ALCOHOL USE DISORDER

General Considerations:

1. Current evidence shows that medications are underused in the treatment of alcohol use disorder, including alcohol abuse and dependence. Clinicians should consider prescribing one of these medications when treating a patient who is dependent on alcohol or who has stopped drinking but is experiencing problems including cravings or relapses.
2. Medications should be prescribed as part of a comprehensive treatment approach that includes counseling and other psychosocial therapies and social supports through participation in Alcoholics Anonymous and other mutual-help programs.
3. SBIRT (Screening, Brief Intervention, and Referral to Treatment) can be used to screen for Alcohol Use Disorder.

Documentation Required

A. FDA approved indications

First Line Agents:

1. Naltrexone Oral (Alcohol Dependence)
2. Naltrexone for Extended-Release Injectable Suspension (Alcohol Dependence)
3. Acamprosate (Alcohol Dependence Maintenance Treatment)

Second Line Agent:

- Disulfiram (Alcohol Dependence)

Documentation Required

B. Non-FDA approved common uses:

1. Gabapentin
2. Topiramate
3. Baclofen

Documentation Required

C. Minimal Documentation

All standard outpatient & inpatient requirements

Documentation Required

D. Dosing Information

(For more details refer to Medication Maximum Daily Dose (MDD Table) And PI for each drug for more details.

Acamprosate: Requires dosage adjustment in moderate renal impairment (CrCl 30-50ml/min) and should not exceed 1tab tid).

Disulfiram: Disulfiram should never be administered to a patient who is in a state of alcohol intoxication, or without patient's full knowledge.

Naltrexone Oral: 25mg/day for 7 days then 50mg once daily. Some studies have used 100mg daily. Caution advised for patients with Renal or Hepatic impairment.

Naltrexone IM: 380mg gluteal IM q4wks, alternate buttocks, use only the needle in the accompanying box. Must not be administered IV or SQ.

Documentation Required

E. Duration of Use/Medication Changes

Documentation Required

F. Polypharmacy

Combining Medications: Combining medication, particularly those with different mechanisms of action, offers the possibility of more effective treatment for patients who do not respond adequately to an individual agent. However, two trials compared the combination of oral naltrexone and acamprosate, found mixed results. See Ref. list.

Documentation Required

H. Black Box Warnings (See Contraindications)

I. Serious Side Effects

Disulfiram:

- Optic neuritis
- Peripheral neuritis, polyneuritis, peripheral neuropathy (complaints of numbness or tingling)
- Hepatitis, including cholestatic and fulminant hepatitis as well as hepatic failure

Acamprosate:

- Acute renal failure was temporally associated with Acamprosate.

Naltrexone:

- Dose dependent hepatotoxicity has been reported with Naltrexone.

Naltrexone IM:

- Serious injection site reactions
- Eosinophilic pneumonia
- Serious allergic reactions
- Accidental opioid overdose

- Depression and suicidality

J. Drug Interactions: Refer to Epocrates/PI for details)

Acamprosate: Acamprosate is not hepatically metabolized and has no induction or inhibition potential on the cytochrome CYP1A2, 2C9, 2C19, 2D6, 2E1, or 3A4.

Disulfiram: Disulfiram may decrease the rate of metabolism of many drugs resulting in toxicity i.e. when given with Phenytoin (may result in Phenytoin toxicity). (Refer to Epocrates/PI for details).

Documentation required

I. Standard laboratory and examination requirements

1. For Inpatient: Basic laboratory studies on admission
2. For Outpatient:
   Acamprosate: Panel 7 at baseline to assess renal function.

   Disulfiram: Comprehensive metabolic panel at baseline & 10-14 days later to detect hepatic dysfunction.

   Naltrexone: Comprehensive metabolic panel at baseline to assess renal and hepatic function.

   Gamma-Glutamyl Transferase (GGT)

   Testing for vitamin deficiency

J. Pregnancy and Lactation
(Refer to Table 1)

Documentation Required

K. Contraindications

1. Acamprosate: CI in patients with severe renal impairment (CrCl≤30ml/min) and in those who have a known hypersensitivity to the drug or its component.

2. Disulfiram: CI in the presence of severe myocardial disease or coronary occlusion, psychoses, pregnancy, and those with high levels of impulsivity, suicidality, and hypersensitivity to disulfiram or to other thiuram derivatives used in pesticides and rubber vulcanization.

Contraindicated in patient who are taking or have recently taken metronidazole, paraldehyde, alcohol, or alcohol-containing preparations i.e. cough syrups, tonics.

3. **Naltrexone PO and IM:**
   A. Patients with acute hepatitis or liver failure (Naltrexone IM)
   B. In patient receiving opioid analgesics and those receiving long-term opioid therapy or anticipating a need for opioids (e.g. surgery).
   C. Patients currently dependent on opioids, including those being maintained on opioid agonists such as methadone or partial agonists such as buprenorphine.
   D. Patients in acute opioid withdrawal
   E. Patients who have failed the naloxone challenge test or whose urine tests positive for opioids.
   F. Patients with a hypersensitivity to naltrexone or its components.

Documentation

M**. Warnings/Precautions: (Refer to Table 4 for Black Box Warnings and Pregnancy Categories)**

Disulfiram:

1. Use with caution in patients with heart disease, diabetes, hypothyroidism, epilepsy, cerebral damage, chronic or acute nephritis, acute hepatitis or other hepatic disease, and in patients>60y.o.
2. Hepatotoxicity has occurred in patient with or without a h/o abnormal liver function. Patients should be advised to immediately notify their physician of any early sxs of hepatitis, including fatigue, weakness, malaise, anorexia, nausea, vomiting, jaundice, or dark urine.
3. Psychotic reactions have been noted, attributable to the unmasking of underlying psychoses in patients**.**

Acamprosate:

1. For patients with moderate renal impairment (Cr. Cl. 30-50ml/min), a reduced dose of acamprosate (one 333mg tablet 3 times a day) is recommended
2. Baseline and frequent renal function test are important in patients>65y.o. due to elevated risk of diminished renal function**.**

Naltrexone:

1. Use with caution in patients with moderate to severe renal impairment.
2. Patients should take no opioids, including opioid-containing medications, of a minimum of 7 to 10 days before starting naltrexone to avoid precipitating opioid withdrawal.
3. Patients should be told of the serious consequences of trying to overcome the opioid blockade.
4. Hepatotoxicity: Discontinue use of naltrexone in the event of symptoms of signs of acute hepatitis.
5. Depression, suicide, attempted suicide and suicidal ideation have been reported in post marketing experience with REVIA used in the treatment of opioid dependence.

Attachments: Table 1: Pregnancy Categories & Nursing Mother
Attachment 2: VMC; Algorithm for Pharmacologic Treatment to Reduce Heavy Alcohol Use

References:

1. SOURCE: SAMHSA and NIAAA. (2012, September). *Report of the SAMHSA-NIAAA Consensus Panel on New and Emerging Pharmacotherapies for Alcohol Use Disorders and Related Comorbidities.* Rockville, MD: SAMHSA.
2. PI for each of the above RXs.
3. National Institute on Alcohol Abuse and Alcoholism NIH Publication 07–3769
4. UpToDate 2018: Pharmacotherapy for alcohol use disorder