Addiction Expert: Care Needed in Implementing New Buprenorphine Prescribing Rules

By Celia Vimont | March 15, 2013

[From Join Together]

In January, new government regulations took effect that allow greater take-home privileges for buprenorphine patients who are treated in clinic-based Opioid Treatment Programs (OTPs). While this change will allow more patients to have increased flexibility as they progress in their recovery, providers must be careful in deciding who to give the medication to, in order to avoid diversion, says a New York addiction specialist.

“Prescribers and the rest of the health care team need to have a dual focus on both doing everything they can to help the patient, and also trying to keep buprenorphine prescribing safe by limiting misuse, abuse and diversion that may come about by their prescribing,” says Dr. Edwin A. Salsitz, MD, Medical Director, Office-Based Opioid Therapy at Beth Israel Medical Center.

The changes in regulations, made by the Substance Abuse and Mental Health Services Administration (SAMHSA), do not apply to methadone treatment. Previously, patients could not receive a one-week take-home supply of buprenorphine or methadone from an OTP until they were stable in treatment for nine months. Under the new rule, this time requirement for patients receiving buprenorphine products no longer applies. If an OTP physician program physician determines that a patient is suitable, the program can dispense a one-week supply of medication, or longer, to a newly admitted patient.

SAMHSA made the changes based on several factors, including differences between methadone and buprenorphine in abuse potential and actual abuse, death rates, and the fact that methadone is subject to tighter federal controls than buprenorphine. “Buprenorphine abuse has been increasing, but SAMHSA believes that the controls and oversight in place in the OTP, as well as enhanced monitoring will mitigate abuse concerns,” the agency stated in a letter to treatment providers.

Buprenorphine also can be prescribed by certified physicians in an office-based setting, known as office-based opioid treatment (OBOT). Office-based treatment is a popular choice among patients who wish to avoid daily visits to a treatment clinic, Dr. Salsitz notes. However, he adds, not all patients are initially suitable candidates for office-based treatment. “The main benefit of someone going to an opioid treatment program and being dispensed buprenorphine is the security and structure that OTP provides,” he says. “It is virtually impossible for an OBOT to provide the same oversight, structure and security for both the patient and the medication, as is provided by clinic-based treatment. One possible paradigm is to begin buprenorphine treatment in an OTP if enhanced oversight and structure are needed, and then when the patient has stabilized, the patient can be referred to an office-based treatment program.”

Choosing whether a patient addicted to opioids should be treated with buprenorphine or methadone, and whether they should be treated in a clinic or in a physician’s office, are complicated issues, Dr.
Salsitz observes. “These issues currently have no clear answers, but they need to be researched and evaluated,” he says.

In stressing the need for strict oversight of buprenorphine prescribing, Dr. Salsitz pointed to a recent SAMHSA report that found hospital emergency department visits linked to buprenorphine increased substantially – from 3,161 visits in 2005 to 30,135 visits in 2010, with 52 percent involving non-medical use. He notes, “If a doctor gives a new patient 30 days of buprenorphine without any real follow-up, some of that medication may end up on the street.”