THE ASAM Treatment of Opioid Use Disorder Course

Includes waiver qualifying requirements

Session 5

Keeping Your Patient Safe

Session Learning Objectives

1. Examine misconceptions, stigma, and complexities (bioethical, social, clinical, public health) associated with OUD and the use of medications to treat opioid use disorder.

JENNIFER'S CASE

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- Jennifer was diagnosed with OUD, which started with opioid analgesics and then segued into IN heroin.
- She has been on buprenorphine/ naloxone film strips, 12 mg daily, for 5 years. Patient had a positive response to the medication and has had negative UDTs, with the occasional +THC, for years.

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- Jennifer is employed as an IT specialist at a law firm. She has been careful to "hide" her medication use from her family, friends, and co-workers, for fear of a negative reaction. She also thinks that if her co-workers knew about her OUD and medication, if a wallet were stolen, they would automatically suspect she was the thief.
- One year ago, Jennifer met her future wife at the law firm. Karishma is a paralegal at the firm and has no history of "drug" use.

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- As their relationship developed, Jennifer was ambivalent and fearful about disclosing her history of OUD and current OAT with buprenorphine. A few months before their wedding, Jennifer did disclose and Karishma was taken aback, but said it was not a problem.
- On Jennifer's last visit with you, she inquires about "getting off" buprenorphine. She relates that Karishma has never really been okay with the medication. Karishma has heard that it's "just substituting one drug for another" or "one addiction for another."

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- Karishma has a friend who has an AUD and attends AA meetings. The friend tells Karishma that her AA group is not okay with people on buprenorphine or methadone.
- Karishma and Jennifer had also planned on having a child, but Karishma is concerned that buprenorphine would be a problem if Jennifer were to be the birth mother.
- Jennifer has resumed weekly psychotherapy and they both see a couple's therapist.

Jennifer:

32-year-old woman who has been your patient for the past five years. She wants to taper and withdraw from buprenorphine.

- You are concerned that Jennifer wants to taper and withdraw from buprenorphine because of all these misconceptions, myths, and stigmas - which Karishma believes.
- You schedule an appointment with both Jennifer and Karishma to discuss each of the misconceptions individually and provide evidence for your suggestion that Jennifer continue with her successful treatment paradigm with buprenorphine.

Case Discussion – Jennifer

Discuss:

What stigmas and misconceptions would you address with Jennifer and Karishma?

What would you suggest for Jennifer's treatment plan?

Should Jennifer still want to taper down, how would you proceed?

Stigma and Treating OUD

Provider Myths

- It's substituting one drug/addiction for another.
- It's not really "recovery."
- The shorter the duration of therapy, the better.
- You can't be on buprenorphine if you are pregnant or breastfeeding.
- I'm worried about the DEA storming into my office.

Patient Myths

- It's substituting one drug/addiction for another.
- It's not really "recovery."
- The shorter the duration of therapy, the better.
- Other people may relapse, but not me.
- It must be damaging my liver, brain, kidney, heart, or bones.
- They won't be able to treat my pain.
- The pre-employment drug test will disqualify me.
- If I miss a dose, I'll go into terrible withdrawal.

Addiction Terminology

Correct	***Incorrect***
Person with substance use disorder.	Substance abuser, drug abuser, alcoholic, addict, user, abuser, drunk, junkie.
Babies born with an opioid dependency.	Addicted babies, born addicted.
Substance use disorder or addiction, use or misuse, risky or unhealthy use.	Drug habit, abuse, problem.
Person in recovery, abstinent, not drinking or taking drugs.	Clean.
Treatment or medication for addiction, medication for OUD/AUD, positive/negative results.	Substitution or replacement therapy, medication-assisted treatment, clean/dirty.

General Language

- *Use gender/sexuality-inclusive language.*
  - Be mindful of gender use in language, specifically during anecdotes and question response. Avoid assumptions.
  - Use “they,” “one,” and “who” as opposed to “he” or “she.”
- *Avoid jokes at the expense of patient and stigmatizing/offensive language.*

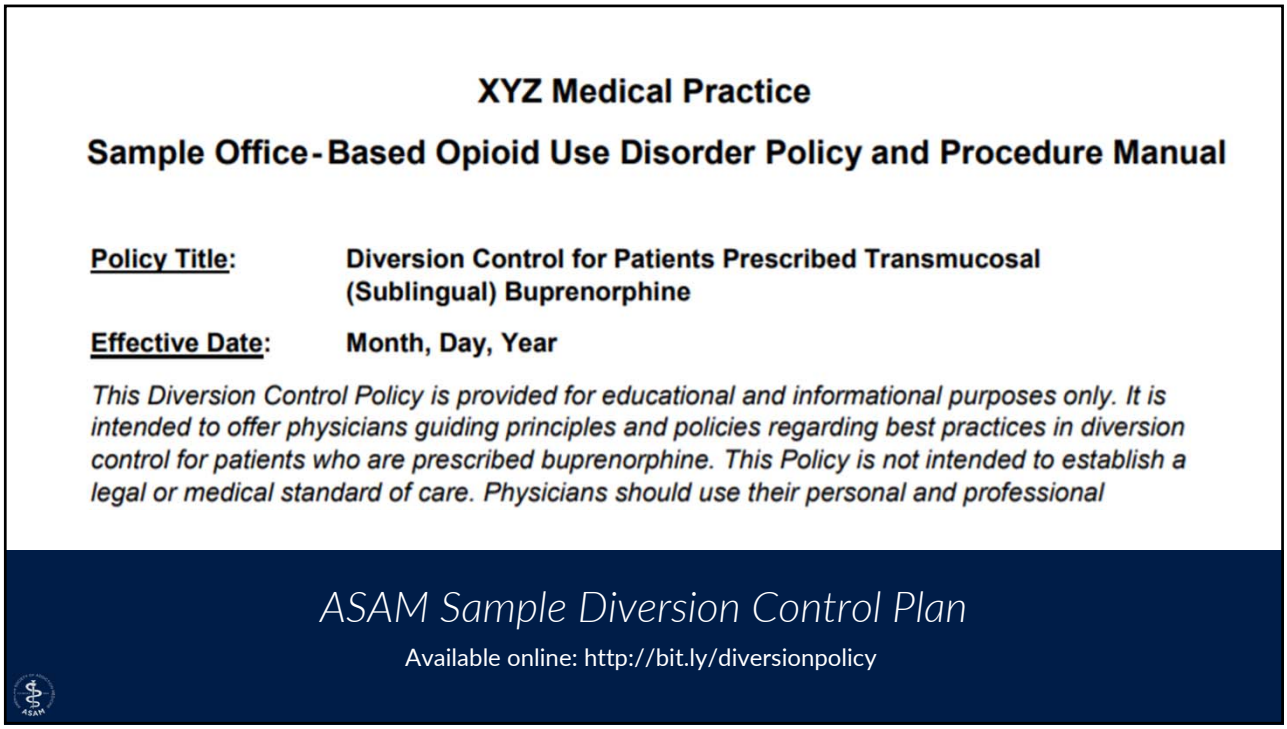
Where Patients Experience Stigma

Healthcare Setting

- Waiting room
- Intake with MA/nurse
- Pharmacy
- Other healthcare provider's practice
- Emergency Department
- Mutual help group

Outside Healthcare Setting

- Significant other
- Work
- Friend group
- Family
- Interest/hobby group
- Religious institution
- Media representation



ASAM Sample Diversion Control Plan

Available online: http://bit.ly/diversionpolicy

Diversion

People self-treating with diverted buprenorphine reported:

- 97% take it to prevent cravings
- 90% take it to prevent withdrawal
- 29% take it to save money

Why? Limited access to treatment, lack of health insurance.

Potential Diversion
Common Signs

- Requests for early refills (medication lost or stolen).
- Inconsistent laboratory testing (e.g., bup negative).
- Claims of being allergic to naloxone and requesting monotherapy.
- Police reports of patient selling in streets.
- Reports of concerning behavior.
- Inconsistent appointments (e.g., missed).

Risk Management:
Educate Patients about Harms of Diversion of Misuse

Misuse and Diversion

- Can lead to harmful medical and social consequences, overdose, and an increase in stigma for patients and providers.

Legislation

- Periodically re-evaluated by DEA and SAMHSA for risks and benefits.

What patients do with their medications matters for us all!

Responding to Misuse and Diversion

Evaluate
and reassess treatment plan and patient progress.

Intensify Treatment
or refer to higher Level of Care.

Document and Describe
clinical thinking that supports a clinical response, should be aimed at minimizing risk and treating patient at the level of care needed.

Harm Reduction

1. Naloxone and Overdose Education
2. Syringe Service Programs
3. Polysubstance Use
4. HIV, PrEP and PEP
5. Safer Sex

Opioid Mu Receptor Agonist Drug Effects

- *Acute Exposure*
  - Euphoria, nausea, vomiting, depressed respiration, sedation, analgesia.
- *Large Dose Acute Exposure*
  - Non-responsive, pinpoint pupils, hypotension, skin cyanotic, pulmonary edema.
- *Chronic Use Effects*
  - Physical dependence, withdrawal, tolerance, lethargy, constipation.

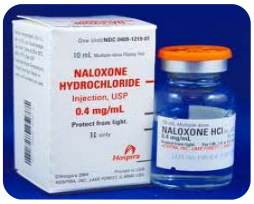
Opioid-induced Respiratory Depression

Opioids depress the brain stem's response.

- Depression of the medullary respiratory center.
- Decreased tidal volume and minute ventilation.
- Decreased respiratory response to elevated CO2.

- Hypercapnea, hypoxia and decreased oxygen saturation.
- Life threatening hypoxia.
- Sedation occurs before significant respiratory depression, and, therefore, is a warning sign.

Naloxone Formulations



Injection

1 dose = 0.4mg/1ml

Intramuscular

Nasal w/atomizer

"Multi-step"

1 dose = 2mg/2ml

Intranasal

Nasal spray

"Single-step"

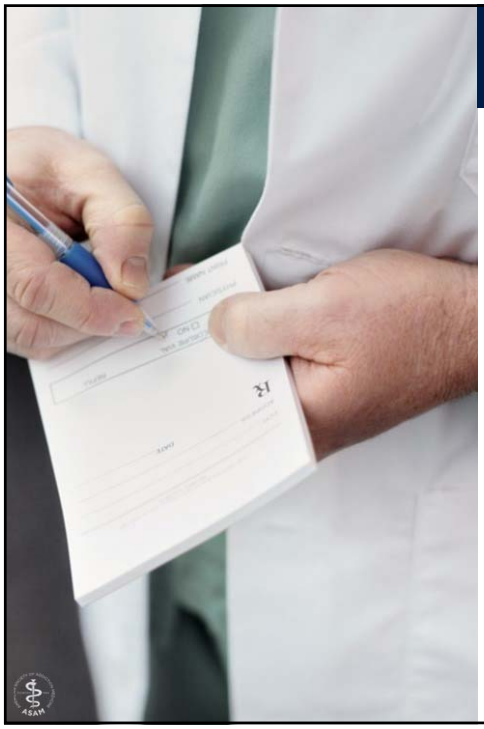
1 dose = 4mg/0.1ml

Intranasal

Auto-injector

1 dose = 0.4mg/1ml

Intramuscular



Naloxone

Prevent Overdose

- Broader provision of naloxone has been shown to prevent opioid overdose morbidity and mortality.

Co-Prescribe

- U.S. Department of Health and Human Services urges that all patients receiving medications for OUD be co-prescribed naloxone.

Coffin PO, Behar E, Rowe C, Santos GM, Coffa D, Bald M, Vittinghoff E. Nonrandomized intervention study of naloxone coprescription for primary care patients receiving long-term opioid therapy for pain. Annals of Internal Medicine. 2016;165(4):245–252.

Evaluations of Overdose Education and Naloxone Distribution (OEND) Programs

- Feasibility
- Increased knowledge and skills
- No increase in use, increase in drug treatment
- Reduction in overdose in communities
- Cost-effective

Piper et al. Subst Use Misuse 2008; Doe-Simkins et al. Am J Public Health 2009; Enteen et al. J Urban Health 2010; Bennett et al. J Urban Health. 2011; Walley et al. JSAT 2013

Green et al. Addiction 2008; Tobin et al. Int J Drug Policy 2009; Wagner et al. Int J Drug Policy 2010

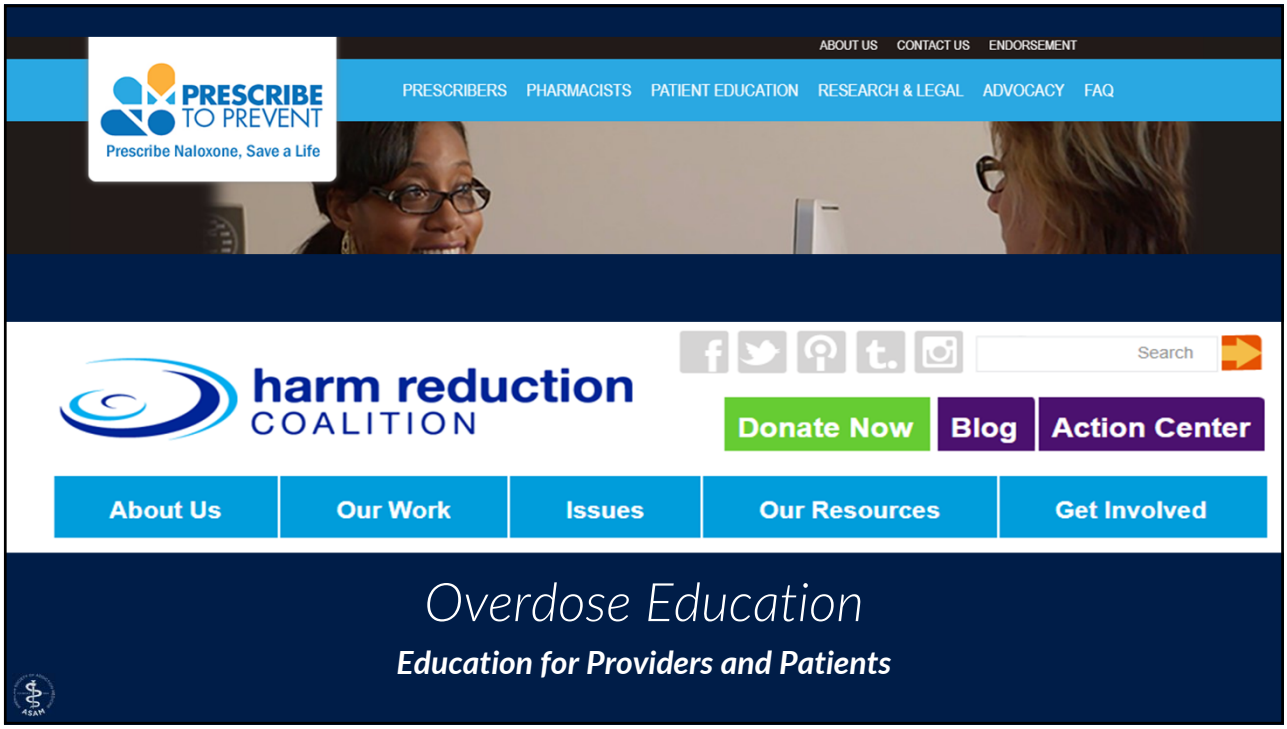
Seal et al. J Urban Health 2005; Doe-Simkins et al. BMC Public Health 2014; Jones et al. Addictive Behaviors 2017

Maxwell et al. J Addict Dis 2006; Evans et al. Am J Epidemiol 2012; Walley et al. BMJ 2013; Coffin et al. Ann Intern Med 2016

Coffin & Sullivan. Ann Intern Med. 2013

Overdose Education and Naloxone
Communicate to Patients

- *Don't use opioids alone. Beware of fentanyl.*
  - Known overdose risk factors: mixing substances, abstinence, using alone, unknown source.
  - Opportunity window: heroin overdoses take minutes to hours; fentanyl takes seconds to minutes.
  - Call 911 before administering naloxone.



Audience Response

Overdose education is important for which of the following groups?

a. Injection opioid users themselves
b. Family and friends of opioid users
c. Community members who may be exposed to opioid use
d. All of the above

Polysubstance Use
Tobacco, Alcohol, Cannabis

Substance	*Medication Options*	*Psychosocial Treatment*
Tobacco	Nicotine replacement therapy (patch, gum, lozenge); bupropion; varenicline	Cognitive behavioral therapy (CBT); mindfulness; telephone support and quitlines; mutual help
Alcohol	Naltrexone; acamprosate; disulfiram	CBT; motivational enhancement therapy; martial/family counseling; mutual help
Cannabis	No FDA-approved medications	CBT; contingency management; motivational enhancement therapy; mutual help

Polysubstance Use
Cocaine, Methamphetamine, Benzodiazepines

Substance	*Medication Options*	*Psychosocial Treatment*
Cocaine	No FDA-approved medications	CBT; contingency management; therapeutic communities; mutual help
Metham-phetamine	No FDA-approved medications	CBT; contingency management; mutual help
Benzo-diazepines	Diazepam and gradual dose reduction	CBT; contingency management; mutual help

Tobacco

~480,000 Deaths
Leading cause of preventable death (CDC)

2-4 times higher
Smoking rates higher in patients with SUD than general public

~67% smoke
Smoking rates among SUD patients who enter treatment

Death from tobacco
SUD patients more likely to die from tobacco than other substances

HIV and Injection Drug Use

- *Injection drug use accounts for ~1 in 10 HIV diagnoses in US.*
  - Sharing equipment increases risk: HIV can survive on a used syringe for 42 days.
  - **4th generation HIV test important (looks for HIV 1 & 2 antibodies and P24 antigen).**
  - Educate patient on Syringe Service Programs (e.g., needle exchange).
  - Educate patient on safe practices (e.g., do not share needles).

Visit: https://www.cdc.gov/hiv/risk/idu.html and https://www.hiv.gov/hiv-basics/hiv-testing/learn-about-hiv-testing/hiv-testing-overview

PrEP

- ☑ *Pre-exposure prophylaxis:*
  when people who don't have HIV take HIV medicine every day to reduce their chances of getting HIV.
- ☑ *Reduces risk of getting HIV:*
  from sex by ~88%.
  from injection drug use by >74%.

PrEP

Current FDA-Approved Medications

- Emtricitabine (200mg)/Tenofovir Disoproxil Fumarate (300mg): Truvada®.
- Emtricitabine (200mg)/Tenofovir Alafenamide (25mg): Descovy®.

Which is best?

- Truvada® vs Descovy® based on individual risk factors.
- Descovy® not for use in people assigned female at birth who are at risk of getting HIV through vaginal sex (effectiveness not yet studied).

PEP

- ☑ *Post-exposure prophylaxis:*

  when a patient takes HIV medicine very soon after possible exposure to HIV in order to prevent HIV infection.

- ☑ *Not meant for regular use:*

  PEP intended for emergency situations.

  Must be started within 72 hours after a possible exposure to HIV. The sooner, the better.

PEP

Current preferred medication regiment:

- Tenofovir disoproxil (300 mg)/emtricitibine (200 mg) QD, PLUS.
- Raltegravir (400 mg) BID or dolutegravir (50 mg) QD.

Length of treatment:

- If prescribed PEP, patient will take HIV medicine every day for 28 days.

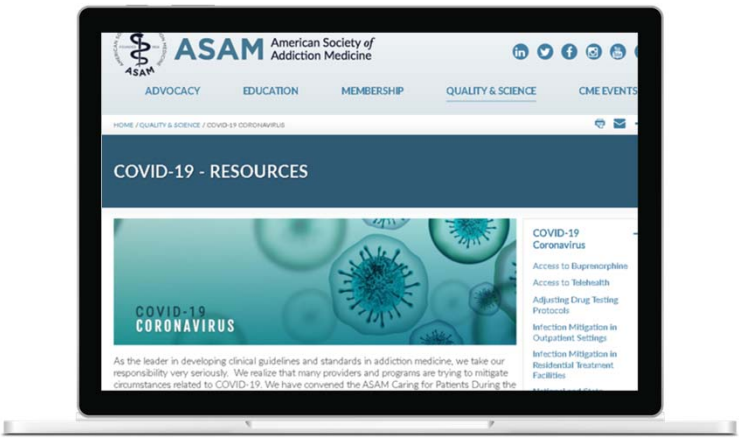
Safer Sex

- *People under the influence of drugs are more likely to engage in risky sex and could get HIV.*
  - Those who share needles/syringes are more likely to have unprotected sex.
  - Provider should educate patient on: contraception options, condoms, PrEP and PEP, regular STI testing.
  - Be aware of "club drug" use leading to unsafe sex.

Gyarmathy VA, Neaigus A. The relationship of sexual dyad and personal network characteristics and individual attributes to unprotected sex among young injecting drug users. AIDS Behav. 2009;13(2):196–206.

Buprenorphine and Naltrexone for OUD: COVID-19

Treating OUD During the COVID-19 Pandemic



Guidance for:

- Infection mitigation
- OTPs
- OBOT
- Telehealth
- Virtual Support Groups

- ***Overview of Federal and State Policy Changes related to COVID-19***

Methadone Access Under National COVID-19 Emergency - Highlights

- ***Telehealth***
  - Waiver of regulations related to HIPPA compliant telehealth platforms (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts, Skype).
  - Expansion of Medicare Coverage for telehealth.
  - Medicaid and private payer coverage varies by state and payer – check.
  - Check state laws/regulations on licensing.
- ***Existing Patients***
  - Can treat and dispense medication via telehealth (also use of telephone).
- ***New Patients***
  - Continued requirement for in-person physical exam for methadone initiation.
  - Take steps to minimize any exposures to provider or patient.

Methadone Access Under National COVID-19 Emergency - Highlights

- ***Take-home medications:***
  - States may request exceptions for stable patients to receive 28 days of take-home medications and for less stable patients to receive up to 14 days.
    - Providers should make decisions on an individual patient bases based on a risk-benefit analysis and considerations for risk related to both OUD and COVID-19.
  - Educate patients about safe storage, use, and management.
  - Ensure patients have access to naloxone.
  - Use telehealth/telephone to monitor patients.
  - Encourage patient participation in virtual support groups.

Methadone Access Under National COVID-19 Emergency - Highlights

- ***Alternative home delivery for isolated/quarantined patients:***
  - Allows designated staff members, law enforcement officers, or National Guard personnel to make deliveries of methadone, including "doorstep" delivery using an approved lockbox.
- ***Drug Testing:***
  - OTPs still required to provide a minimum of 8 drug tests/yr for each patient.
  - Consider pausing or exploring testing at a distance.

Methadone Access Under National COVID-19 Emergency - Highlights

- ***ASAM COVID-19 Resources:***
  - ASAM Methadone Access Guidance:
  - ASAM Telehealth Guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth
  - ASAM's Drug Testing Guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/adjusting-drug-testing-protocols
  - ASAM Support Group Guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/support-group

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Telehealth***
  - Waiver of regulations related to HIPPA compliant telehealth platforms (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts, Skype).
  - Expansion of Medicare Coverage for telehealth.
  - Medicaid and private payer coverage varies by state and payer – check.
  - Check state laws/regulations on licensing.
- ***Existing & Existing Patients***
  - New and existing patients can be evaluated and treated via telehealth including telephone; telehealth and phone for follow-up and monitoring.
  - Home induction to start new patients.
  - Do not require patients to participate in counseling – virtual or in-person – in order to access medication. (Generally recommended practice.)
  - Ensure patient access to naloxone.

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Flexibility prescribing using telehealth:***
  - DEA-registered practitioners may prescribe controlled substances to patients via telemedicine in states in which they are not registered with DEA.
- ***Use and Disclosure of Confidential Information (42CFR Part2):***
  - Patient information may be disclosed to medical personnel, without patient consent, to the extent necessary to meet a medical emergency.
  - Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed for treatment purposes as needed.

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Oral vs. Injectable Formulations***
- ***Factors to weigh:***
  - Is the patient experiencing any symptoms consistent with COVID or have they had any potential exposures?
  - Any anticipated risk to the patient associated with switching formulations?
    - Are they likely to be compliant with the oral medication?
  - The risk to the patient associated with an in-person visit:
    - Are they at high risk for severe illness?
    - Are they living with or caring for someone at high risk?
    - Would they need to take mass transit to the visit?
    - What is their level of anxiety around coming to an in-person visit?
  - Does your facility have sufficient staff and PPE to provide injections?

Buprenorphine Access Under National COVID-19 Emergency - Highlights

- ***Drug testing:***
  - Consider pausing or exploring testing at a distance.
- ***ASAM COVID-19 Resources:***
  - ASAM Buprenorphine Access: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-buprenorphine
  - ASAM Telehealth guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth
  - ASAM's drug testing guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/adjusting-drug-testing-protocols

Extended-Release Naltrexone Access Under National COVID-19 Emergency - Highlights

- Continued need for in-person patient contact for injection.
- Take steps to minimize any exposures to provider or patient.
- Oral naltrexone has not been proven to be effective for the treatment of OUD due to low compliance. But could be considered under limited circumstances.
  - See *ASAM's National Practice Guidelines for the Treatment of OUD*:
    - https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

Pregnant Women with OUD: COVID-19

Pregnant women with OUD in the Context of COVID-19: Buprenorphine

- ***Telehealth:***
  - Waiver of regulations related to HIPPA compliant telehealth platforms (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts, Skype.)
  - Expansion of Medicare Coverage for telehealth.
  - Medicaid and private payer coverage varies by state and payer – check.
  - Check state laws/regulations on licensing.

Pregnant women with OUD in the Context of COVID-19: Buprenorphine

- ***Existing Patients:***
  - Existing patients can be evaluated and treated via telehealth including telephone; telehealth and phone for follow-up and monitoring.
  - Do not require patients to participate in counseling – virtual or in-person – in order to access medication. (Generally recommended practice.)
  - Ensure patient access to naloxone to save the mother's life.

Audience Response

COVID-19's effects on persons with opioid use disorder include:

a. Decreased risk for opioid overdose death
b. Increased risk for social isolation
c. Decreased access to telehealth treatment
d. Decreased risk of new initiation to opioids

Activity 9

Challenges to Providing Care

Share your thoughts and/or concerns with office-based treatment of OUD.

Prompting Questions

- What issues do you foresee facing in treating OUDs?
- What challenges do you anticipate that were not covered in the course material?

10 minutes

KATIE'S CASE

Katie:

35-year-old woman who presents for follow-up care. She has diagnoses of severe opioid use disorder and moderate cocaine use disorder.

- She has been treated with buprenorphine/ naloxone 16/4 mg daily for 6 months and has stopped using heroin, which is confirmed by urine drug testing.
- However, her urine drug tests show evidence of continuous cocaine use.
  - *How will you respond to Katie's continued cocaine use?*

Activity 10

Susan, Emma, Jonathan

Assess the assigned cases and identify an appropriate treatment approach for each case. Determine if the patient meets DSM-5 criteria for an opioid use disorder.

Prompting Questions

What more information do you need to decide on a diagnosis(es) and treatment plan? Is the patient a suitable candidate for OBOT? Was your group in agreement or did you disagree? If you decide the patient is a good candidate for OBOT, what will the treatment plan include?

35 minutes

After the discussion, one member of each group shares key takeaways with the whole class.

SUSAN'S CASE

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She started using oxycodone with her roommate and has been using intranasal heroin (1 gram) daily for the last 15 months.
- Some of her friends are now switching to intravenous use because it takes less heroin to keep from getting sick.
- She does not want to inject drugs but may be "forced" to because she cannot keep paying the "extra cost" of sniffing heroin.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She has used all the money her parents gave her for school expenses to buy heroin, her credit cards are maxed out, and she has borrowed money from her friends.
- Until last semester, she had an overall B average, but this semester she is struggling academically and has been told she will be put on academic probation if her grades don't improve.

Susan:

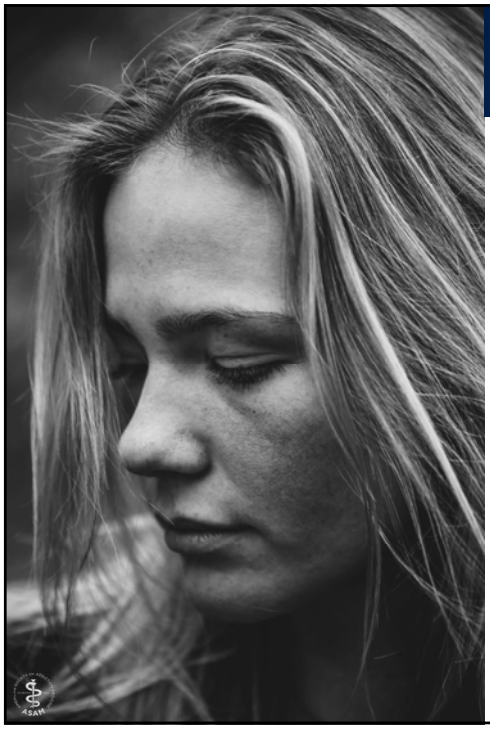
20-year-old community college student requesting treatment for her heroin addiction.

- When she doesn't use heroin, she has anxiety, muscle aches, diarrhea, and can't sleep.
- She recognizes the symptoms as heroin withdrawal. She was surprised because she thought she could not develop withdrawal from only sniffing drugs.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She smokes one pack of cigarettes per day.
- She drinks alcohol on the weekends, up to 3 drinks per occasion.
- She denies other drug use.
- She has no prior history of addiction treatment.



Case Discussion – Susan

Discuss:

- **Does she meet the criteria for DSM-5 moderate to severe OUD?**
- Is she a candidate for office-based opioid treatment with buprenorphine/ naloxone?
- What additional information would you need to make that decision?
- If you decide to treat Susan, what are your treatment plan and goals?

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She was induced on buprenorphine in the office and given a prescription for 6-day supply of bup/nx (16/4 mg/day) and was told to participate in the clinic's 2x per week relapse prevention group and to schedule individual counseling at an off-site program.
- She was told she needed to attend the relapse prevention group in order to get her next bup/nx prescription.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She returns in 6 days for her next bup/nx refill.
- She has not attended the relapse prevention group nor arranged for counseling.
  - *What will be your treatment approach at this time?*

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She was only partially adherent with the recommended counseling for 3 weeks including attending all but 1 of the relapse prevention groups but never started counseling.
- She states she has been too busy to go to counseling. She goes to school 5 days a week and has a new job working evenings as a waitress at a pub.
  - *Should you require Susan to attend counseling? Why? Why not?*

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She then returns in 4 days (3 days before her follow up appointment) and states that one of her friends stole her bup/nx tablets.
- Her urine is buprenorphine negative and opiate positive. She states she is sniffing heroin again to prevent withdrawal after running out of bup/nx.

Susan:

20-year-old community college student requesting treatment for her heroin addiction.

- She has been missing too many classes and has had to change her status to part-time student. She told her parents that she needs time away from school to figure out what her major should be.
- She wants "one more chance" to restart bup/nx treatment.
  - *What would you recommend for Susan at this point?*

EMMA'S CASE

Emma:

26-year-old assistant department store manager who has been using nonprescribed oxycodone on and off since age 18.

- Emma uses oxycodone when she feels down or socially isolated and it helps her deal with the stress of her work.
- No history of withdrawal management or addiction treatment.
- Stopped on her own for 6 months but relapsed 3 months ago and is now using daily.

Emma:

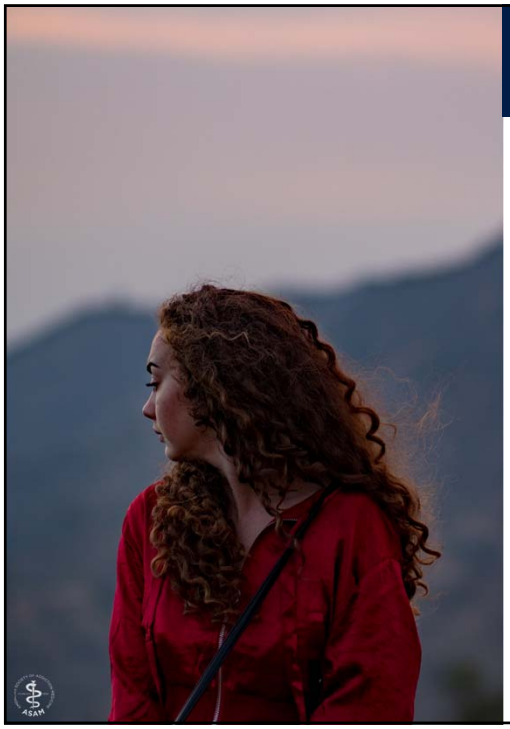
26-year-old assistant department store manager who has been using nonprescribed oxycodone on and off since age 18.

- She lives in an apartment with her fiancé.
- In the past, her boyfriend was concerned about the amount of money she spent on illicit opioids.
- Her boyfriend does not know about her current use of oxycodone.
- She is at risk of losing her job due to absenteeism.

Emma:

26-year-old assistant department store manager who has been using nonprescribed oxycodone on and off since age 18.

- No family history of alcoholism or substance use.
- She drinks alcohol "socially" with friends.
- She smokes ½ pack cigarettes per day.
- She denies other drug use.
- Her only current medical problem is mild asthma.
- She does not know her hepatitis C and HIV status.



Case Discussion – Emma

Discuss:

- **Does she meet DSM-5 criteria for an opioid use disorder?**
- Is Emma's OUD mild, moderate, or severe?
- What more information would you like before deciding on a diagnosis(es) and treatment plan?

JONATHAN'S CASE

Jonathan:

48-year-old engineer requesting transfer from methadone maintenance to office-based buprenorphine treatment.

- On methadone maintenance treatment program for 12 years but is tired of all the strict rules and policies.
- Current methadone dose is 95 mg.
- His 13-day take-homes were recently discontinued when he missed his 2nd group counseling session in 3 months. He is now required to have daily observed dosing.

Jonathan:

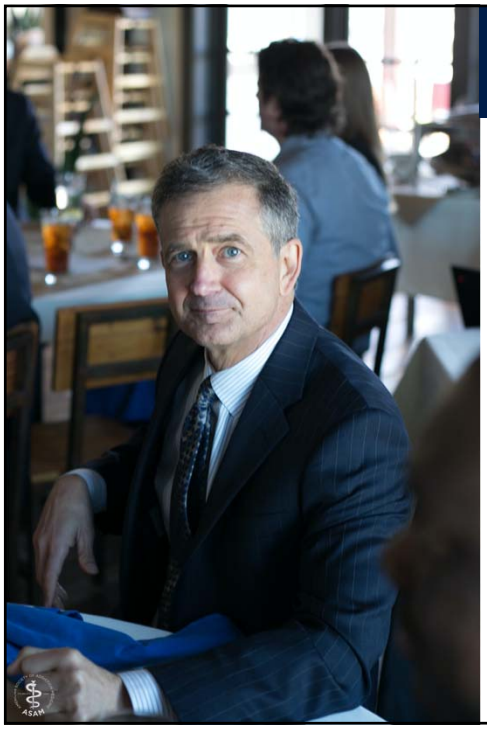
48-year-old engineer requesting transfer from methadone maintenance to office-based buprenorphine treatment.

- He does not think the group counseling is helping him anymore. He thinks it was helpful in the beginning but now it is just a burden.
- He is caring for his sick parents along with working full time which makes it difficult for him to reliably attend his weekly afternoon counseling session.
- Prior to methadone maintenance, he had an 8-year history of intravenous heroin use.
- Since starting methadone maintenance, he has been abstinent from heroin use.

Jonathan:

48-year-old engineer requesting transfer from methadone maintenance to office-based buprenorphine treatment.

- He is hepatitis C positive (never treated) and HIV negative.
- He has been in a stable relationship with a non-drug-using girlfriend for the past 7 years.
- He wants to discontinue methadone maintenance ASAP and transfer to buprenorphine so that he can “get on with my life.”



Case Discussion – Jonathan

Discuss:

- **Is Jonathan a good candidate for OBOT?**
- What additional information do you need?
- If you decide he is a good candidate for transfer to OBOT with buprenorphine/ naloxone, what will the treatment plan include?

Activity 11

End of Course Reflection

Take five minutes to revisit the training goal you wrote down at the beginning and jot down what you found most valuable from the course, where you could use the knowledge gained in your work, and challenges you anticipate in prescribing medication for OUD.

Prompting Questions

- What are some strategies and solutions for overcoming challenges when treating opioid use disorder?

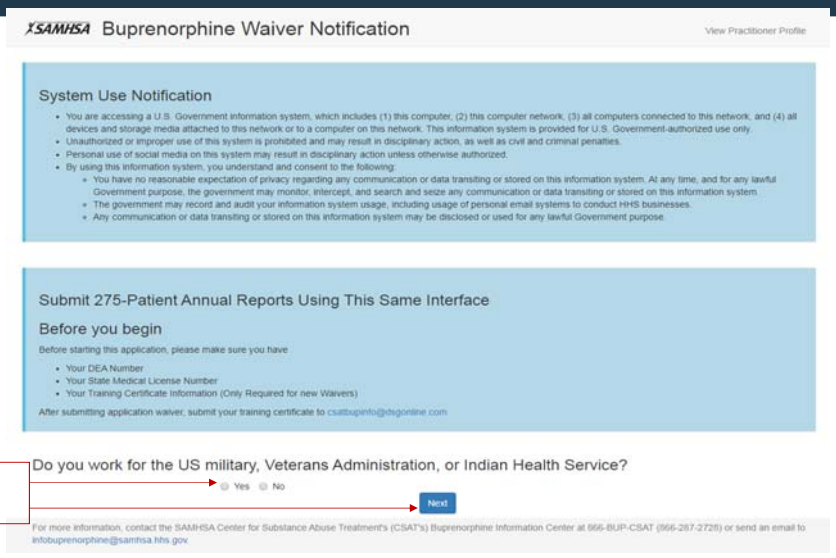
10 minutes

After the discussion, one member of each group shares key takeaways with the whole class.

Entering a 30 Patient Notification

Buprenorphine Waiver Notification Form

Go to this link: **http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php**



Select “Yes” or “No.”
Click “Next.”

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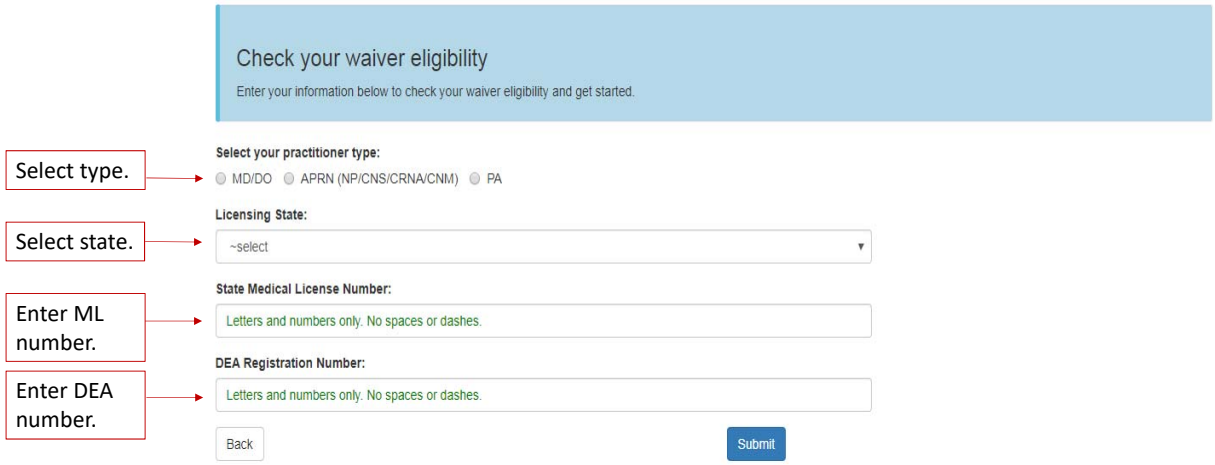
Look up your DEA number and address on file here: **https://apps.deadiversion.usdoj.gov/webforms/validateLogin.jsp**



Select type.

Select state.

Enter ML number.

Enter DEA number.

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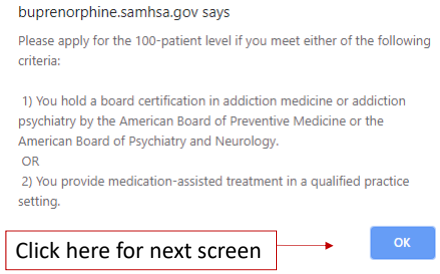
You will receive a prompt to apply for the 100-patient level if you meet certain criteria.



Click here for next screen

What is a Qualified Practice Setting?

- A qualified practice setting is a practice setting that:
  i. provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
  ii. provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
  iii. uses health information technology systems such as electronic health records;
  iv. is registered for their State prescription drug monitoring program (PDMP) where operational and in accordance with Federal and State law; and
  v. accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or Federal health benefits.

Please note, all five criteria must be met.

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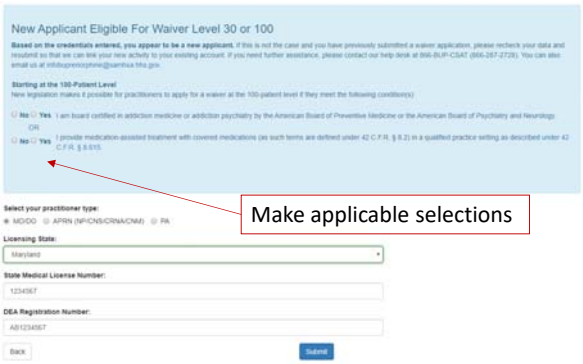
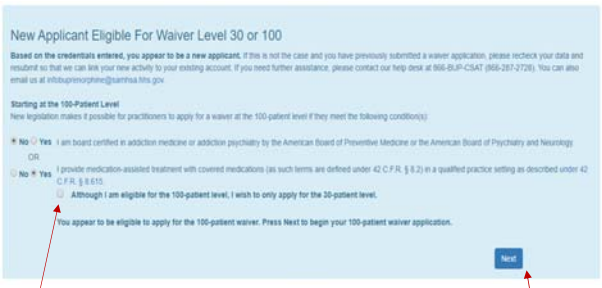
We encourage eligible providers to apply for the 100-patient waiver. This does not mean you have to treat 100 patients.





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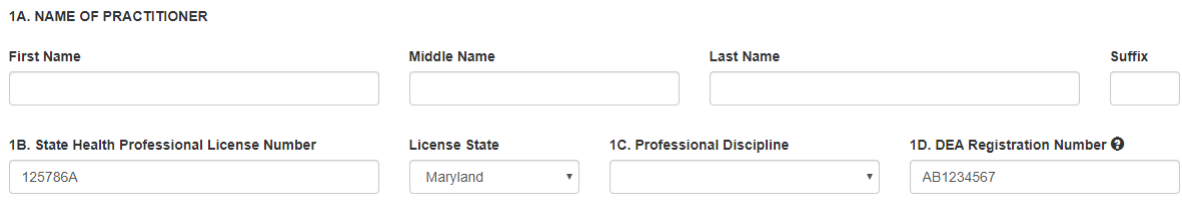
1A. Type in name.
1B. (Auto populated).
1C. Select professional discipline.
1D. (Auto populated).



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2. Type in primary/service address where you intend to practice.
3. Type in primary/service phone number.
4. Type in fax number (optional).
5. Type in e-mail twice. (This e-mail is where you will receive your approval letter.)

Only one address should be specified. For the practitioner to dispense the narcotic drugs or combinations to be used under this notification, the primary address listed here must be the same primary address listed in the practitioner's registration under § 823(f).

2. ADDRESS OF PRIMARY LOCATION

Address Line 2

City

State

New Mexico

Zip Code

3. TELEPHONE NUMBER

xxx-xxx-xxxx

Extension (if applicable)

4. FAX NUMBER

xxx-xxx-xxxx

5. EMAIL ADDRESS

Confirm Email Address

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New Notification - an initial notification for a waiver submitted for the purpose of obtaining an identification number from DEA for inclusion in the registration under 21 USC § 823(f).

***New Notification 100** - an initial notification for a waiver .....

New Notification, with the intent to immediately facilitate treatment of an individual (one) patient - an initial notification submitted for the purpose described above, with the additional purpose of notifying the Secretary and the Attorney General of the intent to provide immediate opiate addiction treatment for an individual (one) patient pending processing of this waiver notification.

Second Notification - For physicians who submitted a new notification not less than one year ago and intend and need to treat up to 100 patients. (See Office of National Drug Control Policy Reauthorization Act of 2006.)

6. PURPOSE OF NOTIFICATION

- [x] New Notification to treat up to 30 patients
- [ ] Second notification of need and intent to treat up to 100 patients
- [ ] New Notification, with the intent to immediately facilitate treatment of an individual (one) patient
- [ ] New notification to treat up to 100 patients*

*NOTE: In order to treat up to 100 patients in the first year, practitioners must either hold additional credentialing as defined under 42 C.F.R. § 8.2, or provide medication-assisted treatment with covered medications (as such terms are defined under 42 C.F.R. § 8.2) in a qualified practice setting as described under 42 C.F.R. § 8.615.

7. CERTIFICATION OF USE OF NARCOTIC DRUGS UNDER THIS NOTIFICATION

- [x] When providing maintenance or detoxification treatment, I certify that I will only use Schedule III, IV, or V drugs or combinations of drugs that have been approved by the FDA for use in maintenance or detoxification treatment and that have not been the subject of an adverse determination.

6. (Auto selected for 30 or 100).
7. Check off box.

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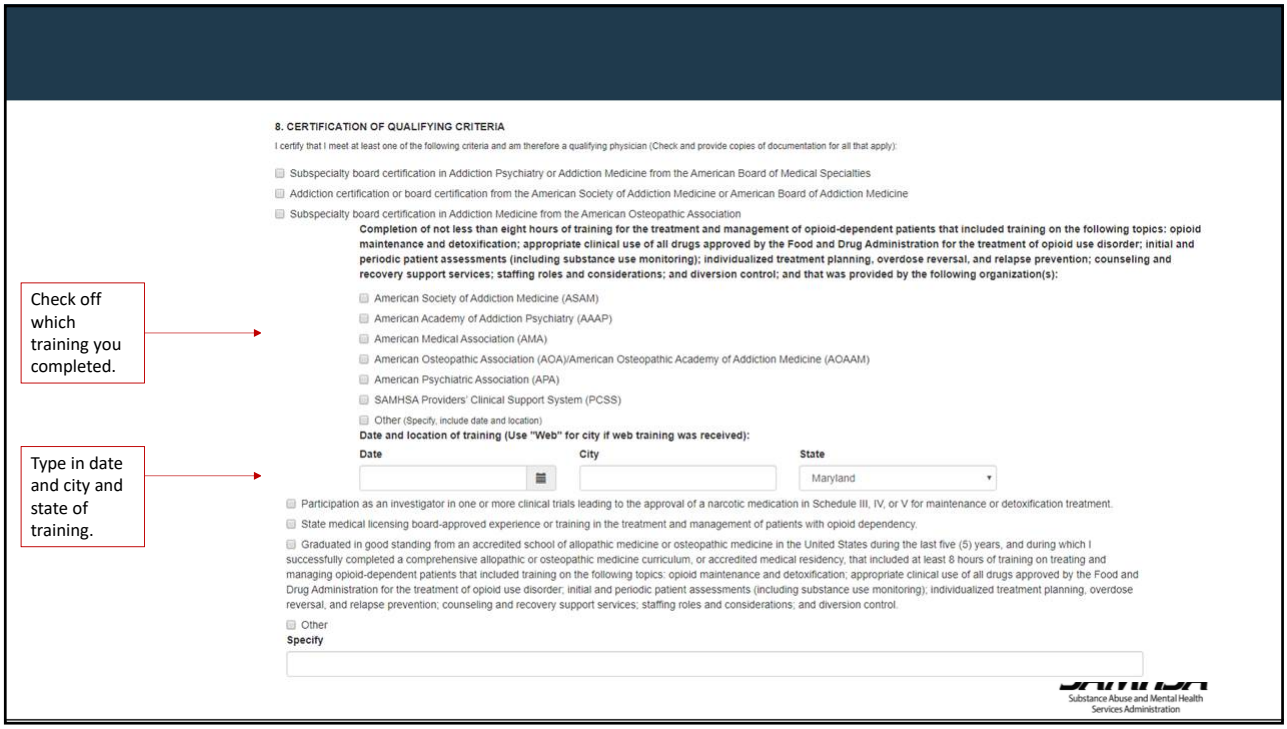
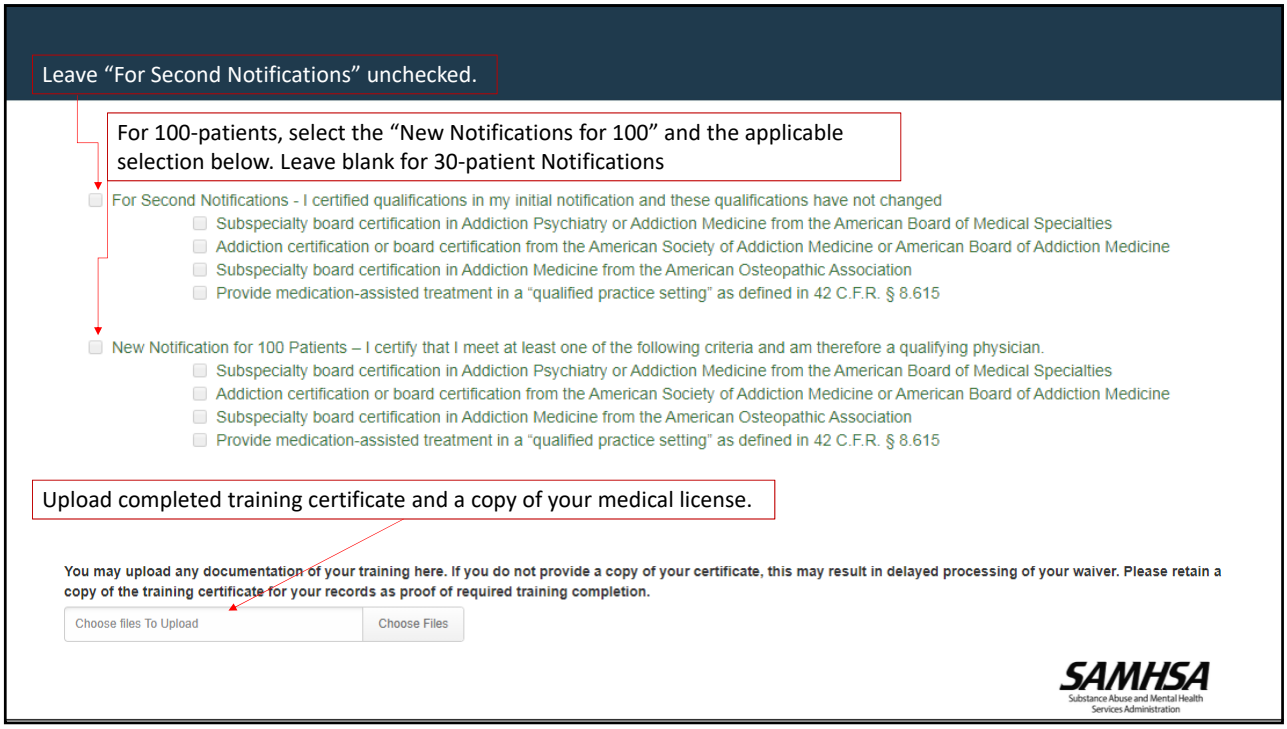


Check off which training you completed.

Type in date and city and state of training.



9. Check off both boxes.
9B. (Auto selected for 30 or 100).

9. CERTIFICATION OF CAPACITY

☑ I certify that I have the capacity to provide patients with appropriate counseling and other appropriate ancillary services, either directly or by referral.

☑ I certify that I have the capacity to provide, directly or through referral, all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention.

9B. CERTIFICATION OF MAXIMUM PATIENT LOAD

◉ I certify that I will not exceed 30 patients for maintenance or detoxification treatment at one time.

○ Second Notification – I have provided treatment at the 30 patient limit for one year and need to treat up to 100 patients and I certify that I will not exceed 100 patients for maintenance or detoxification treatment at one time if I meet the criteria under 21 U.S.C. 823(g)(2)(B)(iii)(II)(aa)-(cc).

○ New Notification for 100 Patients – I will not exceed 100 patients for maintenance or detoxification treatment at one time.

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Check a box indicating whether or not you consent.

Check "yes" or "no"—whichever applies to you.

Check off box.

Sign.

Re-enter DEA number.

Hit the "submit" button.

The SAMHSA Treatment Locator Web site is publicly accessible at http://buprenorphine.samhsa.gov/bwns_locator. The Locator Web site lists the names and practice contact information of physicians with DATA waivers who agree to be listed on the site. The Locator Web site is used by the treatment-seeking public and health care professionals to find physicians with DATA waivers. The Locator Web site additionally provides links to many other sources of information on substance abuse. No physician listings on the SAMHSA Treatment Locator Web site will be made without the express consent of the physician.

10A. CONSENT

◉ I consent to the release of my name, primary practice address, and phone number to the SAMHSA Treatment Locator Web site.

○ I do not consent to the release of my name, primary practice address, and phone number to the SAMHSA Treatment Locator Web site.

10B. CONSENT Do you also want to be identified on the SAMHSA Treatment Locators as providing treatment with:

	Yes	No
1. Long-acting injectable naltrexone	○	○
2. Long-acting injectable buprenorphine	○	○
3. Long-acting implantable buprenorphine	○	○

11.

☑ I certify that the information presented above is true and correct to the best of my knowledge. I certify that I will notify SAMHSA at the address below if any of the information contained on this form changes. Note: Any false, fictitious, or fraudulent statements or information presented above or misrepresentations relative thereto may violate Federal laws and could subject you to prosecution, and/or monetary penalties, and or denial, revocation, or suspension of DEA registration. (See 18 USC § 1001; 31 USC §§ 3801–3812; 21 USC § 824.)

Please type your name to sign this electronic form. Submission Date: 10/10/2019

Please re-enter your DEA Registration Number to verify:

Submit

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PLEASE NOTE THE FOLLOWING:

DATA Waiver Team Email Address: InfoBuprenorphine@samhsa.hhs.gov

Confirmation e-mails are sent immediately after your application is submitted.

Approval Letters are e-mailed within 45 days of your complete application submission.

*Please check your junk and spam folders if you have not already added InfoBuprenorphine@samhsa.hhs.gov to your contacts.

Any questions or inquiries should be directed to InfoBuprenorphine@samhsa.hhs.gov or call 1-866-287-2728.

SAMHSA Substance Abuse and Mental Health Services Administration

Q&A

KEEPING YOUR PATIENTS SAFE

End of Session 5

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