Test your practical understanding of Naloxone and Naltrexone in clinical practice

1. Patients at higher risk for opioid overdose who are good candidates for co-prescribing naloxone include:
    A. Patients on opioid doses ≥ 50 Morphine Milligram Equivalents (MME)/day
    B. Patients on concomitant opioids and benzodiazepines
    C. Patients with a history of opioid overdose
    D. Patients with a history of substance abuse disorder
    E. All of the above

    Others at higher risk for opioid overdose include those with respiratory conditions, mental health conditions, and/or excessive alcohol use. Patients, family, and friends need to know how to prevent, recognize, and use naloxone in response to overdose. Consider offering naloxone for rescue as a safeguard to everyone on chronic opioids to help protect themselves and others in their household/community who could access the opioids and be at risk of overdose from intentional or accidental ingestion. Co-prescribing naloxone may also encourage improved opioid safety (correct answer is E)

2. (True or False) Patients undergoing an opioid taper to a reduced dose or discontinuation are NOT candidates for a naloxone prescription.
    A. True
    B. False

    Patients currently undergoing an opioid taper or previously on opioids who have lost tolerance to a previous dose (e.g., recent release from prison or detoxification facility) are good candidates for offering a naloxone prescription. Patient tolerance (including respiratory depression) to previous opioid dose is lost after 1 – 2 weeks on a reduced dose or abstinence. There is an increased risk of overdose if patient resumes a previous dose using prescription or illicit drugs (correct answer is B)

3. All of the following statements about naltrexone are true EXCEPT:
    A. Naltrexone is the non-opioid approved medication option for treatment of OUD.
    B. Patients need to be completely off opioids for at least a week before initiating treatment with naltrexone for opioid use disorder (OUD) or alcohol use disorder (AUD).

    Naltrexone, an opioid antagonist, offers no analgesic benefit. Buprenorphine (partial opioid agonist) or methadone (full opioid agonist) may be better options in these patients, or in patients with a lengthy history of opioid use and/or high levels of dependence. There is good evidence that patients with OUD, including patients with comorbid chronic pain who require opioids for pain management, can be well managed with medication assisted treatment (MAT) that includes agonist medication. MAT combines medications (i.e., buprenorphine/naloxone, buprenorphine, methadone, or naltrexone) and counseling/behavioral therapies (correct answer is C)

4. (True or False) Naltrexone long-acting injection is the formulation of choice for most OUD patients.
    A. True
    B. False

    Evidence supports the use of extended release naltrexone INJECTION to prevent opioid relapse and can be an appealing choice for patients who prefer not to be treated with opioids. The monthly IM dosing provides sustained opioid receptor blockade and circumvents some of the adherence issues

with non-supervised oral therapy; e.g., intentional or unintentional missed daily doses. (Medication adherence is critical with ALL medications for addiction treatment.) ORAL naltrexone can be considered for (short-term) transition to the long-acting injection or for longer term use IF administered under supervision; e.g., highly motivated patients who are observed taking oral dose at home. The difficulty of treatment initiation which requires detoxification from opioids before starting naltrexone is a significant limitation independent of formulation. Patients who are able to be opioid free for ≥ 7 days before therapy may be good candidates for naltrexone therapy (correct answer is A)