

Standing order for administration of early or overdue long-acting injectable medications - Protocol

Purpose

To be utilized by registered nurses (RNs) and, when applicable, medical assistants (MAs) at DESC to guide the administration of overdue long-acting injectable (LAI) medications actively prescribed and authorized by a DESC provider to clients. This standing order includes LAI-antipsychotics, LAI-buprenorphine, and LAI-naltrexone.

Criteria to proceed with standing order:

Licensure: Active license as registered nurse or medical assistant in the state of Washington. Employed by DESC.

Setting: Any location, clinic or field-based, where DESC clients receive care.

Inclusion criteria (must meet all criteria):

- Client has an active LAI administration order in the electronic health records, CHASERS.
- The LAI medication is prescribed and authorized by a DESC provider.
- Client can consent to receive the medication

Exclusion criteria [Consult provider to discuss nuances if these apply]:

- The client is or believes they may be pregnant at this time or the near future
- LAI medication is ordered by a non-DESC provider
- Medication is expired or otherwise non-viable

CONSULT decision points are indicated throughout this order and indicate the need to consult with a DESC prescriber **prior to proceeding with injection**.

The LAI-antipsychotics below are not in use at DESC at this time (7/7/25) and so are not included in this standing order. This can change if needed:

- Abilify Asimtufii (LAI-aripiprazole)
- Zyprexa Relprevv (LAI-olanzapine)
- Erzofri (LAI-paliperidone palmitate)
- Risperdal Consta (LAI-risperidone)
- Rykindo (LAI-risperidone)

- Risvan (LAI-risperidone)
- Perseris (LAI-risperidone)

Guidance on “early” injections

RNs and MAs have authorization to administer an LAI medication to a patient as early as the following, without seeking provider approval. If there may be a reason to administer even earlier, provider approval must be obtained.

If the staff member (rather than the client) is initiating the request to administer an LAI early, the staff should clearly communicate to the client (and document) verbal informed consent to receiving the injection earlier than schedule and the reason why (e.g., symptom control, staffing convenience, etc)

LAI medication, regardless of dose	Time frame acceptable to give an “early” injection without seeking provider consult:
Invega Sustenna (after completing full initiation process)	2 days before due date, but not soon than 3 weeks after last injection
Invega Trinza	1 week before due date
Invega Hafyera	2 weeks before due date
Abilify Maintena	No sooner than 26 days after last injection
Aristada	2 days before due date, but not sooner than 3 weeks after last injection
Uzedy	2 days before due date but not sooner than 3 weeks after last injection
Haloperidol decanoate (haldol dec)	2 days before due date but not sooner than 2 weeks since last injection
Fluphenazine decanoate (previously: prolixin dec)	2 days before due date but not sooner than 2 weeks since last injection
Vivitrol	No sooner than 3 weeks after last injection
Sublocade	No sooner than 3 weeks after last injection
Brixadi monthly injections	No sooner than 3 weeks after last injection

Long-acting injectable antipsychotics

General assessment guidance

- Paliperidone (Invega) and risperidone medications are metabolized renally. If renal function has not been assessed in the last 12 months and if time permits, review CHASERS and UW Epic records to see if renal function (eGFR) has been assessed. **CONSULT PROVIDER if eGFR is < 80 mL/min and if this is not known to the prescriber.** It is appropriate to proceed with administration per guidance below if there is no time to assess renal function or is no indication of a new change in renal function.
- Haloperidol, buprenorphine and naltrexone medications are cleared hepatically. If liver function has not been assessed in the last 12 months and if time permits, review CHASERS and UW Epic records to see if albumin and total bilirubin have been assessed. **CONSULT PROVIDER if albumin is < 3.0 or total bilirubin is > 1.5 and if this is not known to the prescriber.** It is appropriate to proceed with administration per guidance below if there is no time to assess liver function or is no indication of a new change in liver function.
- Assess for signs of tardive dyskinesia or other involuntary abnormal movements. Best practice is to complete and document an Abnormal Involuntary Movement Scale (AIMS) every 12 months, or every 6 months in high-risk patients (<https://www.mdcalc.com/calc/10435/abnormal-involuntary-movement-scale-aims>). Completing an AIMS assessment should not otherwise prevent the LAI-antipsychotic administration. **CONSULT PROVIDER** if new, severe abnormal involuntary movements are observed.
- Assess, at least by history, for new problems with falls or symptoms suggestive of orthostasis. If history suggests orthostasis, best practice is to assess orthostatic blood pressure measurements (BP & pulse lying, or at least sitting, then again within 3 minutes after standing). If vitals are assessed, **CONSULT** if systolic blood pressure drops more than 20 mmHg when standing compared to lying or sitting.
- Assess by history for sedation/somnolence after receiving LAI-antipsychotics. **CONSULT** if history suggests excessive sedation.
- Maintain awareness for **neuroleptic malignant syndrome (NMS)**, a neurologic emergency associated with anti-dopamine agents. NMS most often occurs after the initiation or dose increase of first-generation antipsychotic medications but can occur even after years of medication use and with second-generation antipsychotics. Symptoms include mental status change (agitation, delirium); hyperthermia with temperatures above 38 C; muscular rigidity often manifesting as generalized “lead-pipe” rigidity; and dysautonomia often manifesting as tachycardia, labile blood pressures and/or tachypnea. **CONSULT** if there is any concern about or needing assistance assessing for neuroleptic malignant syndrome.
- Check and document weight with every injection if time allows and the patient is willing. Notify a prescriber of weight that is trending upwards. Absence of weight measurement should not delay injection administration.

- Assess by history for other side effects that the patient dislikes or that are causing the patient hesitancy to receive ongoing injections. **CONSULT** if needed.

Guidance on “late” injections

Paliperidone palmitate (Invega Sustenna, Invega Trinza, Invega Hafyera)

Invega Sustenna initiation: Missed/delayed 2nd initiation (156 mg) injection

Time since first (234 mg) injection	Drug label instructions (one option)	Acceptable pragmatic variations (another acceptable option)	When to notify provider
>12 days but < 4 weeks	<p>(1) Administer 156 mg (in deltoid ideally).</p> <p>(2) Arrange for a 117 mg injection 5 weeks after the first (234 mg) injection, regardless of when the 156 mg injection (in step 1) is administered</p> <p>(3) Thereafter, start monthly maintenance dosing 4 weeks after step 2.</p>	Ok to administer the 156 mg injection in gluteal muscle if patient strongly prefers.	Post-injection (156 mg): Notify provider of the situation and need to order a 117 mg injection if not already done.
4-7 weeks	<p>(1) Administer 156 mg (in deltoid ideally).</p> <p>(2) Arrange for a 2nd 156 mg injection (in deltoid ideally) 1 week after step 1.</p> <p>(3) Thereafter, start monthly maintenance dosing 4 weeks after step 2.</p>	Ok to administer the 156 mg injection in gluteal muscle if patient strongly prefers.	Post-injection (1 st 156 mg): Notify provider of the situation and need to order a 2 nd 156 mg injection if not already done.
> 7 weeks to 4 months	<p>(1) Restart initiation: Administer a 234 mg injection if available</p> <p>(2) Arrange for a 156 mg injection 1 week after step 1.</p> <p>(3) Thereafter, start monthly maintenance dosing 4 weeks after step 2.</p>	Ok to administer the 156 mg injection at time of patient presentation if a 234 mg injection is not available and arrange for the patient to return in 1 week.	Post-injection: notify provider of situation and for orders and guidance on next steps
> 4 months	Consult provider to get orders to proceed	Same	Before any injection: Consult provider

Invega Sustenna maintenance: Missed/delayed monthly maintenance injections

Time since last injection	Drug label instructions (one option)	Acceptable pragmatic variations (another acceptable option)	When to notify provider
4-6 weeks	(1) Administer usual Invega Sustenna dose. (2) Arrange for next usual monthly maintenance dose = 4 weeks later.	No change from drug label steps	No need
> 6 weeks to 4 months, AND usual maintenance dose = 39-156 mg	(1) Administer usual maintenance dose. (2) Arrange for a 2 nd usual maintenance dose (same dose) to be administered 1 week later. (3) Then resume usual monthly doses 4 weeks after step 2.	For step (2), ok if the 2 nd usual maintenance dose happens anytime 1 week or beyond. Attempt to return to a monthly cycle after the 2 nd usual maintenance dose.	Post-injection: Notify provider of the need to have a 2 nd usual maintenance dose ordered.
> 6 weeks to 4 months, AND usual maintenance dose = 234 mg	(1) Administer 156 mg Invega Sustenna (2) Arrange for another 156 mg injection to be administered 1 week later (3) Then resume usual monthly doses with 234 mg at 4 weeks after step 2.	If a 156 mg Invega Sustenna injection is not available at the time the patient presents, give the 234 mg injection. Notify the provider to guide next steps.	Post-injection: Notify provider of the situation. If drug label steps are followed, a 2 nd 156 mg injection may need to be ordered. If the pragmatic variation was followed, the provider will guide next steps.
> 4 months	Consult provider prior to any injection	Same	Before any injection: Consult provider

Invega Trinza: Missed/delayed doses

Time since last Trinza injection	Drug label recommended steps (do if possible)	Acceptable pragmatic variations	When to notify provider
3-4 months since last Trinza dose	(1) Administer next usual Invega Trinza dose	same	Post-injection: notify full care team of importance of avoiding missed doses of Trinza.
4-9 months since last Trinza dose AND dose was 410 mg	<p>(1) Do not administer Trinza dose & consult a provider first</p> <p>Drug label notes the following (provider must be consulted):</p> <p>(2) Administer Invega Sustenna 117 mg (after consulting a provider)</p> <p>(3) Arrange for a 2nd Invega Sustenna 117 mg injection 7 days after step 2.</p> <p>(4) Arrange for a 410 mg Invega Trinza injection 4 weeks after step 3.</p>	None. Consult provider prior to deviating from ideal steps.	Consult provider in all cases before any injection
4-9 months since last Trinza dose AND dose was 546 or 819 mg	<p>(1) Do not administer Trinza dose & consult a provider first</p> <p>Drug label notes the following (provider must be consulted):</p> <p>(2) Administer Invega Sustenna 156 mg (after consulting a provider)</p> <p>(3) Arrange for a 2nd Invega Sustenna 156 mg injection 7 days after step 2.</p> <p>(4) Arrange for the usual Invega Trinza injection 4 weeks after step 3.</p>	None. Consult provider prior to deviating from ideal steps.	Consult provider in all cases before any injection
> 9 months since last Trinza dose	Consult provider. Reinitiation is necessary	same	Consult provider in all cases before any injection

Invega Hafyera: Missed/delayed doses

Invega Hafyera injections can be administered 2 weeks before or 3 weeks after the 6-month time point. If a patient is presenting more than 6 months and 3 weeks after the last Hafyera dose, **please consult a provider prior to proceeding.**

Aripiprazole long-acting injectables (Abilify Maintena, Aristada)

Abilify Maintena: missed/delayed maintenance doses

Number of prior consecutive monthly Abilify Maintena injections received (without large gaps)	Time since last Abilify Maintena injection	Drug label recommended steps (do if possible)	Acceptable pragmatic variations	When to notify provider
1 or 2 monthly maintenance doses received	4-5 weeks since last dose	(1) Administer usual Abilify Maintena monthly dose (2) Arrange for next usual monthly dose in 4 weeks	same	No need
	> 5 weeks to less than 4 months since last dose	Re-initiate: (1) Administer usual Abilify Maintena monthly dose (2) Notify patient of the options recommended for reinitiation: either (a) receive a 2 nd Abilify Maintena dose at the same time as the first (in step 1) or within days, or (b) resume oral aripiprazole (10-20 mg) for 14 days	If the patient is not able or likely to take oral aripiprazole or get a 2 nd injection immediately, consult with provider about accelerating timing of next injection.	Post-injection: notify provider of situation and need for either a 2 nd immediate monthly injection or 14 days of oral aripiprazole.
	4 months+	Consult provider first		Consult provider first
3 or more monthly maintenance doses received	4-6 weeks since last dose	(1) Administer usual Abilify Maintena monthly dose (2) Arrange for next usual monthly dose in 4 weeks	same	No need
	> 6 weeks to less than 4 months since last dose	Re-initiate: (1) Administer usual Abilify Maintena monthly dose (2) Notify patient of the options recommended for reinitiation: either (a) receive a 2 nd Abilify Maintena dose at the same time as the first (in step 1) or within days, or (b) resume oral aripiprazole (10-20 mg) for 14 days	If the patient is not able or likely to take oral aripiprazole or get a 2 nd injection immediately, consult with provider about accelerating timing of next injection.	Post-injection: notify provider of situation and need for either a 2 nd immediate monthly injection or 14 days of oral aripiprazole.
	4 months+	Consult provider first		Consult provider first

Aristada (aripiprazole lauroxil): missed/delay maintenance doses

Key step: First, administer the usual Aristada dose as soon as possible, then assess the need for supplementation, unless the following is true:

- **If the injection is over 4 months late, then consult a provider before any injection is given**

Recommended supplementation as applicable:

Dose of last Aristada injection	Length of time since last injection		
	≤ 6 weeks	> 6 and ≤ 7 weeks	> 7 weeks to 4 months
441 mg	≤ 6 weeks	> 6 and ≤ 7 weeks	> 7 weeks to 4 months
662 mg	≤ 8 weeks	> 8 and ≤ 12 weeks	> 12 weeks to 4 months
882 mg	≤ 8 weeks	> 8 and ≤ 12 weeks	> 12 weeks to 4 months
1064 mg	≤ 10 weeks	> 10 and ≤ 12 weeks	> 12 weeks to 4 months
Recommended supplementation: Ask what the patient prefers	No supplementation required	Oral aripiprazole for 7 days or Aristada Initio 675 mg IM once (now or within next few days)	Oral aripiprazole for 21 days or Aristada Initio 675 mg IM once (now or within next few days)
When to notify provider:	No need	Notify provider with patient preference for supplementation and to order medications	Notify provider with patient preference for supplementation and to order medications

Risperidone subcutaneous LAI (Uzedy): missed/delayed doses

The Uzedy drug label does not give nuanced guidance on how to manage missed/delayed doses; it just says “administer the next Uzedy injection as soon as possible.” The half-life is between 14-22 days (presumably at steady state), and therapeutic levels (at steady state) are maintained for 1-2 months. Therapeutic concentrations after a single subcutaneous dose are seen after 6-24 hrs. The guidance below is created by DESC:

Time since last Uzedy injection	Ideal steps (do if possible)	When to notify provider
< 4 months	(1) Administer usual Uzedy maintenance dose (2) Arrange for next injection at usual dosing interval	No need
4 + months	<p>Consult provider before any injection</p> <p>Guidance for providers:</p> <p>(1a) Administer usual Uzedy maintenance dose if 150 mg or less</p> <p>(1b) Administer approximately 150 mg of the injection if the injection is >150 mg. Example: the typical injection is 200 mg; administer approximately $\frac{3}{4}$ of the medication (purpose: to reduce risk of sedation)</p> <p>(2) Arrange for care team to check in with patient within 1-2 days, to assess for sedation.</p> <p>(3) Next injection at usual dosing interval</p>	Consult provider prior to any injection

Haloperidol decanoate (haldol dec), missed/delayed doses

Number of prior consecutive monthly halodol dec injections received (without large gaps)	Time since last haloperidol decanoate injection	Ideal steps (do if possible)	Acceptable pragmatic variations if ideal is not possible	When to notify provider
1-3 monthly maintenance doses received; steady state not yet likely achieved	≤ 12 weeks	<p>(1) Administer usual haloperidol dec injection if 200 mg or less (consult provider if greater than 200 mg)</p> <p>(2) If symptoms of psychosis have returned or worsened, recommend oral supplementation (consult provider)</p> <p>(3) Schedule check-in in 6-7 days (peak dose), ideally, to assess for haloperidol-related adverse effects</p>	Same, no change	<p>Pre-injection: only if haloperidol dec dose is >200 mg</p> <p>Post-injection: to notify provider of situation and to request order for supplementation if needed</p>
	> 12 weeks	Reinitiate, consult provider BEFORE any injection	--	Consult provider in all cases BEFORE any injection
4 or more monthly maintenance doses received; steady state likely achieved	≤ 6 weeks	<p>(1) Administer usual haloperidol dec injection</p> <p>(2) Arrange for next injection in 4 weeks</p>	same	No need
	6-12 weeks	<p>(1) Administer usual haloperidol dec injection if 200 mg or less (consult provider if greater than 200 mg)</p> <p>(2) If symptoms of psychosis have returned or worsened, recommend oral supplementation (consult provider)</p> <p>(3) Schedule check-in in 6-7 days (peak dose), ideally, to assess for haloperidol-related adverse effects</p>	Same, no change	<p>Pre-injection: only if haloperidol dec dose is >200 mg</p> <p>Post-injection: to notify provider of situation and to request order for supplementation if needed</p>
	> 12 weeks	Reinitiate, consult provider BEFORE any injection	--	Consult provider in all cases BEFORE any injection

Fluphenazine decanoate (previously prolixin dec), missed/delayed doses

Number of prior consecutive monthly fluphenazine dec injections received (without large gaps)	Time since last fluphenazine decanoate injection	Ideal steps (do if possible)	Acceptable pragmatic variations if ideal is not possible	When to notify provider
1-2 monthly maintenance doses received (4-8 weeks into the course of therapy); steady state not yet likely achieved	< 4 months	<p>(1) Administer usual fluphenazine dec injection if 50 mg or less (consult provider if greater than 50 mg)</p> <p>(2) If symptoms of psychosis have returned or worsened, recommend oral supplementation (consult provider)</p> <p>(3) Schedule check-in in 24 hours (peak dose), ideally, to assess for fluphenazine-related adverse effects</p>	Same, no change	<p>Pre-injection: only if fluphenazine dec dose is >50 mg</p> <p>Post-injection: to notify provider of situation and to request order for supplementation if needed</p>
	> 4 months	Reinitiate, consult provider BEFORE any injection	--	Consult provider in all cases BEFORE any injection
3 or more maintenance doses received (e.g. beyond 6-8 weeks of therapy generally); steady state likely achieved	≤ 6 weeks	<p>(1) Administer usual fluphenazine dec injection</p> <p>(2) Arrange for next injection at previously planned dose interval</p>	same	No need
	6 weeks to 4 months	<p>(1) Administer usual fluphenazine dec injection if 50 mg or less (consult provider if greater than 50 mg)</p> <p>(2) If symptoms of psychosis have returned or worsened, recommend oral supplementation (consult provider)</p> <p>(3) Schedule check-in in 24 hours (peak dose), ideally, to assess for fluphenazine-related adverse effects</p>	Same, no change	<p>Pre-injection: only if fluphenazine dec dose is >50 mg</p> <p>Post-injection: to notify provider of situation and to request order for supplementation if needed</p>
	> 4 months	Reinitiate, consult provider BEFORE any injection	--	Consult provider in all cases BEFORE any injection

Brixadi weekly (long-acting injectable buprenorphine) injections, missed/delayed doses

Late weekly high-dose Brixadi injections (Brixadi 24 mg or 32 mg) used for maintenance treatment may be administered up to 9 days after the last injection, or otherwise per prescriber guidance.

For those using Brixadi weekly injections for buprenorphine initiation, please refer to the guidance in the DESC MOUD initiation guide, found in the DESC document library [9009.0 - Medical - Buprenorphine and Methadone \(MOUD\) Initiation - Guideline - Rev. C - 06.22.2025](#) and at this [google document link](#).

Guidance as of 1/17/2025 is copied below:

Guidance on missed doses during the multi-injection Brixadi method:

(subject to change with further clinical experience)

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9
Brixadi 8 mg given	Give Brixadi 16 mg	Give Brixadi 16 mg	Restart at Brixadi 8 mg					
Brixadi 8 mg given	Brixadi 16 mg given	Give monthly injection	Give monthly injection	Give monthly injection	Repeat Brixadi 16 mg	Repeat Brixadi 16 mg	Repeat Brixadi 16 mg	Restart at Brixadi 8 mg

Sublocade & Brixadi monthly (long-acting injectable buprenorphine), non-booster doses, missed/delayed doses

[See section on booster doses for guidance on those]

The following guidance table assumes that the most recent injection and the next (delayed) injection are of the same brand and dose. For any changes in types and doses, seek specific guidance from the prescriber.

Definitions for the purpose of this guidance:

“Minimal or no fentanyl dependence” must meet all the following criteria:

- Client reports that they do not experience any significant opioid withdrawal symptoms during a typical day, including no more than mild morning withdrawals after awakening or during the day.
- Client reports that they do not feel any significant effects of fentanyl if they use fentanyl
- Client reports that they can go 6 hours or more without using fentanyl (or other unregulated opioids) and still not experience significant opioid withdrawal.
- Clients reports that their fentanyl use remains “much less” than before they started MOUD

“Significant fentanyl dependence” must meet all the following criteria:

- Client reports significant opioid withdrawal symptoms during a typical day, including experiencing morning withdrawal symptoms prompting use of fentanyl (or other unregulated opioids) within an hour after awakening, and significant withdrawal symptoms during the day
- Client reports using fentanyl every 3 hours or more often during the day.
- Client reports that their fentanyl use is at levels roughly the same as before they started MOUD

“Moderate fentanyl dependence” is defined as a history that fits between the “minimal/no opioids dependence to fentanyl” category and the “significant opioid dependence to fentanyl” category

Sublocade/Brixadi (long-acting injectable buprenorphine) late/missed dose guidance

Dose & type of monthly injection	Length of time since last injection			
Brixadi 64 or 96 mg	3 weeks to ≤ 5 weeks *	> 5 and ≤ 6 weeks *	> 6 and ≤ 8 weeks *	> 8 weeks
Sublocade 100 mg or Brixadi 128 mg	3 weeks to ≤ 5 weeks *	> 5 and ≤ 6 weeks *	> 6 and ≤ 8 weeks *	> 8 weeks
Sublocade 300 mg, and client has only received 2 or fewer Sublocade injections without gaps > 6 weeks	3 weeks to ≤ 5 weeks	> 5 and ≤ 7 weeks	> 7 and ≤ 8 weeks	> 8 weeks
Sublocade 300 mg, and client has received 3 or more Sublocade injections without gaps > 6 weeks	3 weeks to ≤ 7 weeks	> 7 and ≤ 8 weeks	> 8 and ≤ 10 weeks	> 10 weeks
Recommended action	<p>Administer next injection, regardless of level of unregulated opioid use</p> <p>*See guidance below</p>	<p>Administer next injection if the client has “minimal/no fentanyl dependence” or if the client has taken at least 8 mg of sublingual buprenorphine in the last 24 hours.</p> <p>Administer if they have “moderate fentanyl dependence” and are ok with the risk of some bup-induced withdrawal.</p> <p>*See guidance below</p> <p>Otherwise, consult a prescriber.</p>	<p>Administer next injection if the client has “minimal/no fentanyl dependence” or if the client has taken at least 8 mg of sublingual buprenorphine in the last 24 hours.</p> <p>Otherwise, consult a prescriber.</p> <p>*See guidance below</p>	<p>Please consult a prescriber in real-time for guidance. Ok to consult the ORCA Center or medical director. Goal is to avoid having patient leave without guidance</p>

*If Sublocade 100 mg or Brixadi injections are used, and patient reports active use of unregulated opioids, discuss a switch to Sublocade 300 mg and consult prescriber if patient is interested in learning more.

Sublocade & Brixadi monthly (long-acting injectable buprenorphine), booster dose guidance

“Booster dose” is defined as an additional monthly Sublocade or monthly Brixadi injection that is given between the usual scheduled q 4 week monthly dose.

Example: A client received Brixadi 128 mg on 1/1/2026 with plans to receive another Brixadi 128 mg on 1/29/2026. A booster dose of Sublocade 100 mg is desired by the client and has been ordered.

A booster dose may be administered any time if these requirements are met:

- The client wants the booster dose
- At least 24 hours have passed since the last LAI-buprenorphine injection
- The client continues to report use of unregulated fentanyl or other unregulated opioids during the present day

If the client is reporting NO use of unregulated opioids, please consult a provider. The main risk in this situation is too much buprenorphine causing sedation.

Vivitrol (long-acting injectable naltrexone), missed/delayed doses

Definition for the purpose of this guidance:

“Minimal or no fentanyl dependence” must meet all the following criteria:

- Client reports that they do not experience any significant opioid withdrawal symptoms during a typical day, including no more than mild morning withdrawals after awakening or during the day.
- Client reports that they do not feel any significant effects of fentanyl if they use fentanyl
- Client reports that they can go 6 hours or more without using fentanyl (or other unregulated opioids) and still not experience significant opioid withdrawal.
- Clients reports that their fentanyl use remains “much less” than before they started MOUD

In all cases where Vivitrol is being used, take a history to assess the degree of dependence on fentanyl or other opioids. Vivitrol should only be used when the client has minimal or no fentanyl or other opioid dependence.

Key signs that the client has **more than** minimal dependence include a **need** to use fentanyl or other opioids to **stave off opioid withdrawals**; experiencing **noticeable effects** of fentanyl, such as “high” or less anxiety or sedation; and being **unable to go without** using fentanyl.

If any of these signs are reported, do not administer Vivitrol and consult a provider to review the case.

Point-of-care urine drug screens can be flawed and erroneous. The guidance table below indicates when a urine drug screen is needed. Even if the urine drug screen is negative for any opioids, if the history suggests that a client has more than minimal dependence on fentanyl or other opioids, do not administer Vivitrol and instead consult a provider to discuss the case.

See below for detailed guidance.

Indication for Vivitrol (380 mg IM)	Length of time since last injection	Point-of-care urine drug screen needed?	Urine drug screen result for any opioids	Recommended action
Used for treatment of OUD **	> 3 weeks and ≤ 4 weeks	No	Not needed	Administer Vivitrol as long as the patient meets criteria for “minimal or no fentanyl dependence”. Discuss buprenorphine for more robust OUD treatment if there is ongoing active fentanyl or other unregulated opioid use
	> 4 and ≤ 5 weeks	Only if there is report of intentional fentanyl use (if not administer vivitrol) (document in chasers)	Negative	Administer Vivitrol (as long as the patient meets criteria for “minimal or no fentanyl dependence”)
			Positive	Consult provider. Review history carefully to ensure that client truly meets criteria for “minimal or no fentanyl dependence”. If truly no or minimal withdrawals and no significant effects felt from fentanyl, administer Vivitrol or consider naloxone challenge.
	> 5 weeks and ≤ 8 weeks	Yes. Consult provider if unable to do UDS	Negative	Administer Vivitrol (as long as the patient meets criteria for “minimal or no fentanyl dependence”)
			Positive	Further discussion needed on degree of fentanyl or other opioid dependence. Consult provider
	Used for overdose prevention in people without OUD	> 3 weeks and ≤ 5 weeks	No	Not needed
> 5 and ≤ 6 weeks		Yes, unless there is confidence of no opioid use (document in chasers)	Negative	Administer Vivitrol (as long as the patient meets criteria for “minimal or no fentanyl dependence”)
			Positive	Consult provider. Review history carefully to ensure that client truly meets criteria for “minimal or no fentanyl dependence”. If truly no or minimal withdrawals and no significant effects felt from fentanyl, administer Vivitrol or consider naloxone challenge.
> 6 weeks and ≤ 8 weeks		Yes. Consult provider if unable to do UDS	Negative	Administer Vivitrol (as long as the patient meets criteria for “minimal or no fentanyl dependence”)
			Positive	Further discussion needed on degree of fentanyl or other opioid dependence. Consult provider

**If Vivitrol is used for OUD, and patient reports active use of unregulated opioids, discuss a switch to buprenorphine and consult prescriber if patient is interested in learning more.