HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

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

TREATMENT OF ALCOHOL USE DISORDER

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE NOVEMBER 2023

ALL RECOMMENDATIONS P.1

Who to Treat

- Clinicians should recommend and offer pharmacologic treatment to individuals with moderate or severe AUD. (A1)
- Clinicians should recommend behavioral treatment for individuals with AUD and refer as appropriate. (A1)

Treatment Goals and Selection

- Clinicians should inform patients with 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)
- Clinicians should engage in shared decision-making with patients to set specific treatment goals, including harm reduction. (A3)
- Clinicians and patients should choose a pharmacologic agent based on evidence-based recommendations; patient preference; current level of alcohol use; experience of cravings; risk of withdrawal syndrome; available support; available formulations; potential adverse effects; dosing schedules (adherence may be increased with once-daily dosing); medical or psychiatric comorbidities that may preclude use of a specific agent or require increased monitoring, including hepatic or renal dysfunction; depression or anxiety; a concomitant SUD; and concomitant opioid use or misuse. (A3)

Alcohol Withdrawal Syndrome

- Before initiating AUD treatment, clinicians should assess the need for withdrawal management (A3). Mild-to-moderate withdrawal syndrome can be managed in the outpatient setting; severe withdrawal syndrome or other complicating conditions should be referred for inpatient management. Note: See the American Society of Addiction Medicine (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management 2020.

Follow-up

- If a patient taking acamprosate or naltrexone for AUD continues or resumes alcohol use, the clinician should continue to prescribe the medication, advise the patient to continue treatment, and discuss possible modifications to treatment goals. (A3)

Behavioral Treatment

- Clinicians should recommend behavioral treatment for patients with AUD and refer as appropriate. (A1) The type of treatment is based on the individual patient's experience and preference, social factors, treatment availability, and insurance, among other factors.

Preferred Pharmacologic Treatment

- Clinicians should recommend oral acamprosate or oral or injectable XR naltrexone as the preferred medication for AUD treatment. (A1) See Table: Pharmacologic Treatment of Alcohol Use Disorder in Nonpregnant Adults.

Acamprosate

- For the best treatment response, clinicians should initiate treatment with acamprosate as soon as patients have abstained from alcohol use and within 7 days. (A3)
- Clinicians should perform serum CrCl testing before initiating treatment with acamprosate (A3); if CrCl is between 30 and 50 mL/min or eGFR is between 30 and 59 mL/min/1.73 m², clinicians should adjust the dose according to the prescribing information or choose another medication. (A2)
- **Contraindications:** CrCl <30 mL/min or eGFR <30 mL/min/1.73 m²

Oral or Injectable Long-Acting Extended-Release Naltrexone

- Because active alcohol use is not a contraindication to naltrexone therapy, clinicians should initiate naltrexone even if patients continue to use alcohol. (A1)
- 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 ensure that patients tolerate the medication. (A3)
- Clinicians should recommend XR naltrexone if adherence to an oral regimen is a concern. (B3)

ALL RECOMMENDATIONS (continued from P.1) P.2

Oral or Injectable Long-Acting Extended-Release Naltrexone, *continued*

- **Contraindications:** Concomitant use of opioid analgesics or opioid agonists (e.g., methadone or buprenorphine), current physiologic opioid dependence, acute opioid withdrawal, reaction to a naloxone challenge test, or a positive urine test result for opioids
- For a patient with AUD who recently used opioids, the clinician should administer a naloxone challenge and confirm that the patient does not react, to ensure that opioids have been cleared from the system (see NYSDOH AI guideline Treatment of Opioid Use Disorder > Naltrexone). (A2)

Alternative Pharmacologic Treatment

- For individuals with AUD who have not responded to or are intolerant of naltrexone or acamprosate, or who prefer a different medication, clinicians should discuss and offer disulfiram, gabapentin, or topiramate. (A3) See Table: Pharmacologic Treatment of Alcohol Use Disorder in Nonpregnant Adults.

Disulfiram

- Clinicians should emphasize the importance of avoiding alcohol consumption in all forms to patients before initiating and when taking disulfiram. (A3)
- Clinicians should perform liver function testing, including AST/ALT levels before initiating disulfiram. In patients with AST/ALT levels >3 to 5 times the upper limit of normal, avoid treatment with disulfiram. (A3)
- **Contraindications:** Recent or concomitant use of metronidazole, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics). Disulfiram is contraindicated in the presence of severe myocardial disease or coronary occlusion and psychoses.

Gabapentin or Topiramate

- If gabapentin or topiramate is the agent of choice, clinicians should not require abstinence before initiation, because active alcohol use is not a contraindication to either medication. (A3)

ALL RECOMMENDATIONS (continued from P.2) P.3

BOX: GABAPENTIN MISUSE

- Gabapentin can induce a sense of euphoria when taken in combination with other substances, especially opioids, benzodiazepines, or alcohol, and there is the potential for misuse.
- Individuals may take gabapentin for recreational purposes, to control mood or anxiety, to intensify the effects of substances, or for intentional self-harm.
- Gabapentin has been increasingly associated with opioid-related overdose deaths, and caution is required when prescribing gabapentin for individuals with comorbid AUD and OUD.
- If there is a strong concern about gabapentin misuse or diversion, clinicians may want to schedule more frequent follow-up visits and medication counts.

← 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.* The full guideline is available at www.hivguidelines.org.

Table: Pharmacologic Treatment of Alcohol Use Disorder in Nonpregnant Adults

Medication	Dosage	Considerations
Preferred Medications		
Acamprosate oral (Campral)	**Initial and maintenance:** 666 mg 3 times per day	· Initiate treatment as soon as patients have abstained from alcohol use and within 7 days. · Counsel patients about the importance of adherence. · Perform serum CrCl testing before initiating treatment; adjust dose if CrCl is between 30 and 50 mL/min or eGFR is between 30 and 59 mL/min/1.73 m^2. · **Contraindications:** CrCl <30 mL/min or eGFR <30 mL/min/1.73 m^2. See package insert for dose adjustments based on CrCl.
Naltrexone oral (Revia)	**Initial and maintenance:** 50 mg once daily · If adverse effects occur, clinicians can consider a reduced dose of 25 mg once daily. · 100 mg daily has been used and well tolerated in studies.	· Abstinence from alcohol is not required for initiating and maintaining treatment. · Recommend the injectable formulation for patients who have problems with adherence to the oral regimen. · Abstinence from opioids is required for treatment. For patients who use alcohol and opioids, see recommendations in NYSDOH AI guideline Treatment of Opioid Use Disorder > Naltrexone. · Prescribe with caution in patients with abnormal liver function 3 to 5 times the upper limit of normal. The extent of liver abnormalities on baseline testing may guide continued testing or referral to an experienced liver specialist. · **Contraindications:** Concomitant use of opioid analgesics or opioid agonists (e.g., methadone or buprenorphine), current physiologic opioid dependence, acute opioid withdrawal, reaction to a naloxone challenge test, or a positive urine test result for opioids
XR Naltrexone, long-acting injectable (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 (multiple brands)	**Initial and maintenance:** 500 mg once daily for 1 to 2 weeks. Reduce to 250 mg once daily.	· Abstinence from alcohol before initiating and while taking disulfiram is required. – Advise patients to initiate disulfiram only after 12 hours of abstinence. – Inform patients of the disulfiram-ethanol reaction. – Reinforce complete abstinence from any form of alcohol. · 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. · **Contraindications:** Recent or concomitant use of metronidazole, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics). Disulfiram is contraindicated in the presence of severe myocardial disease or coronary occlusion, and psychoses.
Gabapentin oral (multiple brands)	**Initial:** 300 mg once daily **Titrate:** Increase in increments of 300 mg. **Maintenance:** Up to 3,600 mg daily, divided into 3 doses; dose is based on response and tolerance.	· Abstinence from alcohol is not required for initiating or maintaining treatment. · **Caution:** Gabapentin may be misused alone for psychoactive effect or combined with opioids, benzodiazepines, alcohol, or other substances to intensify intoxication.
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	· Abstinence from alcohol is not required for initiating or maintaining treatment. · A dose reduction by half is recommended for adult patients with CrCl ≤70 mL/min or eGFR ≤70 mL/min/1.73 m^2. See package insert for full prescribing information.

Abbreviations: ALT, alanine aminotransferase; AUD, alcohol use disorder; AST, aspartate aminotransferase; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; GI, gastrointestinal; SUD, substance use disorder; XR, extended-release.