Initial Management of Withdrawal and Pain in Hospitalized Patients with Opioid Use Disorder (OUD) Using Fentanyl

- *Patients using >3 bags of fentanyl daily: use these doses, even if patient received higher doses during a recent hospitalization.*
- *Patients using <2 bags fentanyl or who have critical illness, older age, frailty, or significant renal/hepatic impairment: reduce doses by 50%.*

Please reach out for expert guidance:
PPMC: *Addiction Consult Team (ACT), Psych CL*
HUP: *ACT, Psych CL, MEND, Pain Pharmacy HUP*
PAH: *Psych CL*

I. Assess & Diagnose OUD

- Diagnose OUD (using DSM-5), document current substance use, and ask about patient goals & history of treatment
- Obtain urine drug test when feasible; do not wait for results to initiate treatment

II. Stabilize & Engage

Many patients have overlapping withdrawal and pain. Partner with patients to develop a supportive regimen that aligns patient goals for comfort with our responsibility to provide a safe environment.

1. Continue outpatient OUD treatment: if stable on methadone/buprenorphine, confirm dose (PDMP for buprenorphine, call the opioid treatment program for methadone) and continue home dose if no interruptions

2. Start a long-acting opioid (methadone or buprenorphine (MOUD) preferred)

Patient interested in methadone on discharge → Start methadone 30mg AM + 10mg PM daily PO (can order without consult). For refractory vomiting, use IV with 50% reduction of each dose. See below for guidance on dose titration.

Patient interested in buprenorphine on discharge → Start buprenorphine. Use (a) traditional induction once ≥24h from last fentanyl use (ok to bridge with short-acting opioids), or (b) low-dose induction with overlapping opioid continuation

Patient undecided about MOUD on discharge → Use methadone (or oxycodone ER 40mg q12h) while deciding

Patient declines MOUD on discharge → Use methadone (or oxycodone ER 40mg q12h) while hospitalized

3. Start and schedule clonidine: Initial clonidine dose is typically 0.1mg q6-8h; titrate dose up by 0.1-0.2mg q2 hours if tolerated based on BP & HR. Higher doses may prevent need for IV dexmedetomidine for medetomidine withdrawal.

4. Treat additional withdrawal & acute pain: patients with OUD have high tolerance and require higher opioid doses

A. Use non-opioids: consider acetaminophen, NSAIDs (ketorolac or ibuprofen), topicals, and ice/heat; see *Opioid Withdrawal Order-Set*; consider ketamine – see formulary for PO (requires specialist approval at PPMC) or IV (in ICU)

B. Consider short-acting opioids as a supplement to long-acting opioids

- Set expectations: goal is to treat withdrawal/pain without excess sedation; administered medications may not achieve the same effect as drug use; short-acting opioids will not be continued for withdrawal on discharge.
- Dosing:
  - Oral short-acting opioids: PO hydromorphone 8mg (or oxycodone IR 20mg) q4h scheduled, hold for sedation. Can increase hydromorphone by 4mg (10mg for oxycodone IR) every 2h (remaining on q4h administration interval) until COWS <6 or pain is controlled.
  - IV opioids and PCAs: Use IV formulations and/or PCA for the same indications as you would in patients without OUD (e.g. post-op, NPO). IVP: Hydromorphone 2mg IV q4h PRN COWS>5 or severe pain uncontrolled 1h after oral short-acting opioid. Can increase hydromorphone IV by 1mg at 1h (remaining on q4h administration interval) until COWS <6 or pain is controlled.
    - Consider switching to PCA if IVP hydromorphone escalated to 6mg q1h (or more frequent dosing needed) and pain still uncontrolled. PCA Order: no load, no basal rate, demand 50% of most recent IVP dose, 30m lockout, 4h dose limit not ordered. If starting PCA without prior escalation of IVP: no load, no basal rate, 2mg demand, 30min lockout, 4h dose limit not ordered.
  - Offer to split methadone/buprenorphine into 3-4x daily doses for increased analgesic effect.
- Timing: goal is to cross-taper off short-acting opioids and on to long-acting opioid (methadone/buprenorphine preferred) within ~72h. Longer periods might be necessary for acute pain or craving, based on expert guidance.

III. Transition to Maintenance OUD Treatment & Plan for Discharge

Encourage all patients to transition to methadone/buprenorphine. Counsel about benefits, risks, and requirements (e.g., daily visits to OTP for methadone). Consider clinical trajectory and discharge planning (e.g., see below for DC to SNF).

- **New methadone maintenance**: See *Methadone Induction Pathway.* Increase methadone daily up to 60mg/day while reducing full agonist opioid by ~10-25%/day. Reach out for expert guidance beyond 60mg/day.
- **New buprenorphine maintenance**: See *Buprenorphine Induction Pathway.* Can use traditional or low-dose induction.
- **Declined methadone/buprenorphine**: Either (1) abruptly stop opioids on discharge (preferred because tapering reduces tolerance and increases risk of post-hospitalization overdose) or (2) taper opioids by 25% every 1-3 days.

- **Narcan**: On admission, order take-home Narcan nasal spray and have MyPennPharmacy deliver to patient
- **DC to home or community**: Set up linkage to OUD care (bridge prescription & appointment for buprenorphine; next-day OTP intake for methadone). In general, short-acting opioids should not be prescribed on discharge.
- **DC to SNF/rehab**: New methadone starts may not be compatible with discharge to SNF. Ask for expert guidance.