EvidenceNOW
MANAGING UNHEALTHY ALCOHOL USE
AN AHRQ INITIATIVE

Overview of Medications Used in the Treatment of Alcohol Use Disorder and Frequently Asked Questions

Alcohol is the third leading cause of preventable death in the United States, making it a key public health issue. As of 2019, nearly 15 million people ages 12 and older had an alcohol use disorder (AUD) and only 7 percent received treatment. Evidence shows that the use of Food and Drug Administration (FDA)-approved medications is an effective treatment for people with AUD, yet less than 4 percent of people with AUD are prescribed medications.[i] Medications such as naltrexone and acamprosate have been shown to reduce or eliminate alcohol use as well as prevent relapse and symptoms associated with alcohol withdrawal.[ii] Since primary care settings are a frequent entry point for individuals seeking help for AUD, equipping primary care clinicians with information on these medications can serve as a key step for effectively managing AUD and improving patient health. This document is designed to provide information and answer common questions primary care clinicians may have about medications prescribed for the treatment of AUD.

Prescribing First-line Medications for AUD

	Naltrexone	Acamprosate
Benefits[iii]	• Only taken once daily or monthly • Associated with reduction in return to drinking and other drinking outcomes	• Very few medication interactions • Associated with reduction in return to drinking and other drinking outcomes
Side Effects[iv]	• Nausea (dose dependent) • Dizziness • Vomiting	• Anxiety • Diarrhea • Vomiting
Frequency	• Once daily or monthly (extended-release injectable)	• Two pills taken three times daily (total of six pills per day)
Contraindications[v,vi,vii]	• Severe liver disease/use caution when prescribing to patients with elevated liver function tests • Patients using opioid pain medications or with anticipated needs for opiates • Hypersensitivity to naltrexone	• Severe renal disease (contraindicated with creatine clearance less than 30 and dose adjustments needed with creatinine clearance less than 60) • Hypersensitivity to acamprosate
Warnings/Precautions	• Vulnerability to opioid overdose and opioid withdrawal, risk of hospitalization for opioid withdrawal • Pregnancy Category C medication (clinicians should weigh the risks and benefits when prescribing during pregnancy)	• Alcohol-dependent patients should be monitored for development of depression or suicidal thinking • Pregnancy Category C medication (clinicians should weigh the risks and benefits when prescribing during pregnancy)
Other Considerations	• FDA approved for the treatment of AUD	• FDA approved for the treatment of AUD • Found to be most useful when people are abstinent from alcohol

*Information listed in this table was compiled from project partners and grantees of the EvidenceNow Managing Unhealthy Alcohol Use project and is not a comprehensive list of all side effects, contraindications, and warnings/precautions included on medication labels.

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Prescribing Second-Line Medications for AUD

	Topiramate	Gabapentin	Disulfiram
Benefits	• Shows promise for treatment in AUD as studies have shown that it can help patients reduce or stop drinking	• Shows promise for treatment in AUD and decreasing alcohol cravings • Can help treat symptoms of insomnia and anxiety	• Shown to be effective in selected patients with strong psychosocial support to help ensure medications are taken as prescribed
Side Effects	• Paresthesia • Anorexia • Dizziness • Somnolence • Psychomotor slowing • Abnormal vision • Fever[viii]	• Dizziness • Nausea • Headache • Insomnia • Fatigue • Ataxia	• Drowsiness • Metallic or garlic taste in mouth[ix] • Disulfiram reaction if exposed to alcohol (nausea, vomiting, diarrhea, tachycardia, hypotension, difficulty breathing)
Frequency	• Twice daily (should be titrated slowly to reach desired therapeutic doses)	• 600-1,800 mg once daily or divided twice per day (higher doses may be needed for a therapeutic effect)	• One pill taken once daily
Contraindications	• Hypersensitivity to topiramate	• Hypersensitivity to gabapentin	• Psychosis • Severe heart disease • Hypersensitivity to disulfiram
Warnings/ Precautions	• Liver disease • Renal disease • Pregnancy Category C medication (clinicians should weigh the risks and benefits when prescribing during pregnancy)	• Myasthenia gravis • Renal disease • Pregnancy Category C medication (clinicians should weigh the risks and benefits when prescribing during pregnancy)	• Ingesting alcohol • Cardiovascular or pulmonary disease • Previous renal disease • History of psychosis • Diabetes • Abnormal liver function • Pregnancy[x]
Other Considerations	• Off-label use (FDA approved for treatment of seizures and other indications) • Already used in primary care practice	• Off-label use (FDA approved for treatment of seizures and other indications) • Already used in primary care practice • May work better for people experiencing ongoing withdrawal symptoms • Due to potential for inappropriate use, must monitor for opioid use	• FDA approved for the treatment of AUD • Can effectively take away cravings for some people who have committed to the goal of abstinence from alcohol

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1. **Can I use these medications effectively if I am not an alcohol specialist?**
   - Emerging research shows that many patients respond well to medications for AUD offered in primary care practices.
   - Many patients would rather see their trusted primary care clinician, so it makes sense to start in primary care and see how patients do.
   - The cost of a primary care visit is often lower than the cost of a specialist appointment.
   - Most medications for AUD are easier to use than medications already being prescribed in primary care, such as insulin or warfarin.

2. **How will treating patients with AUD help my practice?**
   - Concerns about treating patients with AUD often come from incorrect stereotypes. Many patients with AUD are just like the other patients in a typical primary care practice. In fact, many are already being cared for in primary care but are not receiving treatment that clinicians can easily learn to provide.
   - Unhealthy alcohol use is one of the top preventable causes of death that primary care clinicians have the skills to impact. Many patients with AUD will not receive any treatment beyond what they get from their primary care clinician.

3. **I'm afraid of the time commitment patients with AUD may require.**
   - Knowing about patients' alcohol use is part of good medical care. Prescribing medications for alcohol use is no more time-consuming than prescribing medications for other conditions, such as diabetes or hypertension.
   - Using part of the medical visit for motivational interviewing to help with patient behavior change may take extra time but is still feasible within a 15-minute primary care visit.
   - If the patient requires more time-intensive behavioral change counseling or mental health treatment, primary care clinicians can make referrals as needed to behavioral specialists, often within their own practice settings.

4. **How can other team members in my practice help support medication management?**
   - Medications for AUD are not scheduled narcotics and can be prescribed by licensed healthcare professionals.[xi] Depending on the laws in your state, the following team members may be able to prescribe medications for AUD: physician, nurse practitioner, physician assistant, or pharmacist.
   - In some states, medication management or refill visits for stable patients may be facilitated by a registered nurse, licensed practical nurse, or social worker.

5. **What is the recommended follow-up protocol when treating patients with medications for AUD?**
   - One size does not fit all. This will depend on how the patient is doing, whether they are abstinent, and their risk of relapse.
   - For patients at high risk of relapse, the recommendation is that they should check in weekly with their clinician for a month, then biweekly for a month, and then monthly thereafter.
   - For patients with a lower risk of relapse, the follow-up schedule can be less frequent.
   - Clinicians should monitor adherence to treatment and medication side effects. Clinicians should support patients' efforts to reduce alcohol use in order to reduce alcohol-related health risks while suggesting that abstinence from alcohol is recommended for patients with AUD.
   - Clinicians can also encourage reaching out for mutual support, such as Alcoholics Anonymous, counseling, or other peer-support options.

6. **How long do patients stay on medications for AUD?**
   - There are no evidence-based guidelines for duration of using medications for AUD. Most people continue medication for at least a year (and no less than three months), then reassess whether to

continue. Many people stay on longer than a year. Stable abstinence often begins at a year but is considered more stable after two to three years of abstinence.

7. **How much do medications for AUD cost?**
   - Just like with other medications, the price of medications for AUD can vary based on insurance coverage, dosing, pharmacy benefits, and co-pays. Patients may wish to consider this when deciding on a medication. Clinicians should encourage patients with health insurance to check with the health insurance company about whether the plan will cover any costs of the medication.
   - The price of naltrexone taken orally is estimated to range between $25 to $60[xii] per month but may cost up to $100 per month without insurance coverage.[xiii]
   - For one month of acamprosate, a patient may expect to pay around $125 (between $100 to $200 per month) and for disulfiram between $80 to $100 per month.
   - Gabapentin and topiramate are both estimated to cost approximately $150 per month.

8. **Is it possible to offer these medications via telehealth to patients with AUD?**
   - Yes, it is possible to offer medications for AUD via telehealth, and telehealth services are increasingly available in most states.
   - Some clinics are now contracting with psychiatrists or addiction specialists who are willing to accept telehealth referrals for a variety of services, including diagnosis, behavioral management, and medications.

9. **Aren't community recovery programs the best option for patients with AUD?**
   - One size does not fit all for AUD treatment; medications may help some patients for whom abstinence-based approaches were not successful. Not every patient will have the same goals for treatment and recovery.
   - Clinicians should discuss treatment and recovery goals with their patients, such as abstinence vs. reduction of alcohol use.
   - It is also important to note that each medication works differently for different patients.

10. **What are some additional resources about using medications for AUD?**
    - The Agency for Healthcare Research and Quality (AHRQ) Pharmacotherapy for Adults with Alcohol Use Disorder (AUD) in Outpatient Settings summary provides an overview of the evidence and treatment options when using medications for AUD.
    - The National Institute on Alcohol Abuse and Alcoholism (NIAAA)'s Healthcare Professional's Core Resource on Alcohol is an online resource for healthcare professionals to improve care for patients with unhealthy alcohol use, including information about medications for AUD.
    - The American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder provides clinical practice guidelines when using medications for AUD.
    - The STop UNhealthy (STUN) Alcohol Use Now Program, funded by AHRQ, offers brief videos with information about using several of these medications.
    - The Kaiser Permanente AUD Decision Aid *Options for People Who Are Thinking about Their Drinking* provides more information about dosage, contraindications, and potential side effects of medications.

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