This document is for reference only. Please refer to SWO's for specific indications, dosages, and applications

RX

Drug Name: **Naloxone**
Trade Name: **Narcan**
REVISED: **NOVEMBER 01, 2021**

Class: Narcotic Antagonist

Mechanism of Action:
Binds competitively to opiate receptor sites, displacing narcotics & synthetic narcotics. Antagonizes all actions of narcotics

Indications:
- Complete or partial reversal of depression caused by narcotics or synthetic narcotics
- Coma of unknown etiology

Contraindications:
- Known Hypersensitivity

Precautions:
- Pre-existing cardiac disease
- Patients who have received cardiotoxic drugs
- Abrupt and complete reversal can cause withdrawal-type effects
- Pregnancy (B)
- Use with caution in polypharmaceutical overdoses

Dosage:

Adults:
- IV/IO: 0.1-2 mg slowly. Repeat as needed every 1-2 minutes to a maximum of 10 mg.
- IV/IO *in cardiac arrest*: 2 mg
- IM/IN: 2-4 mg*. Repeat as needed to a maximum of 10 mg if IV access is unavailable
  - *Some IN preparations of naloxone are supplied in 4 or 8 mg applicator packages. These may be used if available.
- If patient has obviously aspirated, consider bypassing Narcan and manage airway if required.
- If patient has obviously aspirated, consider bypassing Narcan and manage airway as required.

Pediatrics:
- IV/IO: 0.01 - 0.05 mg/kg to max single dose of 2 mg. Administer slowly. Repeat as needed every 1-2 minutes to a maximum of 10 mg.
- IM/IN: 2-4 mg. Repeat as needed to a maximum of 10 mg. If IV/IO access is unavailable.
- If patient has obviously aspirated, consider bypassing Narcan and manage airway as required.
- IV/IO *in cardiac arrest*: 2 mg

Naloxone Infusions: Naloxone Infusions: for recurrent somnolence or sedation
- Re-administer bolus of 0.1-2mg naloxone and initiate infusion
- IV/IO 0.1-10 mg/hour titrated for effect.
- To mix: 4 mg/250 cc.

Onset:
- IV/IO--1-2 minutes
- IN: 1-4 minutes
- IM, SubQ: 2-8 minutes

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DRUG: NALOXONE

Duration:

- IV, IM, IN, ET, SubQ--30-60 minutes

Side Effects:

- Tachycardia
- Hypotension
- HTN
- Dysrhythmias
- N/V
- Diaphoresis

Interactions:

- Incompatible with alkaline drugs

PEARLS

ALS evaluation is indicated if Naloxone administered either PTA or by EMS, and transport strongly encouraged.

The physician medical directors direct that suspected opioid overdose patients who are contacted by ACCESS system providers, **even if the overdose has resolved**, should be transported for monitoring and evaluation whenever possible.

A refusal requires medical control contact

- **Clinical Goal:** The goal of naloxone administration is to reverse respiratory depression and hypoxia while avoiding while avoiding combativeness and agitation. Use the *lowest dose* possible to restore spontaneous respirations but avoid precipitating withdrawal
- **Route: Low dose naloxone titrated carefully via the IV route is preferable over large boluses IM or IN. Consider focusing on airway and respiratory support while IV access is established.**
- **Many Opiates have a longer bio-availability than Narcan, therefore assess for re-sedation. Re-administer Narcan as needed.**
- Naloxone in cardiac arrest is adjunctive to, not a replacement for other basic interventions. Focus should remain on high quality CPR and resuscitation.
- Failure to obtain reversal after 10 mg usually indicates another disease process or overdose on non-opioid drugs.
- Use with caution in poly-pharmaceutical overdoses, reversal of opiate may result in an extremely hyperdynamic patient (i.e. “speedball”)
- **If patient has obviously aspirated, consider bypassing Narcan administration and transport the patient. Intubate as required**
- If pushed too rapidly, this medication will induce vomiting
- **Naloxone infusions:** Not every patient will need a naloxone infusion. Naloxone infusions are an option for patients who are re-sedating after initial naloxone administration. Naloxone infusions should be preceded by a supplementary bolus of IV/IO Naloxone, and then initiated at a rate equivalent to the initial dose required to maintain respiratory effort. I.E. if 1 mg was initially required for restoration of respirations, the dose may be initially set at 1 mg/hour to maintain that state.