The New England Comparative Effectiveness Public Advisory Council

An Action Guide for Management of Opioid Dependence: Next Steps for Clinicians

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Completed by:
The Institute for Clinical and Economic Review

Introduction

About this Guide

Evidence from clinical effectiveness reviews is critical to judgments that patients, clinicians, and health insurers must make about treatment choices and coverage policies. Yet that evidence is often not translated in a way that is helpful to inform health care decisions. This document is a companion policy guide designed to help clinicians working with patients with opioid dependence make use of the results from a recent evidence review and meeting results, titled "Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options". This report formed the basis for the deliberations and votes of the New England Comparative Effectiveness Public Advisory Council (CEPAC) – an independent body composed of physicians, methodologists, and patient/public members that meets in a public, transparent forum to provide objective guidance on how information from evidence reviews can best be used by regional decision-makers to improve the quality and value of health care services.[1] The report pulls together the best available evidence on the effectiveness and value of management strategies for the treatment of opioid dependence from the published literature, findings from interviews with expert stakeholders, new survey results benchmarking the status of treatment in New England, and public testimony.

CEPAC held its meeting on management options for opioid dependence on June 20, 2014 in Burlington, VT. During the meeting, CEPAC voted on the comparative clinical effectiveness and value of different treatment approaches, and explored how best to apply the evidence to practice and policy with a distinguished Policy Expert Roundtable of patient advocates, clinical experts, and policy leaders from across New England.

This guide is intended to provide physicians with evidence-based best practices in management of patients with opioid dependence, as well as to highlight action steps that clinicians can take to improve efficiency and quality of patient care. The content provided here is for informational purposes only, and it is not designed to replace professional medical advice.

About ICER and CEPAC

The Institute for Clinical and Economic Review (ICER) is an independent non-profit health care research organization dedicated to improving the interpretation and application of evidence in the health care system. The New England Comparative Effectiveness Advisory Council (CEPAC) is one of ICER's two core programs. CEPAC is a regional body whose goal is to provide objective, independent guidance on the application of medical evidence to clinical practice and payer policy decisions across New England. Backed from a consortium of New England state health policy leaders, CEPAC holds public meetings to consider evidence reviews of a range of topics, including clinical interventions and models for care delivery, and provides judgments regarding how the evidence can best be used across New England to improve the quality and value of health care services. ICER manages the day-to-day operations of CEPAC as one of its core programs designed to translate and implement evidence reviews to improve their usefulness for patients, clinicians, payers, and policymakers.

[1] For more information on CEPAC, visit: http://cepac.icer-review.org/.

Expanding treatment capacity for opioid dependence

Current provider capacity in New England is not sufficient to meet patient need for opioid dependence treatment. Access to treatment for opioid dependence is limited by a multitude of factors. Federal law restricts the dispensing of methadone to federal- and state-approved opioid maintenance programs. To dispense or prescribe buprenorphine-containing medications like Suboxone®, physicians must obtain a special waiver (DATA 2000) proving that they are adequately licensed and trained in the field of addiction medicine. Physicians with a waiver may not treat more than 30 patients with an addiction concurrently, but after one year can apply for a second waiver to treat up to 100 patients at one time.

One oft-cited reason for inadequate access to opioid dependence treatment is the inability and unwillingness of DATA 2000 waivered physicians to serve more patients with addiction. Even with excess demand for treatment, many DATA 2000 waivered physicians are not prescribing to capacity or at all. Some practices abstain from treating more patients with addiction due to insufficient resources to address the full scope of behavioral and psychosocial needs associated with substance abuse disorders, where others fear risk of diversion and potential abuse of medications. Primary care providers in particular often feel undertrained or unsupported to take on new patients with addiction. Coordinated efforts are therefore needed across New England to improve access to opioid dependence treatment for the large number of individuals who lack adequate access to high quality care options.

Action steps that should be considered to support physicians and practice groups in taking on more patients to expand access to care include:

1. Provide more resources to develop the skills and expertise of DATA 2000 waivered physicians in order to increase their capacity and willingness to serve more patients with addiction.

Training and support tools, as well as practice protocols, are provided in the table on the following page to help licensed physicians make use of evidence-based guidelines to expand their capacity to serve more patients with opioid dependence.

Clinical Tools and Training	
Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) training: provides compendium of clinical guidance and training tools on a range of topics, including: • Adherence and diversion of buprenorphine • Buprenorphine induction • Physician billing for buprenorphine treatment • Transfer of patients from methadone to buprenorphine	http://pcssmat.org/resources/essential-materials/
Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices	http://www.nrepp.samhsa.gov/
Providers' Clinical Support System for Opioid Therapies (PCSS-O) Training: provides training and educational products on the effective treatment of opioid dependence. Resources include webinars, articles and reports, online modules, training database, and phone apps for safe prescribing.	http://www.pcss-o.org/about
Precipitated Withdrawal Assessment from the National Alliance of Advocates for Buprenorphine Treatment (NAABT)	http://www.naabt.org/documents/NAABT_PrecipWD.pdf
Risk Management in Methadone Treatment	http://ireta.org/riskmanagementcurriculum
Resources for Physicians Prescribing Buprenorphine, including FAQs, billing codes, clinical guidelines, forms, and regulation information from NAABT	http://www.naabt.org/providers.cfm#pc
The American Osteopathic Academy of Addiction Medicine provides patient information, intake forms, drug accountability forms, and other resources for physicians	http://www.aoaam.org/content.php?pg=3
Resources to Assist in Buprenorphine Prescription	http://www.buppractice.com/resources?keyword_op=OR&keyword=

Policy/Practice Option: Utilizing physician assistants and nurse practitioners to increase physician-prescribing capacity

In Massachusetts, a network of office-based addiction treatment programs called Clean Slate Centers has attempted to increase the number of DATA 2000 waivered physicians prescribing at capacity. In this model, licensed prescribers work as part-time physicians who treat patients with Vivitrol® or Suboxone®. In addition to prescribing treatment, these physicians review patient charts, conduct group medical visits, and answer questions from staff regarding patient management. The model also utilizes full-time clinical and supportive staff to manage all other aspects of care, allowing physicians to increase their prescribing capacity beyond a main clinic. The goal of this approach is to "remove treatment from busy, over-stretched primary care settings, and provide the infrastructure necessary for primary care physicians and psychiatrists to collaborate with behavioral health providers and experienced full-time clinicians so that patients are able to receive the comprehensive care necessary to achieve recovery." (Substance Abuse and Mental Health Services Administration, 2012).

Policy/Practice Option: Use of technology and telemedicine to expand access to treatment

Researchers in Vermont have recently received National Institutes of Health (NIH) funding to make use of a new computerized device called the Med-O-Wheel to help patients on treatment waiting lists access some level of medication-assisted treatment. The device is for take-home use and dispenses a single dose of buprenorphine for a limited three-hour window each day, making it difficult for patients to abuse medication. The transparent back to the device also allows physicians to monitor diversion. Patients receiving buprenorphine through the Med-O-Wheel also receive telephone-based monitoring and support that provides daily check-ins, documents patient cravings, and refers patients to other needed resources. The goal of this model is to expand patient access by offering an alternative, safe delivery option for medication, thereby increasing the willingness of physicians with concerns for diversion to provide treatment.

2. Develop stronger peer networks to help organizations and specialties treating patients with addiction manage care more effectively.

Provider organizations and clinical societies may consider developing or utilizing existing peer networks to help organizations and specialties treating patients with addiction manage care more effectively. Existing peer support networks and mentorship programs are included in the table below:

Physician Peer Support	
Find a mentor or apply to become one	http://pcssmat.org/mentoring/
Substance Abuse and Mental Health Services Administration (SAMSHA) Physicians FAQs about prescribing buprenorphine	http://buprenorphine.samhsa.gov/faq.html
State of NY: Resources for Physicians Treating Patients with Opioid Dependence	http://www.health.ny.gov/publications/1075/index.htm
SAMSHA online discussion for DATA 2000 waivered physicians	http://bup-webboard.samhsa.gov/login.asp

3. Revise highly restrictive entry criteria for some medication-assisted treatment programs that add another barrier to entry for patients.

The highly restrictive entry criteria for some MAT programs add another barrier to entry for patients and should be revised to improve access to pharmacotherapy options. For example, some federally-qualified health centers (FQHCs) impose rules that prohibit practices from treating patients that do not already receive care within the FQHC, greatly limiting the number of providers available to patients with opioid dependence.

4. Screen for opioid addiction in primary care settings in order to support early interventions for recovery.

As the first point of medical contact for many individuals, it is important for primary care providers to be appropriately trained and equipped to identify patients with opioid dependence and refer them to treatment. Trainings are available to assist primary care physicians in effectively screening, referring, and communicating with patients about opioid dependence. Consideration should also be given to screening for opioid dependence in emergency room settings. Resources are available in the table on the following page.

Training and Skill Building for PCPs	
Improve clinical skills in screening, brief interventions, and referral to treatment for substance use problems (CME credit available)	http://www.sbirttraining.com/
National Institute on Drug Abuse (NIDA) Quick Screen Tool	http://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf
Referring Patients to Addiction Specialists	http://www.buppractice.com/howto/refer/talking
Talking to Patients About Sensitive Topics: Communication and Screening Techniques for Increasing the Reliability of Patient Self-Report	http://www.drugabuse.gov/nidamed/centers-excellence/resources/talking-to-patients-about-sensitive-topics-communication-screening-techniques-increasing
Talking with Your Adult Patients About Alcohol, Drug, or Mental Health Problems	http://store.samhsa.gov/product/Talking-with-Your-Adult-Patients-about-Alcohol-Drug-and-or-Mental-Health-Problems/SMA12-4584
Knowing What to Say When Transitioning Patients from Opioid Therapy, NIDA Center for Excellence	http://www.drugabuse.gov/nidamed/centers-excellence/resources/knowing-when-to-say-when-transitioning-patients-opioid-therapy
Find a DATA 2000 waivered physician for referral	http://www.buprenorphine.samhsa.gov/bwns_locator/index.html

Individualizing Patient Care

Clinicians should individualize treatment, including decisions about medication choice, counseling, and supportive social services, according to an initial assessment of a patient's baseline severity and unique health care needs. **For most patients, medication-assisted maintenance therapy will be more effective than attempts at short-term managed withdrawal**. However, short-term managed withdrawal may be a reasonable consideration for a subset of patients with relatively short-term histories of addiction and less intravenous opioid use.

Action steps that should be considered for individualizing patient treatment:

5. Use the results of a patient's initial assessment and evaluation to determine the medication selected for treatment.

There is no "one size fits all" approach to treatment of opioid dependence, and treatment programs should be tailored to meet the specific needs of each patient. A comprehensive assessment can determine a patient's overall health risk; presence of co-morbid disorders or conditions, including chronic pain or co-occurring substance abuse; social and behavioral challenges; and extent of dependence. Understanding these factors will help clinicians adequately refer patients to necessary services and develop a treatment plan tailored to meet each patient's individual needs. Clinicians providing the initial assessment should be qualified and adequately trained in addiction disorders. In patients who have had previous treatment success using a given medication, use of the same medication is recommended. In general, the following guidelines can be considered in choosing which treatment plan is best for a patient:

- Methadone may be most suitable for patients with **higher opioid tolerance, longer histories of use, and unstable living situations**.
- Buprenorphine-containing medications may be a suitable first-line treatment option for individuals with **mild-to-moderate levels of dependence and greater life stability** who require less treatment oversight.
- Naltrexone may be an effective first-line treatment option for individuals with **short histories of opioid use who access treatment early**.

While these generalizations provide some guidance, they are not set criteria for treatment. A patient may have all of the characteristics that would suggest success using one medication but be better suited to a different treatment, while some patients may have great success on a given treatment without having any of the characteristics typically associated with that option. Individualizing treatment as much as possible is critically important for success.

The following table includes information and resources about the various pharmacological options for opioid dependence, as well as guidance for conducting a patient assessment.

More Information about Medication Assisted Therapy	
Medication Assisted Treatment for Opioid Addiction, Substance Abuse and Mental Health Services Administration (SAMHSA)	http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214
Clinical Guidelines for Treatment of Opioid Dependence, American Academy of Managed Care Pharmacy	http://www.amcp.org/data/jmcp/S14-S21.pdf
National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment	http://www.drugabuse.gov/sites/default/files/podat_1.pdf
Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, SAMHSA	http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939
Practice Guideline for the Treatment of Patients With Substance Use Disorders	http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243188&PDFSource=6
Screening, Admission Procedures, and Assessment Techniques, SAMHSA	http://www.ncbi.nlm.nih.gov/books/NBK64165/
Methadone	
Guidelines from the American Society of Addiction Medicine (ASAM)	http://www.asam.org/docs/publicy-policy-statements/1obot-treatment-7-04.pdf?sfvrsn=0
Medication Assisted Treatment -Challenges and Solutions, American Association for the Treatment of Opioid Dependence (AATOD)	http://www.aatod.org/policies/policy-statements/793-2/
Effective Strategies in Outpatient Methadone Treatment - Clinical Guidelines and Liability Prevention, Addiction Technology Transfer Center (ATTC)	http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=557&rcID=9
Strategies in Assessing Individual Impairment in Outpatient Methadone Treatment, ATTC	http://attcnetwork.org/resources/resource.aspx?prodID=558&rcID=9&regionalcenter=*&producttype=*&keywords=methadone
Buprenorphine	
ASAM's statement on the use of buprenorphine	http://www.addictioninstituteny.org/html/Buprenorphine%20in%20Opioid%20Addiction.pdf
How to become DATA 2000 waivered	http://buprenorphine.samhsa.gov/
What It's Like to Prescribe Buprenorphine	http://journals.lww.com/addictiondisorders/pages/articleviewer.aspx?year=2005&issue=09000&article=00003&type=abstract
Naltrexone	
AATOD Guidelines for use of Naltrexone	http://www.aatod.org/policies/policy-statements/aatod-guidelines-for-using-naltrexone-vivitrol-in-otps/

6. Develop evidence-based screening tools, questionnaires, or algorithms through the collaboration of specialty societies, states, and other stakeholders to help identify the most appropriate initial treatment based on individual patients' unique factors

Sample intake questionnaires and medical history and physical evaluation forms are available in the table below:

Screening and Evaluation Forms	
Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) Training Resources	http://pcssmat.org/resources/essential-materials/
Screening Questionnaires, Substance Abuse and Mental Health Services Administration (SAMHSA)	http://www.ncbi.nlm.nih.gov/books/NBK64244/
Clinical Opiate Withdrawal Scale, National Alliance of Advocates for Buprenorphine Treatment	http://www.naabt.org/documents/NAABT_PrecipWD.pdf
Screening Tools for Substance Abuse, SAMSHA	http://www.ncbi.nlm.nih.gov/books/NBK64244/

7. Base treatment plans on individual patient expectations and treatment objectives, as these will vary between patients. Involve short-term goal setting with the patient using a structured treatment protocol. Keep treatment plans flexible, as they should evolve based on a patient's level of engagement and stage of change.

Strategies for Effective Goal Setting	
Creating SMART Goals	http://www.choosehelp.com/topics/recovery/smart-goal-setting
Goal Setting for Real Life, Substance Abuse and Mental Health Services Administration	http://www.samhsa.gov/recoverytopractice/RTP-Contribution-Detail-For-Goal-Setting%20for%20a%20Real%20Life-99.aspx
Stages of Change Readiness and Treatment Eagerness Scale	http://www.ncbi.nlm.nih.gov/books/NBK64241/

Coordinating Care to Develop Comprehensive, Team-Based Care

Treatment centers in New England and across the country are considering innovative ways to allocate resources to more effectively manage the growing numbers of opioid-dependent patients. Practice groups should develop systems to triage patients entering treatment to the level of care most appropriate for their individuals needs in order to support patient-centered treatment and allow for more capacity in the system. Services across these groups should be coordinated to allow patients increased access to comprehensive care that can address the full range of co-occurring clinical, social, and environmental factors surrounding dependence. Housing support, wellness services, occupational rehabilitation, transportation, and legal support are among the social services important for patient success.

Action steps for clinicians and provider organizations to consider for increasing coordination and access to comprehensive services:

8. Develop coordinated care networks in which patients receive short-term intensive outpatient care until stabilized, and then are referred to other outpatient practices for lower levels of ongoing care and MAT in primary care settings or community-based practices.

Coordinated Care Models for Treatment of Opioid Dependence

Policy/Practice Option: Baltimore Buprenorphine Initiative

The Baltimore Buprenorphine Initiative (BBI) is a continuum of care involving outpatient treatment, medication induction, and maintenance. In a three step process, patients are started on buprenorphine in the setting of their choice: outpatient, residential, or office-based. BBI then assists the patient in obtaining insurance and other supportive services to promote recovery. Once insured and stabilized on medication, compliant patients are transferred to a physician in their community to continue receiving buprenorphine treatment.

For more information, visit the BBI website: http://bbi.bsasinc.org/aboutBBI.html#pathways

Policy/Practice Option: Vermont "Hub and Spoke" Model

Vermont is employing a coordinated system-wide model for triaging patients with opioid dependence to appropriate levels of care. The goal for this model is to support patient-centered treatment while more effectively distributing resources to allow for greater capacity in the system. Called the "Hub and Spoke" model, this system makes use of specialty treatment centers ("hubs"), as well as federally-qualified health centers, patient-centered medical homes, and other practices with physicians licensed to prescribe Suboxone® ("spokes"). Patients begin treatment for opioid dependence centrally at the "hub," where they receive a period of intense treatment composed of comprehensive assessment, MAT, and other supportive services for an initial stabilization period. Once stabilized, patients are referred outward to a "spoke" for ongoing care and maintenance with Suboxone®. Clinically complex patients may continue to receive care at the "hub," or are referred elsewhere for inpatient or rehabilitation services if more intensive care is deemed appropriate. Stable patients receive ongoing care at the "spoke," which typically involves a prescribing physician, nurse, case manager, and counselor-led care team that monitors treatment adherence, provides counseling, supports contingency management , and coordinates patient access to other recovery supports as needed. Alternatively, if patients become "unstable" at a "spoke," they can be referred to a "hub" for stabilization. This prevents patients from losing treatment by being dropped by the "spoke" physician for illicit drug use. The "hub" can stabilize patients so they can maintain MAT and if warranted transition back to the "spoke." This model is being implemented in stages and additional improvements are needed, as the average spoke maintains a small number of patients and not all licensed physicians are prescribing to capacity.

For more information: http://www.healthvermont.gov/adap/documents/HUBSPOKEBriefingDocV122112.pdf

9. Establish physician-led care teams within practice groups that allow treatment centers to provide a range of services among a shared network of providers, often within the same facility, which may help improve patient retention.

Care teams can be made up of a variety of disciplines, including addiction-certified physicians, psychologists, counselors, social workers, and other complementary practitioners that coordinate care and integrate with other medical and psychiatric services as necessary. Treatment programs that are unable to provide the full spectrum of services that opioid-dependent patients require on-site should maintain a strong referral network with local mental health providers and other social agencies, as well as a robust case management system that tracks patients' progress and helps coordinate services for them as they access treatment.

Treatment programs across New England have adopted innovative approaches to foster collaboration and integration across providers. For example, some practices require patients to sign HIPAA release forms upon admission so that practitioners can openly communicate and discuss treatment progress for shared patients. Other programs have developed a system of communication across all treating providers, requesting that primary care physicians and pain management

specialists prescribing benzodiazepines fill out information sheets that notify the addiction specialist. Finally, some practices hold weekly meetings for all care team members that discuss each patient's progress, how to prevent patient dropouts, and how services can be better integrated.

USE OF CARE TEAMS TO PROVIDE COMPREHENSIVE ADDICTION SERVICES

Policy/Practice Option: Use of medical homes to foster collaboration across health care providers and expand access to comprehensive, team-based services

Rhode Island is using a patient-centered medical home (PCMH) approach to provide comprehensive, team-based care to patients receiving MAT. Under this model, OTPs act as health home providers and assign participating patients to a health team, which may be specialized to meet their specific health care needs. Each patient is assigned a nurse and case manager to provide ongoing monitoring, assistance with referrals, development of care plans, recovery support, and support for transition between levels of care. The goal of this model is to support stronger, formalized relationships between OTPs, which have daily contact with patients, with community health care providers in order to provide comprehensive treatment for patients with dependence using MAT.

Dosing and Tapering of Medication

Clinical strategies for dosing and tapering of medication-assisted therapy should adopt an individualized approach that engages the patient in setting goals.

Action steps for dosing and tapering medication that physicians may consider:

10. Avoid standardized treatment cut-offs and individualize treatment to the extent possible.

For patients receiving MAT, no standardized approach for dosing and tapering will work for all patients, and therefore the level at which patients receive medication must be individualized. Experts acknowledged that though clinicians generally do not want to keep patients on medication indefinitely, there is little consensus on whether or how best to taper patients off maintenance therapy. Standardized treatment cut-offs are often regarded as counterproductive and even dangerous, and experts reported that even when patients taper and attempt to withdraw from MAT, many ultimately go back on medication or relapse to illicit drug-seeking behaviors.

Resources on deciding when your patient is ready to try a taper and on how to initiate a taper are provided in the table below.

Resources for Initiating a Taper	
Tapering and Discontinuation of Patients from Buprenorphine	http://www.buppractice.com/howto/induction/taper
Tapering Off of Methadone Maintenance: Evidence-Based Guidelines	http://www.aegisuniversity.com/Aegis%20Documents/Tapering%20off%20of%20Methadone%20Maintenance%205-24-02.pdf
Phases of Treatment: Tapering	https://knowledgex.camh.net/amhspecialists/specialized_treatment/methadone_maintenance/Documents/methadonemt_counsch10.pdf

11. Engage patients in determining their readiness to attempt a taper, and frequently re-assess their readiness to decide if the taper should be halted or reversed.

Patient engagement is critical to assess whether a patient is ready and has the support necessary to attempt tapering.

With patient engagement, some programs have had success implementing a gradual tapering strategy that slowly weans patients off medication over the course of several months. Ongoing re-assessment is necessary, with flexibility to halt or reverse the taper as needed. Tapers tend to be most successful in patients with less severe dependency who have a supportive environment (e.g., stable relationships and living environment, active employment, etc). Other programs have suggested that keeping patients unaware of where they are in dosing can also be helpful.

Assessing Readiness for Taper	
Centre for Addiction and Mental Health Tapering Readiness Inventory	https://knowledgex.camh.net/amhspecialists/specialized_treatment/methadone_maintenance/Documents/mmt_tapering_readiness_inven_appf.pdf
Tapering Readiness Inventory from the Center for Substance Abuse Treatment	http://www.danyalearningcenter.org/bup/pdf/Tapering_Inventory.PDF

12. Naltrexone may be a helpful tapering tool when used in appropriate patients.

Naltrexone can be a crucial tool for preventing relapse after a successful taper, as it blocks the patient's ability to feel "high." However, only a limited number of patients are good candidates for naltrexone given the requirements to be opioid-free for at least 7 days. Ideal candidates for taper with this therapy tend to be patients that have lower severity baseline dependence, higher psychosocial stability, and a non-using social network. It is important to note when prescribing this treatment that patients using Naltrexone are often at high risk of relapse. It is recommended that patients are provided with resources to remain in contact with a doctor after the taper is completed so that they can easily get in touch with an addiction specialist if they feel they are at risk of relapse.

Guidelines for the Use of Naltrexone	
American Academy for the Treatment of Opioid Dependence (AATOD) Guidelines for Use of Naltrexone in OTPs	http://www.aatod.org/policies/policy-statements/aatod-guidelines-for-using-naltrexone-vivitrol-in-otps/
Guidance from the Centre for Addiction and Mental Health	https://knowledgex.camh.net/primary_care/toolkits/addiction_toolkit/opioid_toolkit/Pages/how_prescribe_naltrexone.aspx
Substance Abuse and Mental Health Services Administration (SAMHSA) Naltrexone Information	http://www.dpt.samhsa.gov/medications/naltrexone.aspx