University of Idaho
School of Health and Medical Professions

Medications for Opioid Use Disorders Toolkit for Idaho Health Care Providers






Introduction

University of Idaho's School of Health and Medical Professions, with funding support from the Idaho Department of Health and Welfare, developed the Medications for Opioid Use Disorder (MOUD) toolkit to support Idaho health care providers to deliver evidence-based care for individuals with opioid use disorder (OUD) using MOUD. It is intended to be a comprehensive and accessible resource for Idaho providers to deliver compassionate, effective, and sustainable OUD care across clinical settings. It provides practical guidance for implementing MOUD including background information, induction protocols, validated screening and diagnostic tools, workflow checklists and sample policies.

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1.

WHAT ARE MEDICATIONS FOR OPIOID USE DISORDERS?

Understanding Medications for Opioid Use Disorder

Medications for Opioid Use Disorder (MOUD) are a cornerstone of evidence-based treatment for opioid use disorder (OUD). MOUD involves the use of FDA-approved medications to reduce cravings, prevent withdrawal and support long-term recovery.

The term Medication-Assisted Treatment (MAT) has historically been used, but MOUD is now preferred, as it more accurately reflects that medications are central to effective treatment.

FDA-approved medications for OUD include buprenorphine, methadone and naltrexone.

BUPRENORPHINE

A partial opioid agonist that reduces cravings and withdrawal with a lower risk of overdose due to its ceiling effect.

METHADONE

A full opioid agonist that relieves withdrawal and cravings; typically dispensed through certified opioid treatment programs.

NALTREXONE

An opioid antagonist that blocks the activation of opioid receptors. Naltrexone does not treat opioid withdrawal and can worsen withdrawal symptoms if taken by someone who recently used opioids.

Benefits of MOUD

Evidence consistently shows that MOUD saves lives and improves outcomes for individuals with OUD.[1] In spite of the benefits, only a small fraction of eligible patients receive treatment.[2]

Three evidence-based benefits to MOUD:[6]

- Reduces risk of death from overdose by 50% or more
- Improves retention in treatment programs
- Decreases illicit opioid use and related harms

5.7 million Americans had an opioid use disorder in 2023 but **only 18%** received **MOUD.**[2]

Only 1 in 5 people with OUD achieve 2 years of abstinence **WITHOUT medications**, and those who relapse are at **high risk of death.**

After someone has overdosed once, **the chance of dying** in the next year is **1 in 10.**[5]

How MOUD Works

MOUD stabilizes brain chemistry and breaks the cycle of opioid cravings, compulsive use, and withdrawal. This allows individuals to:

- Re-engage in daily life and responsibilities
- Participate in behavioral health services
- Move towards long-term recovery and improved health outcomes[5]

264 Idahoans died from opiod-related **drug overdose** in 2023.[7]

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What is Opioid Use Disorder?

OUD is a chronic brain disorder caused by repeated opioid exposure which hijacks the brain's reward system. Opioids flood the brain with dopamine, a neurotransmitter that drives motivation and reward, making natural rewards (e.g., food, connection) feel less meaningful. This creates intense, compulsive cravings and impaired decision-making.[4]

2.
MYTHS AND FACTS

Medications for Opioid Use Disorder (MOUD) Myths and Facts

MYTH 1:

Buprenorphine is addictive.

FACT:

Buprenorphine doesn't get people high; it helps them stay alive and get better.

Buprenorphine is a safe and effective medication for treating opioid use disorder. It is not addictive in the same way as heroin, fentanyl or other illicit opioids. While long-term use can lead to physical dependence, this is expected and does not mean someone is addicted. When taken as prescribed, buprenorphine does not produce the intense euphoric effects associated with opioid misuse. It helps reduce craving and withdrawal symptoms, supports brain stabilization and allows individuals to lead functional, healthy lives. Treatment with buprenorphine is associated with a significantly lower risk of overdose and death.[1]

MYTH 2:

MOUD is just replacing one drug with another.

FACT:

MOUD replaces chaos with stability and a real path to recovery.

MOUD is not a substitution, it is an evidence-based treatment that saves lives. Medications like buprenorphine, methadone and naltrexone help normalize brain chemistry, reduce cravings and prevent withdrawal. When taken appropriately, they do not produce a high. Instead, they support recovery, reduce overdose risk and help patients fully participate in counseling, employment and activities of daily life.

MYTH 3:

People with OUD just need to try harder, it's a willpower issue.

FACT:

OUD is a chronic brain disease, not a choice or moral failure.

Opioid Use Disorder (OUD) is a chronic medical condition that alters brain chemistry and function. It is not a sign of weak character or lack of motivation. Like diabetes or hypertension, it requires medical treatment and ongoing care. MOUD addresses the neurobiological aspects of addiction, supporting the brain's healing process while reducing the risk of relapse and overdose.

MYTH 4:

Patients divert and misuse buprenorphine to get high.

FACT:

Most people use buprenorphine to get off opioids, not on them.

While diverted buprenorphine does occur, it is most often used for therapeutic purposes. In one study, 79% of individuals reported using non-prescribed buprenorphine to manage withdrawal, 67% to stay off other drugs, and 53% to taper their use. Only 4% considered it their preferred drug. Importantly, many individuals who used diverted buprenorphine reported difficulty accessing prescriptions and said they would prefer legal, supervised treatment if available.[2]

MYTH 5:

Counseling is required to receive MOUD.

FACT:

Medication is treatment; counseling can help but it is not a requirement.

While counseling can be a helpful part of recovery, it is not mandatory to begin or continue pharmacotherapy. Treatment decisions should be based on individual needs. If counseling is declined or unavailable, medication treatment should still proceed. MOUD is effective on its own and access should never be denied due to lack of behavioral health services.[3]

MYTH 6:

Buprenorphine carries the same overdose risk as other opioids.

FACT:

Buprenorphine has a built-in ceiling effect that makes it far safer than other opioids.

Buprenorphine is significantly safer than full opioid agonists like heroin, oxycodone or fentanyl. Its ceiling effect on respiratory depression means that increasing the dosage does not linearly increase the risk of slowed breathing, one of the primary causes of opioid overdose deaths.[4] When taken as prescribed, buprenorphine has a lower risk of overdose and is a life-saving treatment option.

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2. Cicero, T. J., Ellis, M. S. & Chilcoat, H. D. Understanding the use of diverted buprenorphine. *Drug Alcohol Depend.* 193, 117–123 (2018).
3. American Academy of Family Physicians. Treating Opioid Use Disorder as a Chronic Condition: A Practical Manual for Family Physicians. (2025). https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/treating-opioid-use-disorder.pdf
4. Zoorob, R., Kowalchuk, A. & Grubb, M. M. de. Buprenorphine Therapy for Opioid Use Disorder. *Am. Fam. Physician* 97, 313–320 (2018).

3.
MEDICATION OVERVIEW

Key Facts and Clinical Considerations

Overview

Buprenorphine is one of three FDA-approved Medications for Opioid Use Disorder (MOUD), along with methadone and naltrexone. It is the first MOUD that can be prescribed or dispensed in outpatient medical settings, greatly improving access to treatment, especially in rural and underserved areas.

Who can prescribe buprenorphine?

The Consolidated Appropriations Act of 2023 eliminated the federal X-waiver and additional training requirements for prescribing buprenorphine. As a result, any providers with a current DEA registration that includes Schedule III authority may prescribe buprenorphine.[1]

How does buprenorphine work?

Buprenorphine is a partial opioid agonist. This means it binds tightly to the mu-opioid receptor, but activates it less strongly than full agonists like methadone or heroin.[2] Its pharmacologic properties include:

1. **"Ceiling effect":** after a certain dose, opioid-related effects (e.g., respiratory depression) plateau, enhancing safety in overdose scenarios.
2. **High receptor affinity:** It blocks other opioids from binding, which helps reduce the euphoric effects of opioid use.
3. **Slow dissociation:** Provides long-lasting action that helps reduce withdrawal symptoms and cravings.[3]

These properties contribute to its efficacy, safety and lower potential for misuse.[2]

Treatment Duration

MOUD should be provided as long as clinically indicated. There is no universal "treatment endpoint." Maintenance treatment is often associated with improved long-term outcomes, including reduced risk of relapse and overdose.[4]

Available Formulations

Buprenorphine is available in several forms:

- Tablets
- Sublingual films
- Long-acting injectables (weekly to monthly)

Many tablet and film formulations are co-formulated with naloxone to deter misuse.

Table 1: Common buprenorphine monoproduct and combination products[5]

Drug	Available Dose
Buprenorphine (generic) sublingual tablet (XL tab)	2mg, 8mg
Buprenorphine/ naloxone (generic) SL tab	2mg bup/0.5mg nalox 8mg bup/2mg nalox
Buprenorphine/ naloxone (Zubsolv®) SL tab	1.4mg bup/0.36mg nalox 2.9mg bup/0.71mg nalox 5.7mg bup/1.4mg nalox 8.6mg bup/2.1mg nalox 11.4mg bup/2.9mg nalox
Buprenorphine/ naloxone (Suboxone®) SL film	2mg bup/0.5mg nalox 4mg bup/1mg nalox 8mg bup/2mg nalox 12mg bup/3mg nalox
Buprenorphine (Sublocade®) long-acting injection	100mg/0.5mL prefilled syringe 300mg/1.5mL prefilled syringe
Buprenorphine (Brixadi®) long-acting injection	Weekly: 8mg, 16mg, 24mg, 32mg

Table 2: Potential Interactions between Buprenorphine and Other Drugs[3]

Drug Class	Potential Interaction
Anticholinergics	Increased risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.
Benzodiazepines	Co-use, especially via injection, has been linked to coma and death. Benzodiazepines may also reduce the ceiling effect of buprenorphine-induced respiratory depression, making the risk more like that of full opioid agonists.
Cytochrome P450 3A4 inducers (e.g., phenobarbital, carbamazepine, phenytoin, rifampin)	Increased buprenorphine clearance, potentially reducing effectiveness or triggering withdrawal symptoms.
Cytochrome P450 3A4 inhibitors (e.g., azole antifungals, macrolide antibiotics, protease inhibitors, antidepressants)	Decreased buprenorphine clearance, increasing or prolonging opioid effects. Monitor for respiratory depression or sedation; dose adjustment may be needed.
Nonbenzodiazepine muscle relaxants (e.g., carisoprodol [Soma], cyclobenzaprine [Flexeril])	May enhance respiratory depression
Other central nervous system depressants (e.g., sedatives, hypnotics, general anesthetics, tranquilizers, other opioids, alcohol)	Increased risk of respiratory depression, profound sedation, hypotension, coma and death
Psychostimulant: Cocaine	May increase metabolism and lower buprenorphine plasma concentrations, reducing its effectiveness.

Brief Notes on Other FDA-approved MOUD

Methadone:
Methadone is a long-acting, full opioid agonist and a Schedule II controlled substance. Because it is a full agonist, it carries a higher risk of respiratory depression and overdose. Methadone for OUD must be dispensed through a SAMHSA-certified opioid treatment program, where it is typically administered in person on a daily basis. It is available in oral formulations and requires regular monitoring due to its potency and risk profile.

Naltrexone:
Naltrexone is a mu-opioid receptor antagonist. It works by blocking the effects of opioids at the receptor level, meaning it prevents the euphoric and sedative effects of opioids such as heroin. Naltrexone is approved for the treatment of both opioid use disorder (OUD) and alcohol use disorder (AUD). For OUD, it is most commonly administered as a once-monthly extended-release intramuscular injection. Patients must stop using opioids before initiating naltrexone, usually 7-14 days of abstinence.[5]

More Resources on Buprenorphine
ECHO Idaho – Buprenorphine in Primary Care | Derek Hayton, DO | 11/14/2024

https://youtu.be/y1T6XWhPQtw?si=KMJh1jsY3bzjSjFX

ECHO Idaho – Long-Acting Injectable Buprenorphine | Alicia Carrasco, MD | 08/08/2024

https://youtu.be/zjfHWifvNzs?si=aSepwyvPQx3ROIwg

SAMHSA Buprenorphine Quick Start Guide: https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

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2. SAMHSA. What is Buprenorphine? Side Effects, Treatment & Use. https://www.samhsa.gov/substance-use/treatment/options/buprenorphine
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4. Fiellin, D. A. *et al.* Primary Care–Based Buprenorphine Taper vs Maintenance Therapy for Prescription Opioid Dependence: A Randomized Clinical Trial. *JAMA Intern. Med.* 174, 1947–1954 (2014).
5. American Academy of Family Physicians. Treating Opioid Use Disorder as a Chronic Condition: A Practical Manual for Family Physicians. (2025). https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/treating-opioid-use-disorder.pdf

4.

BUPRENORPHINE INDUCTION

Buprenorphine Induction Overview

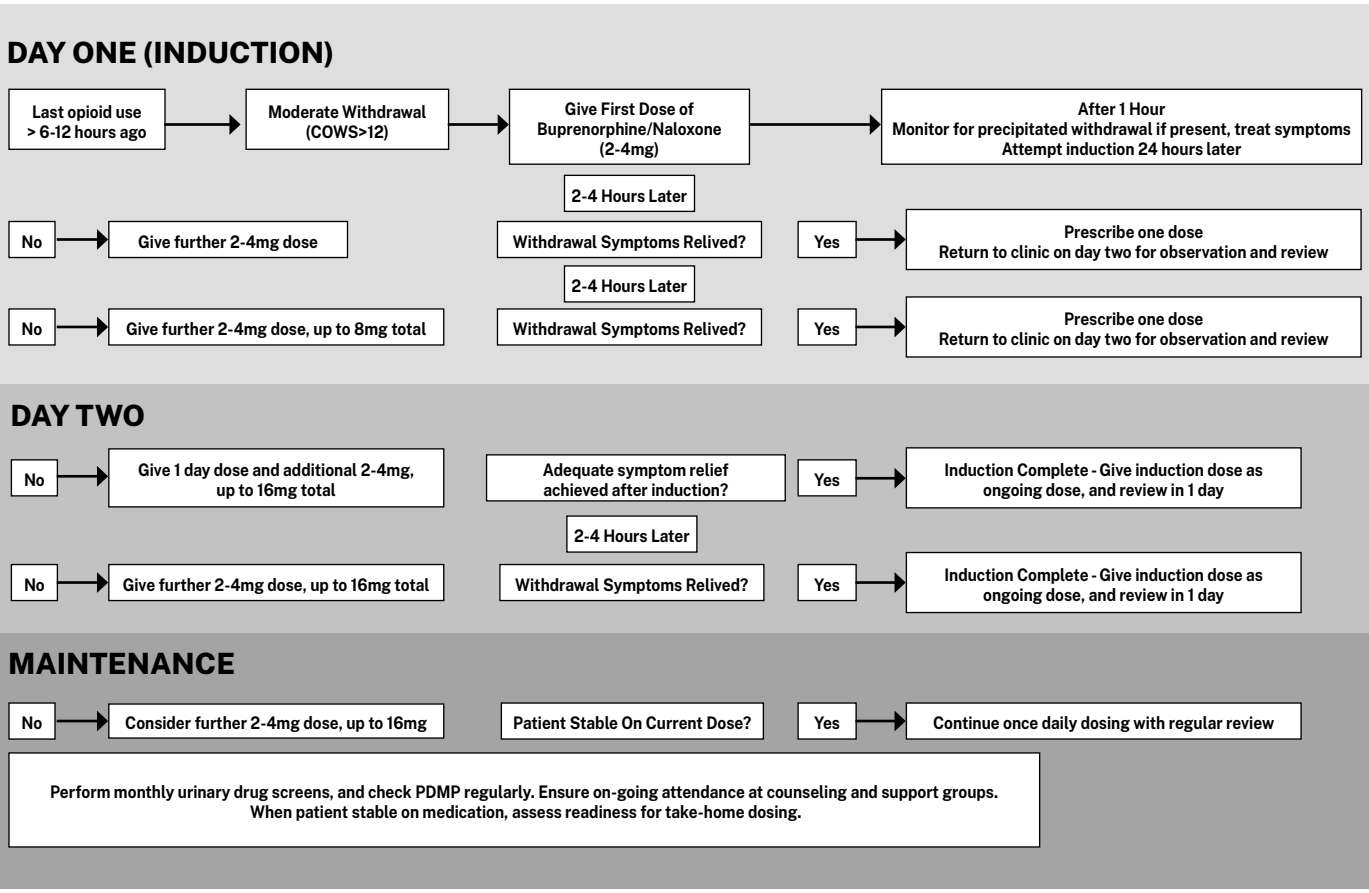
Buprenorphine induction is the process of starting a patient on buprenorphine for opioid use disorder (OUD). The goal is to initiate treatment without triggering precipitated withdrawal, manage side effects and adjust the dose to effectively reduce withdrawal symptoms and cravings.[1]

Precipitated Withdrawal: What to Know

Buprenorphine has a high affinity for the mu-opioid receptors but is a partial agonist, meaning it displaces a full agonist (e.g., heroin, fentanyl) without fully activating the receptor. If started too soon after recent opioid use, this can cause precipitated withdrawal, a sudden and intense onset of withdrawal symptoms.

To prevent this from happening, begin induction only after the patient has entered at least mild to moderate withdrawal. Use evidence-based tools to assess readiness. If precipitated withdrawal occurs, supportive symptom management can help:

- **Myalgia:** NSAIDS and acetaminophen
- **Muscle spasms:** tizanidine
- **Nausea:** ondansetron or promethazine
- **Diarrhea:** loperamide
- **Restlessness and sweating:** clonidine
- **Anxiety, dysphoria, lacrimation and rhinorrhea:** hydroxyzine
- **Insomnia:** trazodone



Home Induction

Home induction is a safe and effective option for many patients and offers greater flexibility and privacy. It may be appropriate when the patient has a stable home environment or support system, there are transportation or scheduling barriers to office visits, or the patient has prior experience with buprenorphine.

Home Induction Clinic Protocol Example (Appendix 4-1)

A Patient's Guide to Starting Buprenorphine at Home Example (Appendix 4-2)

Office-Based Induction

Office-based induction allows for real-time symptom monitoring and can be ideal for patients who are new to MOUD or anxious about induction, may be at a higher risk for precipitated withdrawal, or lack a safe, private environment for home induction.

Additional Induction Resources

Introduction to Buprenorphine Induction:

Idaho Department of Health & Welfare | Magni Hamso, MD

https://youtu.be/ILCCp4ydm5M?si=Ni2cVK4DDAPJxu0U

Low-Dose Induction for Converting to Buprenorphine:

ECHO Idaho – Low Dose Induction with Buprenorphine | Todd Palmer, MD | 10/10/2024

https://youtu.be/rzy89PlcndM?si=p0k99QDY1U8OhM9N

Induction Considerations for Recent Fentanyl Use:

ECHO Idaho - Fentanyl | Andrew Kloberdanz, DO | 09/26/2024

https://www.youtube.com/watch?v=qItF_vukRjk&t=732s

Emergency Department Induction:

ECHO Idaho – Emergency Treatment with Buprenorphine | Brian Powers, DO | 01/09/2025

https://youtu.be/H8mJ3RhyVOM?si=5eusBSIjaql-Ik90

More on MOUD in Idaho:
https://healthandwelfare.idaho.gov/providers/opioid-use-disorder/managing-substance-use

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1. Alaska Department of Health and Social Services. Medications For Addiction Treatment Guide. (2021). https://health.alaska.gov/media/jkmlmjlq/mat_guide.pdf

2. Mauger, S., Fraser, R. & Gill, K. Utilizing buprenorphine–naloxone to treat illicit and prescription-opioid dependence. *Neuropsychiatry. Dis. Treat.* 10, 587–598 (2014).

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SCREENING AND ASSESSMENT TOOLS

Screening and Assessment Tools

This section provides a quick reference to commonly used, validated clinical tools for identifying, diagnosing, and managing opioid use disorder (OUD). These tools are particularly helpful during initial intake, treatment planning, and buprenorphine induction. Full versions of each tool listed below are available in the appendices. For a more comprehensive list of screening and assessment tools, visit the following website: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Screen

Drug Abuse Screening Test (DAST-10)

Appendix 5-1

Tobacco, Alcohol, Prescription Medication and Other Substance Use (TAPS)

Appendix 5-2

Diagnose

DSM 5 Criteria for Opioid Use Disorder

Appendix 5-3

Withdrawal Assessment

Subjective Opiate Withdrawal Scale (SOWS)

Appendix 5-4

Clinical Opiate Withdrawal Scale (COWS)

Appendix 5-5

6.

GETTING STARTED CHECKLIST

Getting Started Checklist

Preparing Your Setting

☐ **Policies and procedures**

- ○ Sample buprenorphine policy (Appendix 8-1)
- ○ Sample diversion policy (Appendix 8-2)

☐ **Staff training**

- ○ Overview of MOUD
- ○ Avoiding stigmatizing language
- ○ MOUD policies and procedures
- ○ Signs of medication diversion and control techniques

Initiating Treatment

The following content has been adapted from the *"Implementing Technology and Medication-Assisted Treatment Team Training in Rural Colorado (IT MATTTRs™)"* program, designed to support integration of MOUD in diverse clinical settings (Full details available at: https://medschool.cuanschutz.edu/itmatttrs.)

While specific workflows may vary, this example offers a practical, team-based approach to preparing patients and initiating treatment.

Step-by-Step Overview for Starting MOUD

1. Is MOUD Right for This Patient?

☐ **Provide patient education**

- ○ MOUD overview
- ○ How buprenorphine works
- ○ Treatment expectations and goals

☐ **Offer the treatment agreement (Appendix 8-4) and consent form (Appendix 8-5) for review**

2. Complete Evaluation and Labs: Before induction, conduct a full clinical evaluation including:

- ○ Patient history and physical exam
- ○ DSM-5 criteria for OUD (Appendix 5-3)
- ○ Review for comorbidities and other substance use
- ○ Lab testing (may vary by setting)

3. Conduct MOUD Overview Appointment: This visit (~30 minutes) is foundational for patient engagement. Use it to:

- ○ Confirm diagnosis of OUD
- ○ Review lab results
- ○ Check the Prescription Drug Monitoring Program
- ○ Review and sign consent and treatment agreement forms
- ○ Submit prior authorization if needed
- ○ Confirm the pharmacy carries buprenorphine and is supportive of OUD treatment
- ○ Determine whether home or office-based induction is most appropriate
  - Appendix 4-1: Unobserved (Home) Induction Clinic Protocol
  - Appendix 4-2: A Patient's Guide to Starting Buprenorphine at Home
- ○ Schedule follow-up visits (weekly for the first 4 weeks)
  - **Note:** telehealth visits are reasonable, especially in low-resource settings

7.

COMMON BARRIERS

Common Barriers to MOUD and Strategies to Overcome Them

Although MOUD are safe, effective and evidence-based, many healthcare providers still face real-world barriers when trying to initiate or sustain MOUD in their practice. Below are common challenges and practice strategies to address them.

Knowledge & Confidence Gaps

Many providers receive limited training on OUD and MOUD during their formal education. As a result, providers may feel a lack of confidence initiating treatment or managing cases or hold outdated beliefs about addition and recovery. Stigma, both personal and cultural, can further reduce provider willingness to engage in OUD care, even when treatment is accessible.

Strategies:

- Participate in continuing education courses and seek out additional online resources.
- Integrate concise, practical clinical guidance into your workflow (e.g., a getting started checklist, dosing, etc.).
- Challenge internalized stigma through reflective practice and exposure to recovery stories and patient-centered models of care.
- Advocate for enhanced OUD content in health professions student training programs.

Perceived Risks: Diversion, Misuse & Organizational Resistance

Some providers have concerns about medication diversion, misuse, or scrutiny from peers or administrators.

Strategies:

- Emphasize MOUD as a standard-of-care treatment for a chronic medical condition, not a “last resort” or specialist only service.
- Share knowledge that most non-prescribed buprenorphine use is for withdrawal management, not misuse.
- Implement clear protocols for treatment agreements, urine drug screening and Prescription Drug Monitoring Program use.

Logistical and System-Level Barriers

Even when providers are ready to treat opioid use disorder, real-world system barriers can interfere. Common barriers include insurance challenges (e.g., prior authorizations), staffing shortages, lack of workflow support and infrastructure issues (e.g., geographic constraints), particularly in rural or resource-limited settings. Additionally, time constraints and unclear institutional policies may further limit provider capacity.

Strategies:

- Train care team members to assist with treatment navigation and patient follow-up.
- Adopt standardized clinic workflow, including protocols, consent templates and order sets to reduce burden.
- Create a system that allows staff to assist with prior authorizations and insurance navigation.
- Leverage telehealth and asynchronous tools (e.g., e-consults, secure messaging) when appropriate to provide flexibility and increase reach.

Professional Isolation and Lack of Support

Providers, especially those in rural or solo practices, may feel isolated in prescribing MOUD or navigating patient care challenges.

Strategies:

- Join and participate in statewide or regional mentoring programs or learning collaboratives. Project ECHO Idaho https://cme.shamp.uidaho.edu/echo-idaho/group/echo-idaho has a network of thousands of healthcare providers across the state and offers free continuing education sessions for OUD.
- Engage leadership and care team members to foster a team-based approach to care.

REFERENCE

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Barriers to Broader Use of Medications to Treat Opioid Use Disorder. in *Medications for Opioid Use Disorder Save Lives* (National Academies Press (US), 2019).

8.

ADDRESSING LOGISTICS

Providers in a wide range of settings can successfully integrate offering buprenorphine into their workflow. This section outlines practical steps to support providers in preparing to start and sustain MOUD services.

Prepare Your Setting

Identify key members of your care team who will support MOUD services. Depending on your setting, this may include prescribing providers, nurses, medical assistants, behavioral health professionals, pharmacists, or administrative staff. Together, assess your current workflow to determine where OUD screening, evaluation, and treatment can be integrated. Consider what support systems already exist and identify any potential barriers to implementation (e.g., staff training needs, time constraints, etc.) and strategies to overcome them.[1] For example, plan for provider coverage during absences and after-hours care to ensure continuity of MOUD services. Use a collaborative process to build shared understanding, address concerns early, and adapt sample protocols or policies to fit the unique needs of your setting. As part of staff development, explore external training opportunities, such as Project ECHO, which offers free continuing education for SUD, access to a network of peer providers, and expert consultation support.

Streamline MOUD into Ongoing Practice

Once MOUD services are launched, integrating them into your day-to-day workflow is essential for sustainability. Many providers find that using brief, structured screening tools like SBIRT (Screening, Brief Intervention, and Referral to Treatment) helps normalize conversations about substance use while identifying individuals who may benefit from further assessment of treatment. SBIRT can be embedded into routine health visits across settings and is both evidence-based and billable. To learn more about SBIRT visit the link here: https://www.samhsa.gov/substance-use/treatment/sbirt

Additionally, it is recommended to maintain a simple patient registry, even in spreadsheet form, to allow care teams to track active MOUD patients, follow-up on lab results or appointments, and support long-term engagement. This registry can be overseen by a nurse, case manager, or any designated team member depending on your staffing model and practice type.

Sample Workflow from AAFP[1]

- ☐ Patient checks in: screening (if self-administered/paper/e-screener)
- ☐ Patient in waiting room: posters, brochures, educational information on walls
- ☐ Nurse checks remaining vital signs and screens patient for OUD in the exam room
- ☐ Patient meets with physician: screen for OUD if not completed previously, counsel patient, develop goals and strategies together and offer treatment options
- ☐ Patient meets with counselor/behavioral health counselor, if available, or care is coordinated and referred to behavioral health counselor
- ☐ Plan for future visits: maintenance of MOUD and counseling, reassess, revisit goals and address other primary care needs
- ☐ Patient leaves

Sample Buprenorphine Patient Registry

Buprenorphine patient registry											
HR#	**Last Name**	**First Name**	**Induction Date**	**Provider**	**Last Rx date**	**Total daily dose**	**Qty**	**Days supply**	**# of refills**	**Next refill date**	**Comments**
12345	Jane	Doe	11/7/2024	Rodgers	6/20/2025	24 mg	42	14	1	7/18/25	Phase 1
6789	John	Smith	2/11/2024	West	3/6/2025	24 mg	14	14	2	4/17/25	Phase 2
10111	Major	Elizabeth	5/9/2023	Rodgers	2/27/2025	12 mg	7	7	3	3/27/25	Pregnant-subutex

Understand Billing and Reimbursements

To support the sustainability of MOUD services, it is important to ensure your team is equipped to bill appropriately for all related care activities. Services such as patient evaluation, treatment planning, medication induction and management, SBIRT, lab testing, and behavioral health coordination are eligible for reimbursement under standard ICD-10 and CPT codes. While billing requirements may vary across payers and settings, establishing a clear internal process for coding, documentation, and prior authorization (when needed) will help ensure continuity of care and financial sustainability.

A detailed billing and coding reference guide can be found in Treating Opioid Use Disorder as a Chronic Condition: A Practice Manual for Family Physicians (pages 12-19), and Prescriber Billing for Office-Based Treatment of Opioid Use Disorder. For SBIRT services, visit Coding for Screening and Brief Intervention Reimbursement.

Appendix 8-1: Sample Buprenorphine Policy

Appendix 8-2: Sample Diversion Policy

Appendix 8-3: Documentation template

Appendix 8-4: Sample Treatment Agreement

Appendix 8-5: Sample Patient Consent Form

Team Discussion Guide: Getting Started with MOUD

Roles and Responsibilities:

- Who will screen patients for SUD?
- Who completes assessments and labs?
- Who follows-up with patients?

Workflow Integration

- Do we need to adjust visit types or scheduling templates?
- How will we handle urgent vs. planned inductions?

Support and Training

- Do team members feel confident discussing MOUD with patients?
- What training or resources would be helpful?

Infrastructure & Coordination

- Are labs and screenings available on site?
- Who will handle prior authorizations, if needed?
- How will we coordinate care if behavioral health or external referrals are requested?

REFERENCE

1. American Academy of Family Physicians. Treating Opioid Use Disorder as a Chronic Condition: A Practical Manual for Family Physicians. (2025). https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/treating-opioid-use-disorder.pdf

9. RESOURCES

National Resources

Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/substance-use/treatment/options
National Harm Reduction Coalition: https://harmreduction.org/issues/facts/
CDC Overdose Prevention: https://www.cdc.gov/overdose-prevention/treatment/opioid-use-disorder.html
Providers Clinical Support System: https://pcssnow.org
National Center on Substance Abuse and Child Welfare: https://ncsacw.acf.hhs.gov
American Society of Addiction Medicine: https://www.asam.org/

Idaho's State Opioid Response

https://healthandwelfare.idaho.gov/providers/behavioral-health-providers/idahos-state-opioid-response

Statewide Resources

Idaho Department of Health & Welfare Information

Managing Substance Use: https://healthandwelfare.idaho.gov/providers/opioid-use-disorder/managing-substance-use
Opioids: https://healthandwelfare.idaho.gov/services-programs/behavioral-health/about-opioids
Opioid Use Disorder: https://healthandwelfare.idaho.gov/providers/opioid-use-disorder/opioid-prescribing
Substance Use Disorders: https://healthandwelfare.idaho.gov/services-programs/behavioral-health/about-substance-use-disorder

Idaho Office of Drug Policy

Prevention Resource Library: https://prevention.odp.idaho.gov/resource-library/

Idaho Medical Association

https://www.idmed.org/Idaho_Public/Idaho_Public/Membership_and_Benefits/Opioid_Training_for_DEA-Registered_Providers.aspx

Idaho Society of Addiction Medicine

https://www.idsam.org

Idaho Law Enforcement Diversion Program

ECHO Idaho Session: https://www.youtube.com/watch?v=UqFrSK817Ts&list=PL7ETCMgAG4iebqOq3mgWzxgBV75s7G9gT&index=13

Identifying Idaho Community-Based MOUD Providers & Programs

Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov
Opioid Treatment Program Directory: https://dpt2.samhsa.gov/treatment/directory.aspx
Buprenorphine Practitioner Locator: https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator
American Board of Addiction Medicine (ABAM) Locator: https://www.asam.org/publications-resources/patient-resources/fad
American Society of Addiction Medicine Physician Locator: https://www.asam.org/publications-resources/patient-resources/fad
Idaho Prescription Drug Monitoring Program (PDMP): https://idaho.pmpaware.net/login

Local Mental Health and Substance Use/Recovery Resources

Recovery Idaho: https://www.recoveryidaho.org
Recovery Advocacy Project: https://www.recoveryvoicesidaho.org
PEER Wellness Center: https://www.peerwellnesscenter.org
Full Circle Health: https://www.fullcircleidaho.org/behavioral-health/
Trivium Life Services: https://www.triviumlifeservices.org/moud/
BPA Health: https://www.bpahealth.com/substance-use-disorder-support/

Center for Hope: https://www.centerforhopeif.org
Latah Recovery Center: https://latahrecoverycenter.org
Raise the Bottom: https://raisethebottomidaho.com
Cornerstone Whole Healthcare Organization: https://c-who.org/about-us/
Allumbaugh House: https://www.trhs.org/allumbaugh-house
Western Idaho Community Crisis Center: https://www.widccc.org
Kootenai Recovery Community Center: https://www.kootenairecovery.org
Southeast Idaho Opioids & Substance Use Disorder Resources: https://www.siphidaho.org/community-health/_pdf/PHD6-OPIOIDS-SUBSTANCE-USE-DISORDER-RESOURCES-2023.pdf
Empower Idaho Behavioral Health Resources: https://www.empoweridaho.org/idaho-behavioral-health-resources/

Recovery Centers by Region

https://www.empoweridaho.org/wp-content/uploads/2020/12/Click-here-for-Idaho-Recovery-Resources.pdf

Educational Training Programs

Project ECHO Idaho, University of Idaho School of Health and Medical Professions

ECHO Idaho offers free, live educational programs for healthcare professionals statewide. Each session features a didactic lecture followed by a case-based discussion, providing free continuing education credits and mentorship. ECHO Idaho offers series focused on behavioral health with OUD and MOUD specific sessions.
ECHO Idaho Website: https://cme.shamp.uidaho.edu/echo-idaho/group/echo-idaho
Email: echoidaho@uidaho.edu

Providers Clinical Support System

Website: https://pcssnow.org/medications-for-opioid-use-disorder/

Idaho Public Health MOUD Related Information

Panhandle: https://panhandlehealthdistrict.org/behavioral-healthcare/opioid-use-prevention/
North Central: https://idahopublichealth.com/drug-overdose-prevention/
Southwest: https://swdh.id.gov/drug-overdose-prevention-program/
Central: https://cdh.idaho.gov/health/clinics/medication-assisted-treatment/
South Central: https://phd5.idaho.gov/drugs/
Southeastern: https://siphidaho.org/clinical-services/moud.php
Eastern: https://eiph.id.gov/healthy-living/drug-alcohol-prevention/

Additional Resources

Addiction Medicine Fellowship

https://uwboiseaddiction.uw.edu

Social Determinants of Health

Guide to Social Needs Screening: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

Language and Stigma

Words Matter: How Language Choice Can Reduce Stigma: https://solutions.edc.org/sites/default/files/Words-Matter-How-Language-Choice-Can-Reduce-Stigma_0.pdf

Treatment-Decision Making

Provides guidance and tools around decision-making in seeking treatment for OUD: https://www.samhsa.gov/technical-assistance/brss-tacs/decision-making

Screening Tools

Catalog of evidence-based screening tools and assessment materials: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
Catalog of screening and assessment tools for use across a treatment continuum for behavioral health needs: https://ibr.tcu.edu/wp-content/uploads/2014/09/TCU-Core-Forms-Matrix-9-9-14.pdf

MOUD in Special Populations

Criminal Justice Setting
Resources:
https://mn.gov/doc/assets/treatment-criminal-justice-pep19-matusecjs_tcm1089-652658.pdf

ECHO Idaho Content:
Criminal Justice & SUD: https://www.youtube.com/watch?v=QT9QvjCHoVc
Reducing Risk for Re-Entry: https://www.youtube.com/watch?v=_KJcGMyW7QA
Something for the Pain Podcast Episode: SUD Treatment for Justice-Involved Patients: https://www.youtube.com/watch?v=HN4ok2jRy1o

Pregnancy
Resources:
https://www.healthrecovery.org/page/maternal-opioid-use
https://harmreduction.org/wp-content/uploads/2023/04/APHR_ENGLISH_NHRC_UPDATE_PSU-2022_2.pdf
https://ilpqc.org/wp-content/docs/toolkits/MNO-OB/Pregnancy-and-MAT-one-pager.pdf

ECHO Idaho Content:
Perinatal Substance Use Disorder Labor and Pain Management Considerations: https://www.youtube.com/watch?v=1ErnPvHwgWw&list=PL7ETCMgAG4iebqOq3mgWzxgBV75s7G9gT&index=24
Treating Alcohol Use Disorder During Pregnancy & Beyond: https://www.youtube.com/watch?v=QwZlb_LRJaY&list=PL7ETCMgAG4iebqOq3mgWzxgBV75s7G9gT&index=22
Something for the Pain Podcast Episode: Postpartum Considerations: Substance Use Disorder Treatment, Recovery, and Parenting
https://www.youtube.com/watch?v=QhPPYd-Aav8

10.
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Full Circle Health; Clinical Instructor in Family Medicine, University of Washington

Dr. Radha Sadacharan is a board-certified family medicine physician with a passion for working with justice-involved populations and people with addiction. She completed residency at Swedish First Hill – Family Medicine in Seattle, WA, and a T32 research fellowship at Brown University in the Infectious Diseases division, focused on the intersection of justice involvement, infectious disease, addiction and primary care. Dr. Sadacharan is the Health Services Advisor for Idaho Department of Correction. She also teaches medical learners throughout Idaho. She serves as a healthcare subject matter expert for All Rise, and has served on multiple expert panels for Project ECHO, focused on addiction and correctional health.

India King, PsyD

Associate Director Behavioral Health, Full Circle Health; Clinical Assistant Professor Family Medicine, University of Washington

India King received her doctorate in Clinical Psychology with a focus in Health Psychology from Pacific University. She completed her doctoral internship at the White River Junction VA in Vermont and her postdoctoral fellowship at the Boise VA, with a focus on integrated primary care. She then joined the Boise VA's Center of Excellence Primary Care Education; there she worked to develop and evaluate interprofessional educational innovations. She currently is Behavioral Science Faculty with Full Circle Health's Nampa Family Medicine Residency program and provides clinical supervision to psychology trainees. In addition to her educational roles, Dr. King provides integrated behavioral health care as a primary care psychologist.

Derek Hayton, DO

Addiction Medicine Faculty, Boise VA Medical Center

Dr. Derek Hayton is board certified in Family Medicine and Addiction Medicine. He attended medical school in his home state of Oklahoma before relocating to Boise, ID for family medicine residency training at the Family Medicine Residency of Idaho (now known as Full Circle Health). After he completed his family medicine training in 2014, he worked in both the hospital and outpatient setting for a number of years before completing an Addiction Medicine fellowship in 2022. Since completing his fellowship, Dr. Hayton has worked in the Primary Care setting practicing family and addiction medicine.

Jennifer Cook, MD

Family Medicine, OB/Maternal Child Health, Full Circle Health, FMRI - Boise

Jennifer Cook, MD graduated from Wake Forest University School of Medicine and completed her Family Medicine Residency at Phoenix Baptist Health (now Abrazo Health), where she served as Chief Resident. She then pursued an OB Fellowship at Swedish Family Medicine in Seattle, WA, before spending three years practicing in New Zealand. In 2009, Dr. Cook returned to Boise and joined the core faculty at the Family Medicine Residency of Idaho (FMRI) in Boise. She went on to oversee the Maternal Child Health curriculum at FMRI - Boise and then started an OB Fellowship in 2015, with the mission to train family physicians in surgical and high-risk obstetrics to serve the rural communities within Idaho and the surrounding states. She splits her time between teaching on the inpatient adult medicine, OB, and pediatric services, precepting a high-risk OB clinic within FMRI, and her continuity family medicine clinic. Outside of work, she enjoys spending time with her New Zealand-born husband and their three children, as well as running, knitting, sewing, and capturing as many sunrises and sunsets as possible.

Stacy Seyb, MD

Maternal Fetal Medicine, St. Luke's Health System

Dr. Stacy Seyb earned his medical degree from the University of Kansas School of Medicine. He also completed his obstetrical residency at the University of Colorado and his maternal-fetal medicine fellowship at Northwestern University. He is board-certified in Obstetrics and Gynecology as well as Maternal-Fetal Medicine. Dr. Seyb specializes in managing a wide range of pregnancy-related conditions, including diabetes, preterm labor, and other complications. He has a particular interest in addressing public health challenges, such as preterm birth and maternal mortality. Passionate about patient education, Dr. Seyb is dedicated to empowering individuals to make informed decisions about their care.

11.
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IT MATTTRs™
Implementing Technology, Medication Assisted Treatment, Team Training, and Resources

Unobserved (Home) Induction Clinic Protocol

PREPARATION

Providing Medication Assisted Treatment (MAT) with Buprenorphine

Your Treatment Agreement and/or Consent Forms should include a program overview, including steps, duration, expectations, and buprenorphine information. Before patients start treatment for opioid use disorder, be sure to discuss their decision to receive MAT with buprenorphine and these other items.

Evaluations

Prior to induction, every patient should have full evaluation, history, physical, and laboratory testing. Patient assessment should be completed and thoroughly reviewed with the MAT care team.

- ❑ Record diagnosis & physiological dependence
- ❑ Determine co-morbidity
- ❑ Check the Prescription Drug Monitoring Program (PDMP)

Office-Based Induction vs. Unobserved (Home) Inductions? Which is right for this patient?

Both office-based and unobserved (home) inductions are safe and effective treatment options. Discuss the pros and cons of office and home inductions with patients and their support (if possible) to determine preference and fit.

- **For patients with good support system,** home induction may be appropriate. Some individuals may be more comfortable in a more private setting or have concerns about transportation.
- **For patients without good support system,** office induction is an opportunity for building connection, trust, and fostering relationships with provider, compassionate staff, supportive nurses, and/or peer counselor. Waiting long enough for full withdrawal can be difficult at home. Patients may not be in full withdrawal when they start treatment, increasing the chance of precipitated withdrawal.

Prescription

Write the prescription for the patient prior to the induction day. The patient should pick up the prescription and bring the prescription to MAT Procedure Review Appointment to review dosing instructions with you prior to induction.

MAT Procedure Review Appointment

This appointment is critical to successful MAT. Allow about 30 minutes. Cover the following:

- ❑ Paperwork: Review and have patient sign the Consent Form and Treatment Agreement Form. Review instructions and give them a copy of the Patient Guide.
- ❑ Check the Prescription Drug Monitoring Program (PDMP).
- ❑ Withdrawal timing (see chart on page 2): Verify with patients their current use (type, amount, duration) and set a "stop time."
- ❑ Precipitated withdrawal potential and recommendations for avoiding it
- ❑ Subjective Opioid Withdrawal Scale (SOWS): score should be ≥ 17 (mild) before starting.
- ❑ Buprenorphine Dose: lowest effective dose should be taken
- ❑ Safety/Concerns: interaction risks, avoid driving, safe storage
- ❑ Consider additional withdrawal medication
- ❑ Identify support person
- ❑ Map out a follow-up plan: Phone call on induction day and daily until clinic visit (approximately Day 7) can be done by provider, nurse, MA, etc. Determine who will make calls and be assigned to take patient's calls.
- ❑ Discuss goals and motivations
- ❑ Review the Home Induction: A Patient Guide with the patient thoroughly.

Withdrawal timing

Type of Opioid	Examples	When to stop
Short-acting	Percocet, Vicodin (hydrocodone), Heroin	12-24 hours before first dose. *Example: Stop at Sunday at 12 noon for a Monday induction.*
Long-acting	Oxycontin, MS Contin/ Morphine, Methadone	• 36 hours before first dose for Oxycontin, Morphine • >48 hours for Methadone *Example: Stop at Saturday at 12 noon for a Monday induction*

DAY 1

- ❑ Patient will stop all opioids for 12-36 hours prior to induction.
- ❑ SOWS score should be ≥ 17 (higher if tolerated) before taking the first dose of buprenorphine.
- ❑ Buprenorphine dosing Day 1, when SOWs score is >17, patient will:
  - Take 4 mg buprenorphine
  - Wait 1 hour. If withdrawal symptoms are present, take a second dose.
  - Call and talk with provider or office staff
  - f feeling worse, call to talk with assigned provider about possibility of precipitated withdrawal and treatment options (clonidine, NSAIDs, anti-emetics, etc.).
  - Wait 1-2 hours. If symptoms persist, take a third dose (4 mg).
  - Wait 1-2 hours. If symptoms persist, take a fourth dose (4 mg).
  - If symptoms persist, call to talk with the provider or office staff.
- ❑ Assign provider or office staff member to check in with patient by phone throughout day.
- ❑ **Maximum Day 1 dose: 16 mg total.**

DAY 2

- ❑ Buprenorphine dosing Day 2 = the total amount of buprenorphine the patient took on Day 1.
  - Patient will take the total dose from day 1 on day 2. If greater than 8mg total, they might want to split the dose into a morning and afternoon/evening dose.
  - Patient may take additional dose if withdrawal symptoms persist.
  - Assign provider or office staff member to check in with patient by phone.
- ❑ **Maximum Day 2 dose: 12-16 mg**

DAY 3

- ❑ Buprenorphine dosing Day 3 = the total amount of buprenorphine the patient took on Day 2.
  - Patient will take the total dose from Day 2 on Day 3. If greater than 8mg total, they might want to split the dose into a morning and afternoon/evening dose.
  - Patient may take additional dose if withdrawal symptoms persist.
- ❑ Assigned provider or office staff member to check in with patient by phone.
- ❑ If withdrawal symptoms persist, patient may schedule a visit with the provider in the office.
- ❑ Consider recommending additional withdrawal treatments for patient.

DAYS 4 - 7

- ❑ Buprenorphine dosing Days 4-7 = the total amount of buprenorphine the patient took on Day 2.
  - Patient will take the total dose from Day 2 on Days 4 -7. If greater than 8mg total, they might want to split the dose into a morning and afternoon/ evening dose.
  - Patient can consult with provider to adjust dose, if needed.
- ❑ Assign provider or office staff member to check in with patient by phone.
- ❑ Patient will need to make an appointment to see their provider between days 3-7.

Adapted from SAHMSA Tip Sheet 40 and PCSS-MAT. Created in partnership with the IT MATTTRs expert consultant panel. For permission to use outside of IT MATTTRs, please contact ITMATTTRsColorado@ucdenver.edu.

IT MATTTRs

A Patient's Guide to Starting Buprenorphine at Home

PREPARATION

Receiving Medication Assisted Treatment (MAT) with Buprenorphone

Medication assisted treatment (MAT) with buprenorphine is a safe and effective method to help people with an opioid use disorder stop using prescription pain medications, heroin, and other opioids. There are three main phases of MAT: induction (first 1-2 days), stabilization (several weeks), and maintenance (as long as it takes). Before you start treatment, be sure to talk with your health care provider about your plans for treatment.

Your care team should schedule an MAT Procedure Review Appointment with you. This is a great time to discuss your decision to receive MAT, your goals and motivations, concerns, and receive important information. Before starting treatment, your health care team will also conduct a physical evaluation and some lab tests.

Home or Doctor's Office?

This process of getting started on buprenorphine is called Induction. You can be at your doctor's office to get started, or you can do this at home. Talk with your doctor and care team about which option is better for you. There are pros and cons for both options. Which option do you prefer?

Induction at the Doctor's Office		Induction at Home	
Pros	**Cons**	**Pros**	**Cons**
• Your care team is there to check on you and answer questions. • You can build a connection and relationships with your care team. • In some practices, a peer counselor or a behavioral health provider might be there to talk with you.	• You might not be as comfortable as home. • Someone should drive you there and home, ideally.	• You might be more comfortable at home. • You do not need to drive anywhere.	• Waiting to be in withdrawal before taking your first dose of buprenorphine can be difficult. If you take your first dose too soon, you increase the chance of an intense withdrawal that comes on very quickly (precipitated withdrawal). • Your health care team is not there to check on you and talk with you.

When to Stop Taking Opioids

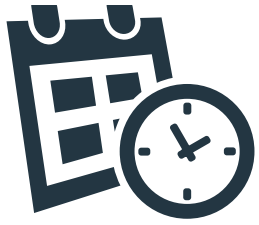
Your treatment will more successful if you prepare for your first dose of buprenorphine (or induction). Before starting your medication, you will need to stop using opioids for a required period. This period of time when you are not using opioids protects you from undesirable side effects, which could delay you from feeling normal again. Be truthful with yourself and your health care team about when you last used opioids and what you used.

Type of Opioid	Examples	When to stop
Short-acting	Percocet, Vicodin (hydrocodone), Heroin	12-24 hours before first dose. *Example: Stop at Sunday at 12 noon for a Monday induction.*
Long-acting	Oxycontin, MS Contin/ Morphine, Methadone	• 36 hours before first dose for Oxycontin, Morphine • >48 hours for Methadone *Example: Stop at Saturday at 12 noon for a Monday induction*

MAT Procedure Review Appointment

Before you start taking buprenorphine and receiving MAT, you and your care team should meet for about 30 minutes. At this meeting, you will receive important information and be able to ask questions. This includes:

- ❑ Review and sign your Consent Form and Treatment Agreement Form.
- ❑ Discuss treatment steps, your goals and motivations, and buprenorphine information.
- ❑ Review the Subjective Opioid Withdrawal Scale (SOWS). This will ensure that you take your first dose of buprenorphine when it will be most effective. Your SOWS score should be ≥17 before starting your first dose.
- ❑ Identify whom you should call to check in.
- ❑ Map out a follow-up plan.
- ❑ Discuss safety, including interaction risks, avoid driving, safe storage



DAY 1

Checklist

Check the boxes next to each step to help you track your progress. Be patient — you're close to feeling better!

Before taking your first dose, stop taking all opioids for 12-36 hours. You should feel pretty lousy, like having the flu. These symptoms are normal. You will feel better soon.

- ❑ Before your first dose of medication, you should feel **at least three** of the following:
  - ❍ Very restless, can't sit still
  - ❍ Twitching, termors, or shaking
  - ❍ Enlarged pupils
  - ❍ Bad chills or sweating
  - ❍ Heavy yawning
  - ❍ Joint and bone aches
  - ❍ Runny nose, tears in your eyes
  - ❍ Goose flesh (or goose bumps)
  - ❍ Cramps, nausea, vomiting or diarrhea
  - ❍ Anxious or irritable
- ❑ Complete the SOWS. You need your SOWS score to be ≥17 before taking your first dose of buprenorphine.

Schedule

- ❑ **Take 4 mg** of buprenorphine under the tongue (tablet or film strip). (Half of an 8 mg tablet, or two 2 mg tablets). Usually one film strip.
- ❑ Put the tablet or film under your tongue. Do not swallow it. Buprenorphine does not work if swallowed.
- ❑ Wait an hour.
  - – If you feel fine, do not take any more medication today. Record your total for the day dose below.
  - – If you continue to have withdrawal symptoms, take a second dose under your tongue (4 mg).
  - – If you are feeling worse than when you started, you might have precipitated withdrawal. Call and talk with your provider about treatment options.
- ❑ Call your provider or office staff to check in.
- ❑ Wait 1-2 hours.
  - – If you feel fine, do not take any more medication today. Record your total for the day dose below.
  - – If you continue to have withdrawal symptoms, take a third dose under your tongue (4 mg).
- ❑ Call your provider or office staff to check in.
- ❑ Wait 1-2 hours.
  - – If you feel fine, do not take any more medication today. Record your total for the day dose below.
  - – If you continue to have withdrawal symptoms,

DAY 1 Dose Summary

Dose	Amount	Time
1st dose (if needed)	4 mg	
2nd dose (if needed)	mg	
3rd dose (if needed)	mg	
4th dose (if needed)	mg	
Total mg on Day 1	mg	

Do not take more than 16 mg total of buprenorphine on Day 1.
If you have taken up to 16mg of buprenorphine and still fee bad, call your doctor right away.

Congratulations! You are through Day 1. See instructions for Day 2 on the next page. You're doing great.

DAY 2

Total from Day 1

What was the total amount of buprenorphine you took yesterday (Day 1)?

Total buprenorphine taken on Day 1	mg

If your Day 1 total was 4 mg:

- ❑ If you feel fine, take 4 mg this morning; however, if you feel some withdrawal symptoms, start with 8 mg this morning.
- ❑ Later in the day, see how you feel. If you feel okay, do not take more. If you still feel withdrawal, take another 4 mg dose.
- ❑ Talk with your provider or office staff.

If your Day 1 total was 8 mg:

- ❑ If you feel fine, take 8 mg this morning; however, if you feel some withdrawal symptoms, start with 12 mg this morning.
- ❑ Later in the day, see how you feel. If you feel okay, do not take more. If you still feel withdrawal, try another 4 mg dose.
- ❑ Talk with your provider or office staff.

If your Day 1 total was 12 mg:

- ❑ If you feel fine, take 12 mg this morning. You might want to split the dose into a morning dose (6 mg) and afternoon dose (6 mg).
- ❑ If you feel some withdrawal symptoms, start with 16 mg this morning.
- ❑ Later in the day, see how you feel. If you feel okay, do not take more. If you still feel withdrawal, try another 4 mg dose.
- ❑ Talk with your provider or office staff.

DAY 2 Dose Summary

Dose	Amount	Time
1st dose (if needed)	mg	
2nd dose (if needed)	mg	
Total mg on Day 2	mg	

NOTES, IDEAS & THOUGHTS

DAY 3

❑ If you felt good at the end of Day 2, repeat the dose you took on Day 2. If the dose was more than 8 mg, you might want to split the dose into a morning dose (6 mg) and afternoon dose (6 mg).

If you felt too tired, groggy, or over-sedated on Day 2, take a lower dose on Day 3 (2-4 mg less).

If you still felt some withdrawal at the end of Day 2, take the same total dose you took on Day 2 plus another 4 mg dose.

❑ See how you feel as the day goes on. If withdrawal symptoms persist, take another dose.

Different people need different doses of buprenorphine. If symptoms persist, consider seeing your provide in the office. Talk with your provider about additional withdrawal treatments that might help.

Do not take more than 32 mg of Buprenorphine in one day.

DAY 3 Dose Summary

Dose	Amount	Time
1st dose (if needed)	4 mg	
2nd dose (if needed)	mg	
Total mg on Day 2	mg	

DAY 4 & BEYOND

On Day 4 and beyond, take the total dose you used on Day 2. You can take more or less medication, depending on how you feel overall, if you still have cravings, or if you are still using.

At this point, you should discuss any dose adjustments with your doctor. If you need to increase your dose, you should not change it by more than 4 mg per day.

NOTES, IDEAS & THOUGHTS

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months…		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No

d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ☐ Yes ☐ No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ☐ Yes ☐ No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)? ☐ Yes ☐ No

If "Yes", answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

Comments:

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Total Number Boxes Checked: _____

Severity: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms

*Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541. For use outside of IT MATTTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu

Name: _____

DOB: _____

Subjective Opiate Withdrawal Scale (SOWS)

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: **0 = not at all** **1 = a little** **2 = moderately** **3 = quite a bit** **4 = extremely**

DATE						
TIME						
SYMPTOM		**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are tearing					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
TOTAL						

Mild Withdrawal = score of 1 – 10
Moderate withdrawal = 11 – 20
Severe withdrawal = 21 – 30

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc. . For use outside of IT MATTTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times: _____ _____ _____ _____

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

COWS / Flow-sheet format for measuring symptoms over a period of time

GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

Buprenorphine for the Treatment of Opioid Use Disorders

Relevant Law / Standard: DATA 2000: Title XXXV, Section 3502 of the Children's Health Act of 2000

Policy and Purpose:

This policy is intended to ensure appropriate assessment, management and monitoring of patients receiving office based treatment with buprenorphine for opioid use disorders.

Overview

Buprenorphine, a partial opioid agonist, was approved by the FDA in 2002 for the treatment of opioid use disorder. Per the "Drug Addiction Treatment Act" of 2000, buprenorphine can be prescribed outside the Narcotic Treatment Program (NTP) setting by physicians who complete a federally mandated 8-hour training, and who have subsequently received a special DEA waiver to prescribe buprenorphine for opioid replacement therapy**.**

Buprenorphine is commonly prescribed in sublingual formulations for opioid replacement. Formulations are composed of buprenorphine alone (in generic forms and under the brand name Subutex), or buprenorphine plus the opioid antagonist naloxone (in generic form and under the brand name Suboxone). The naloxone is not absorbed sublingually and the combination formulations decrease the risk of injection/diversion. The buprenorphine/naloxone combination product is the preferred formulation at [insert]. Exceptions include the case of pregnancy or breastfeeding. Other exceptions will be addressed on a case by case basis. Since buprenorphine acts as a partial agonist as well as an antagonist at the opioid receptors, it may precipitate opioid withdrawal in the opioid dependent patient who has recently used opioid. A patient should not begin buprenorphine treatment if they have used a short-acting opioid such as heroin less than 12 hours before induction, or a long-acting opioid such as methadone less than 24 hours. Therefore, patients should only be induced on buprenorphine if they are showing objective signs of opioid withdrawal or they have been opioid-free for at least several days.

Induction can be safely done at home, as is recommended by UNM Hospitals, Project ECHO Program.

Patient Selection

Inclusion Criteria

- Patient is at least 16 years old
- Patient meets DSM-5 criteria for Opioid Use Disorder

Exclusion Criteria

- Patient has serious uncontrolled/untreated psychiatric problems (suicidality, active psychosis, etc.)
- Patient has a severe alcohol use disorder
- Patient misuses benzodiazepines, sedatives or hypnotics.
- Patient has a known allergy/hypersensitivity to buprenorphine

Initial Assessment of Opioid Dependence and Withdrawal

Patient History
Provider should obtain medical history as below.

- Review current and past symptoms of opioid withdrawal.
- Review substance use history. Review current opioid use, i.e. type of opioid, method of administration, frequency of use, last use. Review alcohol, sedative, and other substance use/abuse. Review past opioid treatments (e.g. Methadone maintenance) including client response to treatment, and perceived effectiveness.
- Review concurrent medical/psychiatric problems, medications and labs.
- For female clients of childbearing age, address contraception.

Objective Data

- Full physical exam should be done at initial assessment: Provider should include:
  - Documentation of signs and symptoms of opioid withdrawal. If present, consider assessing withdrawal severity using the Clinical Opiate Withdrawal Scale (COWS).
  - Assessment of possible needle use sequelae, including presence of track marks, abscesses, cellulitis.
  - Assessment of possible substance intoxication, including but not limited to alcohol odor, nystagmus, positive Romberg test, client disinhibition, or other altered mental status.
- Lab Results: Urine toxicology screen; pregnancy test (serum or urine HCG) for females with childbearing potential; LFTs
- Prescription monitoring program results reviewing prescriptions for opioids and benzodiazepines.

Patient Consent Form

Ensure that “Buprenorphine Treatment Agreement” is reviewed and signed. (See attachment)

Initiating Treatment with Buprenorphine

1. Provide “Starting Buprenorphine at Home- Home Induction Instructions”
2. Provide Patient Info Buprenorphine FAQ
3. Prescribe no more than 14 days of medication when initiating treatment
   a. For withdrawal symptoms, give Buprenorphine 4mg SL every 6 hours as needed
   b. Total Buprenorphine dose for 1st 24 hours typically ranges between 8-16mgs
   c. Total Buprenorphine dose for Day 2 is typically ranges from 8-16 mgs
   d. Total Buprenorphine dose for Day 3 is typically ranges from 12-16 mgs
   e. Most patients experience good control of withdrawal and cravings by the end of their first 3-5 days on buprenorphine.
   f. Target dose: The dose that results in the optimal relief of objective and subjective opioid withdrawal symptoms. This is expected to be in the range of 12 to 20mg daily, though doses from 2 to 24 mg/day may be required to suppress opioid withdrawal effects. In most cases, the maximum daily dose is 24mg.

4. Consider adjunctive medications
    a. Additional medications can be prescribed/provided for symptom management. An EHR template is in place to assist with ordering these medications. These may include the following:
        i. Clonidine 0.1 to 0.3mg PO q4 to 6 hours PRN lacrimation, diaphoresis, rhinorrhea, piloerection
        ii. Promethazine 25mg PO q4 to 6 hours PRN nausea/vomiting
        iii. Ondansetron 4-8mg PO q4 to 6 hours PRN nausea, agitation
        iv. Loperamide 4mg PO x I PRN diarrhea, then 2mg PO PRN each loose stool or diarrhea thereafter, NTE 16mg/24h;
        v. Ibuprofen 400 to 800 mg PO 4 to 6 hours with food prn myalgias/arthralgias, NTE 2400mg/24hours.
        vi. Trazodone 50mg PO at bedtime prn insomnia

Buprenorphine Maintenance Therapy

- **MD Visit Frequency:** It is recommended that following initiation of buprenorphine, the frequency of MD visits be at least monthly for the first 3 months. Pending stability and adherence, MD visit frequency may increase or decrease.

- **Counseling:** It is recommended that patients on buprenorphine see a counselor with experience in treatment of opioid use disorder regularly to support the treatment plan. After the patient has stabilized, counseling sessions may decrease based on patient needs and provider plan. Providers may choose to require patients to attend groups or individual counseling as part of the treatment plan.

- **Prescription Drug Monitoring Program:** Physicians (or their surrogates) will check PMPs prior to each prescription of buprenorphine to ensure no additional opioid, benzodiazepine or other prescriptions were obtained from other sources.

- **Urine Toxicology:** Though there are no Federal or State regulations requiring toxicology screens for patients receiving buprenorphine, the provider might find it helpful to order toxicology screens weekly during the initiation period and then every 4-8 weeks to assess patient stability. If the provider has concerns about the patient, more frequent urine screens are encouraged**.** Tests for other alcohol screening can be added to the standard screen on a case-by-case basis. Assaying for buprenorphine is available and should be considered any time there is any suspicion of diversion, as this can confirm the patient's use of the medication by identifying metabolites in the urine.

- **Cross coverage:** Other providers with DATA 2000 waivers can be available to provide care if the treating provider is not available. This may or may not include prescribing of buprenorphine.

- **Patients transferring care:** Every effort will be made to avoid precipitated opioid withdrawal during transfer of care. New patients presenting to the practice requesting continuation of maintenance buprenorphine will follow the guidelines for a signed contract, review of outside records, PMP report, and urine toxicology screening.

Documentation and Compliance

- Medical Staff Office and Pharmacy will keep on file a copy of the DEA DATA 2000 waiver for each [INSERT] physician prescribing buprenorphine.
- Each provider will maintain a paper or electronic log of all patients they are treating who are receiving buprenorphine for opioid dependence, with close attention to the patient limits for each prescribing provider.
- A paper copy of each buprenorphine prescription written will be filed in the patient's paper chart.
- All buprenorphine prescriptions should include both the physician's DEA number and the "X" DEA number which denotes buprenorphine provider status.
- If a DEA audit occurs, the audited physician should be prepared to present documentation of their waiver to prescribe buprenorphine, paper or electronic treatment log, and paper or electronic documentation of prescriptions they have written.
- In addition to standard HIPAA laws, federal regulations mandate strict confidentiality for information about patients being treated for substance use disorders (42 CFR Part 2). Additionally, the law requires written patient consent before information about substance abuse treatment can be disclosed to any other source.

Attachments

1. Buprenorphine Treatment Agreement
2. Clinical Opiate Withdrawal Scale (COWS)
3. Starting buprenorphine at home- home induction instruction
4. Buprenorphine patient info FAQ

References

1. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. SAMHSA, 2004.
2. Guidelines for Prescribing Buprenorphine as Opiate Replacement Therapy for Opiate Dependence in the CHN. OBIC, 2013
3. How-to Guide. BupPractice.com
4. New Mexico Guidelines for Medical Providers who Treat Opioid Addiction Using Buprenorphine. New Mexico Behavioral Health Collaborative, 2012.

XYZ Medical Practice

Sample Office-Based Opioid Use Disorder Policy and Procedure Manual

Policy Title: **Diversion Control for Patients Prescribed Transmucosal (Sublingual) Buprenorphine**

Effective Date: **Month, Day, Year**

This Diversion Control Policy is provided for educational and informational purposes only. It is intended to offer healthcare providers guiding principles and policies regarding best practices in diversion control for patients who are prescribed buprenorphine. This Policy is not intended to establish a legal or medical standard of care. Providers should use their personal and professional judgment in interpreting these guidelines and applying them to the specific circumstances of their individual patients and practice arrangements. The information provided in this Policy is provided "as is" with no guarantee as to its accuracy or completeness. ASAM will strive to update this Policy from time to time but cannot ensure that the information provided herein is always current.

Preamble: As the availability of buprenorphine treatment for opioid use disorder has increased, so have reports of diversion, misuse, and related harms. In addition to potential harms in the community, diversion indicates medication non-adherence and should be proactively addressed by healthcare providers. There are a range of signs that a patient is misusing or diverting buprenorphine including but not limited to: (1) missed appointments; (2) requests for early refills because pills were lost, stolen or other reasons; (3) urine screens negative for buprenorphine, positive for opioids; (4) claims of being allergic to or intolerant of naloxone, and requesting monotherapy; (5) non-healing or fresh track marks; or (5) police reports of selling on the streets. There are a range of reasons for diversion and misuse including diverting to family/friends with untreated opioid addiction to help convince them to also get into treatment or get through time on a waiting list, selling some or all of medication in order to pay off debts/purchase preferred opioid/pay for treatment in places where there are inadequate providers taking private insurance or public Medicaid for multiple reasons [e.g., inadequate reimbursement/no reimbursement/burdensome PA process].

The safety and health of the patient and others in the community could be at risk if misuse and diversion are not addressed proactively and throughout treatment. The reputation of XYZ Medical Practice may also be put at risk.

Definitions: *Diversion* is defined as the unauthorized rerouting or misappropriation of prescription medication to someone for whom it was not intended (including sharing or selling a prescribed medication).[1] *Misuse* includes taking medication in a manner, by route or by dose, other than prescribed.[2]

Purpose: Misuse and diversion should be defined and discussed with patients at the time of treatment entry, periodically throughout treatment, when the patient has returned to use, and when suspected (e.g., incorrect buprenorphine pill/film count) or confirmed (e.g. police report).

These procedures will establish steps to prevent, monitor, and respond to misuse and diversion of buprenorphine. The providers' response should be therapeutic and matched to the patients' needs as untreated opioid use disorder and treatment drop-out/administrative discharges may lead to increased patient morbidity, mortality, and further use of diverted medications or illicit opioids associated with increased risk for overdose death.

Procedures for Prevention:

- **Use buprenorphine/naloxone combination products when cost is not an issue and medically indicated.** Reserve the daily buprenorphine monoproducts for pregnant patients, patients who otherwise could not afford treatment if the combination product (i.e., buprenorphine/naloxone) was required, patients who have a history of stability in treatment and low diversion risk, or patients with arrangements for observed dosing. While the evidence on the safety and efficacy of naloxone in pregnant women remains limited, the combination buprenorphine/naloxone product is frequently used, and the consensus of ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder committee is that the combination product is safe and effective for this population. Naloxone is minimally absorbed when these medications are taken as prescribed. If the patient encounters cost issues (e.g. loses medical insurance), consider utilizing prescription savings and discount programs to find the most affordable option available to the patient.

- **Counsel patients on safe storage of medications.** Patients must agree to safe storage of their medication. This is even more critical if there are children in the home where the patient lives. Counsel patients about acquiring locking devices and avoiding storage in parts of the home where visitors frequent (e.g., recommend against storage in kitchen or common bathrooms). Proactively discuss how medication should be stored/transported when traveling to minimize risk of unintended loss.

- **Counsel patients on taking medication as instructed and not sharing medication. Explicitly explain to patients the definitions of diversion and misuse with examples.** Patients are required to take medication as instructed by the provider, for example, they may not crush or inject the medication.

- **Check PDMP for new patients and check regularly thereafter.** PDMP reports can be a useful resource when there is little patient history available or when there is a concern for the patient based on observation. Check for prescriptions that interact with buprenorphine or if there are other providers currently treating your patient with buprenorphine or other medications.

- **Prescribe a therapeutic dose that is tailored to the patient's needs.** One patient may need a total dose of 24mg while another may only need 16mg. Do not routinely provide an additional supply "just in case." Have a discussion with patients who say they need a significantly higher dose, particularly when they are already at 24 mg/daily of buprenorphine equivalents. Evidence suggests that 16 mg per day or more may be more effective than lower doses. There is limited evidence regarding the relative efficacy of doses higher than 24 mg per day, and the use of higher doses may increase the risk of diversion.

- **Make sure the patient understands the practice's treatment agreement and**

prescription policies. The XYZ Medical Practice's treatment agreement and/or other documentation is clear about the practice's policies regarding number of doses in each prescription, refills, and rules regarding "lost" prescriptions. Review the policies in person with the patient. Offer an opportunity for questions. The patient and provider must sign the agreement. Review the policies again with the patient at subsequent appointments. See Sample Treatment Agreement.

Procedures for Monitoring:

- **Request random urine tests.** The presence of buprenorphine in the urine indicates that the patient has taken some portion of the prescribed dose. Absence of buprenorphine in the urine may indicate non-adherence. Testing for buprenorphine metabolites (only present if buprenorphine is metabolized) may be included to minimize the possibility that buprenorphine is added directly to the urine sample. Dipstick tests can be subverted or replaced. A range of strategies can be used to minimize falsified urine collections including: (1) observed collection; (2) disallowing carry-in items (purses, backpacks) into the bathroom, (3) turning off running water and coloring toilet water to eliminate possibility of dilution; (4) monitoring the bathroom door so that only one person can go in; and (5) testing the temperature of the urine immediately after voiding.

- **Schedule unannounced pill/film counts.** Periodically ask patients who are at high risk for misuse/diversion to bring in their bottles for a pill/film count.

  With unannounced monitoring (both pill/film counts and urine tests), the patient is contacted and must appear within a specified period (e.g., 24 hours) after contact. If they do not appear, then the provider should consider this as a positive indicator of misuse/diversion.

  In rural areas or where access to treatment is limited, providers may consider partnering with local pharmacies to conduct pill/film counts to reduce potential transportation burdens for patients.

- **Directly observe ingestion.** In this kind of monitoring, the medication is taken in front of a qualified clinician and is observed until the medication dissolves in the mouth (transmucosal, sublingual or buccal absorption). Patients who are having difficulty adhering to their buprenorphine treatment plan can have their medication provided under direct observation in the office for a designated frequency (e.g., three times/week).

- **Limit medication supply.** When directly observed doses in the office are indicated but not practical, short prescription timespans can be used, for example, weekly or three days at a time.

Procedures to Respond to Misuse or Diversion:

Misuse or diversion should never mean automatic discharge from the practice. However, it will require a therapeutic response and consideration of one or more of the procedures listed below.

- **Evaluate the misuse and diversion** – for instance, describe the incident of misuse (e.g., patient took prescribed dose on 1, 2, 3 or more occasions by intravenous route immediately after starting treatment stating that they believed the dose would not be adequate by SL route; has just initiated treatment) or diversion (patient gave half of dose to wife who is still

using heroin and was withdrawing) and tailor the response to the behavior (e.g., re-education of patient on buprenorphine pharmacology in first case, assistance with treatment entry for spouse in second case). **Reassess treatment plan and patient progress. Strongly consider smaller supplies of medication and observed dosing for any patient who is misusing or diverting their medication regardless of reason.** Treatment structure may need to be increased, including more frequent appointments, observed dosing, and increased psychosocial support.

- **Intensify treatment or level of care, if needed.** Some patients may require an alternative treatment setting or change in pharmacotherapy, such as methadone. The clinician should discuss these alternatives with the patient to assure optimal patient outcome. This should be discussed at treatment onset so that patient is aware of consequences of misuse/diversion.

- **Document and describe the misuse/diversion incident, clinical thinking that supports the clinical response that should be aimed at minimizing risk of diversion and misuse and treating the patient's opioid use disorder at the level of care needed.**

[1] Lofwall, Michelle, and Walsh, Sharon. "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Based and Experiences from Around the World." Journal of Addiction Medicine, Volume 8, Number 5. P. 316.

[2] Ibid, p. 31

History of Present Illness (HPI) Assessment and Plan Template

Templates for induction and follow-up appointments for medication assisted treatment (MAT) in opioid use disorder (OUD). Consider saving this document electronically to quickly cut and paste sections into your EHR.

Underlined sections are options, choose the answer that represents the current patient experience.

History of the Present Illness Template

- Patient is a x yrs. old, (fe)male who presents today for MAT, patient was recently in hospital on a hold. Patient started on opioids after surgery x years ago. Took mostly prescription medications. Then became dependent on opioids and borrowed/stole medications from family and/or friends. Occasionally purchased prescription opioids on the street. Has been using opioids for x years. Occasional heroin use.

- Patient has used opioids for 5 years after ACL tear. Patient stated (s)he uses around 150mg of oxy per day. Patient admits to using heroin X 2 and once is it was mixed with meth. Here with his father.

- Desires to get off opioids. Has had several friends commit suicide in the past month and really wants to get help. Has started seeing counselor at _____ last month.

- Patient applied for Medication Assisted Treatment (MAT) and the [clinic] MAT Team reviewed and approved patient for MAT. Patient has agreed to participate in all aspects of treatment plan including follow-up appointments, counseling, group visits, urine drug testing, and other requirements as noted in the treatment protocol and patient agreement.

- Last opioids x hours ago of long-acting / short acting opioid.

- Today, patient feels pretty lousy today. Anxious, slight abdominal pain.

- Patient has good / limited social supports with family, neighbors, and friends. Specifically, patient will have support from_____

- **Opioid Use Disorder Criteria. Mark all that apply to this patient. Include in HPI.**

  - ☐ Opioids are often taken in larger amounts or over a longer period of time than intended.

  - ☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

- ☐ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ☐ Craving, or a strong desire to use opioids.
- ☐ Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
- ☐ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ☐ Important social, occupational or recreational activities are given up or reduced because of opioid use.
- ☐ Recurrent opioid use in situations in which it is physically hazardous
- ☐ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
- ☐ *Tolerance, as defined by either of the following:
  - a need for markedly increased amounts of opioids to achieve intoxication or desired effect
  - markedly diminished effect with continued use of the same amount of an opioid
- ☐ *Withdrawal, as manifested by either of the following: the characteristic opioid withdrawal syndrome, the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

MAT Induction Assessment and Plan Template

- Opioid use disorder. MAT Induction. Patient desires medication assisted treatment with buprenorphine/naloxone. Discussed long-term treatment. Understands the benefits and risks. Patient has developed treatment goals and life goals.
- Stopped opioids yesterday for short-acting opioids, two days ago for long-acting.
- Patient applied for Medication Assisted Treatment (MAT) and the [your practice name] MAT Team reviewed and approved patient for MAT. Patient has agreed to participate in all aspects of treatment plan including follow-up appointments, counseling, group visits, urine drug testing, and other requirements as noted in the treatment protocol and patient agreement. Patient agreement/consent signed.
- Physical exam completed. See PE, pertinent findings include:

  - Labs reviewed: HIV, HBV, HCV, LFTs, Urine toxicology, and pregnancy test.
  - No opioids for xx hours. In _____ withdrawal. COWS = _____

- Begin buprenorphine induction with 2mg/0.5mg or 4mg/1mg SL suboxone.

- Patient picked up prescription at the pharmacy and brought with them to this appointment. Patient instructed in proper use of medication and long-term treatment per practice protocol. Observed 1st dose in office.

- 1 hour re-check; doing much better. Less anxious and shaky. Not 100% but overall much better. Discussed treatment goals for the future, long-term nature of treatment, and how the patient will utilize the other components of treatment; counseling, group visits, drug testing, and family and community support.

- Second dose of suboxone 4mg/1mg given.

- 2 hour re-check; doing much better. Near baseline. COWS=_____
- Continue counseling and education about medication assisted treatment. MAT is most effective when combined with counseling and expanding family and social supports. Provided patient with a handout about opioid use disorder and medication assisted treatment, reviewed components of this handout, treatment and potential side-effects, how to access professional and community support systems, contingency plans for cravings and/or withdrawal symptoms.

- Enroll in Opisafe, online management for MAT. Opisafe will provide weekly and bi-weekly check on withdrawal (SOWS), depression (PHQ2/9), Generalized Anxiety, sleep, and medication side effects. We will follow these clinically and patient can check in with us, and we will check in with the patient if there are any important changes. Patient's preferred email is_____.

- Naloxone education and training provided to patient to decrease overdose risk.

- Plan for patient to use total dose of 12mg/3mg per day. 8mg in am and 4mg pm for next few days. We will check in with patient tomorrow and in 3 days by phone. See patient back in clinic in 1 week for follow-up and prescription refills. Continue full MAT program through Southeast Health Group with counseling, support, random UAs. Precautions discussed. Call or return if worse symptoms, withdrawal, or cravings.

- Patient in office for 2.5 hours. Greater than 60 minutes/50% of visit spent in medical care, education, and counseling as noted above. Tolerated MAT induction well. Much improved.

Other Potential Components of Induction Note

- Plan daily dose of 12mg/3mg. Given his/her prior dose of opioid use, may need higher dose. Will follow closely over next few days.

- Patients not currently dependent on opioids but high risk for relapse and meet other criteria for OUD (has been in jail or detox and has gone through withdrawal)

- Patient desires MAT for OUD. Patient meets criteria for recurrent opioid use disorder. Not currently dependent, but very high risk for relapse.

Follow-Up Appointment

- Opioid use disorder. Patient desires medication assisted treatment with buprenorphine/naloxone. Understands the benefits and risks. Here today for follow-up appointment after suboxone induction on __/__/20__.

- Reviewed Opisafe patient reported measures. Depression score _____ / GAD/Anxiety_____ / Quality of Life_____ / Pain/function_____

- Now in stabilization / maintenance phase of treatment.
- Today, no signs of withdrawal. COWS = _____
- Patient reports side effects of: none, constipation, nausea, headaches
- Cravings: none / few / often
- Current dose: _____
- Last fill: _____
- Pill/film count: _____
- PDMP/OpiSafe Check: _____
- Last UDT date and results: _____

- Doing well / very well with treatment. Has gotten enrolled in counseling and I stressed the critical importance of counseling and behavioral health care in addition to MAT. Patient voiced understanding and willingness to participate fully in treatment. No evidence of drug diversion. No relapse / relapse with continued interest in continuing buprenorphine MAT program.

- Patient instructed in proper use of medication and long-term treatment per practice protocol.

- Naloxone education and training provided to patient to decrease overdose risk.

- We will check in with him weekly. Precautions discussed. Call or return if worse symptoms, withdrawal, or cravings. Enrolled in Opisafe, online management for MAT. Opisafe will provide weekly and bi-weekly check on withdrawal (SOWS), depression (PHQ2/9), Generalized Anxiety, sleep, and medication side effects.

- Discussed potential side effects and their management. Osmotic stool softener for constipation. (Miralax)
- Continue suboxone SL total daily dose of 16mg/4mg, divided dose, 8mg/2mg am and 8mg/2mg evening. Scripts written.
- Appointment in 3-4 weeks for recheck and refills. Continue full MAT program through the practice with counseling, support, random UAs, etc.
- UA today for buprenorphine and opioid drugs of abuse.

Suboxone Script Writing

Induction day script

- Suboxone 4mg/1mg
- Sig. 1-3 daily as directed by provider
- #30. No refill

Maintenance

- Suboxone 4mg/1mg 8mg/2mg 12mg/3mg
- Sig.
- #30

Suboxone comes in boxes of 30 and if you write for fewer, the pharmacist must waste the remainder and cannot relabel or reuse.

This form is provided for educational and informational purposes only. It is not intended to establish a legal or medical standard of care. Physicians should use their personal and professional judgment in interpreting this form and applying it to the particular circumstances of their individual patients and practice arrangements. The information provided in this form is provided "as is" with no guarantee as to its accuracy or completeness. ASAM will strive to update this form from time to time, but cannot ensure that the information provided herein is current at all times.

Sample Treatment Agreement

I agree to accept the following treatment contract for buprenorphine office-based opioid addiction treatment:

1. I will keep my medication in a safe and secure place away from children (e.g., in a lock box). My plan is to store it (describe where and in what)?

   _____
2. I will take the medication exactly as my doctor prescribes. If I want to change my medication dose, I will speak with the doctor first. Taking more than my doctor prescribes OR taking it more than once daily as my doctor prescribes is medication misuse and may result in supervised dosing at the clinic. Taking the medication by snorting or by injection is also medication misuse and may result in supervised dosing at the clinic, referral to a higher level of care, or change in medication based on the doctor's evaluation.
3. I will be on time to my appointments and be respectful to the office staff and other patients.
4. I will keep my doctor informed of all my medications (including herbs and vitamins) and medical problems.
5. I agree not to obtain or take prescription opioid medications prescribed by any other doctor.
6. If I am going to have a medical procedure that will cause pain, I will let my doctor know in advance so that my pain will be adequately treated.
7. If I miss an appointment or lose my medication, I understand that I will not get more medication until my next office visit. I may also have to start having supervised buprenorphine dosing.
8. If I come to the office intoxicated, I understand that the doctor will not see me, and I will not receive more medication until the next office visit. I may also have to start having supervised buprenorphine dosing.
9. I understand that it is illegal to give away or sell my medication – this is diversion. If I do this, my treatment will no longer include unsupervised buprenorphine dosing and may require referral to a higher level of care, supervised dosing at our clinic, and/or a change in medication based on the doctor's evaluation.
10. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from our clinic.
11. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.
12. I understand that I will be called at random times to bring my medication bottle into the office for a pill count. Missing medication doses could result in requirement for supervised dosing or

referral to a higher level of care at this clinic or potentially at another treatment provider based on your individual needs.

13. I understand that initially I will have weekly office visits until I am stable. I will get a prescription for 7 days of medication at each visit.
14. I can be seen every two weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row. I will then get a prescription for 14 days of medication at each visit.
15. I will go back to weekly visits if I have a positive drug test. I can go back to visits every two weeks when I have two negative drug tests in a row again.
16. I may be seen less than every two weeks based on goals made by me and my doctor.
17. I understand that people have died by mixing buprenorphine with other drugs like alcohol and benzodiazepines (drugs like Valium®, Klonopin® and Xanax®).
18. I understand that treatment of opioid addiction involves more than just taking my medication. I agree to comply with my doctor's recommendations for additional counseling and/or for help with other problems.
19. I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is to stop using all illicit drugs and become successful in all aspects of my life.
20. I understand that I may experience opioid withdrawal symptoms when I go off buprenorphine.
21. I have been educated about the other two FDA-approved medications for opioid dependence treatment, methadone and naltrexone.
22. If female, I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and offered methods for preventing pregnancy.
23. If female, I have been educated about the effects of poor diet, illicit opioid use, use of dirty needles/sharing injection equipment, physical and mental trauma, and lack of pre-natal medical, substance use and mental health care during pregnancy and how these things can adversely affect my health and my current or future fetus/newborn's health. I understand that neonatal abstinence syndrome can occur when taking illicit opioids and that neonatal abstinence syndrome (NAS) is less severe, but can still occur, when pregnant women take methadone or buprenorphine as prescribed/dispensed in substance use disorder treatment. Cigarette smoking can make the severity of NAS worse and cause pre-term birth and small babies. Alcohol use can cause significant cognitive/brain damage in fetuses and newborns.
24. Other specific items unique to my treatment include:

_____	_____	_____
Patient name (print)	Patient signature	Date

Patient Consent Form

This is a sample Patient Consent Form for medication assisted treatment with buprenorphine. Adapt any aspect of this policy to fit your clinic's needs and specific protocols for office-based treatment of opioid use disorder.

1. Policy Statement:

Patients who agree to participate in the Medication Assisted Treatment (MAT) Program at this clinic must adhere to the policies and procedure of the program. Failure to adhere to the rules will result in dismissal from the program.

2. MAT Procedures

- Deciding if MAT with buprenorphine (suboxone) is right for you:
  - This practice will have a MAT team consisting of
    _____
    _____
    _____
    [list providers, nurses, BHP, support staff]
  - The practice team will review the MAT program with the patient, including duration, expectations, pros and cons of medication, and the patient's motivations and goals.
- Preparation for Induction:
  - Patients will be given a physical exam, including lab tests.
  - Patients will have a MAT Overview Appointment. This visit will last approximately 30 minutes. The health care team will review lab results, as needed. The patient will review and sign the Treatment Agreement and Consent Form. Additional information covered during this appointment include safe storage, instructions for Induction Day 1 (including opioid stop times), communication plans, and follow-up visit schedule.
  - Patients and health care teams should discuss possible behavioral health care needs. If a need is identified at this stage, a referral will be requested or appointment scheduled for 1-4 weeks after Induction.
  - Patient may be asked to provide urine, hair, and blood sample or mouth swab at any time during the treatment process.
- Induction:
  - Patients may begin induction on the day of intake or the following business day
  - Induction lasts 1-3 days. Patients must come every day until the MAT provider determines induction is complete.

- Patients must abstain from taking any illicit drugs and notify the MAT provider or his/her staff of all drugs, herbals, and other medication they are taking.

- Maintenance:
  - Patients are expected to attend follow-up visits as agreed upon with health care team.
  - Patients follow-up will be scheduled to coincide with refills.
  - Patients will bring all buprenorphine/Suboxone pills/films with them to be counted at each appointment and each drug screening.
  - Patients are expected to participate in any referrals, if deemed necessary.

- Random Drug Screening:
  - Patients must appear within 24 hours of receiving call for a random screening.
  - Patients are expected to provide urine, hair, and blood sample or mouth swab.
  - Patients must inform the MAT provider or his/her staff of any relapse before it is found on drug screening.
  - If screening is positive, patients must be able to meet with the MAT provider at that time or when appointment is made.

- Medication:
  - It is illegal to give or sell your buprenorphine/Suboxone.
  - It is illegal to receive buprenorphine/Suboxone from more than one physician at a time.
  - There will be no early refills and no refill without an appointment.
  - You are expected to continue taking buprenorphine/Suboxone until your MAT provider instructs you to stop.

3. Reasons for Discontinuation of MAT with Buprenorphine (Suboxone)

- Failure to follow any rules or agreement.
- Cheating or attempting to cheat on drug screening.
- Selling or giving your medication.
- Discrepancies in medication count.
- Failure to provide payment or payment agreement for visits.
- Relapses – consuming illegal drugs or medication not approved by the MAT provider, including medication prescribed by another physician – will be discussed with the patient and health care team. Expectations and plans for handling relapses will be discussed prior to Induction (starting treatment).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