# WISAM Monthly Teleconference - June 22, 2017

**Attendees:** Dr. Aleksandra Zgierska (WISAM President, Moderator); Dr. David Galbis-Reig (WISAM Secretary); Dr. Nameeta Dookeran (WISAM Chair of Educational Committee); Dr. Subhadeep Barman; Miranda Behnke (Hope Grant); Dr. Joe Blustein; Dr. John Ewing; Dr. Selahutin Kurter; Dr. Mary Kowall; Dr. Bob Lea; Dr. Charles Schaumberger; Dr. Robert Sedlacek; Dr. Dan Sessler; Dr. Erin Trost; Andrew Whitacre (Pew Charitable Trust).

**Main Topics Addressed:**

1) **Naltrexone Delivery Protocol:**
   a. Articles in the *New York Times* (https://www.nytimes.com/2017/06/11/health/vivitrol-drug-opioid-addiction.htm)l and the *NPR* story (http://www.npr.org/sections/health-shots/2017/06/12/523774660/a-drugmaker-tries-to-cash-in-on-the-opioid-epidemic-one-state-law-at-a-time) regarding predatory techniques by pharmaceutical companies to promote naltrexone (especially Vivitrol®) at the expense of the use of agonist-based medication-assisted treatment (buprenorphine and methadone) were briefly discussed.

   b. Pharmacists may deliver Vivitrol® in the pharmacy with a prescriber order. Some of the attendees on the call expressed concern regarding the administration Vivitrol® by pharmacists in the pharmacy settings. The main concerns are related to the possible adverse reactions at the injection-site (this is an IM injection, recommended into gluteal muscles) and precipitated withdrawal and the ability of a pharmacist to limit and/or respond to these adverse events. Several others attendees voiced the opinion that having a pharmacist who can administer these injections can help expand access to this treatment in their communities. Overall, there was a consensus that those who administer IM injections should receive appropriate training in this type of injections to limit the risk of complications associated with the injection site problems.

   c. In one of the previous teleconferences, Ted Hall, a pharmacist, discussed different protocols and practices regarding initiation of Vivitrol® in the outpatient settings. There was a discussion regarding WISAM's developing a protocol of Best Practice Recommendations when implementing an injectable naltrexone treatment program. Dr. Barman discussed the protocol utilized at Pro Healthcare for administration of injectable naltrexone that he is willing to share with the group.

      The question about a utility of and practices related to administering an initial "test dose" of naltrexone (whether SC or orally) prior to Vivitrol® initiation was also discussed. Many clinicians on the call stated they do not routinely use a "test dose" prior to

Vivitrol® initiation; they have not experienced substantial side effects with this approach. Others though use a test dose, as described in the previous Newsletter, mainly by prescribing a low-dose oral naltrexone (12.5-25 mg) and initiating Vivitrol® after the oral medication is well-tolerated. This latter approach allows to "test" the patient's reaction to naltrexone and gives time to check on insurance coverage; downside though is that the patient may drop out from treatment prior to receiving a Vivitrol® shot…

In addition, clinicians on the call discussed the use of "supplemental" naltrexone during the fourth week of Vivitrol® therapy where, in the experience of some clinicians, the effectiveness of Vivitrol® seems to be reduced. Some of the clinicians prescribe oral naltrexone (50-100 mg/day) to take during the 4$^{th}$ week of Vivitrol® therepy, and prior to the next shot, while others may shorten the injection cycle from 28 to 21 days, especially in the initial 1-3 months of Vivitrol® therapy. Some also prescribe oral naltrexone as a PRN medication to assist with cravings and to mitigate the risk of relapse while on Vivitrol®, especially during the first months.

There was a consensus that the development of practice recommendations for outpatient initiation and maintenance of Vivitrol® therapy would be helpful – several clinicians volunteers to collaborate on this project.

2) **Pew Charitable Trust –** Mr. Whitacre provided a summary of the role of Pew Charitable Trust and explained that the Trust is seeking to work with selected States to provide resources and strategies for education and implementation of evidence-based practices to help reduce barriers and improve patient access to evidence-based addiction care.

3) **Medication-Assisted Treatment for Opioid Use Disorder in Pregnancy**: Dr. Zgierska discussed the possibility of applying for a $3-4 million grant from the Patient-Centered Outcomes Research Institute to address scientific questions and best helps this patient population in Wisconsin.

Meeting adjourned a little at 8:02 PM.