1. Assess for active, moderate to severe opioid use disorder (OUD) using DSM-5 criteria

- Document current substance use: drugs, quantity, route, & amount
- Ask patient about current goals and history of treatment: medications, psychosocial, residential, or other
- Obtain urine drug testing
- Consider consult to appropriate specialist team: Addiction Med/Psych/Pain as determined by entity resources.

2a. Offer methadone or buprenorphine

New start: see Methadone & Buprenorphine Induction Pathways

Continuation: confirm and document dose/timing (PDMP for buprenorphine, call OTP* for methadone), & then continue (see Methadone Guideline for MOUD for missed doses)

Patient declines: *may still proceed with short-acting opioids*

*Opioid Treatment Program

2b. Monitor withdrawal, sedation, and pain

- Nurse assessments of COWS, RASS/POSS, pain per unit standard

3. Offer short-acting opioids. *Note: 1 bag of "dope" ≈ 500-1,000 oral morphine milligram equivalents (MME)*

Step 1: Discuss with patient.

- Set goals & expectations*. In general, short-acting opioids will not be continued on discharge.*
- Choose opioids & route of administration. For scheduled short-acting opioids, PO preferred if patient does not use intravenously. PCA preferred if patient is using intravenously ≥14 bags or ≥1 bundle per day.

Step 2: Order a scheduled long-acting opioid.

- Continue or start methadone/buprenorphine per UPHS guidance. For pain, consider splitting dose into 3-4x/day.
- If methadone and buprenorphine both declined or contra-indicated, use oxycodone ER 40mg Q12h.

Step 3: Order scheduled short-acting opioids.

Consider lower doses if patient uses <3 bags/day, is frail, or has impaired renal/hepatic function.

- PO: Oxycodone IR 20mg (or hydromorphone 8mg) q4h scheduled, hold for sedation.
  - At least every 4 hours, evaluate need to increase scheduled oxycodone IR in 10mg increments (4mg for hydromorphone opioid withdrawal/pain is reported as tolerable.
  - Patients may receive additional PO or IV opioids PRN if this regimen is insufficient.

or

- IV: Hydromorphone PCA (2mg load; 0.5mg basal, 0.5mg demand q15 min, no lockout). If there is delay in starting the PCA, use oxycodone IR 20mg, PO hydromorphone 8mg, or IV hydromorphone 2mg q4h to bridge.
  - Increase demand by 0.5mg as often as q1h up to 2 mg. Beyond 2 mg, increase basal by 0.5mg/h no more often than q4h.

Step 4: Consolidate short-acting opioids.

- Once withdrawal/pain is reported as tolerable, either cross-taper to methadone/buprenorphine (preferred) or give total daily requirement as divided doses of oxycodone ER q8-12h.

4. Use non-opioid adjuvants.

- Opioid withdrawal: schedule clonidine, PRNs: ondansetron, dicyclomine, & others per Opioid Withdrawal Orderset
- Analgesia: Scheduled acetaminophen, NSAIDs (ketorolac), topicals, and ice/heat. Consider ketamine – see formulary links for PO on general units (at HUP) or IV administration in ICU (may require specialist approval).
- Xylazine withdrawal: Consider clonidine, dexmedetomidine, or benzodiazepines. See Xylazine Withdrawal Guidelines.

5. Transition to methadone or buprenorphine

- New methadone: reduce scheduled full agonist opioids by ~10-25%/day as methadone is increased to therapeutic dose. See Methadone Guideline for MOUD..
- New buprenorphine: maintain scheduled full-agonist opioids & use low-dose initiation (Buprenorphine Induction Pathway). Full-agonist opioids may be tapered starting on Day 2 of induction or rapidly tapered once buprenorphine ≥16-24mg/day.
- Declined methadone/buprenorphine: once withdrawal is stabilized, either (1) abruptly stop on discharge (preferred) or (2) taper full agonist opioids by 25% daily (rapid) or 25% every 2-3 days (preferred, if time allows) while hospitalized. NOTE: tapering without methadone or buprenorphine will reduce tolerance and increases the risk of post-hospitalization overdose.

6. Discharge planning

- Treatment: encourage all patients to transition to methadone or buprenorphine & counsel patients about benefits, risks, and requirements for both (eg., daily visits to OTP for methadone).
- Narcan: On admission, order take-home Narcan nasal spray and have discharge pharmacy deliver to patient.
- DC to home or community: in general, short-acting opioids should not be prescribed on discharge.
- DC to SNF/rehabilitation facilities: patients discharged to facilities can continue to receive short-acting opioids. for acute pain, but a taper should be prescribed with clear instructions to patient & facility.