



Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment —Breakout Resource

The [Urine Drug Testing Breakout Resource](#) was developed in response to calls from clinicians for more guidance on urine drug testing (UDT) in the clinical management of opioid use disorder (OUD). This document reviews the current evidence for UDT, provides an overview of the use of UDT in the primary care management of patients with OUD who are receiving oral OAT (i.e., buprenorphine/naloxone, methadone, or slow-release oral morphine), and offers guidance and general practices for ordering, collecting, and interpreting UDT. Brief guidance on the use of UDT for patients who are receiving injectable OAT is also provided.

This UDT breakout guidance effectively replaces the UDT information in the 2017 [Guideline for the Clinical Management of Opioid Use Disorder](#), and updates the guidance on UDT published in the 2019 [Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder](#).

Guidance summary and key practice changes:

- Urine drug testing should be used when results will change clinical management, including
 - Confirming opioid use at baseline
 - Informing changes to care plan (e.g., take-home dosing)
 - Identifying substances patient may not be aware they were exposed to
- Urine drug testing should not be used punitively or when results will not impact clinical management
- The purpose of UDT should be discussed with patients, including how unexpected results will be addressed
- Confirmatory testing should only be ordered when the results would change clinical management
- A 24- to 48-hour window should be provided for random UDT (expanded from 24 hours in 2017 OUD guideline)
 - Barriers such as childcare, transportation, or travel should be discussed and a plan should be made collaboratively, as needed
- Urine samples should be collected following the procedures for supervised UDT in clinical settings
 - During a supervised UDT, the patient produces a sample in a designated collection area without being witnessed
 - Patients should not be asked to provide witnessed UDT (i.e., where the patient provides the sample under direct visual observation)
- Increased clinical discretion regarding frequency of UDT is recommended
 - For example, for take-home dosing: 2–4 per year for buprenorphine (rather than 4), and 6–8 for methadone and slow-release oral morphine (rather than 8)
- Guidance on interpreting and managing unexpected UDT results, detection times, collection and testing procedures, UDT and virtual care, immunoassay-based and confirmatory testing, false-negative and false-positive results, and a list of additional resources on UDT for clinicians who provide OUD care are also included