This fact sheet outlines how AIDS Drug Assistance Programs (ADAPs) can support substance use treatment medications and related services for the clients they serve. It also provides drug-specific information for medications that are most frequently used as part of substance use treatment.

Substance Use Treatment Needs among PLWH

Substance use disproportionately impacts people living with HIV (PLWH), posing challenges in terms of the overall effectiveness of their HIV care and treatment as well as their broader health. In addition to deleterious effects on HIV-specific health outcomes, they must also contend with risks of overdose and death from overdose, a common cause of non-AIDS-related death among PLWH. Yet individuals with substance use disorders may not seek treatment for these issues because of inadequate screening, stigma, or a lack of available and adequate services.

When used in combination with behavioral therapy, substance use treatment medications allow individuals to manage addiction or dependency by reducing their risk for overdose, cravings and/or symptoms of withdrawal. For PLWH who use substances, these treatments bolster multiple “bars” within the HIV care continuum, including adherence to antiretroviral (ARV) treatment and viral load suppression. Substance use treatment medications fall into the following categories: (1) overdose prevention; and/or (2) medication assisted treatment (MAT). While they are most frequently prescribed for treatment for alcohol and opioid dependency, substance use treatment medications may also be used as stimulant substitution therapy (e.g., cocaine, methamphetamine).

Many substance use treatment medications require: regular and close monitoring by a prescribing physician; laboratory testing to manage symptoms, dosage, and side-effects; and access to broader substance use, mental health, and psychosocial support services. ADAPs should work in concert with other entities, including Ryan White Part B services, to ensure comprehensive access to substance use treatment medications and related services for their clients who need them.
Use of Ryan White Part B and ADAP Funds to Expand Access to Substance Use Treatment

Beyond the provision of ARVs, ADAPs play a critical role in supporting the availability of medications for many co-morbid conditions that may impact PLWH, including substance use treatment medications. The Ryan White HIV/AIDS Program Section 2616(c)(6) of the Public Health Service Act contains language that places the following requirements on ADAP formularies: (1) ADAP formularies must include at least one drug from each class of HIV antiretroviral medications; (2) ADAP funds may only be used to purchase medications approved by the Food and Drug Administration (FDA) or devices needed to administer them; they must be consistent with the Department of Health and Human Services’ (HHS) Adolescent and Adult HIV/AIDS Treatment Guidelines; and all treatments and ancillary devices covered by the ADAP formulary, as well as all ADAP-funded services must be equitably available to all eligible/enrolled individuals within a given jurisdiction. ADAPs’ inclusion of treatment medications for co-occurring conditions demonstrates a commitment to addressing the full health needs of the clients they serve. As of December 31, 2015, 14 ADAPs covered one or more FDA-approved substance use treatment medications on their formularies.

In May 2016, HRSA released guidance regarding federal funding to support syringe services programs (SSPs). Highlights of HRSA’s guidance include:

- In order to reallocate funds, documentation of the CDC Jurisdictional Eligibility Finding as well as a letter signed by the state health officer which states that SSP operation is lawful.
- All FY2016 federal notices of awards (FOAs) can potentially be used for SSP and future FOAs will include whether or not SSP can be funded.
- Ryan White HIV Program funds can be used for SSP as long as the SSP is comprehensive and serves people living with HIV.
- Applications require health department support.

ADAPs cannot, in isolation, cover or pay for the full breadth of costs associated with these vital medications, however. As detailed in Health Resources and Services Administration’s (HRSA) Policy Notice 10-02, outpatient and residential substance use treatment are considered a core medical and supportive service, respectively, under the Ryan White HIV/AIDS Program. Outpatient substance use treatment services for which Ryan White Program funds may be allowable include: pre-treatment/recovery readiness programs; harm reduction; mental health counseling to reduce depression, anxiety, and
other disorders associated with substance use; outpatient drug-free treatment and counseling; opiate MAT (e.g., methadone); neuro-psychiatric pharmaceuticals; and relapse prevention. All services must be provided by a physician or under the supervision of a physician or other qualified/licensed personnel.

The Impact of the Affordable Care Act (ACA)

Passed prior to the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act of 2008 ensures that financial requirements (e.g., co-payments, deductibles) and treatment limitations (e.g., visit limits) for mental health or substance use are no more restrictive than the those for all other medical and surgical benefits.

The ACA builds on the Parity Law by requiring coverage of mental health and substance use disorder benefits in the individual and small group markets which currently lack these benefits, and expanding parity requirements to those with coverage that did not previously comply with those requirements. For ADAP clients enrolled in qualified health plans (QHPs), this presents an enormous opportunity for them to access the full breadth of services necessary to receive holistic care and to successfully achieve viral load suppression.

Substance Use Treatment Medications: Drug-Specific Information

The following are the most commonly prescribed medications used to substitute and relieve drug and alcohol dependency and symptoms as well as reverse adverse drug effects. Sources used to inform this fact sheet include the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Library of Medicine, and drug manufacturers.

Acamprosate calcium (Campral): Campral is an FDA-approved medication for the treatment of post-withdrawal alcohol dependence. It is prescribed by a medical provider with a suggested one-year regimen of two pills, three times daily. It is most effective when combined with either naltrexone or disulfiram as well as with psychosocial supportive services. Campral is not metabolized by the liver and therefore should be prioritized for ADAP clients who are co-infected with hepatitis C (HCV) or other liver diseases.
**Buprenorphine (Subutex):** Buprenorphine is an MAT and a partial opioid agonist tablet used to treat opioid dependence and symptoms of withdrawal. It is available as a generic or under its brand name (Subutex). Buprenorphine carries a lower risk of abuse, addiction, and side effects compared to full opioid agonists such as heroin and methadone. It can either be used for long-term maintenance or short-term use and is often co-prescribed with naloxone. It is prescribed by a provider and can be taken outside of the clinical setting daily. Providers may initially require counseling and urinary analysis during multiple clinical visits as they monitor and determine the appropriate maintenance dose for the patient. Buprenorphine can be difficult to access because very few providers feel comfortable prescribing and monitoring its use. Also, there are regulatory caps on the number of patients a prescribing provider can treat (30 for the first year following certification and 100 annually thereafter).

**Buprenorphine, naloxone (Suboxone):** Suboxone is a sublingual pill used as an opioid MAT. Unlike Subutex, Suboxone also contains the opioid antagonist, naloxone, which prevents opioid overdose among patients who inject Suboxone, in an attempt to achieve a high. The patient will therefore go into immediate and severe withdrawal.

**Dextroamphetamine (Adderall):** Currently, the FDA has not approved the use of any medication as a MAT for stimulants, e.g. methamphetamine. Yet studies show that stimulant agonists like dextroamphetamine (Adderall), approved to treat attention deficit and hyperactivity disorder (ADHD), is sometimes used off-label to reduce cravings and withdrawal symptoms for stimulants.

**Diazepam (Valium):** Diazepam (Valium), is benzodiazepine used to treat anxiety. It is sometimes prescribed off-label to treat withdrawal from alcohol, stimulants, and other substances. Benzodiazepines depress nerve-cell activity in the brain and relieve life-threatening withdrawal symptoms including seizures. Providers prescribe diazepam to patients during the initial withdrawal period. It is recommended for short-term use for up to four months. It can be dangerous in combination with alcohol and opioids since depressants suppress the central nervous system.

**Disulfiram (Antabuse):** Disulfiram is the most widely recognized alcohol treatment medicine. It is an alcohol antagonist, blocking receptors in the brain which metabolize alcohol. Ingesting alcohol while taking disulfiram will also cause a person to become violently ill, inducing vomiting, shaking, and blurred vision. Disulfiram is prescribed by a provider and is taken once daily. It is more easily accessible through primary care settings than other forms of MAT. It is toxic to the liver and therefore requires frequent tests for
liver functioning and may not be appropriate for ADAP clients who are co-infected with HCV.

\[\text{Librium: Librium is an extended-release benzodiazepine which is sometimes prescribed off-label to treat withdrawal from alcohol, stimulants, and other substances. As an extended-release formulation, librium may be used for longer-term use than diazepam (Valium).}\]

\[\text{Methadone: Methadone, a narcotic analgesic, is the most widely recognized opioid MAT. It can be used to reduce pain and to relieve opioid withdrawal symptoms. Dosage depends on a person’s body weight and opiate tolerance. It is most commonly prescribed in oral solutions (as a liquid or a powder), but is also available in tablet and injectable form. Methadone requires daily adherence. “Methadone maintenance” refers to the long-term nature of this treatment and the system through which an individual must access it. Methadone maintenance is delivered via registered methadone maintenance clinics. Participation in a methadone maintenance clinic program leads to reduced or ceased opioid injection, which in turn reduces a client’s risk for HCV and other comorbidities. ADAPs should be aware that many methadone clinics require a client to have insurance coverage.}\]

\[\text{Modafinil – extended release (Provigil): Modafinil is a narcolepsy medication. The FDA has not approved the use of any medication as a MAT for stimulants, e.g. methamphetamine. Yet like dextroamphetamine (Adderall), modafinil is sometimes used off-label daily as a stimulant MAT. It does not cause euphoria and has a low abuse potential. Studies show that extended release Modafinil reduces cocaine cravings and increases periods of abstinence.}\]

\[\text{Naloxone (Narcan) – Injectable and Intranasal: Naloxone is an opioid antagonist that is administered to someone experiencing an opioid overdose. Naloxone temporarily occupies the dopamine receptors for 30 - 90 minutes, allowing the person experiencing the opioid overdose to immediately enter withdrawal and regain normal respiratory functions. After the naloxone wears off, the high or overdose will continue. Naloxone is suggested to be prescribed and carried in two doses. It only need be administered in the case of an overdose and does not have any adverse side effects. Naloxone is available in injectable, intranasal, and auto-injector form.}\]

\[\text{Injectable naloxone is to be injected directly into the muscle. A provider or pharmacist who dispenses the naloxone is required to give the recipient training on how to use the}\]
medication. It is important to note that due to the nature of overdose, a person is rarely able to use the medication on themselves. Rather, they will use it on someone else who is experiencing an overdose or someone else will use it on them. Injectable naloxone comes in vials and requires a 25+ gauge 1.5-inch syringe to be effective. **ADAPs should consider covering a client's injectable naloxone syringes or referring clients to a syringe services program (SSP) that will provide their syringes free of charge.**

Naloxone is also available in an intranasal form as it is **absorbed quickly** through nasal membranes. Intranasal naloxone is as effective as intravenous naloxone, although the intranasal device requires two more steps to assemble before use. **Intranasal naloxone is important to keep on ADAP formularies for clients who feel uncomfortable using syringes or who do not have ready access to syringes.** Intranasal naloxone requires the use of an atomizer which does not have a billing reimbursement code. **If the atomizer cannot be covered, an ADAP might consider prioritizing either intramuscular or auto-injector forms of naloxone.** An FDA-approved naloxone nasal spray has also recently become available.

**Naloxone Auto-Injector (Evzio):** Evzio is a hand-held auto-injector that is an alternative to other forms of naloxone which require assembly. Evzio provides step-by-step audio instructions for the user. Evzio is one form of naloxone that can currently be provided in its entirety. That is, it does not require separate syringes or atomizers.

**Naltrexone – Injection (Vivitrol):** As an opioid antagonist, naltrexone blocks the dopamine receptors in the brain so that a person does not crave opiates and cannot feel pleasure or euphoria when using opiates. Naltrexone can also be used as **alcohol MAT** as it reduces alcohol cravings and consumption. Naltrexone should be used in combination with comprehensive substance use treatment and psychosocial support services.

Vivitrol is an extended-release injectable form of naltrexone that is administered once a month and is ideal for persons who are primarily abstinent from opioids. If clients relapse and use opioids, Vivitrol may increase their risk of overdose. Vivitrol can also reduce liver function and therefore may not be appropriate for clients who are co-infected with HCV. It has been used as MAT within and upon release from jails and prisons.

**Naltrexone – Oral (Revia, Depade):** Revia and Depade are both oral forms of naltrexone that are taken once daily. Similar to Vivitrol, Revia and Depade should be prescribed to clients who have access to comprehensive substance use treatment and psychosocial support services.
Topiramate: Topiramate is an anti-seizure and migraine medication that is sometimes used off-label as alcohol MAT. Unlike other alcohol MAT, topiramate can begin to be taken while a client continues to consume alcohol. Topiramate has the added effect of acting as a partial alcohol antagonist reducing psychological symptoms associated with alcohol withdrawal and early recovery. Topiramate is important to keep on ADAP formularies for clients who would like to slowly withdraw from their alcohol use. Studies show that it is associated with reduced rates of relapse and longer periods of alcohol abstinence, which have been associated with improved HIV treatment outcomes.

Resources:

- NASTAD (National Alliance of State & Territorial AIDS Directors)
  - www.NASTAD.org
    - NASTAD – Health Care Access
    - NASTAD – Drug User Health
    - National ADAP Monitoring Project Annual Report
    - National ADAP Monitoring Project Formulary Database
    - Maximizing Health, Minimizing Harm: The Role of Public Health Programs in Drug User Health
    - Modernizing Public Health to Meet the Needs of People Who Use Drugs
- Food and Drug Administration
- HRSA HIV/AIDS Bureau
- HRSA TARGET Center – technical assistance for the Ryan White community
- Ryan White HIV/AIDS Treatment Modernization Act (2009)
- U.S. National Library of Medicine (Drug Information and Research)
- Substance Abuse and Mental Health Services Administration (SAMHS)
  - Implementation of the Mental Health Parity and Addiction Equity Act
- The Center for Consumer Information & Insurance Oversight (CCCIIO) – The Mental Health Parity and Addiction Equity Act