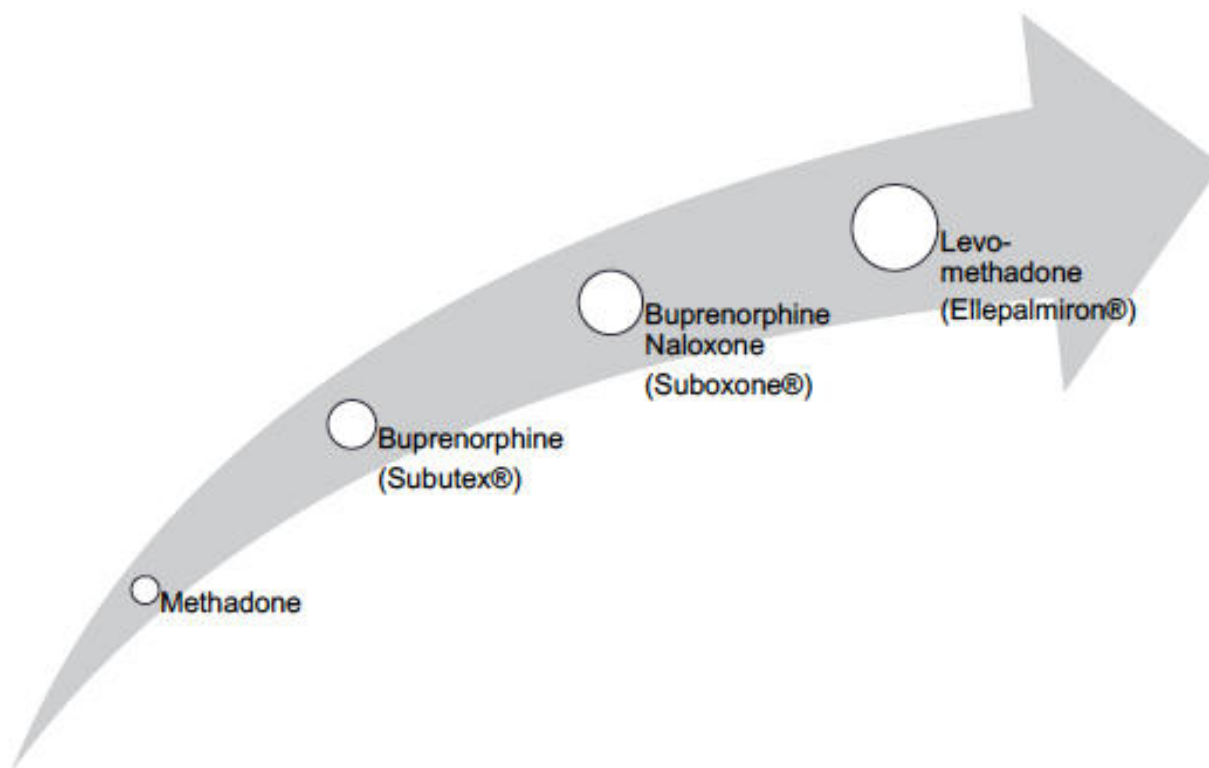
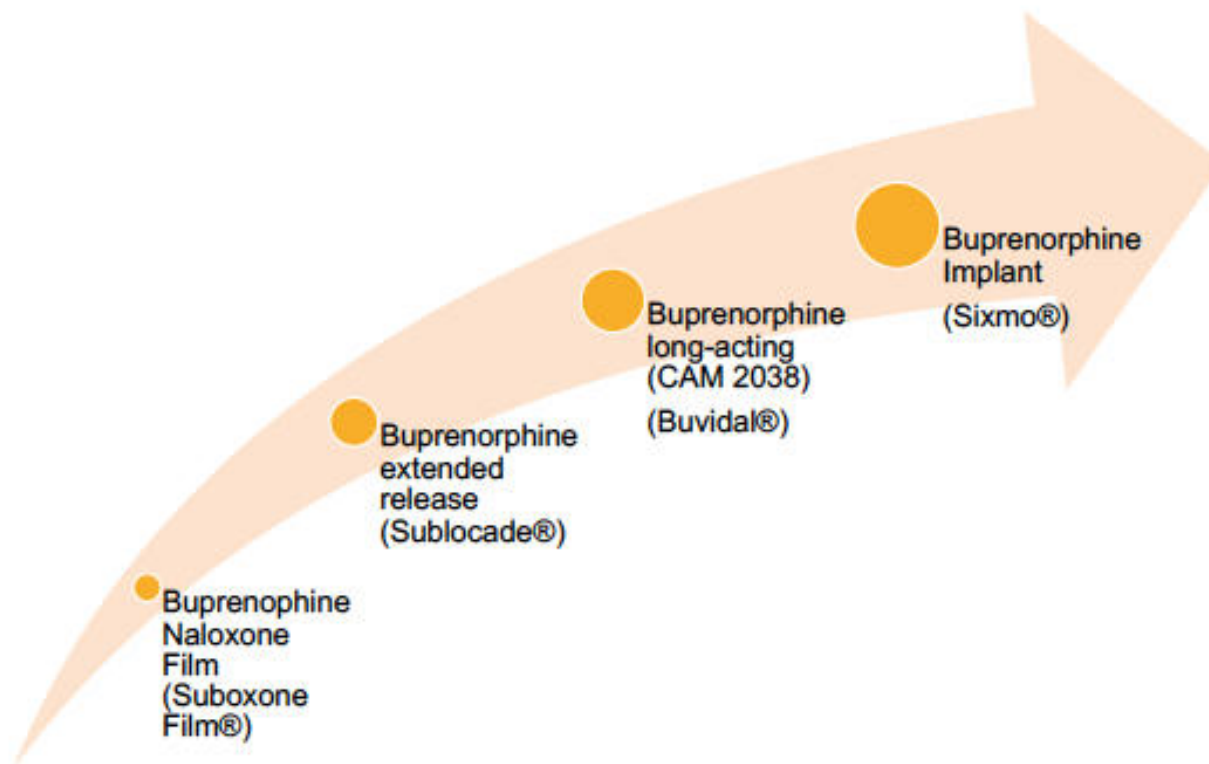


## **Cosa può cambiare nella farmacoterapia agonista con le nuove formulazioni**

<b>Treatment</b>	<b>Dosage range</b>	<b>Consideration</b>
Buprenorphine Implant (26 mm in length and 2.5 mm in diameter)	74.2 mg (equivalent to 80 mg of buprenorphine hydrochloride)	Maintenance treatment of opioid addiction that provides non-fluctuating blood levels of buprenorphine around the clock for a period of six months following a single treatment procedure
Buprenorphine extended-release formulation (SQ)	80-300 mg/monthly injection	Two formulation available-. FDA approved in 2016 and 2017
Buprenorphine long-acting (SQ) (CAM2038)	8-32 mg (one weekly q1w) 64-160 mg (once-monthly q4w)	Maintenance treatment of opioid addiction, intended for administration one weekly (q1w) and once monthly monthly (q4w)
Buprenorphine and naloxone sublingual film	2 mg/0.5mg – 12 mg/3 mg	Maintenance treatment of opioid addiction
Levo-methadone	1:2 vs. methadone typical range	Maintenance treatment of opioid addiction



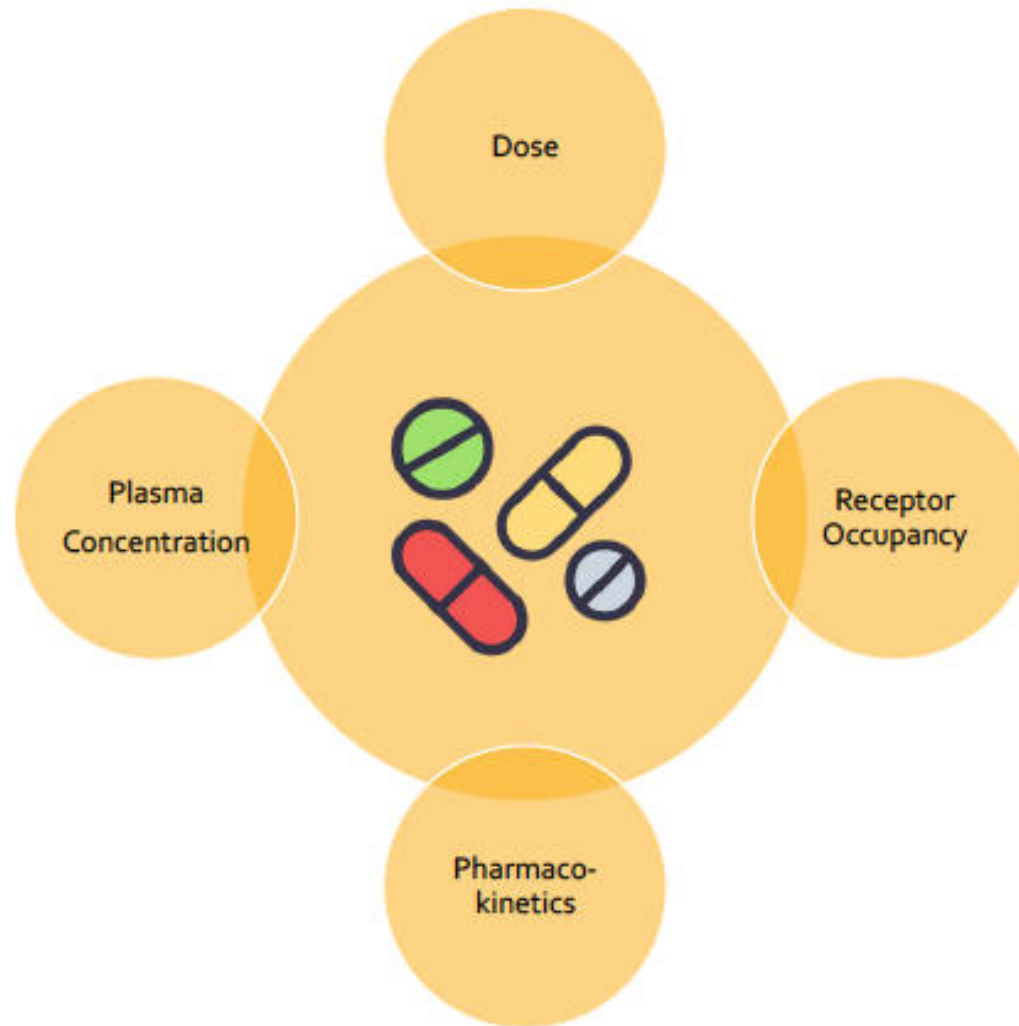


**Table 1** Comparison of commonly available products to treat opioid dependence

Drugs	Active ingredients	Administration	Average dosage/target range	Half-life
Revia <sup>®</sup> , Depade <sup>®</sup>	Naltrexone	Oral (tablet)	50 mg, 1×/day	13 hours <sup>45</sup>
Vivitrol <sup>®</sup> XR	Naltrexone	IM	380 mg, 1×/month	5–10 days <sup>59</sup>
Methadose <sup>®</sup> , Diskets <sup>®</sup> , Dolophine <sup>®</sup>	Methadone HCl	Oral (dispersible tablet in liquid), IM	2:1 (parental-to-oral ratio), 80–120 mg oral <sup>60</sup>	8–59 hours <sup>61</sup>
Xtampza <sup>®</sup> ER	Oxycodone HCl	Oral (capsule)	9–36 mg, 2×/day <sup>62</sup>	5.6 hours <sup>63</sup>
Narcan <sup>®</sup>	Naloxone HCl	Nasal spray	4 mg, 1 spray <sup>33</sup>	0.5–1.35 hours <sup>64</sup>
Suboxone <sup>®</sup>	Buprenorphine/naloxone	Oral (SL) tablet, buccal (film)	4/1 mg, 8/2 mg, 12/3 mg <sup>62</sup>	24–42 hours/2–12 hours <sup>65</sup>
Bunavail <sup>®</sup>	Buprenorphine/naloxone	Buccal (film)	2.1/0.3 mg, 4.2/0.7 mg, 6.3/1 mg <sup>66</sup>	16.4–27.5 hours/1.9–2.4 hours <sup>67</sup>
Zubsolv <sup>®</sup>	Buprenorphine/naloxone	Oral (SL) tablet	Two 5.7 mg/1.4 mg tablets 1×/day (11.4 mg/2.8 mg) <sup>68</sup>	24–48 hours/2–12 hours <sup>65</sup>
Probuphine <sup>®</sup>	Buprenorphine HCl	Subdermal implant	Four implants deliver equivalent to daily doses <8 mg suboxone <sup>55</sup>	24–48 hours <sup>55</sup>

**Abbreviations:** IM, intramuscular; IV, intravenous; SL, sublingual.





## What OST should do?

- Abstinence management
- Relapse prevention
- Craving control
- Improve functioning



## What OST should not do?

- Barrier for relationship
- Obstacle for recovery
- Stigma

## The main limits of OST

- Adherence
- Misuse and diversion
- Pharmacological interactions
- Overdose

# The match paradigm

- Identify the patient
- Match the treatment

## **The match paradigm: the limits on the patient's side**

- The patient could change
- The assessment may be not complete
- The assessment could be wrong
- The patient might disagree

## **The match paradigm: the limits on the drug's side**

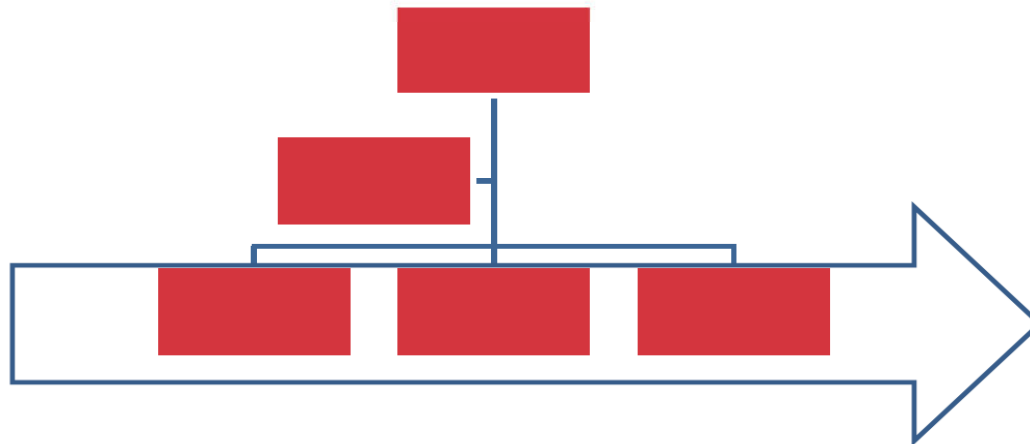
- The drug is unmatched
- The drug is underdosed
- The drug cannot be managed by clinician

The organization should not preserve the “internal order” that can be a “barrier” for client’s need....



The organization is vertical while the client’s service is horizontal

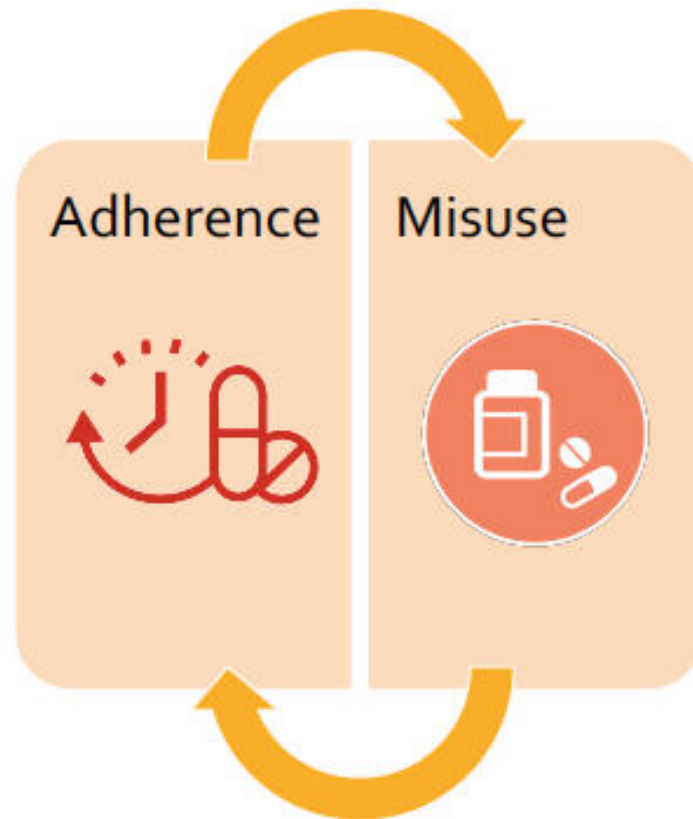
*George Fisher former Motorola CEO*



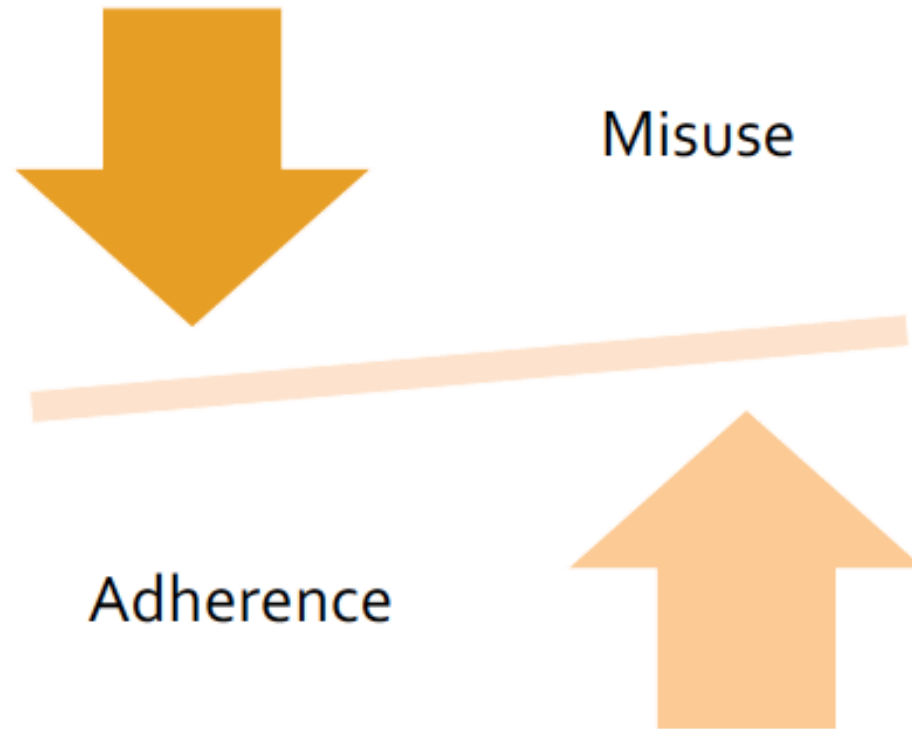
# The traditional management of OST therapy

- Induction
- Stabilization
- Monitoring
- Follow-up

# The traditional management of OST therapy: the limits



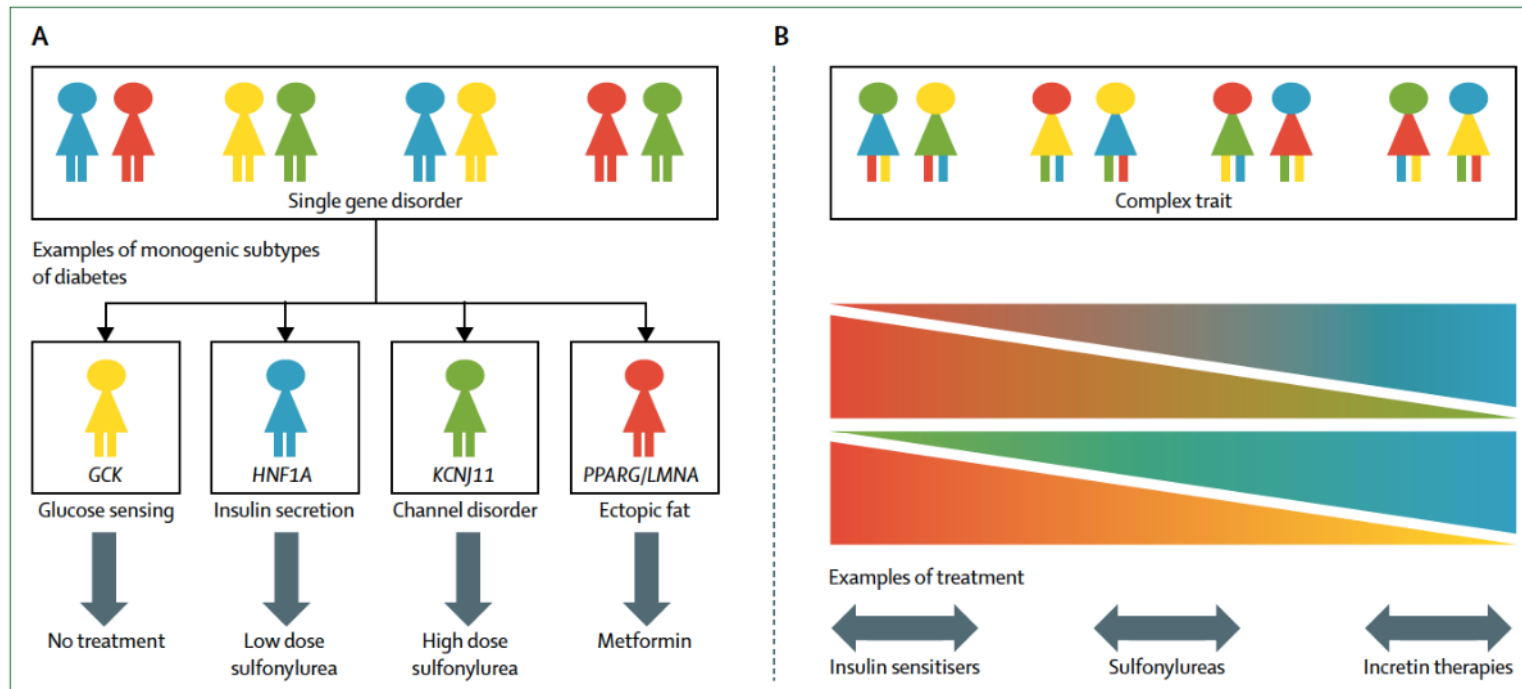




# The traditional management of OST therapy is lean?

- Time
- Distribution
- Access
- Cost
- Drop-out
- Mistake

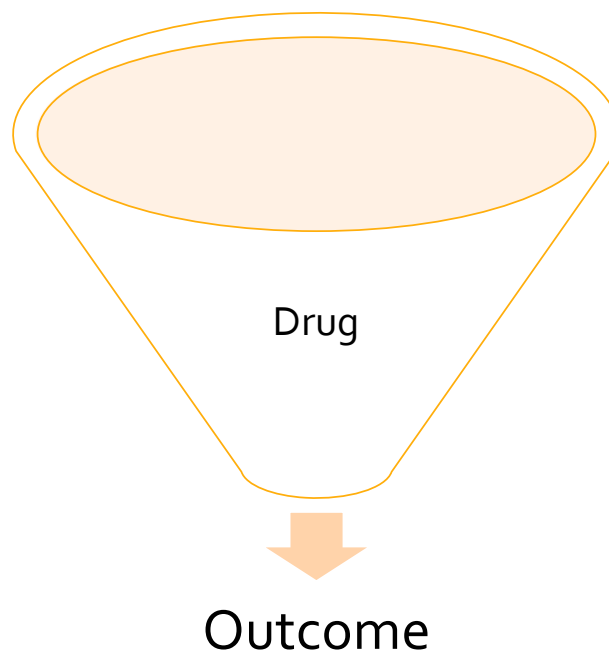
# The precision therapy: concerns



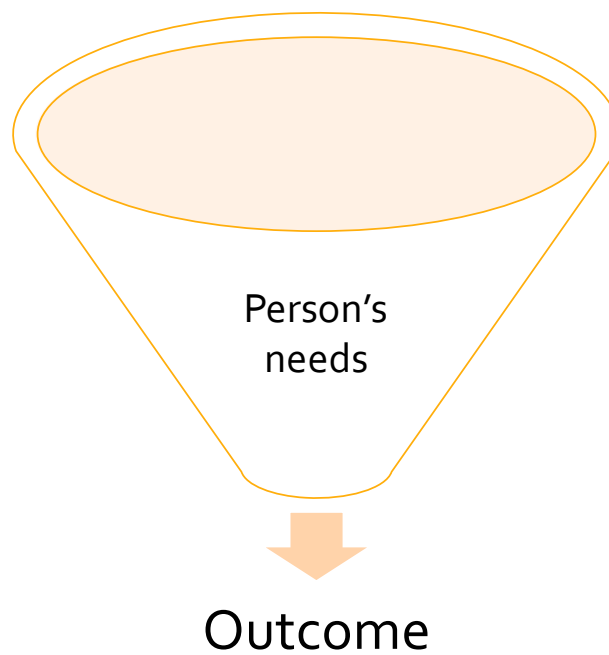
**Figure: Precision medicine approaches for the treatment of type 2 diabetes**

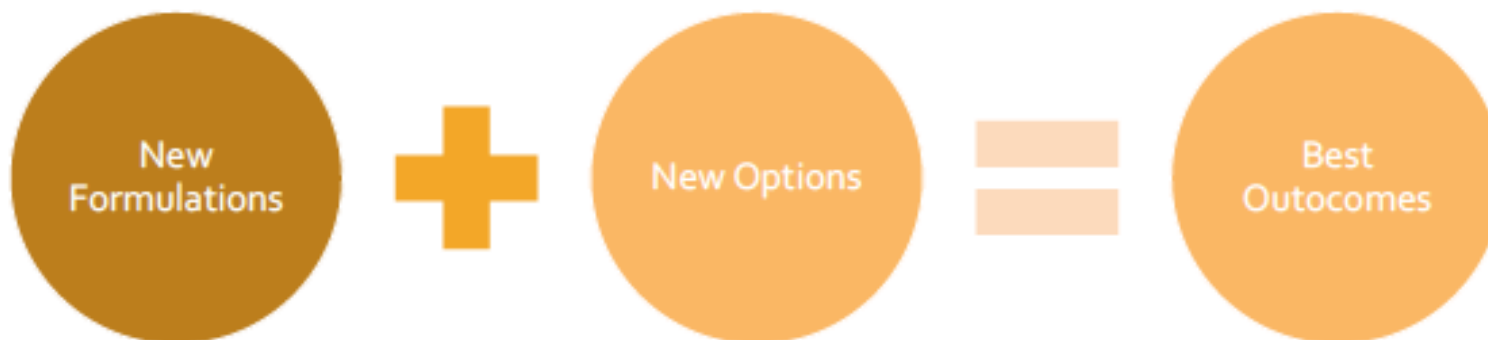
(A) Treatment of patients with selected monogenic subtypes of diabetes. (B) Individuals with complex genetic determinants of type 2 diabetes. Monogenic diabetes subtypes have specific treatments whereas complex trait type 2 diabetes is a sliding scale making individualised treatment more difficult. Many subtypes of monogenic diabetes can be treated with specific pharmacological agents, whereas individuals with type 2 diabetes have a heterogeneous phenotype, with different degrees of abnormalities in multiple pathways.

## The old paradigm



## The new paradigm









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