NORFOLK AND WAVENEY STP THERAPEUTICS ADVISORY GROUP (TAG)

SHARED CARE AGREEMENT

Shared care guidelines for Naltrexone for Abstinence in Alcohol Use Disorder
Monitoring level Amber 0 – Prescribe drug and perform basic monitoring eg annual review

Generic and Proprietary/Brand Name
Naltrexone / Adepend®
Indications for shared care
Alcohol Use Disorder (AUD) to assist in maintenance of abstinence - Initiated after consultation from Drug and Alcohol Agencies

Specialist Prescribing and Monitoring Responsibilities – summary. Full details in main body of document	GP / Community Team - Primary Care Prescribing and Monitoring Responsibilities – summary. Full details in main body of document
Prescribing: Naltrexone therapy should be initiated in secondary care. The mechanism of action and expected effects and side effects and duration of therapy should be explained to the patient using the NRP (or equivalent) Patient Information Leaflet. **Monitoring:** Detailed specialist monitoring requirements are explained in full further down in the main body of the document	**Prescribing:** The patient's GP may be asked to take over the prescription for naltrexone after 4 weeks of abstinence (e.g. post detoxification). **Monitoring:** NICE does not recommend routine blood monitoring however raised LFTs have reported at 100mg+ doses, and manufacturers' SPCs states that liver function abnormalities have been reported in the elderly and obese patients. Monitoring can be considered for older people, those with obesity, and monitoring recovery of liver function possibly as a motivational aid for some patients to show improvement.

Patient Information

- Naltrexone may affect the performance of skilled tasks (e.g. driving or operating machinery).
- If surgery is needed, inform anaesthetist and medical team that you are taking naltrexone
- Patients must be warned against concomitant use of opioids (e.g. opioid-containing cough medication, opioid-containing medication for symptomatic treatment of common cold or opioid containing medication for diarrhoea etc.
- Do not use opioids "on top" as this carries a serious risk of overdose
- If you become pregnant, stop naltrexone immediately and seek medical advice.
- Stop treatment immediately if an allergic reaction occurs to naltrexone.
- Separate Patient Information also provided by the NRP.
- Manufacturer's Patient information sheet (available via http://www.medicines.org.uk/emc/)
- *Choice and Medication* (www.choiceandmedication.org/nsft) has a two-page standard, two-page easy-read and one-page brief leaflet plus free access to the extensive website, with over 30 Q&As on naltrexone.
- NSFT Medicines Information Helpline: call 01603-421212 (12 noon to 4.00pm, Monday to Friday)

Specialist Contact Details

Norfolk Recovery Partnership (NRP) via http://www.norfolkrecoverypartnership.org.uk/Professionals/alcohol/Pages/home.aspx, Tel: 0300 7900 227

GENERAL PRINCIPLES FOR SHARED CARE PRESCRIBING

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- GPs are **invited** to participate. If GPs are not confident to undertake these roles, they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist.
- **If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable if they are unwilling to do so.**
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP and when the patient's condition is stable or predictable.
- Safe prescribing must be accompanied by effective monitoring.
- **The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.**

Background to Treatment

Naltrexone can be used as an adjunctive prophylactic therapy in the maintenance of detoxified, formerly alcohol-dependent patients, where there is risk of relapse into alcohol use and the patient has made an informed choice to take the medication. The reduction of desire for alcohol lowers the risk of a full relapse.

Naltrexone is a competitive opioid receptor antagonist, and will block the effects of all opioids. It is thought to diminish the reinforcement which promotes drinking behaviour in alcohol use disorders by blocking the effect of alcohol-induced □-endorphin release in the nucleus accumbens and the ventral tegmental area which are involved in the reward circuit in the brain.

Licensed use and agreed local off-label use

Naltrexone is licensed in the UK and recommended as a treatment option for AUD according to NICE (Clinical Guideline 115, February 2011 http://www.nice.org.uk/guidance/CG115).

Criteria for Patient Selection

Patients aged ≥18 years with alcohol use disorder (including dependence and harmful drinking / binge use).

Form and strength of preparation

50mg tablets, scored

Side Effects and Management

Link to BNF

Link to SPC

Common side effects (incidence of more than 10%) - difficulty sleeping, anxiety, nervousness, abdominal pain/cramps, nausea and/or vomiting, low energy, joint and muscle pain and headache.

Uncommon side effects (incidence of less than 10%) - loss of appetite, diarrhoea, constipation, increased thirst, increased energy, feeling down, irritability, dizziness, skin rash, delayed ejaculation, decreased potency, chills, chest pain, increased sweating and increased lacrimation.

Drug Interactions

Link to BNF

Link to SPC

Concomitant administration of naltrexone with an opioid-containing medication should be avoided. Patients should be warned that attempts to overcome the blockade may result in acute opioid intoxication which may be life threatening.

Cautions and Contraindications

Link to BNF

Link to SPC

Contraindications

Patients currently dependent on opioids since an acute withdrawal syndrome may ensue.

Patients who are currently taking medication containing opioids.

Patients who are hypersensitive to naltrexone.

Patients with acute hepatitis or liver failure.

Patients with severe renal impairment.

Precautions

Clients who are breast-feeding, pregnant or planning to become pregnant - Animal studies do not suggest a teratogenic effect. Because of absence of documented clinical experience naltrexone should only be given to pregnant or breast-feeding women when, in the judgement of the clinician, the potential benefits outweigh the possible risks.

In an emergency requiring opioid analgesia an increased dose of opioid may be required. The patient should be closely monitored for evidence of respiratory depression or other adverse symptoms. Patents should be warned of this risk and advised to alert treating doctors

Initiation of therapy and ongoing dose regimen

Initiated by Specialist alcohol services

Initial dose:

Half a tablet each day for one week (25mg/day) then one tablet daily (50mg/day)

Maintenance dose:

50mg daily.

Naltrexone can also be given at extended intervals up to 72 hours by increasing the dose as follows:

24 hour interval – 50mg 48 hour interval – 100mg 72 hour interval - 150mg

The naltrexone SPC states:

"*The dosage-regimen can (therefore) be modified in order to improve compliance to a three-times-a-week dosing schedule as follows:*
administration of 2 tablets (=100 mg naltrexone hydrochloride) on Monday and on Wednesday and 3 tablets (=150 mg naltrexone hydrochloride) on Friday"

Duration of Therapy

The evidence base does not offer clear guidance as to the duration of therapy. The prescription should be reviewed at least monthly within secondary care for the first 6 months to assess efficacy. Following this, the patient should be seen by the prescriber at 6-monthly intervals. The prescription may be continued if the patient remains abstinent and feels that naltrexone continues to be helpful in maintaining this.

Baseline assessment and ongoing monitoring – by Specialist

If there is a history of opiate dependence:

There must be clear evidence of abstinence from opioids for 7 -10 days. If there is uncertainty about abstinence, naltrexone should be started after screening for opioids by firstly obtaining a negative urine dipstick for opioids then administering a short acting opiate blockade (e.g. naloxone) to screen for the presence of opioids as follows:

- Administer naloxone 400mcg IM

- Observe for 30 minutes
- If any evidence of opiate withdrawal (including anxiety and sweating) do not proceed. Reassess or repeat the following day

If abstinence from opioids is longstanding and the prescribing doctor is confident of the patient's informed consent, naltrexone may be commenced without a naloxone challenge.

Liver Function Tests:
LFTs are recommended before therapy to exclude significant liver disease. There is no existing literature which identifies an exact cut-off in terms of liver function. In most cases liver function abnormalities, whether due solely to alcohol misuse or other conditions such as chronic HCV infection, are likely to deteriorate if heavy drinking continues. Therefore in the context of non-severe liver function abnormality (i.e. using Child-Pugh Classification system to grade liver impairment, patients must be grade A or below (scores < 5)), particularly where other treatments have failed, the decision to prescribe should be based on a discussion of the risks and benefits with the patient and informed consent obtained.

NICE CG 115 recommends that patients should be reviewed at least monthly for the first 6 months and subsequently at reduced intervals if the drug is considered to be effective and continued.

GP / Community Team or other Primary Care monitoring responsibilities

NICE does not recommend routine blood monitoring however raised LFTs have reported at 100mg+ doses, and manufacturers' SPCs states that liver function abnormalities have been reported in the elderly and obese patients (see http://www.medicines.org.uk/emc/).

Monitoring can be considered for older people, those with obesity, and monitoring recovery of liver function possibly as a motivational aid for some patients to show improvement.

Consultant / Specialist prescribing responsibilities

Naltrexone therapy should be initiated in secondary care. The mechanism of action and expected effects and side effects and duration of therapy should be explained to the patient using the NRP (or equivalent) Patient Information Leaflet.

GP prescribing responsibilities

The patient's GP may be asked to take over the prescription for naltrexone after 4 weeks of abstinence (e.g. post detoxification).

Indications for referral back to Specialist

Naltrexone should be stopped and the patient referred back to the local specialist alcohol treatment agency if the patient fails to maintain abstinence or if significant liver impairment develops

Further information and supporting documents

Child-Pugh Classification System

		Scores	
	1	**2**	**3**
Ascites	Absent	Slight	Moderate
Encephalopathy grade	None	1-2	3-4
Bilirubin (umol / L)	< 34	34-51	> 51
Albumin (g /L)	> 35	28-35	< 28
Prolongation of Prothrombin time (sec)	1-4	4-6	> 6

By summing the scores appropriate grade or classification can be determined. Continuing down the table and adding up the total score, the grade (A, B or C) of liver impairment can be determined.
Grade A = 5-6; Grade B = 7-9; Grade C = 10-15

Author(s) and Organisation	• Dr Hayley Pinto, Andrea Nunney – Norfolk Recovery Partnership (NRP), Norfolk & Suffolk NHS Foundation Trust • Transferred to new template by Jen Carroll, TAG Lead Technician, NWICB
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Document history:

Version	Date	Author / Editor	Status	Comment
1.	28/3/12	Dr Hayley Pinto, Consultant Psychiatrist, Trust Alcohol & Drugs Service (TADS), Norfolk & Suffolk Foundation Trust / Fiona Marshall	Superseded	Final version agreed with authors post March 2012 TAG meeting and confirmed by TAG Support Group
2.	March 2014	Dr Hayley Pinto, Consultant Psychiatrist, Trust Alcohol & Drugs Service (TADS), Norfolk & Suffolk Foundation Trust / Fiona Marshall	Superseded	No changes recommended by the author – continued use supported by the TAG March 2014.
3.0	August 2016	Dr Hayley Pinto, Consultant Psychiatrist, (others TBC) Trust Alcohol & Drugs Service (TADS), Norfolk & Suffolk Foundation Trust / Fiona Marshall, NEL CSU Anglia	Draft for consultation	Headers and footers updated into current TAG SCA template. General information on the principles of share care Text stating that use to support abstinence in AUD is unlicensed highlighted for removal since is now licensed.

				Suggested dosage regimen for 3 times weekly administration added. Hyperlinks to the manufacturer's SPC, the BNF and the Choice and Medication website added. NSFT Medicines Helpline service times updated in line with the Trust website. Author names TBC.
3.1	October 2016	As per 3.0	Draft for consideration by the TAG	Comments version 3.0 received from Andrea Nunney, Lead Clinical Pharmacist, Acute Services, NSFT, for consideration by the TAG - Nov16
3.2	November 2016	Dr Hayley Pinto, Andrea Nunney – Norfolk Recovery Partnership (NRP), Norfolk & Suffolk NHS Foundation Trust / Fiona Marshall, NEL CSU (Anglia)	Final	Recommendations from AN and HP supported by the TAG and incorporated into the final version.
4.0	Aug 2021	Jen Carroll, TAG Lead Technician	FINAL	Discussed at August 2021 TAG meeting. Review dates extended for a year from meeting due to covid pressures
5,0	March 2024	Jen Carroll, TAG Lead Technician	Final	SCA moved to new template ready for publication on KNoW. Content not yet reviewed but remains current