Opioid Addiction Treatment ECHO

For Providers and Primary Care Teams

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Learning Objectives

1. Discuss common clinic concerns in taking care of patients on buprenorphine
    - Urine drug testing
    - Relapse or continued use: what to do?
    - Monitoring for diversion
    - Frequent requests for early refills

Urine Drug Screens

- Familiarize yourself with what is available through your lab and toxicologist (ELISA vs Confirmation)
- Have a way to confirm unexpected results
- Do not base treatment decisions solely on urine drug screen results
- Ask patients what you will find
- No need to "catch" patient in a lie – be upfront about results

Common Urine Drug Screens

- Opiates – will include heroin, morphine, hydrocodone
  - Will NOT include oxycodone, methadone, fentanyl, buprenorphine (buprenorphine)
- Cocaine – false positives are highly unusual
- Benzodiazepines- low sensitivity
- Marijuana – may stay positive for 28 days in frequent user, CBD oil may contain THC
- Amphetamines/Barbiturates – false positives common
- Alcohol urine screen- ETG highly sensitive

Case 1

A patient stable on buprenorphine for months has the following urine drug screen result. He reports doing well on treatment and has no concerns.

Urine drug screen result:
Buprenorphine + Opiates + otherwise negative

Component Results

Component	Value
BUPRENORPHINE, QL,	POSITIVE (A)
OXYCODONE (SCREEN)	NEGATIVE

AMPHETAMINES (1000 NG/ML SCREEN)	NEGATIVE
BARBITURATES	NEGATIVE
BENZODIAZEPINES	NEGATIVE
COCAINE METABOLITES	NEGATIVE
MARIJUANA METABOLITES (50 NG/ML SCREEN)	NEGATIVE
METHADONE	NEGATIVE
OPIATES (Abnormal)	POSITIVE
PHENCYCLIDINE	NEGATIVE
PROPOXYPHENE	NEGATIVE
COMMENT	SEE NOTE

Comment:

THE SUBMITTED URINE SPECIMEN WAS TESTED AT THE CUTOFF LEVELS LISTED BELOW.

DRUG CLASS	INITIAL CUTOFF LEVEL
AMPHETAMINES	1000 ng/mL
BARBITURATES	300 ng/mL
BENZODIAZEPINES	300 ng/mL
COCAINE METABOLITES	300 ng/mL
MARIJUANA METABOLITES	50 ng/mL
METHADONE	300 ng/mL
OPIATES	300 ng/mL
PHENCYCLIDINE	25 ng/mL
PROPOXYPHENE	300 ng/mL

PLEASE READ THIS IMPORTANT MESSAGE:

THIS DRUG SCREEN IS FOR MEDICAL USE ONLY. THE RESULTS ARE PRESUMPTIVE; BASED ONLY ON SCREENING METHODS, AND THEY HAVE NOT BEEN CONFIRMED BY A SECOND INDEPENDENT CHEMICAL METHOD. THESE RESULTS SHOULD BE USED ONLY BY PHYSICIANS TO RENDER DIAGNOSIS OF TREATMENT, OR TO MONITOR PROGRESS OF MEDICAL CONDITIONS.

Possible Scenarios

1. Patient relapsed with an opioid such as heroin or prescription opioids
2. Patient was prescribed opioids for a medical reason, such as cough syrup with codeine
3. Patient has false positive from poppy seed ingestion or technical error

How to approach patient who absolutely denies use despite positive urine

- Consider confirmatory testing with quantitative levels
- Do not focus on patient characteristics “you relapsed” but focus on result “the urine was positive for opioids”
- If patient reluctant to intensify treatment, present this as standard care and not a personal decision

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Addressing Relapse

- Relapses are expected and will vary in severity
- Do not “fire” a patient for positive urine
- Intensify treatment plan through more frequent visits, urine drug screens, and psychosocial supports
- Have a guide for when you will refer for higher level of care (i.e., IOP, methadone or inpatient)
- Is the patient on an adequate dose?

Back to Case… Next Steps

- Tell patient “urine showed opioids”
- Confirm with patient any prescriptions, poppy seed ingestion, recent medical procedures

Patient denies relapse -->

- Ask lab to confirm results
- Check PDMP
- Inquire about recent triggers
- Intensify treatment by increasing visit frequency, behavioral health (BH) support

Case 2

A patient has been struggling since engaging in treatment. She has had intermittent relapses with heroin and benzos. She continues to smoke MJ daily. She is at risk of losing custody of her child. She struggles with anxiety and insomnia. Today she presents as sedated and guarded, and denies any recent drug use.

Urine drug screen result:

Buprenorphine + otherwise negative

Possible Scenarios

1. Patient is taking buprenorphine and sedation is due to non-drug effect

2. Patient is taking buprenorphine and sedation is due to use of drug not tested for on urine drug screen (such as alcohol, fentanyl, benzo-like drugs)

3. Patient tampered with urine, since it would be unusual for a daily cannabis user to have a urine negative for cannabis

Back to Case… Next Steps

- Let patient know that you're concerned about how they're doing, and aim to build rapport
- Intensify treatment with frequent clinic visits, mental health support, and possible SSRI to treat anxiety
- If concern for tampering, ask for repeat urine or consider other testing (such as oral swab, urine temperature/creatinine)
- If safety is concern consider holding prescription till patient presents non-sedated

Case 3

A patient has been receiving buprenorphine thru your office for 4 months. He appears to have stopped heroin use with negative urine screens for 4 months. However urine screens remain positive for methamphetamines.

Urine drug screen result:

Negative except for amphetamine/methamphetamine

Case 3

- Check urine for buprenorphine to confirm patient is taking
- Concurrent drug use is common, often patients view it less of an issue then heroin addiction
- Weigh the risk of overdose/death vs continued treatment
- Increase level of care to address to address recovery

Case 4

A patient is stabilizing on buprenorphine, has been adherent with recommended treatment, and you have no concerns.

Urine drug screen result:

Negative for all substances (including buprenorphine)

Possible Scenarios

1. Patient is diverting buprenorphine
2. Patient has run out early of buprenorphine
3. Patient has dilute urine
4. Patient has tampered with urine to hide relapse

Detecting Diversion

- Urine drug screens must include buprenorphine testing
- Consider occasional specific metabolite testing (norbuprenorphine)
- Consider urine temperature monitoring, urine creatinine levels (dilution)
- Do random visits with pill counts for stable patients
- Routine PDMP checks

Addressing Diversion

- Use of non-prescribed buprenorphine is often to self-treat withdrawal *
- Risk of diversion may increase as patients stabilize and choose to self-taper the medication
- Educate patients up front about importance of not diverting
- Must stop prescribing if strong evidence of diversion

* Allen B J Subst Abuse Treat. 2016 Nov

Back to Case… Next Steps

- Ask lab to run quantitative testing
- Consider checking urine creatinine/specific gravity
- Call patient back for random pill count
- Increase visit frequency/daily dosing at OTP
- Disclose result with patient “the urine did not show any buprenorphine”
- Confirm they are taking buprenorphine as prescribed
- If patient no-shows to random call back, high suspicion for diversion