Special Situation – Carfentanil Guideline

Starting 5/12/2025 in response to Carfentanil laced illicit drugs, the following adjustments to the administrative guideline for patients with suspected opiate overdose, who do not respond to initial dose of naloxone are in effect until further notice:

Basic (EMT)

- Do not delay administration of positive pressure ventilation in patients with suspected opioid overdose.
- Administer naloxone 4 mg intranasal. May repeat X1. Max intranasal dose of 8 mg. Subsequent doses should be IV/IO.

Paramedic

- Administer an initial dose of naloxone 0.4-2 mg IV/IO.
- Administer subsequent doses as needed in an escalating manner every 3-5 minutes as follows:
    - 0.4 mg, then 0.8 mg, then 2 mg, then 4 mg, then 8 mg IV/IO
    - Additional doses of naloxone should be given IV/IO
- Anticipate the need for subsequent re-dosing of naloxone.
- Consider alternate etiologies for the unconscious/unresponsive patient.

The risk of clinically significant exposure to emergency responders is extremely low. According to a position statement published by the American College of Medical Toxicology (ACMT) and the American Academy of Clinical Toxicologists (AACT):

- Incidental skin absorption is unlikely to cause clinical signs of toxicity.
- Nitrile gloves provide sufficient protection for routine handling.
- Simple washing with soap and water is adequate to remove fentanyl from contaminated skin. Hand sanitizers and cleaning agents may increase fentanyl absorption and should not be used.
- If drug particles are suspended in the air, a fit-tested N95 respirator provides reasonable protection. Assisted ventilation and naloxone administration is the standard first aid response to opioid overdose.

Additional Information on Carfentanil

The Pima County Department of Public Health and the U. S. Department of Justice recently released statements concerning the identification of carfentanil in the regional illicit drug supply, specifically in the blue colored tablets marked M30.

Carfentanil is a synthetic opioid that is 10,000 times more potent than morphine and 100 times more potent than fentanyl. As with other opioids, toxicity is characterized by depressed mental status, hypoventilation, and small pupils. Pupillary findings, however, may be unreliable in our patient population due to the potential presence of co-ingestants or due to cerebral hypoxia. Mid-range or even dilated pupils cannot reliably exclude carfentanil toxicity.

As with other opiates, the treatment of carfentanil toxicity is ventilatory support, oxygenation, and administration of the antidote, naloxone.

The duration of action of carfentanil is longer than the duration of action of naloxone. Recurrence of symptoms should be expected. Prehospital personnel may need to administer higher doses of naloxone than is typical to reverse the signs and symptoms of toxicity and should anticipate the need to repeat treatment with additional doses of naloxone if signs and symptoms return.