

FACTS ABOUT FENTANYL

FACT ONE:

Touching fentanyl does not itself cause overdose.

Touching fentanyl powder or pills has not caused overdose as it does not absorb well through the skin. There are prescription fentanyl patches that are designed to be absorbed by the skin over time. Children who have had accidental contact with these patches have overdosed. Other forms of fentanyl are not formulated like the prescription patches and do not pose an overdose risk through skin contact. There has not been a confirmed case of harm from simply touching fentanyl. High-profile stories of people touching fentanyl and experiencing an opioid overdose have been debunked. There may be a risk if fentanyl touches mucous membranes such as eyes, nose, or mouth.

FACT TWO:

Second-hand fentanyl smoke exposure has never caused fentanyl overdose.

There is no known case of second-hand fentanyl smoke exposure causing an opioid overdose. Inhaling smoke of any kind (e.g., cigarette, marijuana, wildfire) is known to have negative impacts on physical health and is not recommended. However, there is no known risk of opioid overdose from inhaling second-hand smoke from fentanyl. Any long-term effects beyond what is known regarding the inhalation of smoke in general are not known.

FACT THREE:

Naloxone can reverse an opioid overdose and is safe for all ages.

Naloxone is a safe and effective medication to reverse opioid overdose, including those caused by fentanyl. Naloxone is safe to give to everyone, including children and infants. Dosing guidelines are the same regardless of age, weight, or other physical factors. Sometimes, more than one dose of naloxone is needed to reverse the overdose. After giving the first dose of naloxone, a second dose should be given after 2-3 minutes if the person is still unresponsive. Whenever naloxone is given for a suspected overdose, 911 should be contacted for monitoring and addressing other medical needs. Naloxone cannot be self-administered by the person experiencing an overdose.

FACT FOUR:

Medications for opioid use disorder (MOUD) are the gold standard for treatment.

MOUD are proven to effectively treat opioid use disorder. There are three FDA-approved medications for opioid use disorder: methadone, buprenorphine, and long-acting naltrexone. Methadone and buprenorphine have both been shown to reduce deaths from any cause, including death from opioid overdose. While long-acting naltrexone can treat opioid use disorder, it has not been shown to reduce death from all causes or to reduce risk of overdose. Even if someone is in residential treatment, they should work with their health care provider to determine the best MOUD treatment.

FACT FIVE:

Buprenorphine does work to treat someone who is using fentanyl.

Buprenorphine (aka Suboxone) is one of three FDA-approved medications to treat opioid use disorder. At sufficient doses, buprenorphine is an effective treatment for opioid use disorder. While methadone is generally considered the most effective MOUD, because it is difficult for many patients to access, it is important to recognize that buprenorphine is also an effective medication option. Due to the potency of fentanyl as compared to heroin or morphine, some evidence suggests that higher doses of buprenorphine than previously prescribed during other eras of the opioid epidemic are needed. The type of medication used to treat a person's opioid use disorder and the dose is determined by a healthcare provider, typically an MD, DO, PA or NP, in coordination with the patient and the available resources.

FACT SIX:

A baby born to someone using fentanyl or other opioids is not born with an addiction.

A fetus exposed to fentanyl or any opioid prescribed or illicit ongoing in utero may experience withdrawal when they are born. This withdrawal is called neonatal abstinence syndrome and can be treated effectively with an evidence-based protocol called Eat Sleep Console. Withdrawal is a sign of physical dependence on a substance. Physical dependence is distinct from substance use disorder, commonly called addiction. Substance use disorder includes psychosocial diagnostic criteria such as hazardous use, attempts to quit, or trouble at work, school or home, in addition to physical dependence. A baby can be born with neonatal abstinence syndrome, but is not born with addiction because they have not demonstrated any psychosocially disruptive behaviors. A baby cannot have an addiction.

When a pregnant person is taking MOUD, the best course of action for both them and the fetus is to continue to take MOUD as prescribed. A baby born to someone taking these forms of MOUD may also experience neonatal abstinence syndrome. If a person abruptly stops their MOUD while pregnant, this could result in opioid withdrawal, which is associated with fetal demise.