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Web browser: **pollev.com/nzingaharris835**

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Not X-Rated Anymore:
The Future of Suboxone

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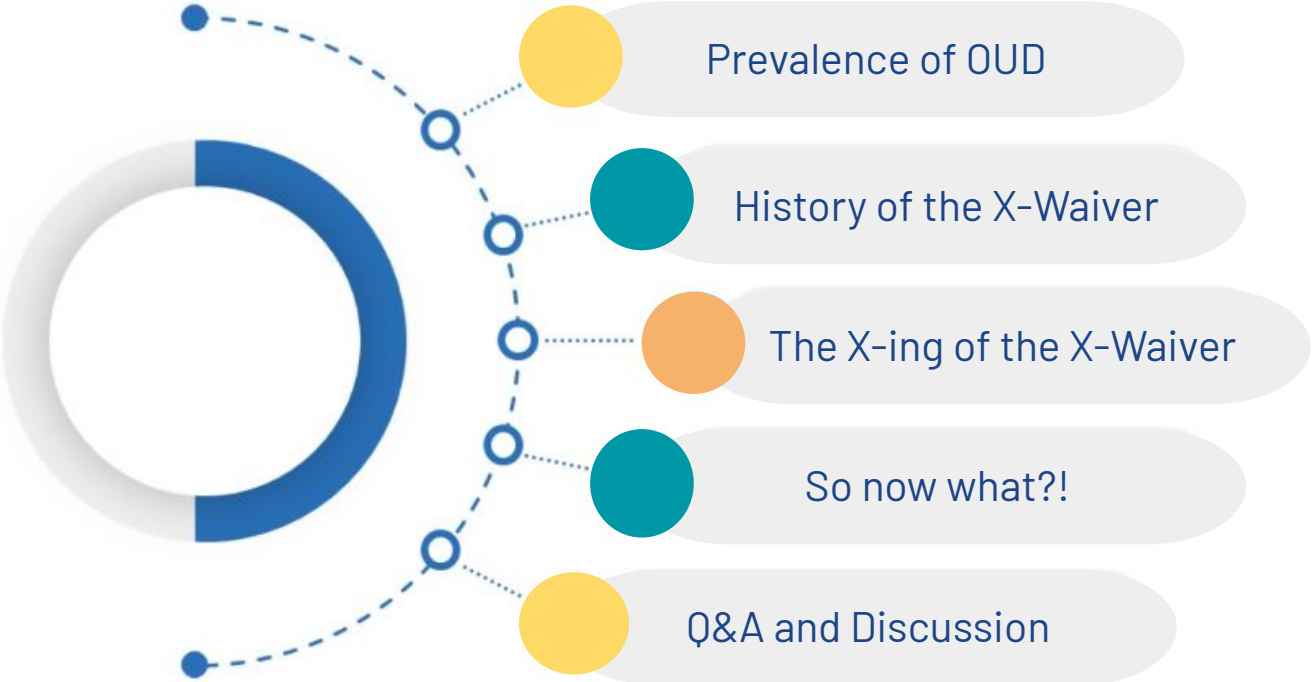
Author, *Un-Addiction: 6 Mind-Changing Conversations That Could Save a Life*

Disclosures

I have no disclosures.

What month were you born?

Agenda


Prevalence of OUD
History of the X-Waiver
The X-ing of the X-Waiver
So now what?!
Q&A and Discussion

Prevalence of OUD

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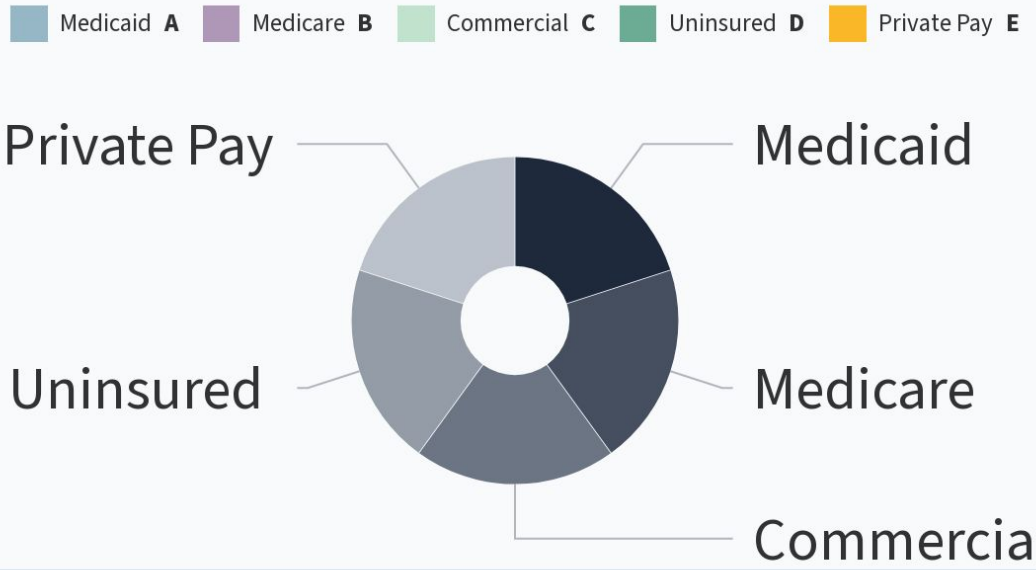
What is the predominant patient population you serve?



Prevalence of OUD

National Average

- 5% of U.S. adults say they have misused or been addicted to opioids or prescription painkillers
- Medicaid 8.9 per 1000: Prevalence of OUD is higher among
  - Males compared to females (5.7 percent compared to 4.4 percent)
  - Whites compared to African-Americans and Hispanics (6.6 percent compared to 2.7 percent and 2.4 percent)
  - Enrollees in rural areas, states report a growing problem in urban areas
- Medicare 5.39 per 1000
- Commercial 3.28 per 1000

2018 Milliman Report
2019 KFF Report

OUD Treatment

- Buprenorphine
  - reduces opioid misuse
  - decreases risk for injection-related infectious diseases
  - decreases risk for fatal and non-fatal overdoses

Only

22%

of people with opioid use disorder receive medications

Key Substance Use and Mental Health Indicators in the United States

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What is your primary practice geography?

Urban

Suburban

Rural

Other

OUD Treatment Disparities

Race/Ethnicity Disparities

- Following an opioid-related event such as an overdose, infection, or detox admission, White patients received medication for opioid use disorder (OUD):
  - up to 80% more frequently than Black patients and
  - up to 25% more frequently than Hispanic patients
  - AI/PI not even mentioned

Geographic Disparities

- Rural/Geographic: 56 percent of rural counties do not have a provider who can prescribe buprenorphine, a treatment for opioid use disorder. Further, 2 percent of Americans living in urban areas are without access to a buprenorphine provider, compared with 30 percent of rural residents.

Socioeconomic Disparities

- Socioeconomic : three-quarters of prescriptions for buprenorphine go to those who pay cash or have private insurance

Substantial racial inequalities despite frequent healthcare contact
Exploring Urban-Rural Disparities in Accessing Treatment for OUD
Stark racial, financial divides found in opioid addiction treatment

History of the X-Waiver

DATA2000

- Allowed physicians for first time in almost a century to prescribe for OUD in an office-based setting
- Requirements
  - DEA (State)
  - Board Certified in Addiction Psychiatry or Addiction Medicine
  - 8 hours training
  - Researcher
  - Apply for waiver - X (federal)
- Waiver: 30, 100, 275
- Worries: Precipitated withdrawal, OD and Diversion

Model Policy on DATA 2000 & Treatment of Opioid Addiction in the Medical Office

Overdose and Buprenorphine

- Between July 2019 and June 2021 buprenorphine-involved overdose deaths represented 2.6% of the 74,474 opioid-involved overdose deaths recorded in the SUDORS dataset.
- Between April 2020 and June 2021, when buprenorphine prescribing regulations were relaxed in response to the COVID-19 pandemic, monthly opioid-involved overdose deaths increased overall but the proportion of those deaths involving buprenorphine did not increase.
- 92.7% of buprenorphine-involved overdose deaths also involved at least one other drug

X-Waiver Usage

2015

- **16% of Psychiatrist waivered** representing 41.6% of waivered docs and primarily in rural areas
- **3% of PCPs waivered**
- 30 Million people living in counties without Suboxone waivered physician

2019

- The **number of DATA-waivered providers more than doubled** from 32,129 in 2016 to 70,020 in 2019.
- Approximately 44% of DATA-waivered providers chose to not be publicly listed in the SAMHSA treatment locator tool.
- **ED Docs: 1 in 5 waivered**
  - 1/3 order Bup for OUD in last 3 months
  - <30% felt prepared to initiate Bup

2020

- PCPs affiliated with hospital health systems less likely to have waiver than unaffiliated (3.6% versus 8.2%)
- Reverse is true for psychiatrists (33.2% versus 26.2%).
- **70% of waivered PCPs** in health systems have only a 30-patient limit
- **77% of waivered psychiatrists** in health systems have only a 30-patient

2022

- Survey study of 126 clinicians attending a GetWaiveredTX waiver training:
  - 61 clinicians received an X-waiver; among them, 36% were prescribing buprenorphine and **64% were not.**

Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder
Geographic location of buprenorphine-waivered physicians and integration with health systems
Survey of Barriers and Facilitators to Prescribing Buprenorphine and Clinician Perceptions on the Drug Addiction Treatment Act of 2000 Waiver

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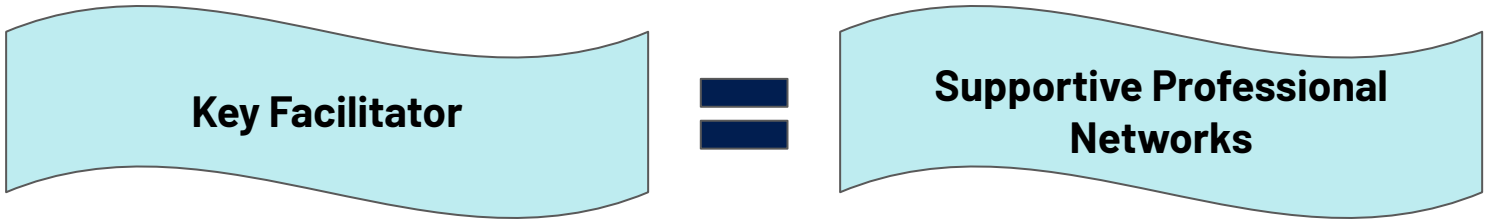
Before the X-waiver was X'd, were you waivered?

Barriers to Prescribing Suboxone

- Complexity of X-waiver process
- Perceived lack of professional support
- Referral network as barriers to prescribing buprenorphine



Survey of Barriers and Facilitators to Prescribing Buprenorphine and Clinician Perceptions on the Drug Addiction Treatment Act of 2000 Waiver

The X-ing of the X-Waiver

Waiver Elimination Act

Waiver Elimination Act

Effective June 2023

All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law and SAMHSA encourages them to do so.

Waiver Elimination Act

- No longer need X-DEA number
- No longer have to register with SAMHSA
- No more prescribing limits

Upon submission of new or renewal DEA application, **ALL physicians** must have **one** of the following:

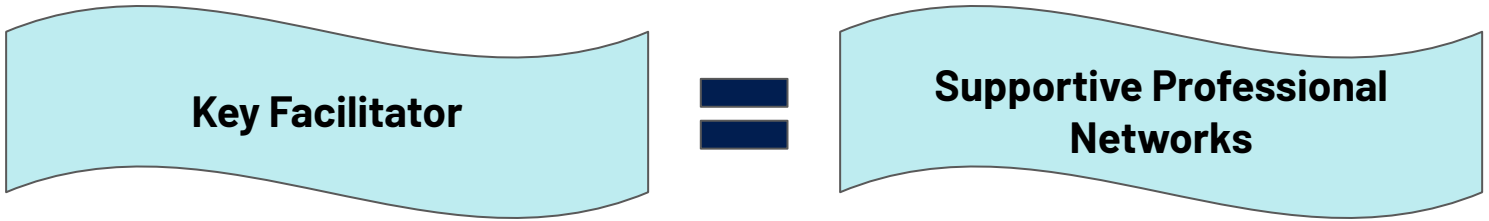
A total of eight hours of training from certain organizations on opioid or other substance use disorders for practitioners renewing or newly applying for a registration from the DEA to prescribe any Schedule II-V controlled medications;

Board certification in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, American Board of Addiction Medicine, or the American Osteopathic Association; or

So now what?!

Barriers to Prescribing Suboxone

- ~~Complexity of X-waiver process~~
- Perceived lack of professional support
- Referral network as barriers to prescribing buprenorphine



Survey of Barriers and Facilitators to Prescribing Buprenorphine and Clinician Perceptions on the Drug Addiction Treatment Act of 2000 Waiver

What are barriers that are keeping you from prescribing buprenorphine?

Top

Quick Start Guide to Prescribing Bup

- Screening
- Induction
  - Fentanyl
  - Precipitated Withdrawal
- Brixadi
- Follow up
- Billing

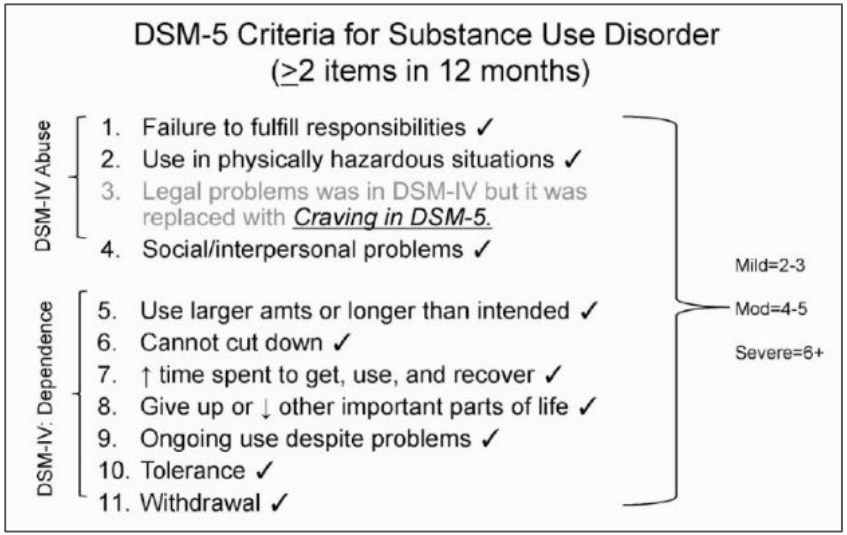
Quick Start Guide to Prescribing Bup

Screening for SUD

C	Have you ever felt the need to **cut** down on your drinking or drug use?	Yes	No
A	Have people **annoyed** you by criticizing your drinking or drug use?	Yes	No
G	Have you ever felt **guilty** about drinking or drug use?	Yes	No
E	Have you ever felt you needed a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-Opener**)?	Yes	No

1 "yes" = 79% sensitivity for SUD
77% specificity for SUD

Screening for mod/severe OUD



CAGE-AID Questionnaire

COWS

CLINICAL OPIATE WITHDRAWAL SCALE

For each item, circle 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 assesment, the increase pulse rate would not add to the score.

Resting Pulse Rate: beats / minute
Measured after patient is sitting or lying for one minute
(0) pulse rate 80 or below
(1) pulse 81 to 100
(2) pulse 101 to 120
(4) pulse rate greate than 120

GI Upset:
over last 1/2 hour
(0) no GI symptoms
(1) stomach cramps
(2) nausea or loose stool
(3) vomiting or diarrhea
(5) multiple episodes of diarrhea or vomiting

Sweating: over past 1/2 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

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

Restlessness:
Observation during assessment
(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

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

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

Anxiety or Irritability:
Measured after patient is sitting or lying for one minute
(0) none
(1) patient reports increasing irritability or anxiousness
(2) patient obviously irritable or anxious
(4) patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches:
If the patien 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

Gooseflesh skin:
(0) skin is smooth
(3) piloerrection of skin can be felt or hairs standing up on arms
(5) prominent piloerrection

Runny nose or tearing:
Not acounted 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

Total Score:
The total score is the sum of all 11 items
Initials of person completing assessment:
Score: 5- 12 = ***mild;*** 13-24 = ***moderate;***
25-36 = ***moderately severe;***
more than 36 = ***severe withdrawal***

Quick Start Guide to Prescribing Bup

- This is your history and physical exam
- Can be done virtually by patient report
- Total Score = Sum of all 11 items
  - 5-12 MILD
  - 13-24 Moderate
  - 25-36 Moderately severe
  - >36 Severe

COWS

Quick Start Guide to Prescribing Bup

- **Induction**

Evaluation	COWS <4	COWS 4-7	COWS>8

• OUD History
• COWS
• UDS (POC or send out)
• Hep C, HIV
	• No induction	• Day 1: 8 mg + 4mg PRN, max 12mg
		• Day 2: 8mg BID
		• Day 4: Nurse Check-In for COWS
		  ○ Adjust to 8mg TID for COWS>0 or craving
			• ASAP: 8mg + 8mg PRN, max 16mg
			• Day 2: 8mg BID
			• Day 4: Nurse Check-In for COWS
			  ○ Adjust to 8mg TID for COWS>0 or craving

Prescribe Narcan + comfort meds: NSAID, antihistamine, anti-emetic, anti-diarrheal			
Recommend hydration and multi-vitamin			
Mental health screening and refer for psychosocial support			

Incidence of Precipitated Withdrawal During a Multisite Emergency Department–Initiated Buprenorphine Clinical Trial in the Era of Fentanyl

Quick Start Guide to Prescribing Bup - Brixadi!

Indication	for the treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a single dose of a transmucosal buprenorphine product or who are already being treated with buprenorphine.

Evaluation	COWS <4	COWS 4+
• OUD History • COWS • UDS (POC or send out) • Hep C, HIV	• No induction	• Day 1: 4 mg SBX SL, wait 30 minutes → 16mg SQ BRX • Day 3: +8mg SQ BRX • Day 4-7: +8mg SQ BRX PRN elevated COWS score • Day 8+: 1st week total dose (24mg-32mg) SQ q7 days • ***Maximum weekly dose 32mg***
Prescribe Narcan + comfort meds: NSAID, antihistamine, anti-emetic, anti-diarrheal		
Recommend hydration and multi-vitamin		
Mental health screening and refer for psychosocial support		

Quick Start Guide to Prescribing Bup – Brixadi!

Patients currently being treated with a transmucosal buprenorphine-containing product may be switched directly to either BRIXADI (weekly) or BRIXADI (monthly).

Daily dose of sublingual buprenorphine	BRIXADI (weekly)	BRIXADI (monthly)
≤ 6 mg	8 mg	--
8-10 mg	16 mg	64 mg
12-16 mg	24 mg	96 mg
18-24 mg	32 mg	128 mg

Patients may be transitioned from weekly to monthly or from monthly to weekly dosing of BRIXADI based on clinical judgment

BRIXADI (weekly)	BRIXADI (monthly)
16 mg	64 mg
24 mg	96 mg
32 mg	128 mg

Consider Brixadi

From a health equity perspective, special needs populations with significantly negative OUD outcomes disparities that would benefit from a weekly formulation that can be started after only one SL test dose include:

- **Individuals being discharged from EDs** in communities without adequate access to buprenorphine
  - ED docs are often reticent to prescribe buprenorphine if there is not access to outpatient care within 3 days.
  - a shot of Brixadi would provide coverage for one week follow-up

- **Unhoused individuals**: Face unique barriers to care including requirements for:
  - lengthy intake processes
  - frequent visits with consistent attendance
  - complete abstinence from other substances

- **Incarcerated individuals**: Jails with short stays are particularly reticent to prescribe buprenorphine on initial incarceration because of concerns about:
  - in-jail diversion
  - lack of adequate community access to continue care
  - *individuals prescribed buprenorphine during incarceration are less likely to face rearrest and reconviction*
  - *opioid overdose risk is 10x greater for those recently released from incarceration, a weekly shot to allow time for connection to ongoing services could be life saving*

Quick Start Guide to Prescribing Bup

- Fentanyl
  - Increases risk of precipitated withdrawal
  - Increases risk of overdose death
  - More reason to do the induction: anticipatory guidance, comfort meds, higher dose of Bup
- Precipitated Withdrawal
  - Among 1200 enrolled patients, there were 9 cases of PW, or 0.76% (95% CI, 0.35%-1.43%)
  - All patients had urine tests positive for fentanyl, 7 with multiple drugs
  - All patients experiencing PW were discharged after symptoms resolved, with 1 self-directed discharge

Incidence of Precipitated Withdrawal During a Multisite Emergency Department–Initiated Buprenorphine Clinical Trial in the Era of Fentanyl

Quick Start Guide to Prescribing Bup

- Stabilizing Bup
  - **Goal**: COWS = 0, Craving = 0
  - Increase dose as high 24mg per day as early as Day 4
- Billing - not exhaustive!
  - E+M Codes: 9920x-9921x
  - Psychotherapy add-on: 90833, 90838
  - Psychotherapy codes: 90832-90837
  - Presumptive Toxicology: 80305
  - Oral medication administration: H0033
  - Behavioral Health Screening: 96156
  - Telehealth modifiers
  - Medicare G Codes

Quick Start Guide to Prescribing Bup

- What about telemedicine?

YES

Telemedicine Use and Quality of Opioid Use Disorder Treatment in the US During the COVID-19 Pandemic

Ruth Hailu, AB[1]; Ateev Mehrotra, MD[1,2]; Haiden A. Huskamp, PhD[1]; et al

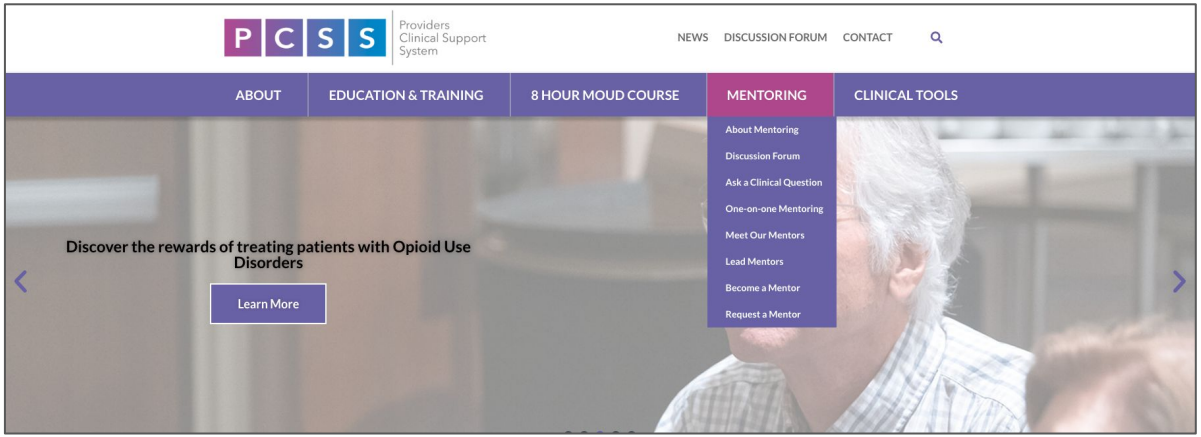
» Author Affiliations | Article Information

JAMA Netw Open. 2023;6(1):e2252381. doi:10.1001/jamanetworkopen.2022.52381

Findings In this cohort study of 11 801 patients with OUD with commercial insurance or Medicare Advantage coverage, there were no significant differences in visit frequency, initiation of medications for OUD, or OUD-related adverse outcomes between those who were treated by clinicians with high vs low telemedicine use across the prepandemic and pandemic periods.

Key Facilitator to Prescribing Suboxone

Key Facilitator = **Supportive Professional Networks**



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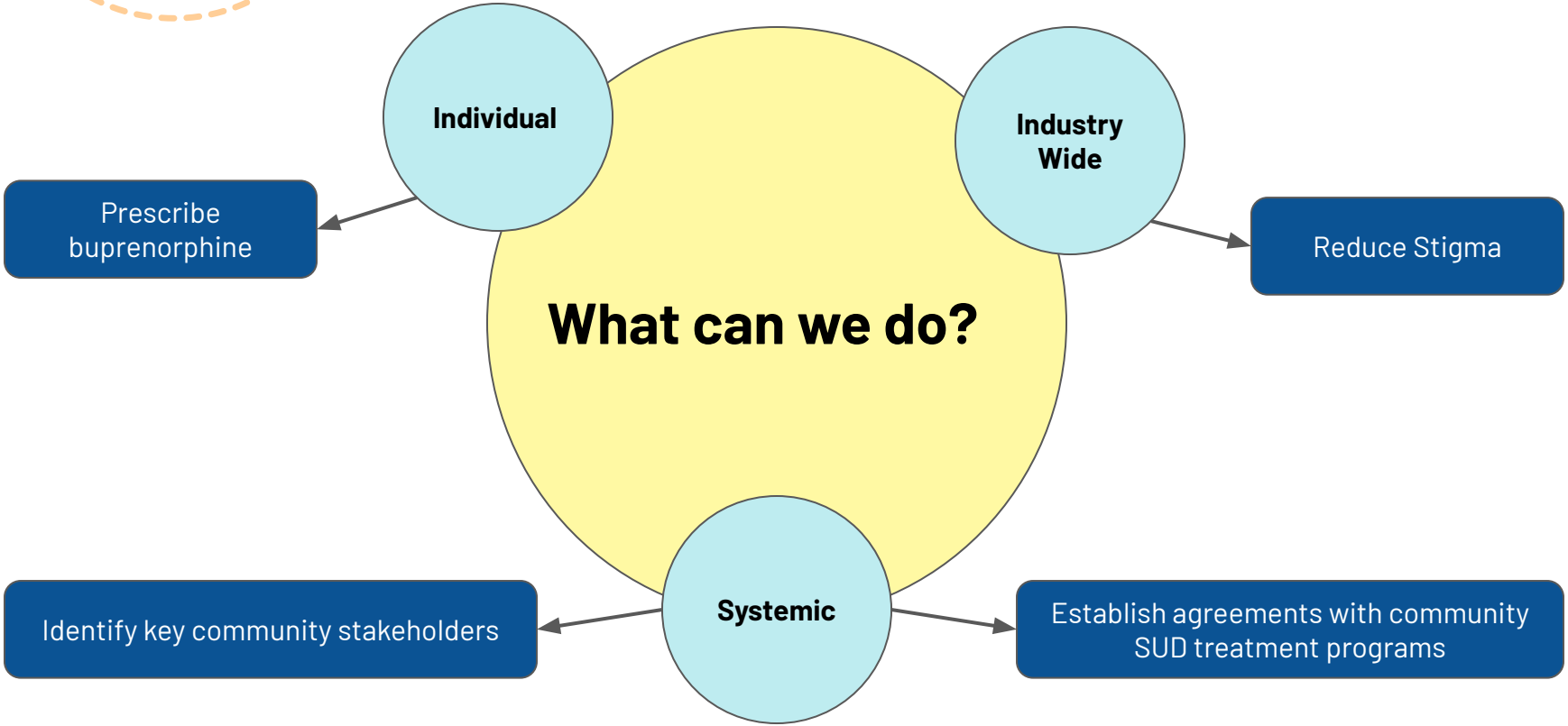
What can we do?



Questions & Discussion