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, discontinue injectable naltrexone 30 days prior)
- with acute hepatitis
- elevated liver enzymes 3 or more time normal
- in liver failure

Administer:

Nnaltrexone 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.")
- ❑ 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 # _____

RFGH Co-signature _____ Date_____ time_____
if above non-RFGH

Revised: 8/25

Patient name_____

Date of birth_____

Patient phone number_____