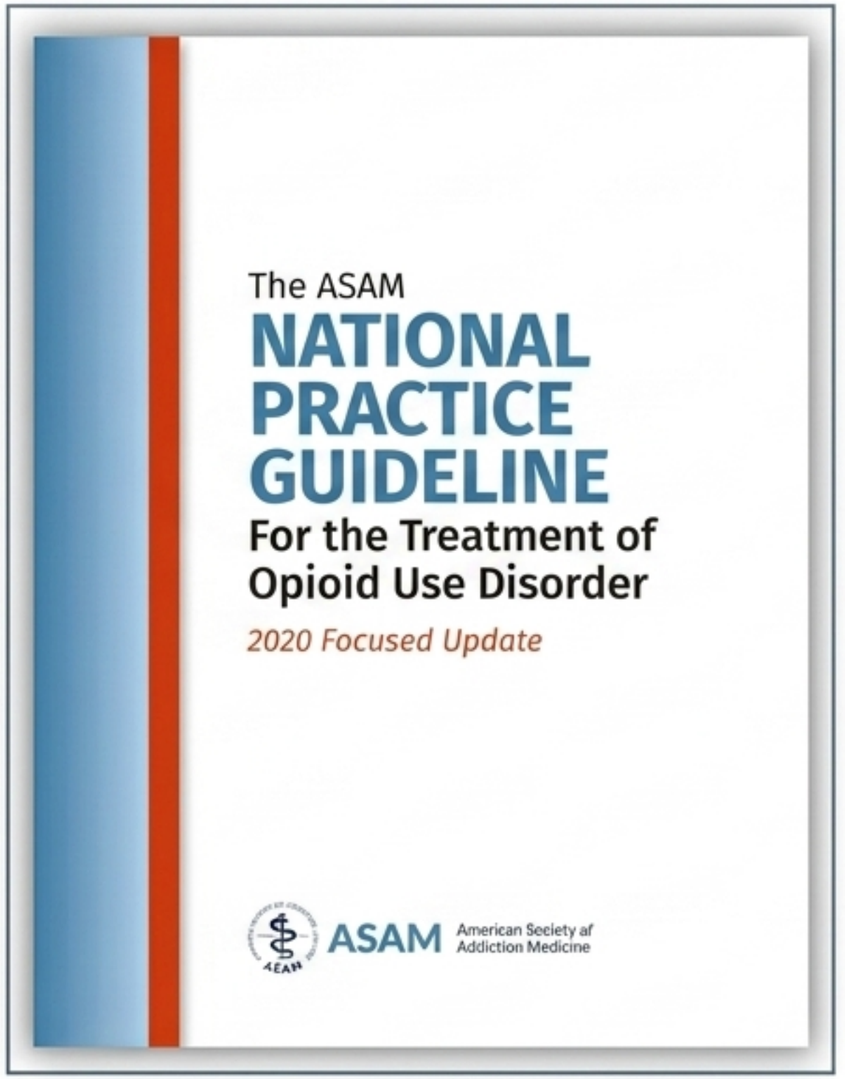
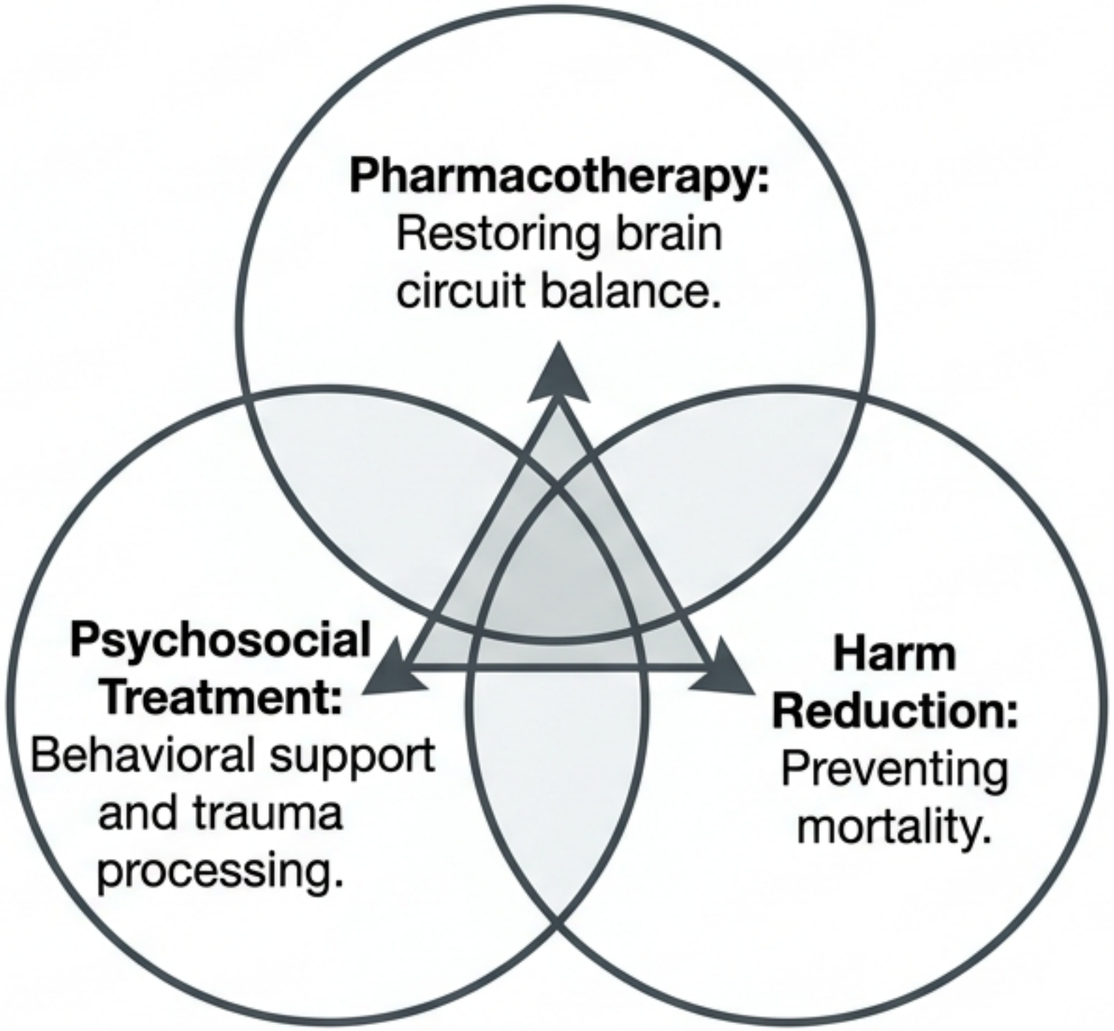
The Clinical Blueprint: ASAM 2020 National Practice Guideline

Evidence-Based Treatment Pathways for Opioid Use Disorder

Distilled for Clinical Navigation: Assessment, Pharmacotherapy, and Special Populations.



Opioid Use Disorder: A Biopsychosocial Paradigm



The Disease:

OUD is a chronic, treatable medical disease involving complex interactions among brain circuits, genetics, the environment, and life experiences.

The Paradigm Shift:

People with addiction use substances compulsively despite harmful consequences. Prevention and treatment are as successful as those for other chronic diseases.

Phase 1: Assessing and Diagnosing OUD

Urgent Triage

- Assess for emergent medical or psychiatric problems.
- Evaluate immediate overdose risk.
- Identify acute intoxication or severe withdrawal.

Biomedical & Infectious

- Order CBC, liver enzymes, Hep B/C, HIV, TB.
- Check for injection-related trauma (abscesses, endocarditis, track marks).
- Test for pregnancy in women of childbearing potential.

Psychosocial & Co-occurring

- Evaluate co-occurring alcohol or sedative/ benzodiazepine use.
- Assess living environment and readiness for change.
- Evaluate psychiatric stability.

Note: Concurrent use of other drugs is **NOT a reason to withhold OUD treatment.**

Phase 1: Objective Clinical Measurement

Severity Gauge: DSM-5 criteria

Pharmacotherapy is optimized for **Moderate to Severe** OUD.

Mild	Moderate	Severe
(2-3 symptoms)	(4-5 symptoms)	(6+ symptoms)

12 months

Primary Clinical Withdrawal Scales
COWS (Clinical Opioid Withdrawal Scale): 11-item objective/subjective clinical assessment.
SOWS (Subjective Opioid Withdrawal Scale): 16-item patient-rated scale.
OOWS (Objective Opioid Withdrawal Scale): 13-item clinician observation scale.
CINA (Clinical Institute Narcotic Assessment): 11-item mixed objective/subjective scale.

Drug Testing Protocol
Minimum 8 tests/year for OTPs. Fluids detect opioids typically 1-3 days post-use.

Withdrawal Management Without Maintenance = High Risk

Abrupt cessation or tapering without ongoing pharmacotherapy triggers strong cravings and severely increases the risk of relapse, overdose, and death.

UROD (Ultra-rapid opioid detoxification under anesthesia) is strictly contraindicated due to cardiac arrest risk.

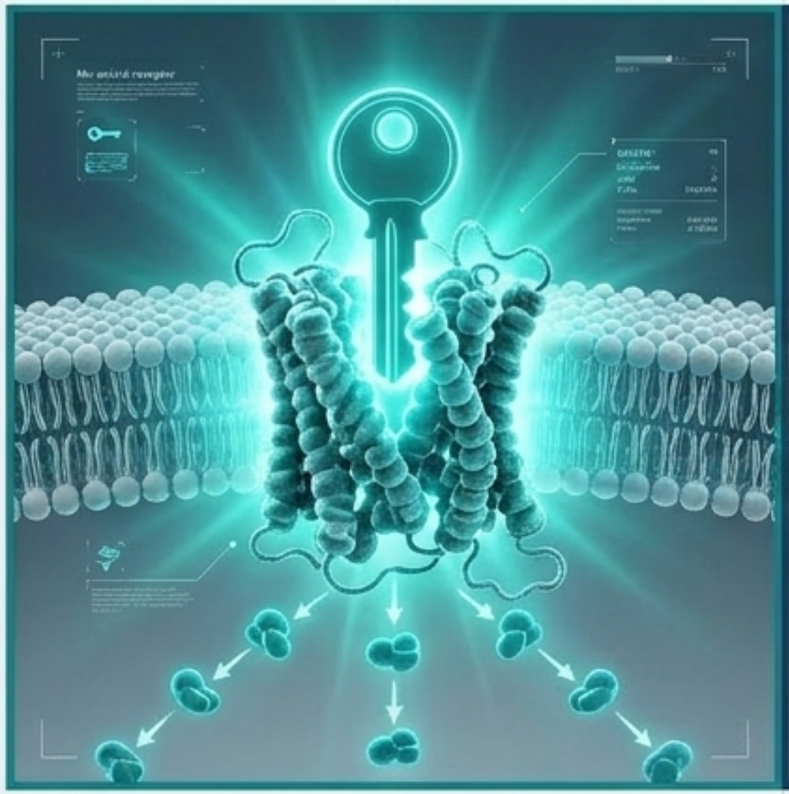
Phase 2: Withdrawal Management Protocols

Agonist Tapers	**Methadone** (20-30mg start, 6-10 day taper) or **Buprenorphine**. Highly effective at retaining patients.
Alpha-2 Adrenergic Agonists	**Lofexidine** (FDA-approved, up to 14 days) or **Clonidine** (Off-label). Safe and effective, but less effective than agonists in completing withdrawal.

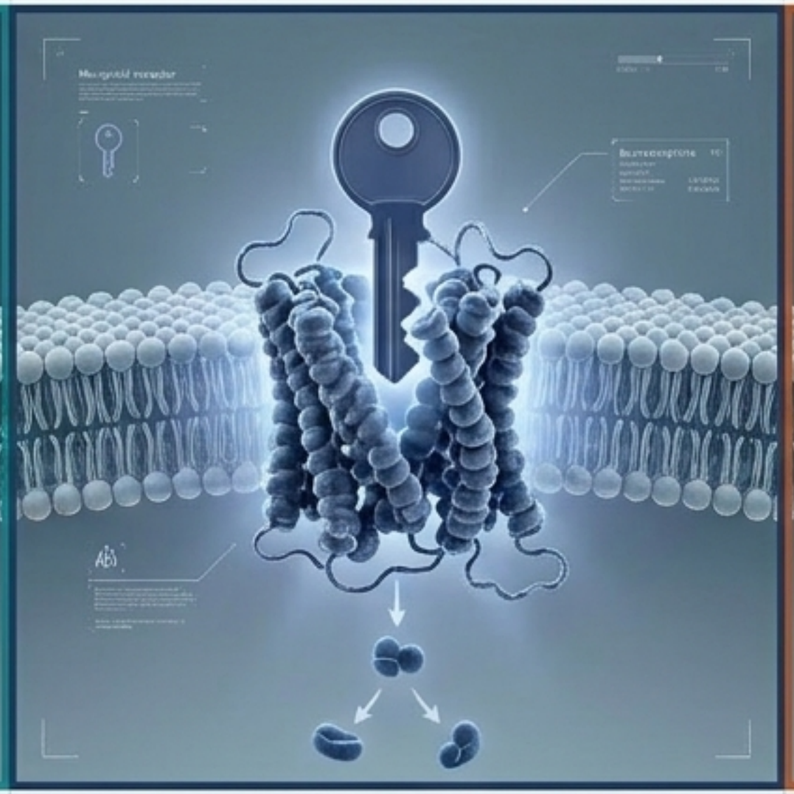
Phase 3: The Pharmacotherapy Master Matrix

	Methadone	Buprenorphine	Naltrexone
Receptor Action	Full Agonist	Partial Agonist	Antagonist
Clinical Setting	OTP & Acute Care only	OBOT & OTP	Any clinical setting
Initiation Requirement	Mild withdrawal	Mild/Moderate withdrawal (COWS 11-12)	Completely opioid-free (7-14 days)
Overdose Risk	Higher (no ceiling)	Lower (ceiling effect)	None (unless overriding overriding blockade)
Adherence Profile	Daily supervised	Daily unsupervised / Monthly injection / Implant	Daily pill Monthly injection

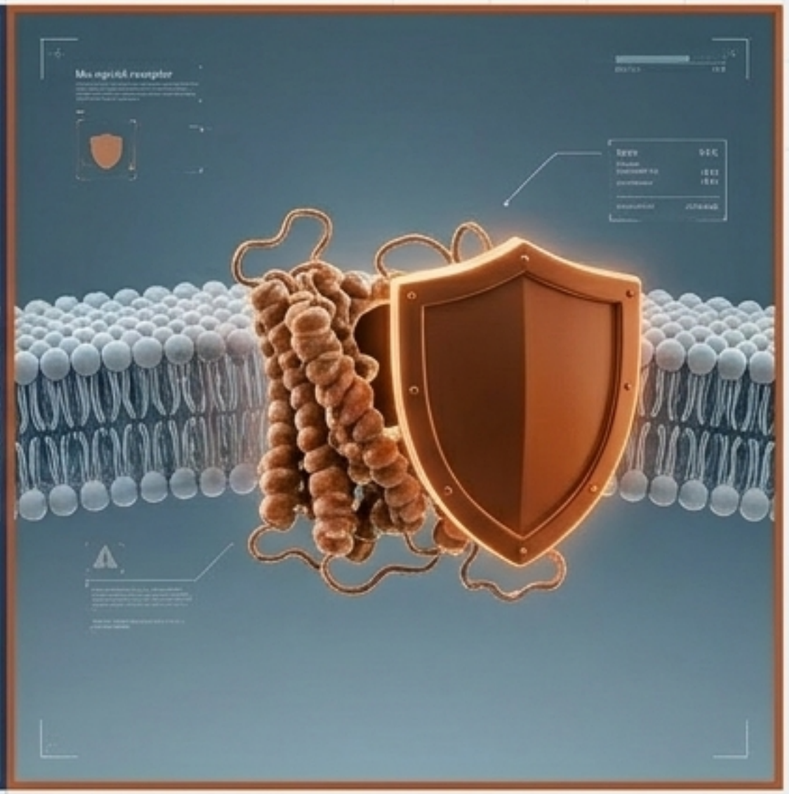
Neurobiology of Receptor Binding



Methadone (Full Agonist): 100% receptor activation. Creates physiological dependence but completely suppresses withdrawal and builds tolerance to block illicit euphoric effects.

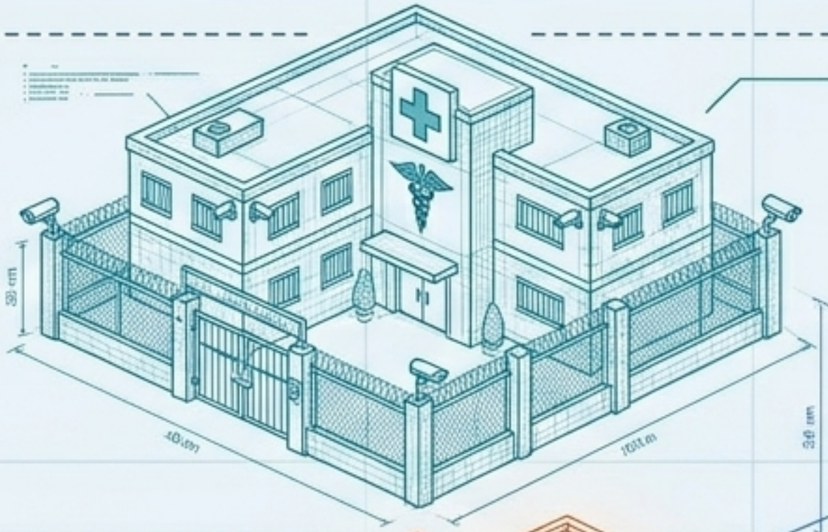


Buprenorphine (Partial Agonist): High affinity but limited intrinsic activity. Has a ‘ceiling effect’ on respiratory depression, making it significantly safer against overdose.



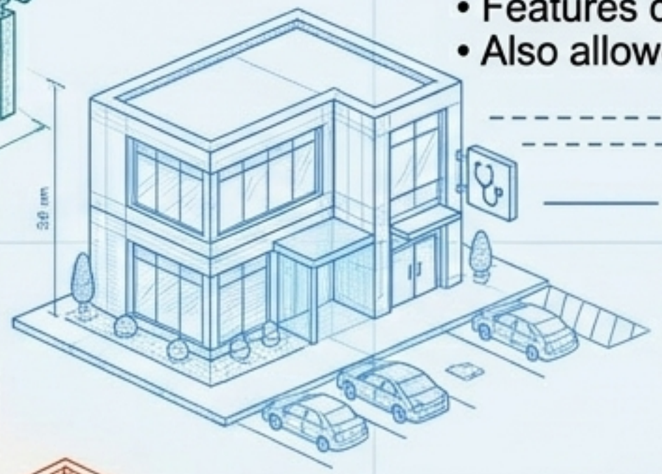
Naltrexone (Antagonist): Occupies the receptor with zero activation. Effectively blocks other opioids from attaching. Causes immediate precipitated withdrawal if opioids are already present.

Pharmacotherapy Treatment Settings



Opioid Treatment Programs (OTP)

- Heavily regulated facilities.
- Required for Methadone dispensing.
- Features daily supervised dosing until stability is proven.
- Also allowed to administer Buprenorphine and Naltrexone.



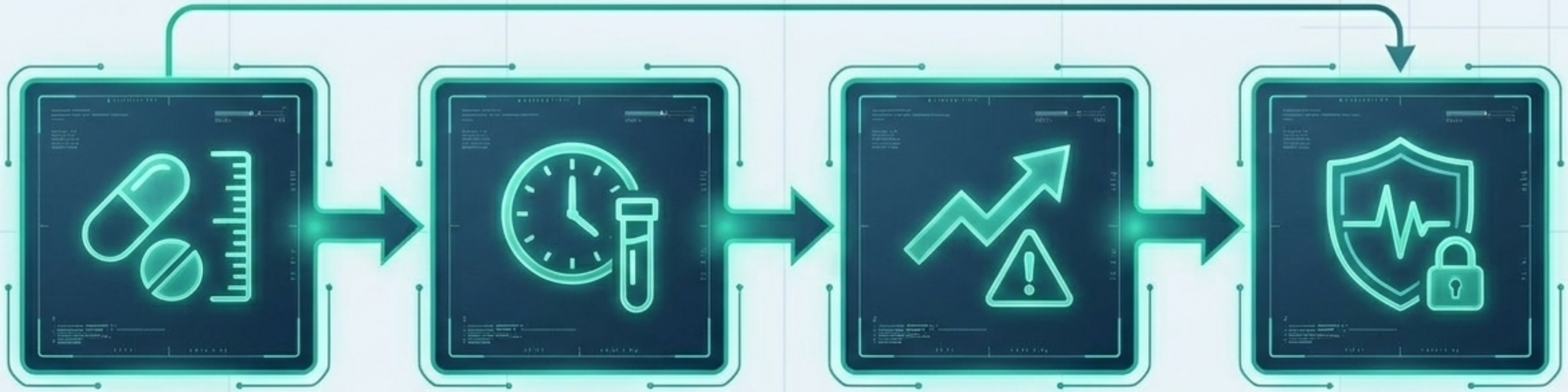
Office-Based Opioid Treatment (OBOT)

- Outpatient settings (private practices, clinics).
- Primarily for Buprenorphine.
- Requires a DATA 2000/CARA/SUPPORT waiver for clinicians.
- Allows regular pharmacy prescriptions.

Acute Care / Hospital

- Non-waivered clinicians can order Methadone/Buprenorphine for up to 3 days (“3-day rule”) to treat acute withdrawal while arranging referral, or for patients admitted for another medical condition.

Methadone Protocol: Initiation & Titration



Step 1: Initiation

Initial dose 10-30mg. (Use 2.5-10mg for low tolerance). Do not exceed 30mg initial or 40mg first-day total by federal law.

Step 2: Reassessment

Check peak levels in 2-4 hours.

Step 3: Titration

Go slow. Increase by no more than 10mg every 5 days. Doses do not correlate perfectly with blood blood levels.

Step 4: Maintenance

Target is typically 60-120mg/day. Prevents withdrawal, reduces cravings, and blocks illicit

No recommended time limit.

Methadone: Cardiac Safety & QTc Algorithm

Trigger: Assess for risk factors (family history, syncope, >120mg/day methadone dose).

Action: Conduct baseline ECG.

QTc < 450ms

Safe to proceed with normal Methadone titration.

QTc 450-500ms

Caution. Discuss risks/benefits. Adjust modifiable risk factors (e.g., electrolyte imbalances, other QTc-prolonging meds).

QTc > 500ms

High Risk of Torsades de Pointes. Do not start Methadone. Consider lowering dose if already on it, or switch to Buprenorphine.

Buprenorphine Protocol: The Critical Wait & Initiation

Step 1: The Wait

Patient MUST be in mild/moderate withdrawal (COWS 11-12) to avoid precipitated withdrawal. Wait 6-12 hours for short-acting opioids, 24-72 hours for long-acting.

Step 2: Initiation

Can be done in-office or at-home. Start with 2-4mg. Observe for 60-90 minutes.

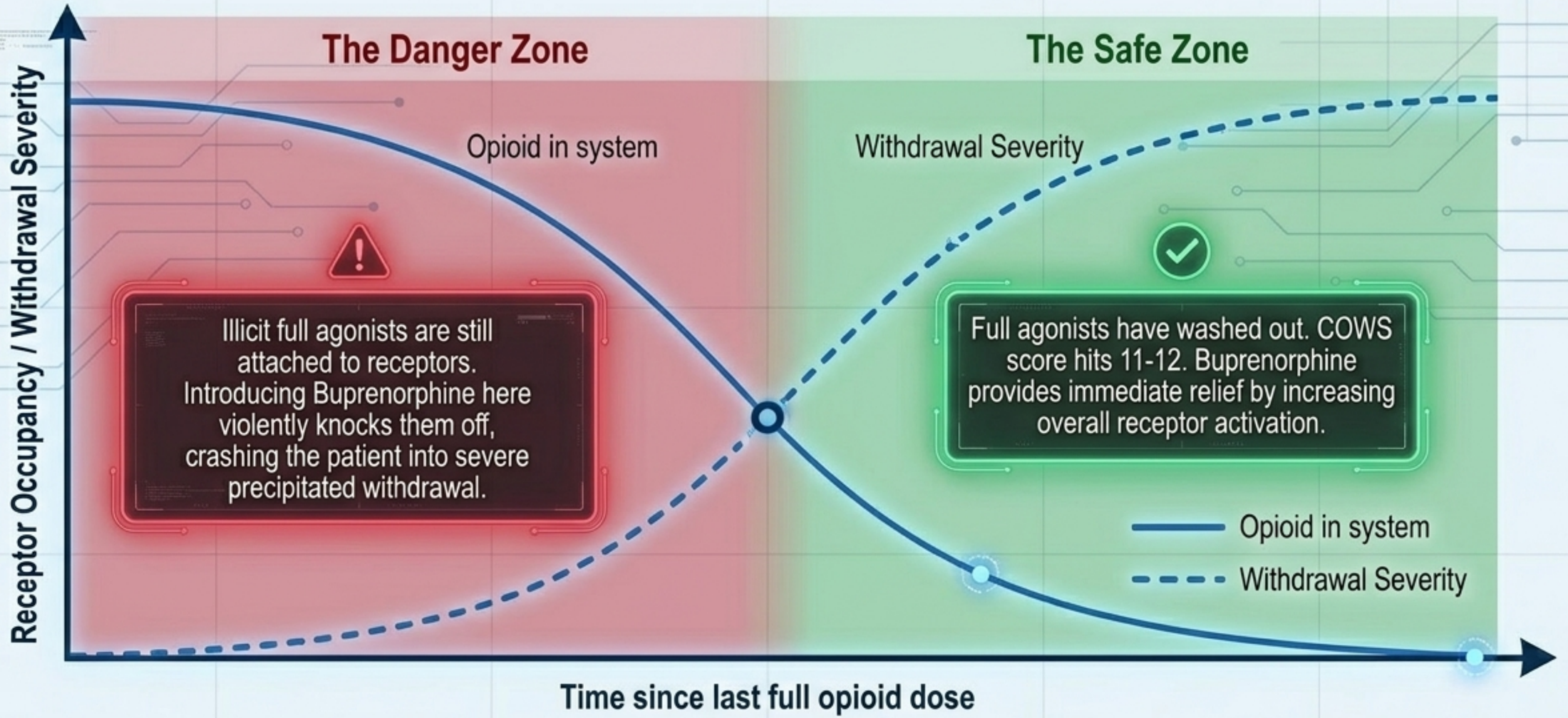
Step 3: Titration

Increase in increments of 2-8mg as needed to suppress symptoms.

Step 4: Maintenance

Target dose is typically 16mg+ per day. Available as sublingual film/tablet, extended-release injections, or 6-month implants.

Buprenorphine: Avoiding Precipitated Withdrawal



Naltrexone Protocol: Washout & Blockade

Step 1: The Strict Washout

Patient must be 100% physically withdrawn from all opioids.
Typically requires waiting 7 to 14 days.
This is non-negotiable.

Step 2: Verification

Conduct a Naloxone Challenge test.
If the patient exhibits any objective signs of withdrawal, abort initiation immediately.

Step 3: Administration

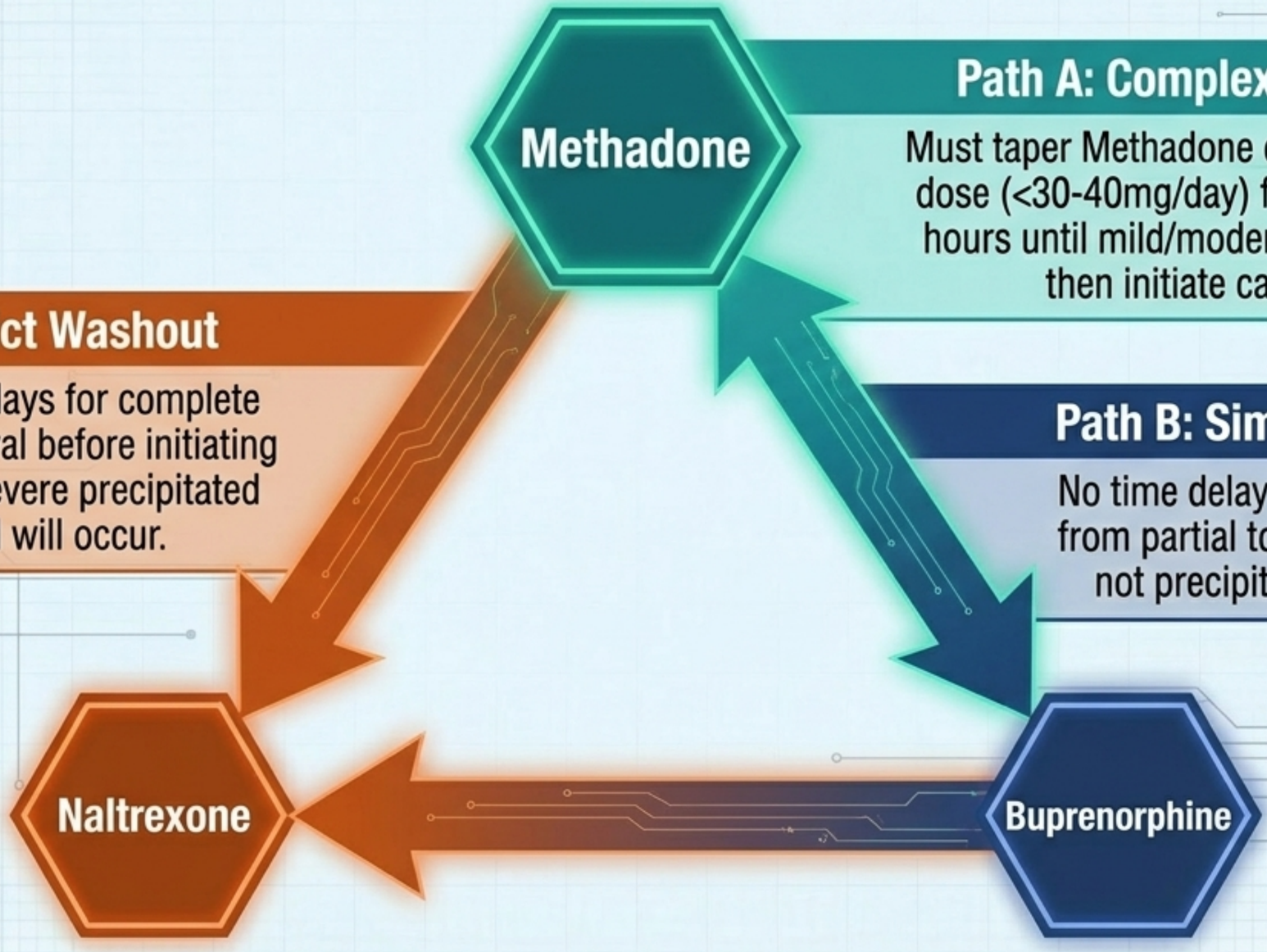
Extended-release injectable naltrexone preferred.
380mg deep IM injection in gluteal muscle every 4 weeks.
Oral naltrexone has poor adherence and is rarely recommended.

Clinical Goal: Provides zero euphoria and complete blockade to prevent relapse in highly motivated, completely detoxified patients.

Contraindications & Precautions Dashboard

Patient Conditions	Methadone	Buprenorphine	Naltrexone
Severe Liver Impairment	⚠ Risk of encephalopathy	✖ Contraindicated for OBOT	✖ Active hepatitis/failure
Respiratory Depression / Asthma	✖ Contraindicated if unmonitored	⚠	✔
Co-occurring Sedative/Benzo Use	⚠ Severe overdose risk	⚠ Overdose risk	✔
	Do not withhold agonist treatment entirely, but increase monitoring.		
Lack of Physical Opioid Dependence	⚠ Start very low	⚠	✔ Optimal state

The Medication Transition Map



Phase 5: Special Populations (Physiological)

Pregnant Women

Rule: Agonist therapy (Methadone or Buprenorphine) is the standard of care. Withdrawal management is NOT recommended.

Adjustment: Pregnancy alters pharmacokinetics (increased clearance). Methadone may require increased or split dosing as pregnancy progresses.

⚠ **Naloxone challenge is contraindicated.**

Individuals with Pain

Rule: MME guidelines for chronic pain do NOT apply to OUD treatment dosing.

Adjustment: For acute pain on agonists, temporarily increase dose, split doses for analgesic effect, or add short-acting full agonists. For surgery on Naltrexone, discontinue oral 72hrs prior, and injectable 30 days prior.

Phase 5: Special Populations (Structural)

Co-occurring Psychiatric Disorders

Rule: Assess mental health and suicide risk at onset. Do not delay OUD medications.

Adjustment: Monitor interactions between psychotropics and OUD meds. Consider Assertive Community Treatment (ACT) for patients with schizophrenia + OUD at risk for homelessness.

Criminal Justice System

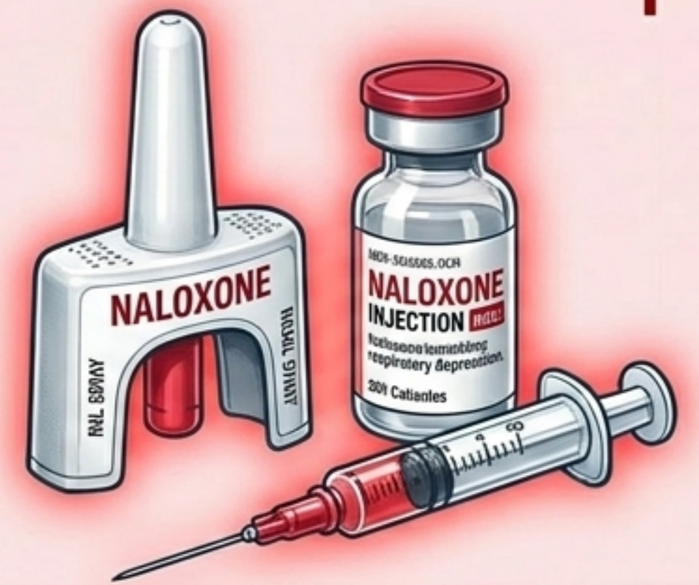
Rule: Forced withdrawal upon entry is medically improper. Continue established treatments.

Adjustment: Risk of fatal overdose is extreme immediately following release. Patients MUST be stabilized on pharmacotherapy prior to release and provided a Naloxone kit.

Phase 6: Harm Reduction & Reversal

The Mandate

Naloxone for the prevention of opioid overdose death must be co-prescribed or provided to ALL patients treated for OUD, patients leaving incarceration, and their family members.



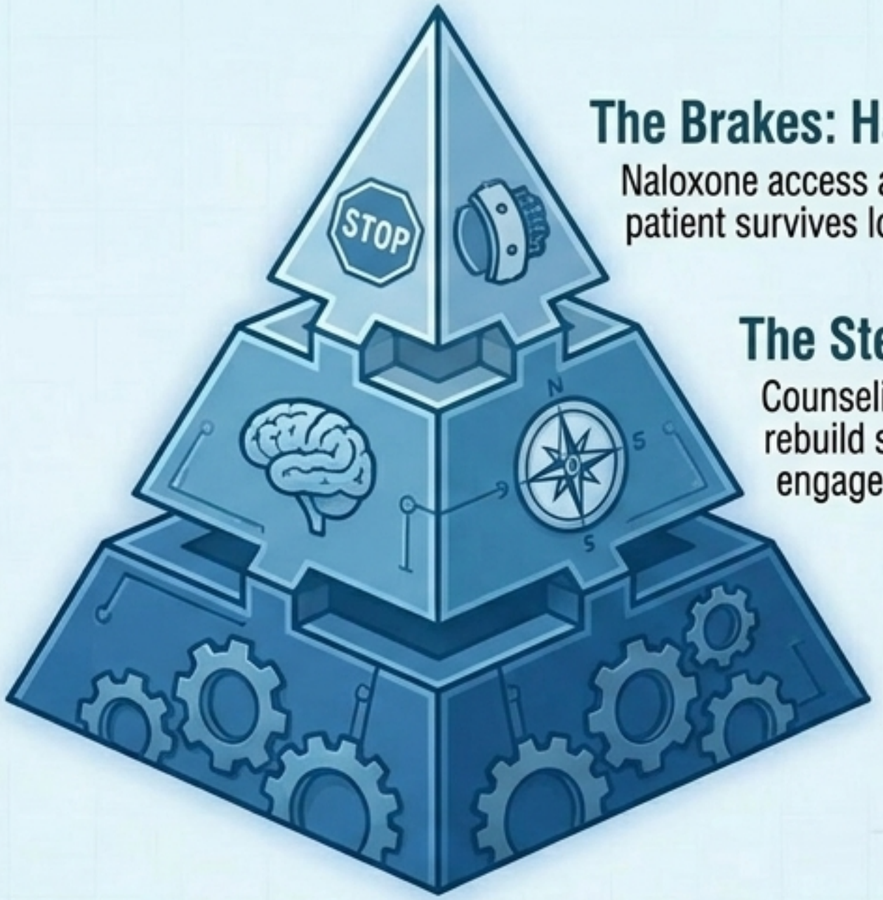
The Mechanism

A fast-acting antagonist that displaces full agonists from the receptor within 1-3 minutes, instantly reversing life-threatening respiratory Effects last 30-60 minutes.

Actionable Takeaway

Because longer-acting opioids may outlast Naloxone's half-life, monitoring is required. First responders, police, and families must be trained and authorized to administer.

The ASAM Gold Standard of Care



The Brakes: Harm Reduction

Naloxone access and safe practices to guarantee the patient survives long enough to achieve recovery.

The Steering: Psychosocial Treatment

Counseling, behavioral therapies, and peer support to rebuild social functioning and address trauma. (Lack of engagement should never delay pharmacotherapy).

The Engine: Evidence-Based Pharmacotherapy

Methadone, Buprenorphine, or Naltrexone to stabilize brain chemistry, eliminate withdrawal, and block illicit use.

Together, these elements transform a fatal epidemic into a manageable, treatable chronic disease.