Naltrexone Long-acting Injection for Substance Use Disorder

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Diagnosis: Patient should be stable on oral naltrexone for at least 7 days prior to first dose of injection.

- ❑ Alcohol use disorder
- ❑ Opioid use disorder. Pregnancy testing required prior to initiation in patients of gestational potential.

  Negative pregnancy test_____

Not recommended for patients:

- currently taking opioids. If opiate use anticipated (e.g. elective surgery) stop injectable naltrexone 30 days prior.
- with acute hepatitis
- elevated liver enzymes 3 or more time normal
- in liver failure

Administer:

Naltrexone long acting intramuscular injection – 380 mgs **IM** every 28 days x _____ months
(if fewer than 12 months. Re-order required every 12 months minimum.)

- If used for opiate use disorder, assess patient for signs of opiate withdrawal prior to administration. (See COWS)
- Allow drug to come to room temperature for at least 45 minutes prior to use. (stable x 7 days at RT)
- Complete naltrexone injection checklist
- Administer IM into the gluteal muscle, using one of the needles provided in the kit.
- Document exact location and alternate sides with each dose.

Ongoing monitoring: Periodic lab assessments may be collected during clinic for patient convenience. Doses will not be held pending results.

- ❑ Hepatic function panel every _____.
  Labeling recommends "periodic" but specific interval is required if to be drawn in clinic.
- ❑ Other:

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] Complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Name:_____

Duration of authorization:_____

Checklist for non-RFGH providers. Please:

[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .

Contacted provider:_____

[ ] Problem list attached
[ ] Medication and allergy list attached.

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Provider_____ Date_____ time_____

Printed name_____ Phone # _____

Revised: 8/25

Patient _____

dob_____ phone #_____