Treatment Options

- Clinicians should inform patients with alcohol use disorder (AUD) about all available pharmacologic and behavioral treatment options and all available treatment settings, including outpatient primary care and addiction specialty treatment (intensive outpatient, inpatient, and residential treatments). (A3)

Choosing a Treatment Option

- Clinicians should recommend pharmacologic treatment for individuals with moderate-to-severe AUD (see inside *Table 1: Pharmacologic Treatment of Alcohol Use Disorder in Nonpregnant Adults*). (A1)
  - Clinicians should recommend oral acamprosate or oral or injectable extended-release (XR) naltrexone as the preferred medications for treating AUD. (A1)
- Clinicians and patients should choose a pharmacologic agent based on: (A3)
  - Evidence-based recommendations.
  - Ease of administration.
  - Available formulations.
  - Adverse effects.
  - Presence of medical conditions (e.g., hepatic or renal disease, conditions that require treatment with opioids).
  - Comorbid psychiatric conditions (e.g., depression, anxiety) and/or substance use disorders (e.g., opioid use disorder, tobacco use disorder).
  - Presence of specific features of AUD (e.g., craving).
  - Patient preference.
- Clinicians should recommend behavioral treatment for individuals with AUD. (A1)

Managing Withdrawal Syndrome

- Before treating patients with alcohol use disorder (AUD), clinicians should assess the need for withdrawal management and (A3):
  - Manage mild to moderate withdrawal syndrome in an outpatient setting.
  - Refer patients with severe withdrawal syndrome or other complicating conditions for inpatient management.

Initiating Pharmacologic Treatment

- **PREFERRED: Acamprosate:** For use if patients have the treatment goal of either reduction of or abstinence from alcohol use.
  - Clinicians should perform serum creatinine clearance (CrCl) testing before initiating treatment with acamprosate (A3); if CrCl is between 30 and 50 mL/min or estimated glomerular filtration rate (eGFR) is between 30 and 59 mL/min/1.73 m2, clinicians should adjust the dose according to prescribing information or choose another medication. (A2)
  - Contraindication: Clinicians should not prescribe acamprosate for patients with a CrCl <30 mL/min or eGFR <30 mL/min/1.73 m2. (A2)
  - For the best treatment response, clinicians should initiate treatment with acamprosate as soon as a patient has abstained from alcohol use and within 7 days. (A3)
- **PREFERRED: Oral or injectable Long-Acting Extended-Release (XR) Naltrexone:** For use if patients have the treatment goal of either reduction of or abstinence from alcohol use.
  - For patients with AUD who also use opioids, clinicians should administer a naloxone challenge and confirm that the patient has no reaction to ensure that opioids have been cleared from the system (see the *NYSDOH AI guideline Treatment of Opioid Use Disorder > Implementing Opioid Use Disorder Treatment*). (A2)
  - Before initiating treatment with injectable XR naltrexone, clinicians should prescribe an oral trial of naltrexone (50 mg once daily for at least 3 days) to assure that the patient tolerates the medication. (A3)
  - Clinicians should recommend XR naltrexone if adherence to an oral regimen is a concern. (B3)
  - Because active alcohol use is not a contraindication to naltrexone, clinicians should initiate naltrexone even if patients continue to use alcohol. (A1)
  - **Contraindications:** Clinicians should not prescribe naltrexone for individuals with acute hepatitis or liver failure; individuals taking opioid analgesics; individuals currently physically dependent on opioids, including those currently maintained on opioid agonists (e.g., methadone) or partial agonists (e.g., buprenorphine); or individuals in acute opioid withdrawal. (A2)

Initiating Pharmacologic Treatment, *continued*

- **ALTERNATIVE: Disulfiram:** For use if patients have the treatment goal of abstinence from alcohol use.
  - Clinicians should consider disulfiram for individuals with AUD who have not responded to or are intolerant of naltrexone or acamprosate, or who may prefer disulfiram. (A3)
  - Clinicians should advise patients that they should not take disulfiram until they have been abstinent from alcohol for 12 hours or longer. (A3)
  - Clinicians should emphasize the importance of avoiding alcohol consumption in all forms to patients taking disulfiram. (A3)
  - Clinicians should perform baseline liver function testing, including aspartate aminotransferase (AST)/alanine aminotransferase (ALT) levels, before initiating disulfiram treatment. (A3)
    - In patients with AST/ALT levels >3 to 5 times the upper limit of normal, clinicians should avoid treatment with disulfiram. (A3)
    - Clinicians should repeat liver function testing at least monthly during the first 3 months of treatment and every 3 months thereafter while the patient is taking disulfiram. (A3)
    - Clinicians should discontinue disulfiram treatment in any individual with signs or symptoms of acute hepatitis or acute liver failure. (A3)
  - **Contraindications:** Clinicians should not prescribe disulfiram for patients who have recent or concomitant use of metronidazole, paraldehyde, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics); coronary artery disease; recent myocardial infarction; psychoses; or signs or symptoms of acute hepatitis or acute liver failure. (A2)
- **ALTERNATIVES: Gabapentin or Topiramate:** For use if patients have the treatment goal of reducing or abstaining from alcohol use. Clinicians should consider gabapentin or topiramate for individuals with AUD who have not responded to or are intolerant of naltrexone or acamprosate, or who may prefer gabapentin or topiramate. (A3)

HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

VISIT **HIVGUIDELINES.ORG** TO LEARN MORE OR VIEW COMPLETE GUIDE

TREATMENT OF ALCOHOL USE DISORDER (AUD)

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE OCTOBER 2020

Goals of Treatment: A traditional goal of treatment for AUD is long-term cessation of alcohol use. Because this goal may not be achievable for many individuals, alternative goals can lead to substantial improvements in the health and lives of those with AUD. Such alternatives may include:

- Staying engaged in care, which can also facilitate prevention, diagnosis, and treatment of other conditions.
- Reducing alcohol use.
- Reducing high-risk behaviors (e.g., driving while intoxicated, alcohol-related unprotected sex).
- Improving quality of life and other social indicators, such as employment, stable housing, and risk of incarceration.
- Improving mental health.

As with other chronic conditions, treatment goals for AUD should be individualized and are likely to change over time. It is important for healthcare providers and patients to discuss, agree on, and review AUD treatment goals regularly. If patients are unable to meet treatment goals, intensifying treatment with frequent visits, behavioral interventions, mental health assessment and treatment, and adjustment of dose or type of medication may be warranted.

← Use this code with your phone's QR code reader to go directly to a mobile-friendly version of the guideline.

This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline *Treatment of Alcohol Use Disorder (AUD)* The full guideline is available at www.hivguidelines.org.

SELECTED GOOD PRACTICES

- Emphasize that consumption of ANY alcohol during treatment with disulfiram can result in flushing, throbbing in head and neck, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitations, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion.
- Inform patients that adverse reactions to alcohol ingestion may occur for up to 14 days after stopping disulfiram treatment.
- Advise patients to carry a wallet card or wear a medication bracelet that states they are taking disulfiram so this information will be available to emergency personnel in case of a severe adverse reaction [NIAAA 2005].
- Educate patients taking disulfiram that alcohol may be found in cough and cold medicines, mouthwashes, tonics, sauces, vinegars, and other food or skin products.

KEY POINTS

- Because gabapentin can induce a sense of euphoria [Mersfelder and Nichols 2016; Smith, et al. 2016] when taken in combination with other substances, especially opioids, benzodiazepines, or alcohol, there is the potential for misuse.
- Individuals may take gabapentin for recreational purposes, to control mood or anxiety, to intensify the effects of substance use disorder medication, or for intentional self-harm.
- If there is a strong concern about gabapentin misuse or diversion, clinicians may want to schedule monthly or more frequent follow-up visits and medication counts [Mersfelder and Nichols 2016; Smith, et al. 2016].

ALL RECOMMENDATIONS: HARM REDUCTION APPROACH TO TREATMENT OF ALL SUBSTANCE USE DISORDERS (SUDs)

Harm Reduction in Treatment of Substance Use Disorders

- For patients who use substances, whether or not they are engaging in SUD treatment, clinicians should continue to offer medical care and offer or refer for harm reduction services and counseling on safer substance use. (A3)
- For patients who inject drugs, clinicians should:
  - Provide patient education on the risks of sharing injection equipment. (A3)
  - Offer to prescribe needles and syringes. (B3)
  - Discuss other options for accessing sterile needles and syringes, including use of the *Expanded Syringe Access Program and Syringe Exchange Programs*, NYS's syringe access initiatives. (A2)
  - Follow the recommendations on providing naloxone in the NYSDOH AI guideline *Treatment of Opioid Use Disorder*.

Implementing a Harm Reduction Treatment Plan

- Clinicians should collaborate with patients to set specific treatment goals (A3); goals other than full abstinence are acceptable (e.g., changes in use resulting in increased well-being and decreased harm or potential harm). (A3)
- To assist patients in planning and reaching treatment goals, clinicians should ask about the role and effects of substance use in their daily lives. (A3)
- Clinicians and patients should decide on an appropriate level of care (e.g., venue and/or intensity) based on: (B3)
  - Medically recommended treatment for the patient's SUDs.
  - The patient's need for support and other services, such as medical and mental health care and psychosocial support.
  - Availability of care.
  - Patient preference.
- For patients with an SUD, clinicians should offer pharmacologic treatment when it is indicated. (A3)
- Clinicians should not discontinue SUD treatment due solely to recurrences or continuation of use. (A3)

Reducing Stigma

- Clinicians should examine their assumptions and decisions for any personal biases that may affect their ability to provide effective care for individuals who use substances. (A3)
- Clinicians and other staff interacting with patients should use neutral terms to describe all aspects of substance use and avoid language that perpetuates stigma (see *Box 4: Changing the Language of Substance Use: Use Neutral Terms* in the NYSDOH AI guideline, *Substance Use Harm Reduction in Medical Care*). (A2)

Table 1: Pharmacologic Treatment of Alcohol Use Disorder in Nonpregnant Adults [a]

Medication [b]	Dosage	Considerations for Use
Preferred Medications		
Acamprosate oral (Brand name: Campral)	**Initial and maintenance:** 666 mg 3 times per day.	• **Contraindication:** Patients with CrCl ≤30 mL/min or eGFR ≤30 mL/min/1.73 m2. See package insert for dose adjustments based on CrCl.
Naltrexone oral (Brand name: Revia)	**Initial and maintenance:** 50 mg once daily. If adverse events occur, clinicians can consider a reduced dose of 25 mg once daily.	• **Contraindication:** Acute hepatitis or liver failure, concomitant use of opioid analgesics or opioid agonists (e.g., methadone or buprenorphine), acute opioid withdrawal. • Abstinence from alcohol is not required for treatment. • Abstinence from opioids is required for treatment. • If possible, perform liver function testing (including AST/ALT testing) at baseline and within 12 weeks of initiating treatment. • Discontinue naltrexone in the event of symptoms or signs of impaired liver function. • Recommend the injectable formulation for patients who have problems with adherence to the oral regimen.
XR Naltrexone, long-acting injectable (Brand name: Vivitrol)	**Initial:** 50 mg oral naltrexone once daily for at least 3 days. **Maintenance:** 380 mg intragluteal injection every 28 days.	
Alternative Medications		
Disulfiram oral (Brand name: Antabuse)	**Initial and maintenance:** 500 mg once daily for 1 to 2 weeks. Reduce to 250 mg once daily.	**Contraindication:** Recent or concomitant use of metronidazole, paraldehyde, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics); coronary artery disease; recent myocardial infarction; psychoses; or signs or symptoms of acute hepatitis or acute liver failure. For all contraindications, see package insert. • Use only in patients who want to completely abstain from alcohol. • Inform patients of the disulfiram-alcohol reaction [c]; reinforce complete abstinence from any form of alcohol. • Advise patients to initiate disulfiram only after 12 hours of abstinence. • Perform baseline liver testing before initiating disulfiram treatment. • In patients with AST/ALT levels >3 to 5 times the upper limit of normal, avoid treatment with disulfiram. • Repeat liver function testing at least monthly during the first 3 months of treatment and every 3 months thereafter while patient is taking disulfiram.
Gabapentin oral (multiple brands)	**Initial:** 300 mg once daily. **Titrate**: Increase in increments of 300 mg. **Maintenance:** Up to 3,600 mg daily, divided in 3 doses; dose is based on response and tolerance.	**Caution:** Gabapentin can be used alone for psychoactive effect or in combination with other substances, including opioids, benzodiazepines, and alcohol, to intensify the effects.
Topiramate oral (multiple brands)	**Initial:** 25 mg once daily. **Titrate**: Increase dose by 50 mg increments each week to a maximum of 400 mg daily administered in 2 divided doses. **Maintenance:** 200 to 400 mg daily divided into 2 doses.	A dose reduction by half is recommended for adult patients with CrCl ≤70 mL/min or eGFR ≤70 mL/min/1.73 m2. See package insert for full prescribing information.

Abbreviation key: AST/ALT, aspartate aminotransferase/alanine aminotransferase; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate.

a. For treatment of pregnant individuals with AUD, see *American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder, Statement 14: Pharmacotherapy in Pregnant or Breastfeeding Women*.

b. Consult package insert for full prescribing information for each medication.

c. Concomitant use of disulfiram and alcohol, even small amounts, can result in the following adverse effects: flushing, throbbing in head and neck, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitations, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. Severe reactions may result in respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.