prescribe bridging medication for up to 30 days while awaiting SUD assessment.
3. Refer persons who self-report problems with opiate use to the SUD program for assessment.
4. Refer persons to the SUD coordinator when an opiate use disorder is identified or suspected in the course of other mental health or medical assessments. Patients at highest risk will be prioritized for assessment including those with a history of opioid overdose and/or known SUD-related complications, such as endocarditis, osteomyelitis, or cellulitis related to IV drug use.
5. For patients on established MAT in the community, screen for tuberculosis (TB), hepatitis B (HBV), hepatitis C (HCV), Hepatitis A, human immunodeficiency virus (HIV), and syphilis along with Comprehensive metabolic panel (CMP), urine drug screening (UDS), and Urine beta-HCG (for females), and **EKG (for methadone).**

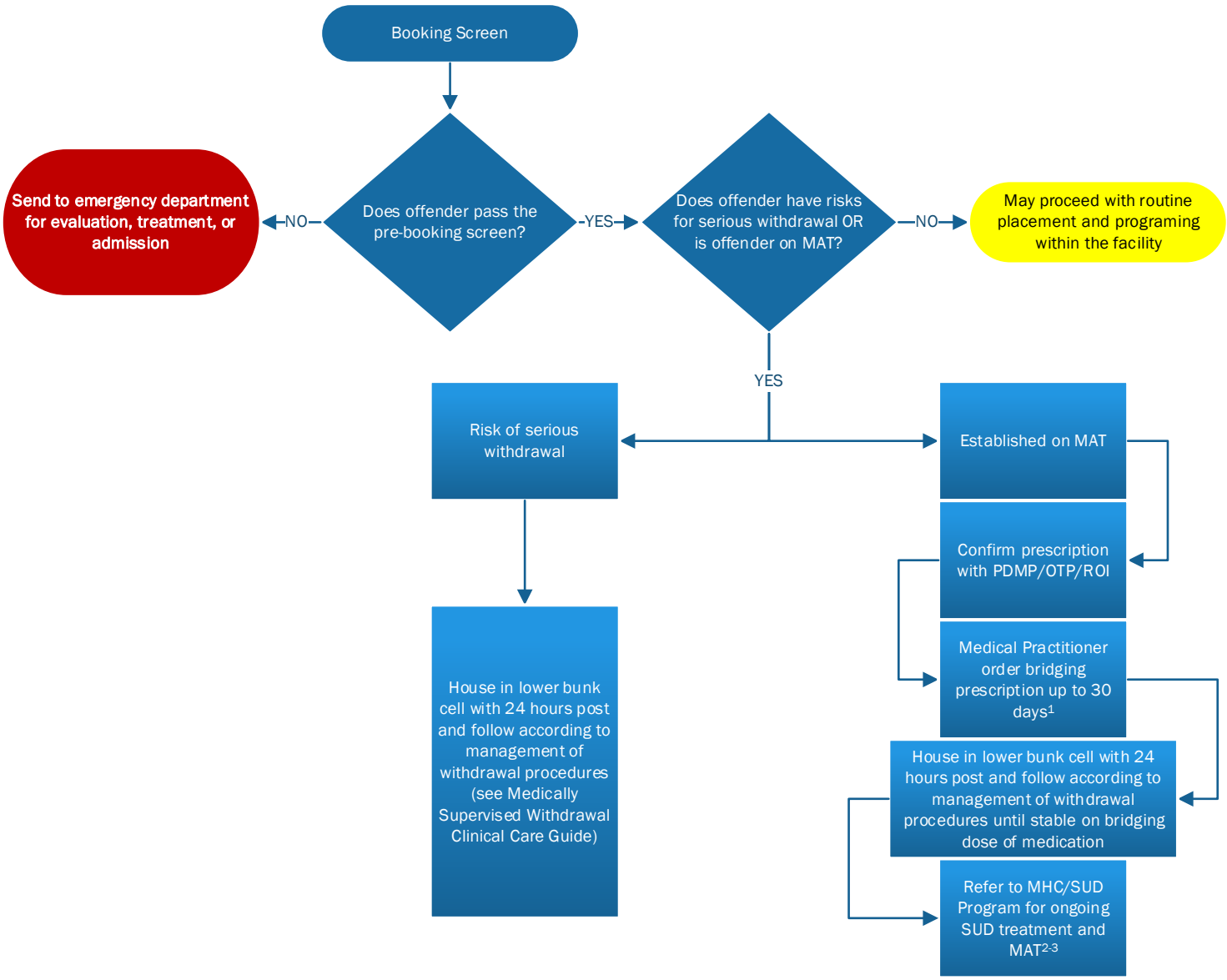
**OUD TREATMENT and MAT CONTINUATION or INITIATION**

1. AKDOC will provide evidence-based approaches to treating OUD that support each patient's recovery.
2. Behavioral treatment will include cognitive behavioral interventions (CBI) based upon assessed needs.
3. Qualifying patients will be referred for Residential Substance Abuse Treatment (RSAT) or other treatment units.
4. MAT will be available for qualifying patients with OUD in the following cases:
   a. **Post Bridging**: After thirty days of bridging, MAT will be continued for the duration of incarceration for inmates who are established on MAT prior to incarceration based upon discussion of risks, benefits, and alternatives with patient as part of an individualized treatment plan. The medication used during incarceration may or may not be the same as the medication prescribed for the individual in the community. For example, a patient established on methadone may be transitioned to buprenorphine for the duration of incarceration. A designated psychiatric prescriber will be responsible for ongoing management and monitoring of patients on MAT and helping with linkage to care at the time of release from incarceration.
   b. **Pregnancy**: Pregnant detainees using opioids will be prescribed MAT by either a medical or mental health prescriber from intake to ensure the well-being of the inmate and her fetus. A pregnant detainee with OUD will be offered MAT consisting of buprenorphine (unless established in an OTP methadone program) and evidence-based behavioral interventions. MAT will continue throughout the duration of the pregnancy. If the patient participates in a lactation program, MAT will continue up to six months postpartum.
   c. **Release Planning**: Inmates may elect to receive MAT with Naltrexone ER when within 30 days of release.

**DISCONTINUATION OF MAT**

Prisoners who are discontinuing MAT for any reason will be supervised and treated according to the Medically Supervised Withdrawal Clinical Care Guide.

# MAT SCREENING ASSESSMENT AND TREATMENT




1. For patients on established MAT, screen for tuberculosis (TB), hepatitis B (HBV), hepatitis C (HCV), Hepatitis A, human immunodeficiency virus (HIV), and syphilis along with Comprehensive metabolic panel (CMP), urine drug screening (UDS), and Urine beta-HCG (for females), and EKG (for methadone)
2. Refer all patients treated for OUD or opiate withdrawals to mental health and/or to the substance use disorder (SUD) program for assessment.
3. Refer persons to the SUD coordinator when an opiate use disorder is identified or suspected in the course of other mental health or medical assessments. Patients at highest risk will be prioritized for assessment including those with a history of opioid overdose and/or known SUD-related complications, such as endocarditis, osteomyelitis, or cellulitis related to IV drug use. Medical or mental health staff may also refer persons who self-report problems with opiate use to the SUD program for assessment.

# BRIDGING MAT (BUPRENORPHINE, METHADONE, NALTREXONE ER)

**MAT Bridging or Tapering**

Alaska DOC will arrange MAT treatment for detainees on established treatment for up to 30 days while the duration of incarceration is being determined. To qualify, the patient must be taking a legally prescribed form of MAT (buprenorphine, methadone, or naltrexone ER) prescribed by a community prescriber or an Opioid Treatment Program (OTP) for an opiate use disorder. Patients receiving MAT medications from a community provider for *pain management* do not qualify for bridging. Non-pregnant DOC patients receiving MAT who do not meet criteria for bridging will be tapered.

**MAT Bridging Criteria (all must be true)**

- ❑ The patient has established care with a community prescriber or an OTP supported by documentation
- ❑ The patient is adherent to a legally prescribed form of MAT
- ❑ The patient consents to participation in available OUD treatment services
- ❑ The patient is not pregnant

**MAT Tapering Criteria (any one or more may apply)**

- ❑ Incarceration is expected to be more than 30 days and alternate OUD treatment options are available to the patient during incarceration
- ❑ MAT will not be continued by a community prescriber upon release of the patient
- ❑ Ongoing illegal use of buprenorphine or other opiate is identified

**MAT bridging may be initiated as soon as 6 hours and preferably within 72 hours from the last dose of opioid**

| BRIDGING PROCEDURE | |
|---|---|
| **Step 1** | Review Criminal Booking Screen for:<br>♦ Opioid abuse<br>♦ Name of community prescriber or OTP<br>♦ Date of last dose<br>♦ Dosage amount |
| **Step 2** | Submit a Request of Information (ROI) to the prescriber and query prescriptions in Alaska PDMP. Verify buprenorphine Rx– print results for scanning into the EHR. |
| **Step 3** | Contact community prescriber or OTP as soon as possible via phone and/or email:<br>♦ Notify the community prescriber or OTP of the DOC patient's incarceration<br>♦ Verify that buprenorphine or methadone is prescribed for opioid use disorder and NOT for pain management<br>♦ Verify date of last dose and dosage amount<br>♦ Ask the community prescriber or OTP if they are willing to continue MAT upon the patient's release from DOC custody<br>♦ Document all information obtained from the community prescriber or OTP |
| **Step 4** | Perform clinical point-of-care urine drug screen as soon as possible with a goal of obtaining the urine within 4-6 hours of intake (may send a sample to Quest if negative for other illicit opiates and fentanyl use is a concern) |
| **Step 5** | Notify DOC medical provider that DOC patient is currently receiving legally prescribed MAT from a community prescriber or OTP |
| **Step 6** | DOC provider documents notification that DOC patient is prescribed MAT by a community prescriber or OTP for treatment of OUD<br>**DOC practitioner/physician orders EKG if daily dose ≥100 mg methadone daily** |
| **Step 7** | If taking Buprenorphine or Naltrexone, submit prescription for Buprenorphine (tabs or extended-release injection) or Naltrexone ER<br>♦ Problem: (ICD-10 Code) Opioid dependence F11.20<br>♦ Under "Additional Information" write: **MAT bridging** |
| **Step 8** | If established on Methadone, submit an Offsite Medical Service (OSM) request:<br>♦ Specialty: MAT<br>♦ Order: Methadone Bridging or Tapering<br>♦ Diagnosis: (ICD Code) F11.20<br>♦ Set Medical HOLD flag—Reason: **OTP METHADONE** |
| **Step 9** | Complete SUD Assessment Form for referral to the SUD Counselor |

**Oral Buprenorphine Caution**

**[US Boxed Warning]:** Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely for respiratory depression, especially during initiation or dose escalation. Misuse or abuse by chewing, swallowing, snorting, or injecting buprenorphine extracted from the buccal film or transdermal system will result in the uncontrolled delivery of buprenorphine and pose a significant risk of overdose and death.

# METHADONE PROCEDURES

**Methadone Administration**

**OTP Nurse-Administered**

- Facilities located within a community with an OTP willing to administer methadone within the facility may authorize specific OTP personnel to provide services within the facility.
- The OTP clinic nurse shall be escorted and observed by a DOC officer or DOC nurse while in the facility.
- The medication label shall be verified by the DOC nurse, and this verification shall be verbalized to the DOC Officer.
- The methadone shall be administered by the OTP clinic nurse and the OTP clinic nurse shall follow DOC methadone administration protocol.
- The DOC nurse will chart the encounter using the EHR MAT Community Provider Visit form.

**OTP Self-administered**

- DOC will transport patient to an OTP for methadone administration.
- OTP staff will provide a daily dose to client and monitor the self-administration of methadone.
- DOC staff will notify OTP nursing staff of anticipated release date once known.
- If duration of incarceration is anticipated to be prolonged beyond 30 days, notify OTP of the need to taper methadone or transition to buprenorphine.

**Methadone Tapering Procedure**

- Confirmation that DOC patient will be in custody for more than 30 days. If DOC patient has a Probation Officer (PO), medical staff should contact PO for this confirmation.
- OTP will design a taper strategy with or without transition to Buprenorphine.
- Methadone treatment beyond 60 days requires authorization by the Chief Mental Health Officer or designee at central office.

**Remanded DOC Patients with Methadone on Person**

- If a remanded DOC patient has methadone on person the methadone will be labeled, placed in a tamper proof bag, and placed in the medical narcotic box until the DOC patient releases from custody.
- If the DOC patient does not request the methadone upon release, send the methadone to the pharmacy within seven days after release for proper disposal.

**Medically Supervised Withdrawal from Methadone Criteria**

**Follow the Medically Supervised Withdrawal Clinical Care Guide if any of the below apply:**

- DOC patient is exhibiting signs of withdrawal
- Methadone prescribed for pain management only
- 72 hours have passed since the last dose of methadone has been taken
- Prescriber or clinic is not a recognized OTP
- OTP unwilling to administer methadone to DOC patient
- DOC patient refused to sign ROI to OTP.

**Community Residential Center (CRC) Patients**

- DOC furlough patients may seek their own medical care following current procedures, including methadone treatment.
- DOC furlough patients in confined placement, will need approval prior to leaving CRC.
- Controlled substances, including methadone, are not permitted in CRCs. If a DOC furlough patient is currently receiving methadone from an agency that is willing to go to the CRC and administer the methadone, this will need to be coordinated through the chief probation officer responsible for classification/CRCS/Contract jails.

**Federal DOC Patients**

- Federal DOC patients on prescribed methadone will be addressed on a case by case basis as governed by federal bureau of prison contract of services in coordination with an AK DOC medical social worker.

**NOTE**: DOC patients prescribed methadone should be placed on a medical hold. Prior to transferring to another facility, medical staff will need to clear the individual.

# BUPRENORPHINE PROCEDURES

**Buprenorphine Continuation Procedure**

- Confirm that DOC patient will be in custody for more than 30 days. If DOC patient has a Probation Officer (PO), medical staff should contact PO for this confirmation
- Follow steps 1-7 (page 4) in buprenorphine bridging, with the addition of notifying the DOC Provider that DOC patient will be in custody longer than 30 days
- Refer to mental health staff and SUD counselor

**Buprenophine Administration**

- DOC patients prescribed buprenorphine are at risk for opiate withdrawals. Prior to transferring to another facility, medical staff will need to clear the individual
- Buprenorphine will be treated according to controlled substance policies and procedures
- Proper administration of Buprenorphine will be verified by nursing. Sublingual tablets should be held under the tongue until completely dissolved (at least 6 minutes for tablets or 4 minutes for film). Buprenorphine tablets or film should not be chewed or swallowed.
- If a DOC patient is receiving buprenorphine from an agency that is willing to administer the buprenorphine within the facility, this will need to be coordinated through the facility shift sergeant:
    1. An offsite medical request (OSM) does not need to be generated as DOC does not pay for buprenorphine administration by an outside prescriber or OTP
    2. Buprenorphine shall be brought in the facility in a locked box by the OTP clinic nurse
    3. The OTP clinic nurse shall be issued a visitor badge; then escorted and observed by a DOC officer or DOC nurse at all times while the OTP clinic nurse is in the facility.
    4. The medication label shall be verified by the DOC nurse. This verification shall be verbalized to the DOC Officer.
    5. The buprenorphine shall be administered by the OTP clinic nurse and the OTP clinic nurse shall follow DOC narcotic administration procedures (see bullet point above regarding proper administration).
    6. The DOC nurse shall make a copy of the OTP **Chain of Custody** form and scan into EHR labeling the (details) as “Buprenorphine Delivery Verification”

**Remanded DOC Patients with Buprenorphine on Person**

- If a remanded DOC patient has buprenorphine on person, the buprenorphine will be labeled, placed in a tamper proof bag, and placed in the medical narcotic box until the DOC patient releases from custody.
- If the DOC patient does not request the buprenorphine upon release, send the medication to the pharmacy within seven days after release for proper disposal.

**Medically Supervised Withdrawal from Buprenorphine Criteria**

**Follow the Medically Supervised Withdrawal Clinical Care Guide if any of the below apply:**

- DOC patient is exhibiting signs of withdrawal
- Buprenorphine is prescribed for pain management only
- Last dose of buprenorphine was greater than 72 hours prior to incarceration
- Community prescriber or OTP clinic cannot be verified
- Community prescriber or OTP is unwilling to resume MAT upon release of the DOC patient
- DOC patient refuses to sign ROI to community prescriber or OTP after multiple requests

**DOC Patients in CRC Placement**

- Buprenorphine is not authorized for self-administration at a CRC. DOC furlough patients may seek their own medical care, including MAT treatment with buprenorphine (oral or injection) administered at the treatment facility.
- DOC furlough patients in confined placement, must have approval prior to leaving CRC
- If the DOC furlough patient is currently receiving buprenorphine from an agency that is willing to go to the CRC and administer the buprenorphine, this will need to be coordinated through the chief probation officer responsible for classification/CRCS/Contract jails.

**Federal DOC Patients**

- Federal DOC patients on prescribed buprenorphine will be addressed on a case by case basis as governed by federal bureau of prison contract of services in coordination with an AKDOC medical social worker.

**NOTE**: DOC patients prescribed methadone should be placed on a medical hold. Prior to transferring to another facility, medical staff will need to clear the individual.

# BUPRENORPHINE INDUCTION

## Initiating Buprenorphine Treatment

**Initial Evaluation**

- ❑ Patient consents to MAT
- ❑ Review PDMP
- ❑ Obtain a urine toxicology screen
- ❑ If female, confirm status of urine HCG and fetal heart tones (if pregnant)
- ❑ Obtain drug/ETOH history
- ❑ ROI for prenatal care records, and OB records if pregnant.
- ❑ Refer to mental health
- ❑ Refer to medical social work
- ❑ Update Problem List with 1 of these ICD Codes:
  F11.20 Opioid Dependence
  F11.10 Opioid Abuse
  O99.320 Drug Use Complicating Pregnancy
- ❑ Check for pre-natal complications: 1st tri-bleeding, pelvic cramping/pain, abnormal discharge, dysuria, recent trauma; 2nd & 3rd tri – fetal movements, loss of fluid, bleeding, waxing/waning pelvic/vaginal/low back pain or pressure. Until stable, these should be asked at each evaluation, and patient coached to advise medical of any symptoms.

**PREGNANT**

Pregnant detainees using opioids will be managed medically to ensure the well-being of the inmate and her fetus. A pregnant detainee using opioids will be offered MAT consisting of pharmacotherapy with methadone or buprenorphine and evidence-based behavioral interventions. MAT will continue through the duration of the pregnancy. If the patient participates in a lactation program, MAT will continue up to six months postpartum.

**COWS Score for Induction**

Clinical judgement is required to determine the best timing for induction. The decision to begin induction should be informed by several considerations:

1) **Induction with buprenorphine works best when the COWS score rises ≥ 12.**
2) Concurrent polysubstance use, especially with methamphetamine, may mask the early symptoms of withdrawal. Consider using a lower COWS score threshold in the setting of polysubstance withdrawal.
3) Significant withdrawal symptoms may begin as early as 6 hours after last opioid use.
4) Fetal heart tones persistently above 160 bpm may be a sign of early fetal distress.

**Writing a Prescription**

**DOC Pharmacy:** use medication ordering tool. A signed copy of the prescription should be faxed to the DOC pharmacy 907-269-7335.

**Community Pharmacy:** For after-hours ordering, a phone order may be called into the local pharmacy. Limit outside pharmacy prescriptions to 5 days or less.

**Instructions**

Place tablet under tongue. Do NOT swallow or chew
Keep under tongue until dissolved (~ 4-6 min.)
Do not eat, drink, or talk during this time.

**Buprenorphine is available in 2mg and 8 mg tablets**


### Day 1

If patient reports heavy opiate use and no precipitated withdrawal, **consider beginning with 8 mg on step 2**; otherwise continue with 2 mg and titrate to effect.

| Step 1 | | Step 2 | | Step 3 | | Step 4 | |
|---|---|---|---|---|---|---|---|
| **Give 2 mg** | Wait 1 hour | If no precipitated withdrawal **Give 2 mg** | Wait 2 hours | If no precipitated withdrawal but symptoms persist **Give 4 mg** | Next dosing time | Give 8 mg at next scheduled facility administration time | Stop |
|  |  |  |  |  |  |  |  |
| Start with 2 mg under tongue ~ 6 min. until dissolved. | | Most people will experience precipitated withdrawals within 15 min-1 hour. | | Most people will experience relief from withdrawal symptoms at this step. | | Stop after this dose. Do NOT exceed 16 mg on day 1. | |

Withdrawal monitoring should continue with COWS scoring (plus FHTs) at prescribed intervals during the induction and early maintenance period. Do NOT mix buprenorphine with benzodiazepines (clonazepam) during buprenorphine treatment without review with a DOC physician.

### Day 2

Most people respond by the 2nd day on 8-16 mg.

If symptoms recur on day two, add 4 mg to the total dose given on day 1 (max 24 mg).

No more than (NMT) 32 mg of buprenorphine per day.

Patients who develop worsening withdrawal symptoms on maximum daily dose (24 mg) of buprenorphine may be experiencing a co-morbid withdrawal (i.e. ETOH or benzodiazepine) or severe opioid withdrawal. Patients with rising COWS scoring despite buprenorphine treatment should be sent to ER for failure of outpatient therapy.

# PREGNANT AND USING OPIOIDS

**Note:** Pregnant detainees using opioids will be managed medically to ensure the well-being of the inmate and her fetus. A pregnant detainee using opioids should be offered MAT consisting of pharmacotherapy with methadone or buprenorphine and evidence-based behavioral interventions. MAT will continue throughout the duration of the pregnancy. If the patient participates in a lactation program, MAT will continue up to six months postpartum.

| MAT Procedures for Pregnant Patients at Risk for Opioid Withdrawal | |
|---|---|
| **Initial Evaluation** | If a pregnant DOC patient states that she is currently using opioids on the criminal booking screen:<br>❑ Obtain COWS score and call medical provider<br>❑ Obtain a urine toxicology screen for opioids and drugs including methadone and buprenorphine<br>❑ Obtain OB and drug/ETOH history; Vital signs, FHTs, and check for prenatal emergencies<br>❑ ROI for any prenatal care records (as soon as possible) and scan under Offsite-Prenatal (provider/date)<br>❑ Based on 5P's results refer to mental health if any yes responses (see pg 16)<br>❑ Refer to medical social work via Social Work Sick Call visit |
| **Hospital Discharge** | If the OB attending initiates methadone, the DOC will either transition the treatment to buprenorphine or establish the patient with an OTP. Pregnant patients who need stabilization of opioid withdrawal outside the scope of DOC capabilities: those in a facility without access to Infirmary; or those having prenatal warning signs, will be sent emergently to the ER for 1st trimester and to OB Triage for 2nd and 3rd trimester gestation. A doctor-to-doctor with satisfactory pregnancy evaluation and plan of care is required before return to DOC. |
| **Established OTP MAT patient (methadone)** | Follow steps 1 through 5 under procedure for methadone bridging (see page 2)<br><br>If patient is established on methadone **DO NOT** transition to buprenorphine because of the significant risk of precipitated withdrawal.<br><br>Step 6—Referral Order process:<br>❑ Submit OSM to Specialty: MAT<br>❑ ORDER REASON: Pregnancy with OUD<br>❑ Problem: ICD Code Drug Dependency Pregnancy-Unspecified 648.30 and ICD Code Opioid Abuse Unspecified 305.50<br><br>Then follow steps 7 through 10 under procedure for methadone bridging (see page 2) |
| **Established MAT patient (buprenorphine)** | 1. Submit a Release of Information (ROI) to buprenorphine community prescriber.<br>2. **Query the Alaska PDMP database**. Look for buprenorphine Rx– print results for scanning into the EHR.<br>3. Contact MAT community provider:<br>❑ Notify the MAT community provider of the DOC patient's incarceration<br>❑ Verify date of last dose and dosage amount<br>❑ Document all information obtained from MAT community provider<br><br>4. Notify X Designated DOC provider that patient is currently treated with buprenorphine for an OUD.<br>5. Update Problem List: ICD-10 Code: F11.20 Opioid Dependence<br>O99.320 Drug Use Complicating Pregnancy<br>6. Refer to SUD counselor or designee<br>7. Notify facility security sergeant. (DO NOT USE EHR) |
| **OUD or Risk of Withdrawal with NO established MAT (see pg 8)** | 1. Complete the initial evaluation (see above)<br>2. Consider initiating buprenorphine during custody (See page 8)<br>3. Referral early to community buprenorphine prescriber with experience/comfort prescribing for pregnant patients and schedule "warm hand-off."<br>4. If patient's opioid tolerance exceeds buprenorphine ceiling, or if patient has declared a preference for methadone and declines buprenorphine, she must be referred to maternity/prenatal inpatient care to stabilize with methadone. |

| **EMERGENT Symptoms/ Signs** | |
|---|---|
| | ❑ pain or cramping in abdomen or lower back<br>❑ contractions<br>❑ vaginal spotting or bleeding<br>❑ fluid or tissue passing from vagina<br>❑ signs and symptoms of active withdraw using the COWS + fetal heart tones above 160 bpm sustained for 30-60 minutes |

**EMERGENT**: If the patient has these signs or symptoms, immediately refer to EMS and notify the facility or on call provider

# PREVENTION OF MISUSE AND DIVERSION PATHWAY

## Proper Buprenorphine Administration

- Premoisten mouth with water
- Place tablet or film under tongue
- **Keep medication under the tongue for at least 6 minutes (tablets) or 4 minutes (film)**

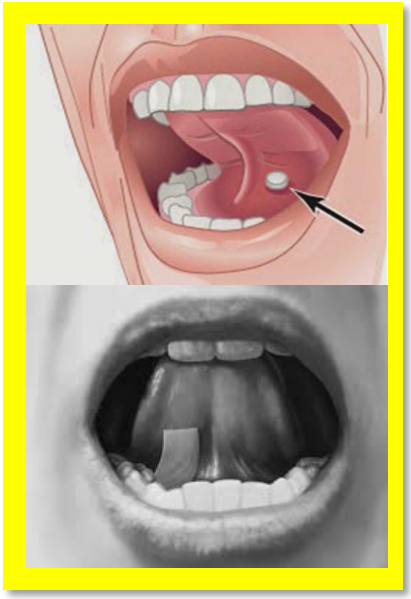


**Image: Proper placement of buprenorphine tables and film**

## Diversion

- The transfer of a legally prescribed med to a person for whom it is NOT legally prescribed
- Any removal of medication from the medication administration process
- Diversion is not isolated to buprenorphine or methadone and can occur during storage, dispensing, administration, or wasting of any medication.

## Misuse

- Taking a medication at a time other than prescribed (saving for later)
- Taking a medication by a route other than prescribed (injection, snorting, etc)
- Taking someone else's medication, even if for a legitimate medical complaint
- Taking a medication for a reason for which the medication is NOT prescribed (to get a high)

## Contraband

- Medication that originates outside the medication administration process

| Medication for Addiction Treatment Administration Integrity—Best Practices to Prevent Diversion, Misuse, or Contraband | |
|---|---|
| **To prevent diversion prior to medication administration** | 1. Do not allow patients to bring anything to the medication line (nothing in their hands or otherwise on their person)<br>2. Roll up sleeves and no jackets or other garments over shirt<br>3. Remove face coverings<br>4. Completely remove dentures and other removable dental appliances<br>5. Tie back hair |
| **To prevent diversion prior to placement in the mouth** | 1. Check mouth pre-medication<br>2. Premoisten mouth with water<br>3. Confirm tab/film is being removed from pouch (staff placing tab/film in mouth mitigates diversion opportunities)<br>4. Direct observation of medicine under the tongue<br>5. Ensure all items are collected before leaving medication line (cup, foil pouch, etc) |
| **To prevent diversion after placement in the mouth** | 1. Give instructions to:<br>A. Keep mouth closed<br>B. Do not swallow (conduct mouth check if patient swallows)<br>C. Patient education that the medication must dissolve under the tongue or inside the cheek to work; it will not work if swallowed<br>2. Visualize patient's hands (options for hand placement include sitting on hands, placing hands behind back, in front or on top of table, etc)<br>3. Monitor for at least 6 minutes for tabs / 4 minutes for film<br>4. Mouth check to confirm tab/film has dissolved<br>5. After the medicine is completely dissolved, have patient take a large sip of water, swish gently around teeth and gums, and swallow.<br>6. Educate patient not to eat or drink for 30 minutes and wait at least 1 hour before brushing teeth to avoid damage to teeth. |

## Naltrexone Extended Release (MATR Program)

- MATR is available to sentenced and unsentenced DOC patients who have a diagnosed opioid use disorder. DOC patients must have between 14 and 90 days before release to complete the MATR program.
- If the DOC patient is releasing before 14 days, the MATR counselor will meet with the individual and provide them with MAT community treatment resources and link the DOC patient to MAT in the community.
- If the DOC patient is releasing more than 90 days, notify the MATR counselor to have the MATR counselor add the DOC patient to the MATR wait list.
- Vivitrol injection SHOULD be administered as close to DOC patient release date as possible.
- MATR referrals come from many sources including self-referral, probation officer, corrections officer, medical staff, mental health staff, family, etc. While it is preferable referrals are made using the MATR Program Referral form (see page 12), referrals can also be made via RFI, email, phone call, direct verbal communication.
- MATR referrals are typically collected in the medical clinic by the MATR counselor or designee
- The MATR order set may be repeated every 28 days after review of symptoms, verification of absence of contraindications or precautions, and confirmation of a negative urine pregnancy test in females. A full exam, informed consent form, and other lab studies are not required unless the time period between injections exceeds 28 days.

## Naltrexone Extended Release (Vivitrol) Procedure

**Step 1**

**Referral/Consent for Treatment**

- ❑ Review **MATR Program Medical Referral** from MATR Counselor or designee
  - If patient requests Naltrexone ER (Vivitrol), refer them to the MATR Counselor for MATR program
- ❑ Review and have patient sign the Naltrexone Extended Release Treatment consent form (See page 8)

**Step 2**

**Pre-Treatment Evaluation**

- ❑ Perform pretreatment exam:
  1. Confirm absence of signs of withdrawal– prior to taking oral naltrexone challenge, must have completed the medically supervised withdrawal period (at least 10 days).
  2. Examine for stigmata of liver disease (ascites, jaundice, right upper quadrant pain, etc.)
  3. Verify adequate accessible muscle mass for gluteal IM injection (severe necrosis can occur if medication is deposited in fat or subcutaneous tissue)
- ❑ Order lab studies:
  1. CMP
  2. Urine Drug Screen for opioids
  3. Urine pregnancy test for females
- ❑ Order Naltrexone challenge
  1. Naltrexone 50 mg tablet; give 1 tab PO daily x 2 days #2 tablets
  2. May give first dose now
- ❑ Order Naltrexone Extended Release (Vivitrol) from DOC pharmacy

**Naltrexone Extended Release Cautions and Precautions**

- Opioid use in prior 7-10 days
- Diagnosed with chronic pain
- Diagnosed with depression or a psychiatric disorder
- Acute opioid withdrawal
- Failed naloxone challenge test
- Positive urine opioid screen
- Acute hepatitis or liver failure
- Hypersensitivity to naltrexone (long or short acting);
- Inadequate muscle mass (cachectic)
- Pregnant (category C)

**Step 3**

**Treatment Day Review and Orders**

- ❑ Review lab results (must be within last 30 days) for the following criteria:
  - Liver transaminase levels (AST and ALT) < 400 U/L
  - Bilirubin within normal limits
  - Creatinine clearance ≥ 50 mL/min
  - Urine opioid screen = negative
  - Urine pregnancy test = negative
- ❑ Confirm absence of contraindications or precautions (see below)
- ❑ Patient acknowledges abstinence from opioids for a minimum of 14 days
- ❑ Medication order set: if patient meets criteria, passed naltrexone challenge, and has normal lab work
  1. NALTREXONE 50 mg PO x 1
  2. Wait 30-60 minutes
  3. If no signs of withdrawal give Naltrexone Extended Release (Vivitrol) 380 mg IM

**Step 4**

**Documentation**

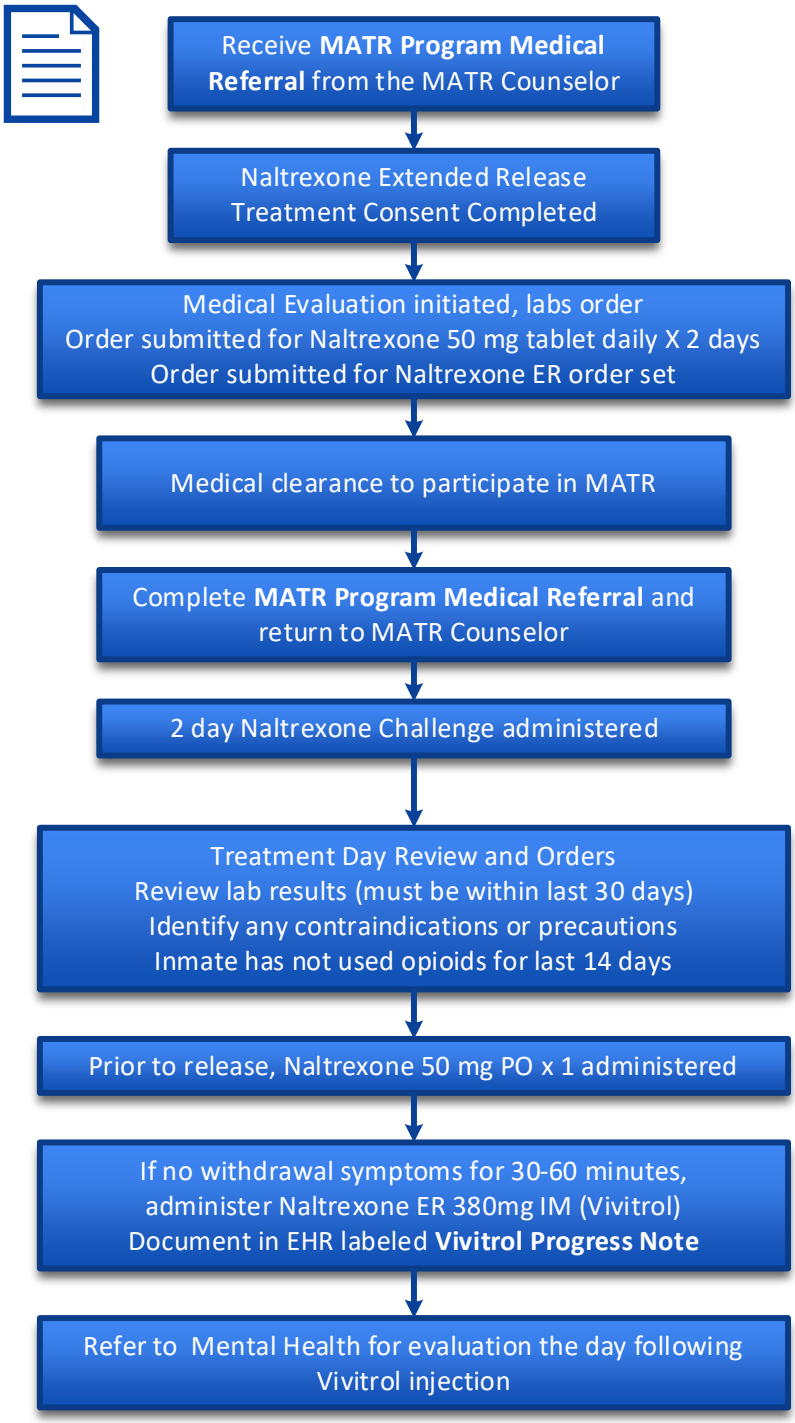
- ❑ Document in EHR using Naltrexone Extended Release (Vivitrol) progress note

**Step 5**

**Post-Treatment Evaluation**

- ❑ Refer to mental health for evaluation on the day following the Naltrexone ER (Vivitrol) injection

# NALTREXONE ER (VIVITROL) MATR PROCESS



# Naltrexone Extended Release Treatment Consent Form

Patient Name:_____ Offender I.D.: _____

Date of Birth: _____ Facility: _____

I, _____, request treatment with Naltrexone extended release (Vivitrol®) injections while in the custody of the Alaska Department of corrections, and I agree that I understand the following risks and important details when receiving this medication (initial each):

1) I understand that I must abstain from taking opioids (anything like Oxycontin, Methadone, Suboxone, Hydrocodone, Morphine, Vicodin, Fentanyl, Druagesic, or Heroin) for a minimum of two weeks prior to receiving Vivitrol. _____
2) I understand that once injected, Vivitrol cannot be removed and will be deposited in muscle tissue for up to one month. _____
3) I understand that I may experience acute withdrawal symptoms if I still have a dependence on opioids. Opioid withdrawal symptoms include runny nose, anxiety, nausea, vomiting, abdominal pain, diarrhea, muscle aches, all of which may be severe. _____
4) I understand that my urine will be tested and must be negative for opioids prior to treatment and I understand that though this test is part of a clinical intervention the results will be reported to security. _____
5) I understand that I may experience symptoms such as nausea, vomiting, and abdominal pain if I have consumed alcohol in the week prior to the first naltrexone injection. _____
6) I understand that it is common to have pain at the injection site for several days. _____
7) I understand that the common side effects are anxiety, agitation, nausea, vomiting, headache, dizziness and tiredness, and redness, swelling, pain and discomfort at the injection site. _____
8) **I have been told that some people experience anxiety, agitation, feelings of depression, or thoughts of suicide in the days after an injection and that I will be evaluated by a mental health clinician on the day following my injection. _____**
9) I understand that some people have a severe injection site reaction that leads to a large sore that must be treated with surgery. _____
10) I understand that if I sustain an injury which may require treatment with opioids, it may be more difficult to treat my pain because naltrexone is blocking the opioid pain receptors. _____
11) I understand that if I attempt to override the effects of Naltrexone, I run the risk of overdose and death. _____
12) I understand that in rare cases Naltrexone has been associated with abnormal liver function and may be affected by poor kidney function; I agree to undergo periodic blood tests to monitor my liver and kidney function. _____
13) I understand that I should not receive naltrexone if I have a **new** liver infection (hepatitis) or a flare of liver inflammation. _____
14) I understand that the risks of being on naltrexone during pregnancy are unknown and therefore naltrexone is not recommended for pregnant persons. _____
15) I understand that naltrexone treatment is not a substitute for recovery and I agree to participate in counseling in order to obtain and maximize benefit from treatment. _____
16) I have been explained all of the points above and have had an opportunity to have my questions answered. _____
17) I understand I need to establish care with a provider in my community immediately upon release to schedule monthly injections . _____

_____ _____
Patient Signature Date

_____ _____
Provider's Signature Date

## Naltrexone ER (Vivitrol) Information Handout

The MATR program is a type of medication assisted treatment. It uses long-acting naltrexone (Vivitrol) with brief counseling interventions and referral to treatment. The program helps reduce the risk of relapse after releasing from a correctional setting. To be effective in the community, Vivitrol must be used with an alcohol and/or drug recovery program.

**What is Vivitrol?**

It is a prescribed injectable medication

Reduces cravings and to block the effects of opioids.

Helps prevent relapse to opioid dependency after opioid detoxification

**Who Should Take Vivitrol?**

People who want to prevent relapse of opioid use

People who have no current opioid withdrawal symptoms

People who are not allergic to Naltrexone or any of the ingredients in Vivitrol (medical will have a complete list)

**Is There a Risk of Opioid Overdose with Vivitrol?**

Yes, a serious side effect of Vivitrol is the risk of opioid overdose. Using opioids, even in amounts that you used before Vivitrol treatment can lead to accidental overdoses, serious injury, coma, or death.

**What Are Other Possible Serious Side Effects?**

Depressed mood with or without suicidal thoughts

Pneumonia

Serious allergic reactions skin rash, swelling of your fact, eyes mouth or tongue, trouble breathing or wheezing, chest pain, feeling dizzy or faint.

This information is from the Vivitrol for Opioid Dependency pamphlet. This information does not take the place of talking with your health care provider. If you would like more information about Vivitrol contact the MATR counselor or medical staff.

# Buprenorphine Information Handout

Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine. For optimal results, patients should also participate in a comprehensive medication-assisted treatment (MAT) program that includes counseling and social support.

## What is Buprenorphine?

Buprenorphine is an opioid partial agonist. This means that, like opioids, it produces effects such as euphoria or respiratory depression. With buprenorphine, however, these effects are weaker than those of full drugs such as heroin and methadone. Because the effects are weaker, there is:

- A lower potential for misuse
- A diminished effect of physical dependency to opioids, such as withdrawal symptoms and cravings
- An increase safety in cases of overdose

## Who Should Take Buprenorphine?

Persons who have been diagnosed with an opioid dependency

Are willing to follow safety precautions for the treatment

Have been cleared of any health conflicts with using buprenorphine

Have reviewed other treatment options before agreeing to buprenorphine treatment

## Is There a Risk of Opioid Overdose with buprenorphine?

Yes, using illegal drugs, drink alcohol, or take sedatives, tranquilizers, or other drugs that slow breathing. Mixing large amounts of other medications with buprenorphine can lead to overdose or death.

## What Are Other Possible Serious Side Effects?

Nausea, vomiting, and constipation

Muscle aches and cramps

Cravings

Inability to sleep

Distress and irritability

Fever

This information is from the SAMHSA.GOV website. This information does not take the place of talking with your health care provider. If you would like more information about buprenorphine contact the MATR counselor or medical staff.

# ALASKA DEPARTMENT OF CORRECTIONS

MATR Program Referral Form DATE: _____

## Referred Inmate Information

| | | | |
|---|---|---|---|
| Inmate Name: | | ACOMS: | |
| DOB: | | Facility: | |
| Release Date: | | | |

## Referral Source Information

| | | | | | |
|---|---|---|---|---|---|
| Name: | | | | Phone or email: | |
| ☐ | Self-Referral | ☐ | Medical | ☐ | Institutional PO |
| ☐ | Field PO | ☐ | Community Agency: | | |
| ☐ | Other: | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Inmate agrees to referral? | ☐ | Yes | ☐ | No | ☐ | Unknown |

****Please forward this completed form to medical where the inmate is located. The MATR counselor will pick up the referral form.**