



## Substance Use Disorders

### OVERVIEW

Specific substance use disorders (SUDs) are outlined below as defined by the American Psychiatric Association (APA):<sup>1</sup>

#### Nicotine Use Disorders

1. Pharmacological treatment is recommended for individuals who wish to stop smoking and have not achieved cessation without pharmacological agents or who prefer to use such agents. There are six medications approved by the U.S. Food and Drug Administration (FDA) for nicotine dependence, including five NRTs (patch, gum, spray, lozenge, and inhaler), varenicline, and bupropion. These are all first-line agents that are equally effective in alleviating withdrawal symptoms and reducing smoking. Any of these could be used based on member preference, the route of administration, and the side-effect profile. Significant adverse events to NRTs, including dependence, are rare. Although combined psychosocial and medication treatment produces the best outcomes in treating nicotine use disorders, these medications are effective even when no psychosocial treatment is provided. Using a combination of these first-line treatments may also improve outcome. Nortriptyline and clonidine have utility as second-line agents but appear to have more side effects. Other medications and acupuncture have not been proven to be effective.
2. Psychosocial treatments are also effective for the treatment of nicotine dependence and include CBTs, behavioral therapies, brief interventions, and MET provided in individual, group, or telephone formats or via self-help materials and Internet-based formats. The efficacy of treatment is related to the amount of psychosocial treatment received. The 12-step programs, hypnosis, and in patient therapy have not been proven effective.

In addition, the current black box warning for Chantix notes that serious neuropsychiatric events have been reported by those who take Chantix. Members should stop taking Chantix and contact a healthcare provider immediately if they experience agitation, hostility, depressed mood, or changes in behavior or thinking that is not typical, or if the patient develops suicidal ideation or suicidal behavior. A phase IV, randomized, double-blind, active and placebo-controlled, multicenter study evaluating the neuropsychiatric safety and efficacy of Chantix and bupropion is underway; data from this trial is expected to be available in late 2015. The FDA Advisory Committee noted that a change in labeling should not be considered until data from this trial are available for consideration.<sup>2</sup>

#### Alcohol Use Disorders

1. Management of intoxication and withdrawal. The acutely intoxicated member should be monitored and maintained in a safe environment. Symptoms of alcohol withdrawal typically begin within 4–12 hours after cessation or reduction of alcohol use, peak in intensity during the second day of abstinence, and generally resolve within 4–5 days. Serious complications include seizures, hallucinations, and delirium. The treatment of members in moderate to severe withdrawal includes efforts to reduce central nervous system (CNS) irritability and restore physiological homeostasis and generally requires the use of thiamine and fluids, benzodiazepines, and, in some members, other medications such as anticonvulsants, clonidine, or antipsychotic agents. Once clinical stability is achieved, the tapering of benzodiazepines and other medications should be carried out as necessary, and the member should be observed for the reemergence of withdrawal symptoms and the emergence of signs and symptoms suggestive of co-occurring psychiatric disorders.

2. Pharmacological treatments. Specific pharmacotherapies for alcohol-dependent members have well-established efficacy and moderate effectiveness. Naltrexone may attenuate some of the reinforcing effects of alcohol, although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may also promote adherence. Acamprosate, a  $\gamma$ -aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated members who are concomitantly receiving psychosocial treatment. Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated members whose drinking may be triggered by events that suddenly increase alcohol craving.
3. Psychosocial treatments found effective for some members with an alcohol use disorder include MET, CBT, behavioral therapies, TSF, marital and family therapies, group therapies, and psychodynamic therapy/IPT. Member participation in self-help groups (e.g., Alcoholics Anonymous [AA]) should be encouraged.

### **Marijuana Use Disorders**

Studies of treatment for marijuana use disorders are limited. No specific pharmacotherapies for marijuana withdrawal or dependence can be recommended. In terms of psychosocial therapies, an intensive relapse prevention approach that combines motivational interventions with the development of coping skills may be effective for the treatment of marijuana dependence, but further study of these approaches is necessary.

### **Cocaine Use Disorders**

1. Management of intoxication and withdrawal. Cocaine intoxication is usually self-limited and typically requires only supportive care. However, hypertension, tachycardia, seizures, and persecutory delusions can occur with cocaine intoxication and may require specific treatment. Acutely agitated members may benefit from sedation with benzodiazepines.
2. Pharmacological treatment is not ordinarily indicated as an initial treatment for members with cocaine dependence. In addition, no pharmacotherapies have FDA indications for the treatment of cocaine dependence. However, for individuals who fail to respond to psychosocial treatment alone, some medications (topiramate, disulfiram, or modafinil) may be promising when integrated into psychosocial treatments.
3. Psychosocial treatments. For many members with a cocaine use disorder, psychosocial treatments focusing on abstinence are effective. In particular, CBTs, behavioral therapies, and 12-step-oriented individual drug counseling can be useful, although efficacy of these therapies varies across subgroups of members. Recommending regular participation in a self-help group may improve the outcome for selected members with a cocaine use disorder.

### **Opioid Use Disorders**

1. Management of intoxication and withdrawal. Acute opioid intoxication of a mild to moderate degree usually does not require specific treatment. However, severe opioid overdose, marked by respiratory depression, may be fatal and requires treatment in an emergency department or inpatient setting. Naloxone will reverse respiratory depression and other manifestations of opioid overdose. The treatment of opioid withdrawal is directed at safely ameliorating acute symptoms and facilitating the member's entry into a long-term treatment program for opioid use disorders. Strategies found to be effective include substitution of methadone or buprenorphine for the opioid followed by gradual tapering; abrupt discontinuation of opioids, with the use of clonidine to suppress withdrawal symptoms; and clonidine-naltrexone detoxification. It is essential that the treating physician assess the member for the presence of other substances, particularly alcohol, benzodiazepines, or other anxiolytic or sedative agents, because the concurrent use of or withdrawal from other substances can complicate the treatment of opioid withdrawal. Anesthesia-assisted rapid opioid detoxification (AROD) is not recommended because of lack of proven efficacy and adverse risk-benefit ratios.
2. Pharmacological treatments. Maintenance treatment with methadone or buprenorphine may be appropriate for some members with a prolonged history (>1 year) of opioid dependence. The goals of treatment are to achieve a stable maintenance dose of opioid agonist and facilitate engagement in a comprehensive program of rehabilitation. Maintenance treatment with naltrexone is an alternative strategy, although the utility of this strategy is often limited by lack of member adherence and low treatment retention.

3. Psychosocial treatments are effective components of a comprehensive treatment plan for members with an opioid use disorder. Behavioral therapies (e.g., contingency management), CBTs, psychodynamic psychotherapy, and group and family therapies have been found to be effective for some members with an opioid use disorder. Recommending regular participation in self-help groups may also be useful.

#### **GUIDELINE HIERARCHY**

CPGs are updated every two years or as necessary due to updates made to the [name of organization] guidelines. When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to Substance Use Disorders, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites.

NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the American Psychiatric Association (APA) on the topic of Substance Use Disorders. Highlights from the organizations are noted below.

#### **USPSTF**

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.<sup>7,8</sup>

#### **AMERICAN PSYCHIATRIC ASSOCIATION (APA)**

WellCare adopts the 2006 practice guideline on Substance Use Disorders set forth by the American Psychiatric Association (APA). The document can be accessed at <http://psychiatryonline.org/guidelines>

The APA stresses that while many of the principles contained within the guideline apply to all substances reviewed in the guideline (e.g., nicotine, alcohol, marijuana, cocaine, and opioids), some may not be applicable to the treatment of every substance use disorder. For example, treatment for nicotine dependence rarely causes the behavioral or social harm seen with other substance dependencies. Providers should be mindful of clinically important features such as:

- Number and type of substances used
- Member's genetic vulnerability for developing a substance use disorder(s)
- Severity of the disorder, rapidity with which it develops, and degree of associated functional impairment(s)
- Member's awareness of the substance use disorder as a problem
- Member's readiness for change and motivation to enter into treatment for the purpose of change
- Any associated general medical and psychiatric conditions (either co-occurring or induced by substance use)
- Member's strengths (protective and resiliency factors) and vulnerabilities
- Social, environmental, and cultural context in which the individual lives and will be treated

NOTE: It is clinically helpful when assessing members to use a spectrum that includes use, misuse, abuse, and dependence.

The goals of treatment include the achievement of abstinence or reduction in the use and effects of substances, reduction in the frequency and severity of relapse to substance use, and improvement in psychological and social functioning. To accomplish these goals, Providers should include the following elements of the treatment:

1. **Assessment.** A comprehensive psychiatric evaluation is essential to guide the treatment of a member with a substance use disorder and includes:
  - A detailed history of the member's past and present substance use and the effects of substance use on the member's cognitive, psychological, behavioral, and physiological functioning; **AND,**
  - A general medical and psychiatric history and examination; **AND,**
  - A history of psychiatric treatments and outcomes; **AND,**
  - A family and social history; **AND,**
  - Screening of blood, breath, or urine for substance used; **AND,**
  - Other laboratory tests to help confirm the presence or absence of conditions that frequently co-occur with substance use disorders; **AND,**
  - Pending member's permission, contacting a significant other for additional information.
2. **Psychiatric management.** Psychiatric management is the foundation of treatment for members with substance use disorders. Psychiatric management has the following specific objectives: motivating the member to change, establishing and maintaining a therapeutic alliance with the member, assessing the member's safety and clinical status, managing the member's intoxication and withdrawal states, developing and facilitating the member's adherence to a treatment plan, preventing the member's relapse, educating the member about substance use disorders, and reducing the morbidity and sequelae of substance use disorders. Psychiatric management is generally combined with specific treatments carried out in a collaborative manner with professionals of various disciplines at a variety of sites, including community-based agencies, clinics, hospitals, detoxification programs, and residential treatment facilities. Many members benefit from involvement in self-help group meetings, and such involvement can be encouraged as part of psychiatric management.
3. **Specific treatments.** Pharmacological and psychosocial treatments are discussed in detail in the APA guidelines.
4. **Formulation and implementation of a treatment plan.** The goals of treatment and the specific therapies chosen to achieve these goals may vary among members and even for the same member at different phases of an illness. Because many substance use disorders are chronic, members usually require long-term treatment, although the intensity and specific components of treatment may vary over time. Duration of treatment will vary by member. The treatment plan includes:
  - Psychiatric management; **AND,**
  - A strategy for achieving abstinence or reducing the effects or use of substances of abuse; **AND,**
  - Efforts to enhance ongoing adherence with treatment program, prevent relapse, & improve functioning; **AND,**
  - Additional treatments necessary for members with a co-occurring mental illness or general medical condition.
5. **Treatment settings.** Treatment settings vary with regard to the availability of specific treatment modalities, the degree of restricted access to substances that are likely to be abused, the availability of general medical and psychiatric care, and the overall milieu and treatment philosophy. Members should be treated in the least restrictive setting that is likely to be safe and effective. Commonly available treatment settings include hospitals, residential treatment facilities, partial hospitalization programs, and outmember programs.
6. **Clinical features influencing treatment.** In planning and implementing treatment, a clinician should consider several variables with regard to members: comorbid psychiatric and general medical conditions, gender-related factors, age, social milieu and living environment, cultural factors, gay/lesbian/bisexual/transgender issues, and family characteristics. Given the high prevalence of comorbidity of substance use disorders and other psychiatric disorders, the diagnostic distinction between substance use symptoms and those of other disorders should receive particular attention, and specific treatment of comorbid disorders should be provided. In addition to pharmacotherapies specific to a member's substance use disorder, various psychotherapies may also be indicated when a member has a co-occurring psychiatric disorder, psychosocial stressors, or other life circumstances that exacerbate the substance use disorder or interfere with treatment. A member's cessation of substance use may also be associated with changes in his or her psychiatric symptoms or the metabolism of medications (e.g., altered antipsychotic metabolism via cytochrome P450 1A2 with smoking cessation) that will necessitate adjustment of psychotropic medication doses.



**MARKET SPECIFIC INFORMATION**

WellCare uses the *Florida Supplement to the American Society of Addictions Medicine Member Placement Criteria* (2nd ed.) (ASAM PPC-2R) for the coordination of mental health treatment with substance abuse providers as part of the integration effort. Criteria is available at <http://www.sfbhn.org/policies/asam%20supplement%20forms.pdf><sup>3</sup>

**HEDIS AND STAR MEASURES**

CMS has not published any measures for this topic. NCQA has published the following measures for this topic:

**Follow-Up After Hospitalization for Mental Illness.** Members who are hospitalized due to a mental health diagnosis should follow up with a mental health practitioner:

- 7-Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge.
- 30 Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge.

**RELATED CLINICAL PRACTICE GUIDELINES**

In addition to the information contained in this CPG, please reference *Substance Use Disorders in Pregnancy: HS-1041*.

**REFERENCES**

1. Practice guideline for the treatment of patients with substance use disorders (2nd ed.). American Psychiatric Association Web site. <http://psychiatryonline.org/guidelines>. Published 2006. Accessed August 14, 2015.
2. Pfizer loses a bet on removing serious warnings from its Chantix pill. National Center for Health Research Web site. <http://center4research.org/>. Published October 17, 2014. Accessed August 14, 2015.
3. South Florida Behavioral Health Network, Inc. (2006). Florida supplement to the American Society of Addictions Medicine Member Placement Criteria for the coordination of mental health treatment with substance abuse providers as part of the integration effort (Second Edition ASAM PPC-2R). Retrieved from <http://www.sfbhn.org/policies/asam%20supplement%20forms.pdf>
4. Connery HS, Kleber HD. Guideline watch: practice guideline for the treatment of patients with substance use disorders (2nd ed.). [http://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/substanceuse-watch.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf). Published 2007. Accessed August 14, 2015.
5. Hajek P, McRobbie H, Smith KM, Phillips A, Cornwall D, Dhanji AR. Increasing varenicline dose in smokers who do not respond to the standard dosage: a randomized clinical trial. *JAMA Intern Med.* 2015;175(2):266-271. doi:10.1001/jamainternmed.2014.6916.
6. Schnoll RA, Goelz PM, Veluz-Wilkins A, Blazekovic S, Powers L, Leone FT, et al. Long-term nicotine replacement therapy: a randomized clinical trial. *JAMA Intern Med.* 2015;175(4):504-511. doi:10.1001/jamainternmed.2014.8313.
7. Drug use, illicit: primary care interventions for children and adolescents. United States Preventive Services Task Force Web site. <http://www.uspreventiveservicestaskforce.org/>. Published 2014. Accessed December 7, 2015. **New**
8. Drug use, illicit: screening. United States Preventive Services Task Force Web site. <http://www.uspreventiveservicestaskforce.org/>. Published 2008. Accessed December 7, 2015.

**LEGAL DISCLAIMER**

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Note: Lines of business (LOB) are subject to change without notice; current LOBs can be found at [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then "Tools" and "Clinical Guidelines".

*Easy Choice Health Plan, Inc. ~ Exactus Pharmacy Solutions, Inc. ~ Harmony Health Plan of Illinois, Inc. ~ Missouri Care, Incorporated  
WellCare Health Insurance of Arizona, Inc., operating in Hawai'i as 'Ohana Health Plan, Inc. ~ WellCare Health Plans of Kentucky, Inc. WellCare Health  
Plans of New Jersey, Inc. ~ WellCare of Connecticut, Inc. ~ WellCare of Florida, Inc., operating in Florida as Staywell  
WellCare of Kentucky, Inc. ~ WellCare of Georgia, Inc. ~ WellCare of Louisiana, Inc. ~ WellCare of New York, Inc.  
WellCare of South Carolina, Inc. ~ WellCare of Texas, Inc. ~ WellCare Prescription Insurance, Inc. ~ Windsor Health Plan, Inc.*

**MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS**

Date	History and Revisions by the Medical Policy Committee
12/16/2015	<ul style="list-style-type: none"> <li>• Approved by MPC. Inclusion of section on children and adolescents.</li> </ul>
9/17/2015	<ul style="list-style-type: none"> <li>• Approved by MPC. Inclusion of items regarding the use of Chantix (varenicline).</li> </ul>
3/5/2015	<ul style="list-style-type: none"> <li>• Approved by MPC. Inclusion of Care Management Training items.</li> </ul>
8/7/2014	<ul style="list-style-type: none"> <li>• Approved by MPC. Included updated HEDIS measure.</li> </ul>
7/31/2014	<ul style="list-style-type: none"> <li>• Approved by MPC. Biennial review.</li> </ul>
7/5/2012	<ul style="list-style-type: none"> <li>• Approved by MPC. New.</li> </ul>