FOR IMMEDIATE RELEASE
November 10, 2026

Media Contact
Sarah Shelson
301-547-4110
sshelson@ASAM.org

ASAM Releases New Guidance for Managing Medetomidine Intoxication and Withdrawal

Medetomidine, an adulterant in the unregulated opioid supply, can cause severe withdrawal that calls for changes in clinical practice

ROCKVILLE, Md. — The American Society of Addiction Medicine (ASAM) today released its first clinical guidance for managing intoxication and withdrawal involving medetomidine, an emerging adulterant in the unregulated opioid supply linked to unique and severe symptoms. This new national resource outlines current clinical considerations for treating patients exposed to medetomidine.

Medetomidine, a veterinary sedative, was first detected in the unregulated opioid supply in 2021. By December 2025, it had been detected nationwide, with the highest prevalence in the Northeast and Midwest. In some mid-Atlantic regions, adulteration is as high as 90%.

Medetomidine intoxication is associated with bradycardia and persistent sedation. Withdrawal can develop rapidly and cause severe symptoms including extreme tachycardia and elevated blood pressure that are not responsive to typical medications used to manage withdrawal from other substances. Because symptoms can be life-threatening, patients presenting to the hospital with severe medetomidine withdrawal may need escalation to critical care more often than those experiencing opioid withdrawal without the adulterant.

“The unpredictable illicit drug supply continues to pose a significant health risk to people and communities across America,” said Stephen M. Taylor, MD, MPH, DFAPA, DFASAM, president of ASAM. “Medetomidine withdrawal can be debilitating and life-threatening, forcing addiction treatment professionals on the front lines of this crisis to innovate and adjust their practices. As medetomidine continues to spread across the country, it's critical that emergency medicine and addiction care teams understand how to properly identify and treat patients exposed to this adulterant."

Because patients are commonly exposed to both medetomidine and fentanyl, giving naloxone during a suspected overdose remains the most critical intervention, according to the guidance. ASAM recommends administering naloxone in incremental doses only until breathing is adequately restored. Naloxone does not reverse medetomidine’s effects, so patients may remain sedated.

- more -

To treat medetomidine withdrawal, ASAM recommends alpha-2 agonist medications, noting that severe cases may require far higher doses than usual. Intravenous dexmedetomidine may be appropriate for symptoms such as severe tachycardia or hypertension, and higher-than-typical doses may be required.

“Medetomidine withdrawal demands a more intensive clinical response than typical opioid withdrawal,” said Jeanmarie Perrone, MD, FASAM, a Philadelphia-based physician and co-author of the guidance. “The course of withdrawal is often unpredictable and can quickly escalate from mild to severe. This new clinical challenge calls for updated treatment approaches to keep patients safe.”

The guidance recognizes that a lack of system-wide medetomidine testing is an impediment to care. In the absence of rapid point-of-care testing, clinicians should use reporting from public health departments and regional surveillance units to understand the local drug supply.

“Toxicology screens don’t include medetomidine, and the results of advanced testing methods are not available to inform point-of-care decision-making,” said Michael Lynch, MD, FASAM, a Pittsburgh-based physician and co-author of the guidance. “That’s why the guidance clearly explains the symptoms of medetomidine withdrawal to allow clinical diagnosis and underscores the importance of regularly monitoring the local drug supply. Severe withdrawal is more likely in regions with high prevalence and concentrations of medetomidine.”

The guidance also addresses where patients should receive treatment. Moderate to severe cases often require more intensive settings, including hospitals and potentially intensive care units. For mild withdrawal, patients may benefit from nurse monitoring in medically managed intensive outpatient and ASAM Criteria Level 3.7 Medically Managed residential programs.

For patients whose withdrawal has stabilized in the hospital, transfer to an ASAM Criteria Level 3.7 Medically Managed Residential treatment program may be appropriate. These programs can provide ongoing medication management, vital sign monitoring, and daily assessments by a medical professional. It is critically important for Medicare, Medicaid, and other payers to cover this level of care due to its crucial role in addressing medetomidine withdrawal and other intensive care needs.

“Addressing the immediate crisis of life-threatening medetomidine withdrawal is just the first step," said Bridget Durkin, MD, a Philadelphia-based physician and co-author of the guidance. "Medically managed residential facilities play a crucial role in providing follow-up care and support services for post-acute withdrawal and cravings, as well as underlying substance use disorders. Community-based Addiction Medicine providers must also be prepared to manage post-acute medetomidine withdrawal, in addition to opioid use disorder. Medications for opioid use disorder remain a key treatment, even in the setting of this novel adulterant."

ASAM will host an educational webinar about the recommendations on Dec. 1, 2026, at 3 p.m. EST. Register here.

About the American Society of Addiction Medicine
The American Society of Addiction Medicine (ASAM), founded in 1954, is a professional medical society representing over 8,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. For more information, visit www.ASAM.org.