TIP 63

MEDICATIONS FOR OPIOID USE DISORDER

Part 5: Resources Related to Medications for Opioid Use Disorder

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

Part 5 of this **Treatment Improvement Protocol (TIP)** provides a collection of resources by audience and a glossary of key terms to help readers better understand how Food and Drug Administration (FDA)-approved medications can be used to treat opioid use disorder (OUD).

TIP Navigation

KEY MESSAGES

- Practice guidelines and decision-making tools can help healthcare professionals with OUD screening, assessment, diagnosis, treatment planning, and referral.
- Patient- and family-oriented resources provide information about opioid addiction in general; the role of medication, behavioral and supportive services, and mutual-help groups in the treatment of OUD; how-tos for identifying recovery support services; and how-tos for locating medical and behavioral health service providers who specialize in treating OUD or other substance use disorders (SUDs).

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

PART 5: RESOURCES RELATED TO MEDICATIONS FOR OPIOID USE DISORDER

PART 5 of 5

Resources Related to Medications for Opioid Use Disorder

There are numerous resources to help healthcare professionals and behavioral health service providers better understand the use of FDA-approved medications for OUD. Many other resources are available to help patients, their families and friends, and the general public better understand OUD and the medications available to treat it and support recovery from it. Part 5 of this TIP provides an audience-segmented collection of resources and a glossary of key terms related to OUD. It is of use to all interested readers.

General Resources

Facts and Figures

American Association for the Treatment of Opioid Dependence (AATOD), Frequently Asked Questions (www.aatod.org/resources/frequently-asked-questions).

Centers for Disease Control and Prevention (CDC), Smoking & Tobacco Use (www.cdc.gov/tobacco/index.htm).

Legal Action Center (LAC), Medication-Assisted Treatment for Opioid Addiction: Myths and Facts (http://lac.org/wp-content/uploads/2016/02/Myth-Fact-for-MAT.pdf).

Missouri Department of Mental Health, Methadone Maintenance Myths and Resources (https://dmh.mo.gov/docs/ada/methadonemyths.pdf).

National Institute on Drug Abuse (NIDA) (www.drugabuse.gov):

- Addiction Science (www.drugabuse.gov/related-topics/addiction-science). Provides two short videos that explain the nature of addiction. These are useful in educating people in primary care who suffer from addiction. This site has links to publications for professionals that explain the nature of addiction.
- NIDAMED, Medical and Health Professionals (www.drugabuse.gov/nidamed-medical-health-professionals). Disseminates science-based resources to healthcare professionals on the causes and consequences of drug use and addiction and advances in pain management.

Office of National Drug Control Policy, Medication-Assisted Treatment for Opioid Addiction (https://online.ndbh.com/docs/providers/SubstanceUseCenter/Medication-Assisted-Treatment-Edited.pdf): Offers a factsheet with a useful summary of pharmacotherapy for OUD and its effectiveness.

Partnership for Drug-Free Kids, Commentary: Countering the Myths About Methadone (www.drugfree.org/news-service/commentary-countering-the-myths-about-methadone).

Substance Abuse and Mental Health Services Administration (SAMHSA):

- Addiction Technology Transfer Center **(ATTC)** (http://attcnetwork.org/home). Network with 10 regional centers across the country that provide training and information on evidence-based practices to practitioners. The ATTC website's section on OUD medication has many resources for clinicians, patients, and family members (www.attcnetwork.org/explore/priorityareas/wfd/mat/mat.pubs.asp).
- State Opioid Treatment Authorities (SOTAs) (https://dpt2.samhsa.gov/regulations/smalist.aspx).

United States Surgeon General's Report, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (https://addiction.surgeongeneral.gov).

Groups and Organizations

AATOD (www.aatod.org): Works with federal and state agencies on opioid treatment policy throughout the United States. Convenes conferences every 18 months on evidence-based clinical practice, current research, and organizational developments related to OUD treatment. AATOD develops publications that serve as resources for addiction counselors and peer support providers.

American Academy of Addiction Psychiatry (AAAP) (www.aaap.org): Offers education and training materials on addiction psychiatry (e.g., webinars, continuing medical education courses).

American Society of Addiction Medicine (ASAM) (www.asam.org): Provides medical education and resources on the treatment of SUDs, including OUD.

LAC (https://lac.org): Offers information about the rights of people with criminal records, HIV/AIDS, and SUDs.

Medical Assisted Treatment of America (www.medicalassistedtreatment.org): Raises awareness and understanding of substance misuse, the problems it creates, and ways to address these problems.

National Alliance for Medication Assisted Recovery (NAMA Recovery) (www.methadone.org): Supports quality opioid agonist treatment through its many U.S. chapters and its international network of affiliate chapters. Thousands of methadone clients and healthcare professionals belong to the organization.

National Alliance of Advocates for Buprenorphine Treatment (www.naabt.org): Aims to educate the public about opioid addiction and buprenorphine as a treatment option, to reduce prejudice and discrimination against clients who have SUDs, and to connect clients in need to qualified treatment providers.

SAMHSA (www.samhsa.gov):

- Buprenorphine Practitioner Verification for Pharmacists (www.samhsa.gov/bupe/lookup-form)
- National Recovery Month (https://recoverymonth.gov)
- Opioid Treatment Program (OTP) Directory (https://dpt2.samhsa.gov/treatment)
- SOTAs (https://dpt2.samhsa.gov/regulations/smalist.aspx)

SAMHSA Publications

All publications listed in this section are available for free from SAMHSA's publications ordering webpage (https://store.samhsa.gov) or by calling 1-877-SAMHSA-7 (1-877-726-4727):

- TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (https://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA13-3992)
- TIP 54: *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* (https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671)
- TIP 57: *Trauma-Informed Care in Behavioral Health Services* (https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816)
- TIP 62: *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (Once published, this TIP will be available on SAMHSA's publications ordering webpage, https://store.samhsa.gov)
- *Advisory:* An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence (https://store.samhsa.gov/product/An-Introduction-to-Extended-Release-Injectable-Naltrexone-for-the-Treatment-of-People-with-Opioid-Dependence/SMA12-4682)
- *Advisory:* Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update (https://store.samhsa.gov/product/Advisory-Sublingual-and-Transmucosal-Buprenorphine-for-Opioid-Use-Disorder-Review-and-Update/SMA16-4938)
- *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* (https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/All-New-Products/SMA18-5054)
- *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorders: A Brief Guide* (https://store.samhsa.gov/shin/content//SMA14-4892/SMA14-4892.pdf)
- *A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders* (https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978)
- *Decisions in Recovery: Treatment for Opioid Use Disorders, Handbook* (https://store.samhsa.gov/product/SMA16-4993)
- Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit (https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367)
- Technical Assistance Publication 32: *Clinical Drug Testing in Primary Care* (https://store.samhsa.gov/shin/content//SMA12-4668/SMA12-4668.pdf)
- *What Are Peer Recovery Support Services?* (https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf)

General Information

Agency for Healthcare Research and Quality:

- *Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings* (www.ncbi.nlm.nih.gov/books/NBK402352)
- Academy for Integrating Behavioral Health and Primary Care (https://integrationacademy.ahrq.gov)

American Academy of Family Physicians:

- Chronic Pain Management and Opioid Misuse: A Public Health Concern (Position Paper) (www.aafp.org/about/policies/all/pain-management-opioid.html)
- Pain Management and Opioid Use Resources (www.aafp.org/patient-care/public-health/pain-opioids/resources.html)

ATTC Network (http://attcnetwork.org/home): This nationwide network of SAMHSA-sponsored regional centers is a multidisciplinary resource for professionals in the addiction treatment and recovery services fields. The network has many valuable resources and projects of interest to people involved in treating SUDs. Of particular interest to readers of this TIP are the training programs produced as part of the NIDA/SAMHSA-ATTC Blending Initiative:

- Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals (www.attcnetwork.org/projects/buptx.aspx)
- Buprenorphine Treatment for Young Adults (www.attcnetwork.org/projects/bupyoung.aspx)
- Prescription Opioid Addiction Treatment Study (POATS) (www.attcnetwork.org/projects/poats.aspx)

BupPractice.com Federal Recordkeeping Requirements for Buprenorphine Treatment (www.buppractice.com/node/12246): Provides information about federal recordkeeping requirements.

CDC Smoking & Tobacco Use (www.cdc.gov/tobacco/index.htm): Includes resource links for clinicians on smoking and the treatment of tobacco use.

Centers for Medicare & Medicaid Services (www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html): Gives guidance on the delivery of telehealth.

Department of Health and Human Services (HHS):

- Centers for Medicare & Medicaid Services Clinical Laboratory Improvement Amendments Application for Certification (www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms116.pdf)
- Medication Assisted Treatment for Opioid Use Disorders: Final Rule (www.federalregister.gov/documents/2016/07/08/2016-16120/medication-assisted-treatment-for-opioid-use-disorders)

Drug Enforcement Administration (DEA):

- DEA Requirements for DATA Waived Physicians (www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm). Lists DEA requirements for Drug Addiction Treatment Act of 2000 (DATA 2000)-waivered healthcare professionals.
- Form DEA-106, Report of Theft or Loss of Controlled Substances (https://apps.deadiversion.usdoj.gov/webforms/dtlLogin.jsp). Provides instructions for completing form DEA-106, which must be filed when stored buprenorphine is lost or stolen.
- *Practitioner's Manual* (www.deadiversion.usdoj.gov/pubs/manuals/pract). Provides guidance on how to comply with federal requirements on recordkeeping for ordering, storing, and dispensing buprenorphine in the office. This manual is from the DEA's Office of Diversion Control.

Drugs.com:

- Buprenorphine Drug Interactions (www.drugs.com/drug-interactions/buprenorphine-index.html?filter=3&generic_only=)
- Drug Interactions Checker (www.drugs.com/drug_interactions.php)

FDA:

- Approved Risk Evaluation and Mitigation Strategy (REMS): Buprenorphine Transmucosal Products for Opioid Dependence (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=RemsDetails.page&REMS=9)
- REMS: Probuphine (buprenorphine hydrochloride) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=IndvRemsDetails.page&REMS=356)
- REMS: Sublocade (extended-release injectable buprenorphine) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=IndvRemsDetails.page&REMS=376)
- REMS: Suboxone/Subutex (buprenorphine and naloxone/buprenorphine) (www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=IndvRemsDetails.page&REMS=352)
- REMS: Vivitrol (extended-release naltrexone [XR-NTX]) (www.vivitrolrems.com)

LAC (https://lac.org): LAC attorneys provide legal advice by phone to service providers and government agencies. They assist dozens of agencies annually with questions about confidentiality of treatment records, discrimination, and other issues. LAC's confidentiality hotline provides information about the federal law protecting the confidentiality of drug and alcohol treatment and prevention records (42 CFR Part 2). The hotline is free to New York treatment providers and government agencies. Outside New York, the hotline is accessible if the state alcohol/drug oversight agency subscribes to LAC's Actionline service. To speak with a hotline attorney, call LAC Monday through Friday 1–5 p.m. (Eastern Time Zone) at 1-212-243-1313, or toll-free at 1-800-223-4044.

National Alliance of Advocates for Buprenorphine Treatment 30–100 Patient Limit (www.naabt.org/30_patient_limit.cfm): Summarizes the DATA 2000 law.

National Association of State Controlled Substances Authorities State Profiles (www.nascsa.org/stateprofiles.htm): Contains a directory of each state's prescription drug monitoring program (PDMP).

National Conference of State Legislatures Drug Overdose Immunity and Good Samaritan Laws (www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx): Provides information about naloxone and Good Samaritan immunity.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Professional Education Materials (www.niaaa.nih.gov/publications/clinical-guides-and-manuals): Provides professional education materials; offers links to screening, treatment planning, and general information for clinicians in outpatient programs.

National Library of Medicine's DailyMed:

- FDA label information for methadone (https://dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=all&query=METHADONE)
- FDA label information for naltrexone (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd11c435-b0f0-4bb9-ae78-60f101f3703f)

NIDA:

- Available Treatments for Marijuana Use Disorders (www.drugabuse.gov/publications/research-reports/marijuana/available-treatments-marijuana-use-disorders). Provides information about treatment options for individuals with marijuana use disorder.
- Opioid Overdose Reversal With Naloxone (Narcan, Evzio) (www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio). Contains naloxone information for providers.

- NIDAMED, Medical and Health Professionals (www.drugabuse.gov/nidamed-medical-health-professionals). Provides practice-related and professional education-related resources.
- Medications To Treat Opioid Addiction (www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview). Provides an overview of the need for and efficacy of OUD medications and discusses common misconceptions, impacts on outcome, and use of OUD medications with certain specific populations.
- *Effective Treatments for Opioid Addiction* (https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction).
- Therapeutic Communities (www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-are-therapeutic-communities). Gives a brief overview of OUD medications and links to additional information.
- *Principles of Drug Addiction Treatment: A Research-Based Guide* (www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface). Discusses how OUD affects the brain and covers the state of addiction treatment in the United States, principles of effective treatment, frequently asked questions about OUD medication, evidence-based approaches to treatment, and additional resources.
- *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide* (www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction). Discusses principles of SUDs in adolescents, addresses frequently asked questions, summarizes treatment settings and evidence-based treatment approaches, and provides treatment referral resources.
- *Treating Opioid Use Disorder During Pregnancy* (www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy). Addresses the risks of OUD to the pregnant woman and the fetus, briefly summarizes OUD pharmacotherapies for use during pregnancy, and provides links to additional information.

North American Syringe Exchange Program (https://nasen.org/directory): Provides a national directory of syringe exchange programs in the United States.

Prescription Drug Abuse Policy System's Naloxone Overdose Prevention Laws (http://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139): Provides a map with a link to each state's naloxone overdose prevention laws, including policies on prescribing, dispensing, and civil and criminal immunity.

Project Lazarus's Naloxone: The Overdose Antidote (www.projectlazarus.org/naloxone): Provides guidance on administering naloxone.

Providers' Clinical Support System's (PCSS's) How To Prepare for a Visit From the Drug Enforcement Agency Regarding Buprenorphine Prescribing (http://pcssmat.org/wp-content/uploads/2014/02/FINAL-How-to-Prepare-for-a-DEA-Inspection.pdf): Provides a description of the DEA inspection process and how to comply with its requirements.

SAMHSA:

- Dear Colleague Letters for Medication-Assisted Treatment Providers (www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/dear-colleague-letters). Offers regular communications to the opioid treatment community regarding clinical and regulatory issues related to opioid treatment. Regulations, policies, and best practices for OTPs and office-based

opioid treatment (OBOT) clinics can change, and Dear Colleague Letters help providers stay up to date.

- Understanding the Final Rule for a Patient Limit of 275 (www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/understanding-patient-limit275.pdf). Provides information about the final rule and how to use it to increase patient access to medication for OUD and associated reporting requirements.
- Buprenorphine Waiver Management (www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management). Provides information on the buprenorphine waiver, including links to the buprenorphine waiver application and an explanation of the processes, requirements, and recordkeeping strategies associated with prescribing buprenorphine.
- Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver (www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers). Provides information for NPs and PAs about the buprenorphine waiver training, with links to trainings and the application process.
- Buprenorphine Training for Physicians (www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training). Offers links to organizations that provide buprenorphine training for physicians.
- *SAMHSA Opioid Overdose Prevention Toolkit* (https://store.samhsa.gov/product/SAMHSA-Opioid-Overdose-Prevention-Toolkit/SMA16-4742). Prepares healthcare professionals, communities, and local governments with material to develop practices and policies to help prevent opioid-related overdoses and deaths. It addresses issues for healthcare professionals, first responders, treatment providers, and those recovering from opioid overdose.
- *Federal Guidelines for Opioid Treatment Programs* (https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP). Provides updated guidelines for how OTPs can satisfy the federal regulations.
- Form SMA-168 Opioid Treatment Exception Request (www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/submit-exception-request). Provides instructions for physicians on how to request exceptions to federal standards for opioid treatment.
- Laws and Regulations (www.samhsa.gov/about-us/who-we-are/laws-regulations). Provides an overview and summary of the most frequent questions about disclosure and patient records pertaining to substance use treatment that federal programs maintain.
- *Substance Abuse in Brief Fact Sheet:* Introduction to Mutual-Support Groups for Alcohol and Drug Abuse (https://store.samhsa.gov/shin/content/SMA08-4336/SMA08-4336.pdf). Provides information to help medical and behavioral health service providers understand mutual-help groups and how to make referrals to such groups.
- SAMHSA has developed several resources to guide healthcare professionals in their use of telehealth and telemedicine approaches for OUD:
  - *In Brief:* Rural Behavioral Health: Telehealth Challenges and Opportunities (https://store.samhsa.gov/shin/content/SMA16-4989/SMA16-4989.pdf)
  - Certified Community Behavioral Health Clinics (CCBHCs) Using Telehealth or Telemedicine (www.samhsa.gov/section-223/care-coordination/telehealth-telemedicine)

Practice Guidelines and Decision-Support Tools

ASAM:

- *Appropriate Use of Drug Testing in Clinical Addiction Medicine* (http://download.lww.com/wolterskluwer_vitalstream_com/PermaLink/JAM/A/JAM_11_3_2017_06_02_SAFARIAN_JAM-D-17-00020_SDC1.pdf). Details the ASAM consensus statement on drug testing in addiction treatment.
- The ASAM Criteria (www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria). Provides criteria and a comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions.
- *The ASAM National Practice Guidelines: For the Use of Medication in the Treatment of Addiction Involving Opioid Use* (www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf). Provides information on prescribing methadone, buprenorphine, naltrexone, and naloxone. The document also discusses the needs of special populations, including women during pregnancy, patients with chronic pain, adolescents, individuals in the criminal justice system, and patients with co-occurring psychiatric conditions.

CDC:

- CDC Guideline for Prescribing Opioids for Chronic Pain (www.cdc.gov/drugoverdose/prescribing/guideline.html).
- Guideline Resources: Clinical Tools (www.cdc.gov/drugoverdose/prescribing/clinical-tools.html). Provides links and tools to help clinicians prevent opioid overdose deaths.

Credible Meds (www.crediblemeds.org): Maintains a list of medications that may increase QTc intervals. Free registration is required to access the most up-to-date list.

HHS:

- BeTobaccoFree.gov News and Resources (https://betobaccofree.hhs.gov/quit-now/index.html#professionals). Offers links for clinicians that provide guidance on the care for patients with nicotine addiction. The Resources section is at the bottom of the page linked here.
- BeTobaccoFree.gov Nicotine Addiction and Your Health (https://betobaccofree.hhs.gov/health-effects/nicotine-health). Provides information on nicotine addiction and its health effects.

Institute for Research, Evaluation, and Training in Addictions' Management of Benzodiazepines in Medication-Assisted Treatment (http://ireta.org/wp-content/uploads/2014/12/BP_Guidelines_for_Benzodiazepines.pdf): Provides information on managing benzodiazepine use in patients taking medications for OUD.

PCSS for Medication Assisted Treatment (https://pcssmat.org): Provides buprenorphine waiver training for clinicians (physicians, NPs, and PAs).

PCSS Mentoring Program (https://pcssmat.org/mentoring): Gives providers guidance on prescribing OUD medications. This national network of experienced providers is available at no cost. Mentors provide support by telephone, email, or in person if possible.

PCSS Models of Buprenorphine Induction (http://pcssmat.org/wp-content/uploads/2015/02/Buprenorphine-Induction-Online-Module.pdf): Provides information about various buprenorphine induction approaches including in-office, non-OTP, and at-home dosing.

Prescribe To Prevent (http://prescribetoprevent.org): Provides information about naloxone prescribing for overdose prevention, including educational patient handouts and videos.

SAMHSA:

- MATx Mobile App To Support Medication-Assisted Treatment of Opioid Use Disorder (https://store.samhsa.gov/apps/mat). Provides information on FDA-approved treatment approaches and medications used to treat OUD. It includes a buprenorphine prescribing guide with information on the DATA 2000 waiver process and patient limits. Clinical support tools (e.g., treatment guidelines; *International Classification of Diseases,* 10th Edition, coding; guidance on working with special populations), help lines, and SAMHSA's treatment locators are also included.
- *Pocket Guide: Medication-Assisted Treatment of Opioid Use Disorder* (https://store.samhsa.gov/shin/content/SMA16-4892PG/SMA16-4892PG.pdf).
- Buprenorphine (www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine).
- Naltrexone (www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone).
- Decisions in Recovery: Treatment for Opioid Use Disorder (https://media.samhsa.gov/MAT-Decisions-in-Recovery). Provides information on shared decision making in pharmacotherapy for OUD.
- Decisions in Recovery: Treatment for Opioid Use Disorder, Planning for Success (https://media.samhsa.gov/MAT-Decisions-in-Recovery/section/how/planning_for_success.aspx). Provides assistance in developing a recovery plan.
- Bringing Recovery Supports to Scale Technical Assistance Center Strategy (www.samhsa.gov/brss-tacs) and Shared Decision-Making Tools (www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making). Offers training and technical assistance on many topics related to medication for OUD, including recovery-oriented systems of care, mutual-support groups, capacity building, leadership by people in recovery and family members, certification requirements for peer specialists and mutual-support group coaches, and core competencies for recovery-oriented behavioral health workers.
- *Pharmacologic Guidelines for Treating Individuals With Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders* (https://store.samhsa.gov/shin/content/SMA12-4688/SMA12-4688.pdf).
- *General Principles for the Use of Pharmacological Agents To Treat Individuals With Co-Occurring Mental and Substance Use Disorders* (https://store.samhsa.gov/shin/content/SMA12-4689/SMA12-4689.pdf).

Veterans Administration (VA)/Department of Defense (DoD) *Clinical Practice Guideline for the Management of Substance Use Disorders* (www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf): Provides information on screening, assessment, and treatment of OUD as well as other SUDs. It is primarily for VA and DoD healthcare providers and others involved in the care of service members or veterans with an SUD.

Assessment Scales and Screening Tools

AAAP, Education & Training (www.aaap.org/education-training/cme-opportunities): Provides Performance-in-Practice Clinical Modules for alcohol use disorder and tobacco use disorder.

American Psychiatric Nurses Association, Tobacco & Nicotine Use Screening Tools & Assessments (www.apna.org/i4a/pages/index.cfm?pageID=6150): Provides the Fagerström screening tools for nicotine dependence and smokeless tobacco and a screening checklist for adolescent tobacco use.

ASAM *Appropriate Use of Drug Testing in Clinical Addiction Medicine* (www.asam.org/quality-practice/guidelines-and-consensus-documents/drug-testing): Gives information on the appropriate use of drug testing in identifying, diagnosing, and treating people with or at risk for SUDs.

Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms (www.ncpoep.org/wp-content/uploads/2015/02/Appendix_7_Clinical_Institute_Narcotic_Assessment_CINA_Scale_for_Withdrawal_Symptoms.pdf).

NIDA, Screening, Assessment, and Drug Testing Resources (www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/additional-screening-resources): Gives resources such as an evidence-based screening tool chart for adolescents and adults and drug use screening tool supports; also has a clinician resource and quick reference guide for drug screening in general medical settings.

World Health Organization *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (www.ncbi.nlm.nih.gov/books/NBK143183): Includes links to the Clinical Opiate Withdrawal Scale (www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf) and other opioid withdrawal scales from Annex 10 of the guidelines.

Resources for Counselors and Peer Providers

Organizations

Community Care Behavioral Health Organization (www.ccbh.com): A provider network focused on recovery that has published *Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance* (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/MethadoneBestPracticeGuideline.pdf), a set of recovery-oriented practice implementation guidelines for methadone programs.

Faces & Voices of Recovery (https://facesandvoicesofrecovery.org): Dedicated to organizing and mobilizing the millions of Americans in recovery from addiction to alcohol and drugs, their families and friends, and other allies into recovery community organizations and networks. Faces & Voices of Recovery promotes the right resources to recover through advocacy, education, and demonstration of the power and proof of long-term recovery.

International Association of Peer Supporters (https://inaops.org): An organization for mental health and addiction peer recovery support specialists, recovery coaches, recovery educators and trainers, administrators of consumer-operated or peer-run organizations, and others.

Medication-Assisted Recovery Services (MARS) Project (www.marsproject.org): A peer-initiated, peer-based recovery support project sponsored by NAMA Recovery that offers, among other resources, an educational video about the MARS peer support program and an online network for MARS peer support personnel:

- MARS Project Video (www.marsproject.org).
- New York State Peer Recovery Network, Peers Organizing for Results Through Advocacy and Leadership (PORTAL) (http://advocacy.marsproject.org). Created to help peers in recovery more effectively organize their communities, communicate with each other, and create a stronger voice for advocacy efforts.

Pillars of Peer Support Services (www.pillarsofpeersupport.org): Develops and fosters the use of Medicaid funding to support peer recovery services in state mental health systems of care.

Recovery Community Services Program—Statewide Network (www.samhsa.gov/grants/grant-announcements/ti-14-001): A SAMHSA grant program for peer-to-peer recovery support services that help people initiate and sustain recovery from SUDs.

Publications and Other Resources

ATTC's Recovery-Oriented Methadone Maintenance (www.attcnetwork.org/userfiles/file/GreatLakes/5th%20Monograph_RM_Methadone.pdf): This guide is the most thorough document on this topic currently available and is applicable to clients receiving other medications for OUD.

Community Care Behavioral Health Organization: These publications outline phase-specific tasks and accompanying strategies for programs that serve clients who take methadone or buprenorphine:

- *Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Recovery-Oriented Methadone Maintenance* (www.williamwhitepapers.com/pr/Recovery-oriented%20Methadone%20Maintenance%20Best%20Practice%20Guidelines%202014%20-%20CCBHO.pdf)
- *Supporting Recovery From Opioid Addiction: Community Care Best Practice Guidelines for Buprenorphine and Suboxone* (www.ccbh.com/pdfs/providers/healthchoices/bestpractice/Community_Care_BP_Guidelines_for_Buprenorphine_and_Suboxone.pdf)

Narcotics Anonymous (NA) (www.na.org): The organization's most recent statement on medications for treating OUD—*Narcotics Anonymous and Persons Receiving Medication-Assisted Treatment*—is available online (www.na.org/admin/include/spaw2/uploads/pdf/pr/2306_NA_PRMAT_1021.pdf).

SAMHSA (https://store.samhsa.gov): This agency oversees medications to treat opioid addiction, including methadone, buprenorphine, and naltrexone; sets regulations; guides policy; and offers information and resources for the field. SAMHSA has many recovery-oriented publications for providers:

- *Dear Colleague Letters for Medication-Assisted Treatment Providers* (www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/dear-colleague-letters). Regulations, policies, and best practices for OTPs can change; these regular communications help providers stay up to date on clinical and regulatory issues related to opioid treatment.
- *Medication-Assisted Recovery: Medication Assisted Peer Recovery Support Services Meeting Report* (www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2015-prss-summary-report.pdf).
- *Financing Recovery Support Services: Review and Analysis of Funding Recovery Support Services and Policy Recommendations* (www.samhsa.gov/sites/default/files/partnersforrecovery/docs/RSS_financing_report.pdf).
- SAMHSA's *Working Definition of Recovery* (https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf).
- *Access to Recovery Approaches to Recovery-Oriented Systems of Care* (https://store.samhsa.gov/product/Access-to-Recovery-ATR-Approaches-to-Recovery-Oriented-Systems-of-Care/SMA09-4440).
- *Building Bridges—Co-Occurring Mental Illness and Addiction: Consumers and Service Providers, Policymakers, and Researchers in Dialogue* (https://store.samhsa.gov/shin/content//SMA04-3892/SMA04-3892.pdf).

Selected Papers of William L. White (www.williamwhitepapers.com): Contains papers, monographs, and presentations on recovery, including recovery-oriented methadone maintenance, methadone and anti-medication bias, discrimination and methadone, NA and the pharmacotherapeutic treatment of OUD, and co-participation in 12-Step mutual-support groups and methadone maintenance.

Resources for Clients and Families

Organizations

AAOTD (www.aatod.org): Offers a variety of resources, news releases about medication for the treatment of OUD, and information about its national conferences.

Al-Anon Family Groups (www.al-anon.org): Describes group meetings where friends and family members of people with substance use issues share their experiences and learn how to apply the principles of the Al-Anon program to their individual situations. Sponsorship gives members the chance to get personal support from more experienced individuals in the program.

Alcoholics Anonymous (AA) (www.aa.org): Offers group meetings for people who have problems relating to drinking and wish to stop. AA sponsors provide members with more personal support from experienced individuals. Many people who are taking medication to treat OUD find AA increasingly receptive to their decisions about medication, and AA meetings are more widely available to these individuals.

ASAM: Provides patient and family education tools about addiction in general and OUD specifically:

- Patient Resources (www.asam.org/resources/patientresources)
- *Opioid Addiction Treatment: A Guide for Patients, Families, and Friends* (http://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece/0?)

Double Trouble in Recovery (www.hazelden.org/HAZ_MEDIA/3818_doubletroubleinrecovery.pdf): Describes a fellowship of people who support each other in recovering from substance use and mental disorders.

Dual Recovery Anonymous (www.draonline.org): Presents information on mutual-help organization that follows 12-Step principles in supporting people recovering from addiction and emotional or mental illness. Focuses on preventing relapse and actively improving members' quality of life through a community of mutual support.

Faces & Voices of Recovery (https://facesandvoicesofrecovery.org): Offers recovery stories, news, events information, publications, and webinars.

Heroin Anonymous (http://heroinanonymous.org): Describes a nonprofit fellowship of individuals in recovery from heroin addiction committed to helping each other stay sober. This organization holds local support meetings, a directory of which can be found on its website.

LAC (https://lac.org): Offers information about the rights of people with criminal records, HIV/AIDS, and SUDs.

Learn to Cope (www.learn2cope.org): Describes a secular mutual-help group that offers education, resources, and peer support for the families of people with SUDs (although the focus is primarily on OUD). The organization maintains an online forum, but groups are only available in a few states.

NA (www.na.org): Provides a global, community-based organization with a multilingual, multicultural membership that supports addiction recovery via a 12-Step program, including regular group meeting attendance. Members hold nearly 67,000 meetings weekly in 139 countries. NA is an ongoing support network for maintaining a drug-free lifestyle. NA doesn't focus on a particular addictive substance.

NAMA Recovery (www.methadone.org): Offers an education series, provides training and certification for Certified MAT Advocates, and has local chapters and international affiliates that act to advocate for methadone patients. It has a helpful webpage titled FAQs About Advocate Training and Certification (www.methadone.org/certification/faq.html).

Nar-Anon Family Groups (www.nar-anon.org): Provides group meetings where friends and family of people with drug use problems can share their experiences and learn to apply the 12-Step Nar-Anon program to their lives. Nar-Anon groups also offer more individualized support from experienced individuals in the program who act as sponsors.

National Alliance on Mental Illness (NAMI) (www.nami.org): Describes the largest grassroots educational, peer support, and mental health advocacy organization in the United States. Founded in 1979 by a group of family members of people with mental disorders, NAMI has developed into an association of hundreds of local affiliates, state organizations, and volunteers.

Parents of Addicted Loved Ones (https://palgroup.org): Presents a secular support group for parents who have a child with an SUD. The organization has meetings in only some states but also hosts telephone meetings.

Pills Anonymous (www.pillsanonymous.org): Offers a 12-Step mutual-support group that holds regular meetings in which individuals in recovery from addiction to pills share their experiences, build their strengths, and offer hope for recovery to one another.

Secular Organizations for Sobriety (www.sossobriety.org): Describes a nonprofit, nonreligious network of autonomous, nonprofessional local groups that support people in achieving and maintaining abstinence from alcohol and drug addiction.

Self-Management for Addiction Recovery (SMART Recovery) (www.smartrecovery.org): Is a self-empowering addiction recovery support group; participants learn science-based tools for addiction recovery and have access to an international recovery community of mutual-help groups.

Stop Stigma Now (www.stopstigmanow.org): Describes an advocacy organization that works to eradicate prejudice associated with taking medication to treat OUD and offers resources and a media library.

Women for Sobriety (https://womenforsobriety.org/beta2): Offers an abstinence-based mutual-help group that helps women find their individual paths to recovery by acknowledging the unique needs women have in recovery. This organization is not affiliated with any other recovery organization. It offers recovery tools to help women in recovery develop coping skills focused on emotional growth, spiritual growth, self-esteem, and a healthy lifestyle.

Publications and Other Resources

AAAP Patient Resources (www.aaap.org/patient-resources/helpful-links): Offers resources and publications for patients and their families.

Addiction Treatment Forum, *Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States* (http://atforum.com/documents/2011NAandMedication-assistedTreatment.pdf): Presents William White's publication for people receiving medication for OUD that gives information on the pros and cons of 12-Step groups and how to prepare for meetings.

ASAM, Opioid Addiction Treatment: A Guide for Patients, Families, and Friends (http://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece): Provides a guide about the treatment of OUD for patients, families, and friends.

HHS:

- Smokefree.gov (https://smokefree.gov). Provides useful information that helps individuals in planning and maintaining tobacco cessation.
- BeTobaccoFree.gov (https://betobaccofree.hhs.gov/health-effects/nicotine-health). Provides information for individuals struggling with nicotine addiction and links for clinicians that provide guidance on the care for patients with nicotine addiction.

LAC (https://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources). Maintains a library of documents related to medication for the treatment of OUD and other resources, including an advocacy toolkit, sample support letter form, training materials, and webinars:

- *Driving on Methadone or Buprenorphine (Suboxone): DUI?* (http://lac.org/wp-content/uploads/2014/07/Driving-on-Methadone-or-Suboxone-DUI.pdf) factsheet.
- *Know Your Rights: Employment Discrimination Against People With Alcohol/Drug Histories* (https://lac.org/resources/substance-use-resources/employment-education-housing-resources/webinar-know-rights-employment-discrimination-people-alcoholdrug-histories) webinar.
- *Know Your Rights: Rights for Individuals on Medication-Assisted Treatment* (https://lac.org/wp-content/uploads/2014/12/Know_Your_Rts_-_MAT_final_9.28.10.pdf) publication.
- *Medication-Assisted Treatment for Opioid Addiction: Myths and Facts* (http://lac.org/wp-content/uploads/2016/02/Myth-Fact-for-MAT.pdf) factsheet.

NAMA Recovery (www.methadone.org): Offers many resources and training opportunities to become a certified advocate for pharmacotherapy for OUD and provides links to resources related to medication for the treatment of OUD.

National Council on Alcoholism and Drug Dependence's *Consumer Guide to Medication-Assisted Recovery* (www.ncadd.org/images/stories/PDF/Consumer-Guide-Medication-Assisted-Recovery.pdf).

NIAAA's Rethinking Drinking (www.rethinkingdrinking.niaaa.nih.gov/help-links): Provides links to patient and family education, help lines, and other recovery resources.

SAMHSA (https://store.samhsa.gov): Provides patient and family educational tools about OUD and medication treatment for OUD treatment. The resources below are available in several languages, including Spanish and Russian:

- *Decisions in Recovery: Treatment for Opioid Use Disorders* (https://store.samhsa.gov/product/Decisions-in-Recovery-Treatment-for-Opioid-Use-Disorders/SMA16-4993). Helps clients identify an appropriate path of recovery from OUD.
- *The Facts About Buprenorphine for Treatment of Opioid Addiction* (https://store.samhsa.gov/shin/content//SMA14-4442/SMA14-4442.pdf).
- *The Facts About Naltrexone for Treatment of Opioid Addiction* (https://store.samhsa.gov/shin/content/SMA09-4444/SMA09-4444.pdf).
- *Know Your Rights: Rights for Individuals on Medication-Assisted Treatment* (https://store.samhsa.gov/product/Rights-for-Individuals-on-Medication-Assisted-Treatment/SMA09-4449).
- *Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends* (www.ct.gov/dmhas/lib/dmhas/publications/MAT-InfoFamilyFriends.pdf).
- *What Every Individual Needs To Know About Methadone Maintenance* (https://store.samhsa.gov/product/What-Every-Individual-Needs-to-Know-About-Methadone-Maintenance/SMA06-4123).
- *What Is Substance Abuse Treatment? A Booklet for Families* (https://store.samhsa.gov/shin/content/SMA14-4126/SMA14-4126.pdf).

Treatment Locators

Faces & Voices of Recovery Guide to Mutual Aid Resources (http://facesandvoicesofrecovery.org/resources/mutual-aid-resources): Offers a comprehensive list of 12-Step and non-12-Step recovery support groups throughout the United States and online.

National Alliance of Advocates for Buprenorphine Treatment (www.treatmentmatch.org/TM_index.php): Offers a free, 24/7 anonymous treatment-matching service for patients and providers.

Probuphine Healthcare Provider Locator (https://probuphinerems.com/probuphine-locator): Offers a list of healthcare professionals who prescribe, insert, and/or remove buprenorphine implants.

SAMHSA:

- Behavioral Health Treatment Services Locator is a directory of inpatient treatment providers (https://findtreatment.samhsa.gov).
- Behavioral Health Treatment Services Locator: Self-Help, Peer Support, and Consumer Groups (Addiction) provides a directory for consumers (https://findtreatment.samhsa.gov/locator/link-focSelfGP).
- Buprenorphine Treatment Practitioner Locator provides an interactive treatment locator of providers who prescribe buprenorphine (www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator).
- Opioid Treatment Program Directory provides an interactive SAMHSA OTP treatment locator (https://dpt2.samhsa.gov/treatment/directory.aspx).

VA Substance Use Disorder Program Locator (www.va.gov/directory/guide/SUD.asp): Provides an interactive treatment locator for VA SUD treatment programs.

Patient Success Stories

Patients' success stories highlight the powerful ways in which medication for the treatment of OUD can help people achieve remission and recovery. Examples of patient success stories include the following:

- Carol (https://vimeo.com/105287902)
- Brandon (https://vimeo.com/105078010)
- Archie (www.youtube/iHJ6K4VQvrw?list=PLGV_2NAg58zkUOZRupfKc6_Z7jaBf7h-V)
- MARS Project Video (www.marsproject.org)

Online Boards and Chat Rooms

12-Step Forums: A variety of NA and AA meetings are available online, each with its own perspective on medication:

- The AA online intergroup directory lists numerous online AA meetings, which occur at specific times (https://aa-intergroup.org/directory_venue.php?code=CH).
- The NA chatroom asks that participants not talk about medication (www.nachatroom.net).

Facebook Forums and Groups: Many medication-assisted recovery organizations maintain a presence on Facebook because of the ease of creating online mutual-support and chat groups:

- A.T. Watchdog: A Pro Methadone Maintenance Support Group (www.facebook.com/groups/1599996730222196)
- Clean & Sober Today (www.facebook.com/groups/1822841161286327)
- Heroin Anonymous (www.facebook.com/HeroinAnonymous)
- Medication-Assisted Treatment Miracles (www.facebook.com/groups/MATMiracles)
- Methadone Discussion (www.facebook.com/groups/MethadoneSupport)

- NAMA Recovery:
  - NAMA-R (www.facebook.com/groups/NAMARecoveryTN)
  - Boston Methadone & Bupe Patient Discussion (www.facebook.com/groups/833560336673414)
  - NAMA Recovery of Washington (www.facebook.com/groups/398175280306632)
- Secular Organizations for Sobriety (www.facebook.com/groups/251215211975)
- Social Media 4Recovery (www.facebook.com/groups/748016625286020)
- Stop Stigma Now (www.facebook.com/Stop-Stigma-Now-1482990085299885)
- Suboxone/Buprenorphine Treatment and Support—Detox/Maintenance (www.facebook.com/groups/Fightingthestigmaofaddiction)

Heroin Addiction & Recovery Forum (http://killtheheroinepidemicnationwide.org/forum): An online discussion forum for both people who are addicted to heroin and their friends and families.

Moms on Methadone (www.circleofmoms.com/moms-on-methadone): An online support group for pregnant women or women with children who are taking medication to treat OUD.

SMART Recovery Online Forum (www.smartrecovery.org/community/forum.php): An online group that welcomes new members.

We Speak Methadone (and Buprenorphine) (www.methadone.org/wespeakmethadone): A discussion forum for medication-assisted treatment patients, their families, and advocates.

Provider Tools and Sample Forms

Provider Screening and Assessment Tools and Aids

Alcohol Use Disorders Identification Test (AUDIT)

1. How often do you have a drink containing alcohol?

(0) Never *[Skip to Questions 9–10]*
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Questions 9 and 10 if total score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Note: Add up the points associated with answers. A score of 8 or more is considered a positive test for unhealthy drinking.

Adapted from material in the public domain.[3] Available online (http://auditscreen.org).

Stable Resource Toolkit

Audit-C – Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, **b** = 1 point, **c** = 2 points, **d** = 3 points, **e** = 4 points

- **In men,** a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women,** a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	MEN[1]	WOMEN[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

	MEN[1]	WOMEN[2]
≥3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. *Arch Internal Med. 1998* (3): 1789-1795.
2. Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. *Arch Internal Med Vol 165,* April 2003: 821-829.
3. Frequently Asked Questions guide to using the AUDIT-C can be found via the website: https://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs-print.cfm

Continued on next page

AUDIT-C Questionnaire

Patient Name: _____ **Dates of Visit:** _____

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

AUDIT-C is available for use in the public domain.

Reprinted from material in the public domain.[4] Available online (https://www.integration.samhsa.gov/images/res/tool_auditc.pdf).

Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" 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 (i.e., 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). The questions do not include alcoholic beverages.

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

Segment: _____ Visit Number: _____ Date of Assessment: _____/_____/_____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1.	**Have you used drugs other than those required for medical reasons?**	☐ No	☐ Yes
2.	**Do you use more than one drug at a time?**	☐ No	☐ Yes
3.	**Are you always able to stop using drugs when you want to?**	☐ No	☐ Yes
4.	**Have you had "blackouts" or "flashbacks" as a result of drug use?**	☐ No	☐ Yes
5.	**Do you ever feel bad or guilty about your drug use?**	☐ No	☐ Yes
6.	**Does your spouse (or parents) ever complain about your involvement with drugs?**	☐ No	☐ Yes
7.	**Have you neglected your family because of your use of drugs?**	☐ No	☐ Yes
8.	**Have you engaged in illegal activities to obtain drugs?**	☐ No	☐ Yes
9.	**Have you ever experienced withdrawal symptoms (i.e., felt sick) when you stopped taking drugs?**	☐ No	☐ Yes
10.	**Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?**	☐ No	☐ Yes

Comments:

Scoring

Score 1 point for each "Yes," except for question 3, for which a "No" receives 1 point.

DAST 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, reassess at a later date
3–5	Moderate level	Further investigation
6–8	Substantial level	Intensive assessment
9–10	Severe level	Intensive assessment

Adapted with permission.[5,6]

DSM-5 Opioid Use Disorder Checklist[7]

Patient's Name: _____ **Date of Birth:** _____

Worksheet for DSM-5 Criteria for Diagnosis of Opioid Use Disorder

DIAGNOSTIC CRITERIA (Opioid use disorder requires that at least 2 criteria be met within a 12-month period.)	MEETS CRITERIA? Yes OR No	NOTES/SUPPORTING INFORMATION
1. Opioids are often taken in larger amounts or over a longer period of time than intended.		
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.		
3. A lot of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.		
4. Craving, or a strong desire to use opioids.		
5. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school, or home.		
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.		
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.		
8. Recurrent opioid use in situations in which it is physically hazardous.		
9. 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.		
10. 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		
11. Withdrawal,* as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms		

*This criterion is not met for individuals taking opioids solely under appropriate medical supervision.

Severity: mild = 2–3 symptoms; moderate = 4–5 symptoms; severe = 6 or more symptoms

Signed: _____ Date: _____

Heaviness of Smoking Index

Ask these two questions of current or recent smokers:

1. How soon after waking do you smoke your first cigarette?
   - Within 5 minutes (3 points)
   - 5–30 minutes (2 points)
   - 31–60 minutes (1 point)
   - 61 or more minutes (no points)
2. How many cigarettes a day do you smoke?
   - 10 or less (no points)
   - 11–20 (1 point)
   - 21–30 (2 points)
   - 31 or more (3 points)

Total score: 1 to 2 points = very low dependence; 3 points = low to moderate dependence; 4 points = moderate dependence; 5 or more points = high dependence

Adapted with permission.[8]

NIAAA Single-Item Screener

How many times in the past year have you had five or more drinks in a day (four drinks for women and all adults older than age 65)?

A response of one or more times is considered a positive screen. Patients who screen positive should have an assessment for alcohol use disorder.

Adapted with permission.[9]

Opioid Overdose: Risk, Prevention, Identification, and Response

Overdose Risk

- Using heroin (possibly mixed with illicitly manufactured fentanyl or fentanyl analogs)
- Using prescription opioids that were not prescribed
- Using prescription opioids more frequently or at higher doses than prescribed
- Using opioids after a period of abstinence or reduced use (e.g., after medically supervised withdrawal or incarceration)
- Using opioids with alcohol, benzodiazepines, or both

Overdose Prevention

- Don't use opioids that were not prescribed.
- Take medications only as prescribed.
- Don't use drugs when you are alone.
- Don't use multiple substances at once.
- Have naloxone available and make sure others know where it is and how to use it.
- Use a small "test dose" if returning to opioid use after a period of abstinence, if the substance appears altered or has been acquired from an unfamiliar source. Beware: This doesn't guarantee safety; illicitly manufactured fentanyl or other substances may be present in the drug, and **any use may be fatal.**

Overdose Identification

- Fingernails or lips are blue or purple.
- Breathing or heartbeat is slow or stopped.
- The person is vomiting or making gurgling noises.
- The person can't be awakened or is unable to speak.

Overdose Response

- Call 9-1-1.
- Administer naloxone (more than one dose may be needed to restore adequate spontaneous breathing).
- Perform rescue breathing. If certified to provide cardiopulmonary resuscitation, perform chest compressions if there is no pulse.
- Put the person in the "recovery position," on his or her side and with the mouth facing to the side to prevent aspiration of vomit, if he or she is breathing independently.
- Stay with the person until emergency services arrive. Naloxone's duration of action is 30–90 minutes. The person should be observed after this time for a return of opioid overdose symptoms.

Adapted from material in the public domain.[10]

Physical Signs of Opioid Withdrawal and Time to Onset

STAGE	GRADE	PHYSICAL SIGNS/SYMPTOMS
Early Withdrawal Short-acting opioids: 8–24 hours after last use Long-acting opioids: Up to 36 hours after last use	Grade 1	Lacrimation, rhinorrhea, or both Diaphoresis Yawning Restlessness Insomnia
Early Withdrawal Short-acting opioids: 8–24 hours after last use Long-acting opioids: Up to 36 hours after last use	Grade 2	Dilated pupils Piloerection Muscle twitching Myalgia Arthralgia Abdominal pain
Fully Developed Withdrawal Short-acting opioids: 1–3 days after last use Long-acting opioids: 72–96 hours after last use	Grade 3	Tachycardia Hypertension Tachypnea Fever Anorexia or nausea Extreme restlessness
Fully Developed Withdrawal Short-acting opioids: 1–3 days after last use Long-acting opioids: 72–96 hours after last use	Grade 4	Diarrhea, vomiting, or both Dehydration Hyperglycemia Hypotension Curled-up position

Total duration of withdrawal:

- Short-acting opioids: 7–10 days.
- Long-acting opioids: 14 days or more.

Signs of Opioid Intoxication

Physical Findings

Drowsy but arousable
Sleeping intermittently ("nodding off")
Constricted pupils

Mental Status Findings

Slurred speech
Impaired memory or concentration
Normal to euphoric mood

Single-Item Drug Screener

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

(A positive screen is 1 or more days.)

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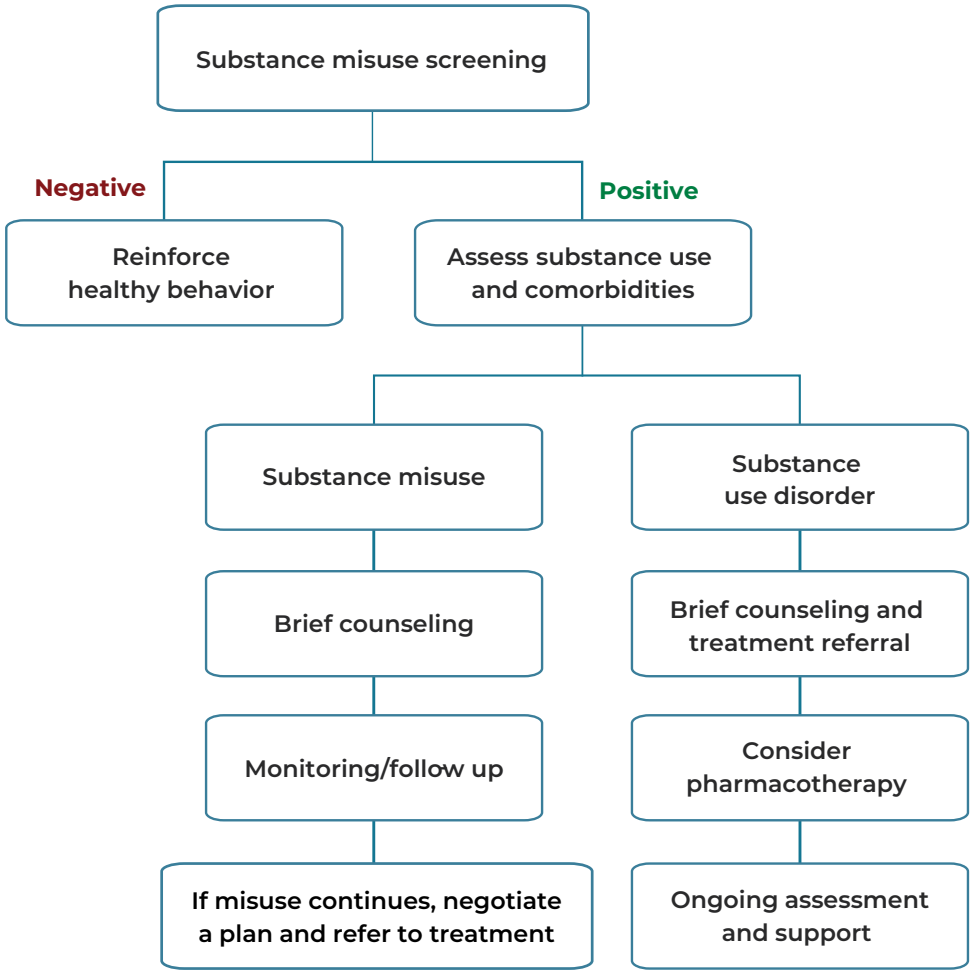
Substance Misuse and SUD Screening



Adapted with permission.[12]

TAPS Tool Part I

Directions: 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 by males, and Question 3 should be answered by females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

In the PAST 12 MONTHS:

1. How often have you used any tobacco product (for example, cigarettes, ecigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

2. How often have you had 5 or more drinks containing alcohol in 1 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.)*

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

3. How often have you had 4 or more drinks containing alcohol in 1 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.)*

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

4. How often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, or ecstasy/MDMA?

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5. 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, or methadone), medications for anxiety or sleeping (for example, Xanax, Ativan, or Klonopin), or medications for ADHD (for example, Adderall or Ritalin).

   ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

TAPS Tool Part 2

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

In the PAST 3 MONTHS:

1. **Did you smoke a cigarette containing tobacco?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No
   - Did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. **Did you have a drink containing alcohol?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Did you have 4 or more drinks containing alcohol in a day?* *(Note: This question should only be answered by females.)* ☐ Yes ☐ No
   - Did you have 5 or more drinks containing alcohol in a day?* *(Note: This question should only be answered by males.)* ☐ Yes ☐ No
   - Have you tried and failed to control, cut down, or stop drinking? ☐ Yes ☐ No
   - Has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. **Did you use marijuana (hash, weed)?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. **Did you use cocaine, crack, or methamphetamine (crystal meth)?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. **Did you use heroin?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Have you tried and failed to control, cut down, or stop using heroin? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. **Did you use a prescription opiate pain reliever (for example Percocet or Vicodin) not as prescribed or that was not prescribed for you?** ☐ **Yes** ☐ **No**

   If "Yes," answer the following questions:

   - Have you tried and failed to control, cut down, or stop using an opiate pain reliever? ☐ Yes ☐ No
   - Has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

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

Continued on next page

7.	**Did you use 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:		
	• 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
	• Has anyone expressed concern about your use of medication for anxiety or sleep?	☐ Yes	☐ No
8.	**Did you use medication for ADHD (for example, Adderall or Ritalin) not as prescribed or that was not prescribed for you?**	☐ **Yes**	☐ **No**
	If "Yes," answer the following questions:		
	• Did you use a medication for ADHD (for example, Adderall or Ritalin) at least once a week or more often?	☐ Yes	☐ No
	• Has anyone expressed concern about your use of medication for ADHD (for example, Adderall or Ritalin)?	☐ Yes	☐ No
9.	**Did you use any other illegal or recreational drugs (for example, ecstasy, molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ["spice"], whip-its)?**	☐ **Yes**	☐ **No**
	If "Yes," answer the following question:		
	• What were the other drug(s) you used? (write in response)		

The complete tool is available online (https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f).
Adapted from material in the public domain.[13]

Two-Item Drug Use Disorder Screener for Primary Care Clinics Serving U.S. Veterans

Question 1: How many days in the past 12 months have you used drugs other than alcohol? (A positive screen is 7 or more days.) If <7, proceed with Question 2.

Question 2: How many days in the past 12 months have you used drugs more than you meant to? (A positive screen is 2 or more days.)

Adapted with permission.[14]

Urine Drug Testing Window of Detection[15,16]

DRUG	POSITIVE TEST	WINDOW OF DETECTION*	COMMENTS
Amphetamine; methamphetamine; 3,4-methylenedioxy-methamphetamine	Amphetamine	1–2 days	False positives w/ bupropion, chlorpromazine, desipramine, fluoxetine, labetalol, promethazine, ranitidine, pseudoephedrine, trazadone, and other common medications. Confirm unexpected positive results with the laboratory.
Barbiturates	Barbiturates	Up to 6 weeks	N/A
Benzodiazepines	Benzodiazepines	1–3 days; up to 6 weeks with heavy use of long-acting benzodiazepines	Immunoassays may not be sensitive to therapeutic doses, and most immunoassays have low sensitivity to clonazepam and lorazepam. Check with your laboratory regarding sensitivity and cutoffs. False positives with sertraline or oxaprozin.
Buprenorphine	Buprenorphine	3–4 days	Will screen negative on opiate screen. Tramadol can cause false positives. Can be tested for specifically.
Cocaine	Cocaine, benzoylecgonine	2–4 days; 10–22 days with heavy use	N/A
Codeine	Morphine, codeine, high-dose hydrocodone	1–2 days	Will screen positive on opiate immunoassay.
Fentanyl	Fentanyl	1–2 days	Will screen negative on opiate screen. Can be tested for specifically. May not detect all fentanyl-like substances.[17]
Heroin	Morphine, codeine	1–2 days	Will screen positive on opiate immunoassay. 6-monoacetylmorphine, a unique metabolite of heroin, is present in urine for about 6 hours. Can be tested for specifically to distinguish morphine from heroin, but this is rarely clinically useful.
Hydrocodone	Hydrocodone, hydromorphone	2 days	May screen negative on opiate immunoassay. Can be tested for specifically.
Hydromorphone	May not be detected	1–2 days	May screen negative on opiate immunoassay. Can be tested for specifically.

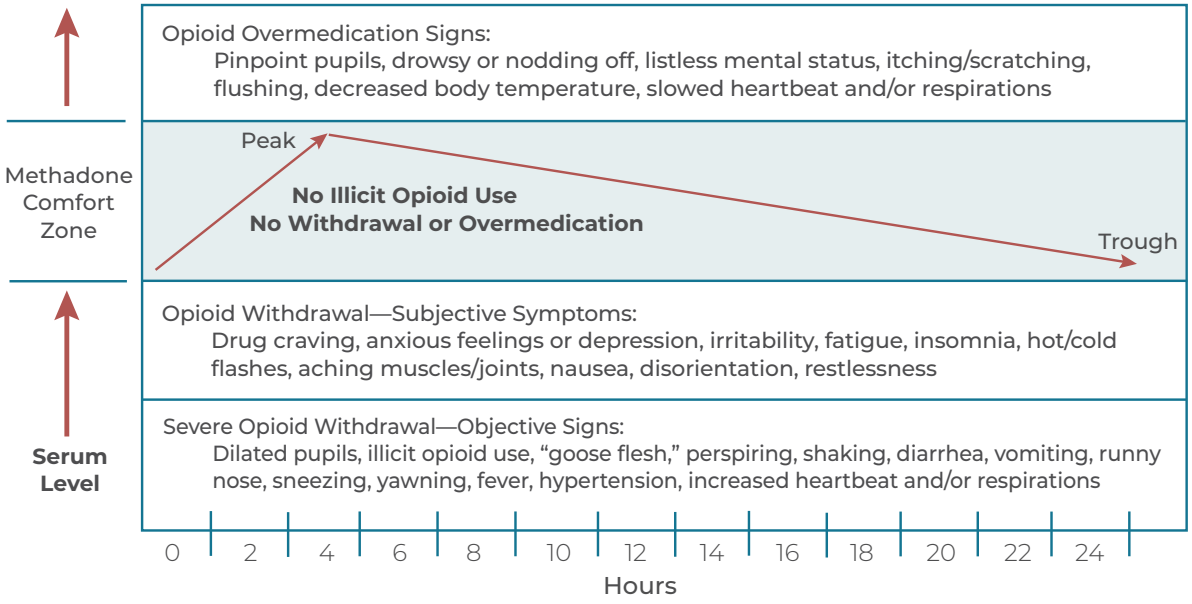
Continued on next page

Urine Drug Testing Window of Detection (continued)

DRUG	POSITIVE TEST	WINDOW OF DETECTION*	COMMENTS
Marijuana	Tetrahydrocannabinol	Infrequent use of 1–3 days; chronic use of up to 30 days	False positives possible with efavirenz, ibuprofen, and pantoprazole.
Methadone	Methadone	2–11 days	Will screen negative on opiate screen. Can be tested for specifically.
Morphine	Morphine, hydromorphone	1–2 days	Will screen positive on opiate immunoassay. Ingestion of poppy plant/seed may screen positive.
Oxycodone	Oxymorphone	1–1.5 days	Typically screens negative on opiate immunoassay. Can be tested for specifically.

*Detection time may vary depending on the cutoff.

Using Signs and Symptoms To Determine Optimal Methadone Level



Adapted with permission.[18]

Provider Informational, Educational, and Decision-Making Tools

Key Elements of an OBOT Clinic Diversion Control Plan[19]

New Patients

Check the state's PDMP before admission to determine whether patients are receiving opioids or benzodiazepine prescriptions from other providers.

Ask patients to sign a release of information to speak with the other prescribers. Patients who are unwilling to sign a release of information are poor candidates for outpatient treatment.

Review the clinic diversion control policy with new patients. This should include counseling patients to:

- Keep buprenorphine locked up and out of children's reach.
- Never share medication with anyone.
- Never sell medication to anyone.
- Acknowledge giving or selling medication to others as illegal.
- Take medication only as prescribed.
- Review, understand, and agree to the practice's buprenorphine treatment agreement before they start.

Prescribe buprenorphine/naloxone when possible, rather than monoproduct. Exceptions would include prescribing the monoproduct for pregnant women with OUD.

Prescribe an adequate but not excessive dose. Most patients respond to doses at or below 24 mg per day. Carefully evaluate requests for higher doses and confirm, document, and assess medication adherence continuously.

Ongoing Patients

Periodically check the state's PDMP.

Conduct random urine tests that include a wide spectrum of opioids—including morphine, oxycodone, and buprenorphine—and periodically include buprenorphine metabolites. This will help monitor response to treatment and determine whether patients are taking at least some of their prescribed buprenorphine.

Use **unobserved** specimen collection to preserve patient privacy and dignity:

- Do not let patients bring backpacks, jackets, or other items into the bathroom.
- Do not let others enter bathrooms with patients.
- Temperature test the urine sample.

Use **observed** specimen collection (obtained by a staff member of the same gender) or oral fluid testing if there is reason to suspect tampering or falsification.

Contact patients at random; ask them to bring in their medication within a reasonable period (24 to 48 hours) to count the tablets/films to ensure that all medication is accounted for.

Provide a limited number of days of medication per prescription without refills (e.g., several days or 1 week per prescription) until the patient has demonstrated stability and lowered diversion risk.

Key Points of Patient Education for Buprenorphine

Before starting OUD treatment with buprenorphine, patients should:

- Tell providers the prescribed and over-the-counter medications they take, to allow drug interaction assessment.
- Understand the goal of the first week of treatment: To improve withdrawal symptoms without oversedation.
- Tell providers if they feel sedated or euphoric within 1 to 4 hours after their dose.
- Be given the appropriate buprenorphine medication guide.
- Know possible side effects, including:
  - Headache.
  - Dizziness.
  - Nausea.
  - Vomiting.
  - Sweating.
  - Constipation.
  - Sexual dysfunction.
- Agree to store medication securely and out of the reach of others.
- Alert providers if they discontinue medications, start new ones, or change their medication dose.
- Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.
- Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.
- Understand the importance of informing providers if they become pregnant.
- Tell providers if they are having a procedure that may require pain medication.
- Be aware of resources through which to obtain further education for:
  - Themselves (https://store.samhsa.gov/product/SMA16-4993).
  - Their families and friends (http://www.ct.gov/dmhas/lib/dmhas/publications/MAT-InfoFamilyFriends.pdf).

Key Points of Patient Education for Methadone

Before starting OUD treatment with methadone, patients should:

- Be told that the methadone dose is started low and increased slowly over days and weeks with monitoring, because it takes 4 or more days for the body to adjust to a dose change. This is necessary to avoid the risk of overdose.
- Understand that the goal of the first weeks of treatment is to improve withdrawal symptoms without oversedation. Patients should tell providers if they feel sedated or high within the first 4 hours after their dose.
- Learn the symptoms of methadone intoxication and how to seek emergency care. The first 2 weeks of treatment have the highest risk of overdose.
- Be aware that rescue naloxone does not last very long, so they should remain in emergency care for observation if they are treated for opioid overdose.
- Know that concurrent alcohol, benzodiazepine, or other sedative use with methadone increases the risk of overdose and death.
- Inform OTP nursing/medical staff about prescribed and over-the-counter medications and herbs (e.g., St. John's wort) they are taking, stopping, or changing doses of to allow assessment of potential drug–drug interactions.
- Inform other treating healthcare professionals that they are receiving methadone treatment.
- Plan to avoid driving or operating heavy machinery until their dose is stabilized.
- Learn about other possible side effects of methadone, including dizziness, nausea, vomiting, sweating, constipation, edema, and sexual dysfunction.
- Agree to keep take-home doses locked up and out of the reach of others. Understand that giving methadone, even small amounts, to others may be fatal.
- Inform providers if they become pregnant.
- Understand that stopping methadone increases their risk of overdose death if they return to illicit opioid use.

Key Points of Patient Education for Naltrexone

- Do not use any opioids in the 7 to 10 days (for short acting) or 10 to 14 days (for long acting) before starting XR-NTX, to avoid potentially serious opioid withdrawal symptoms. Opioids include:
  - Heroin.
  - Prescription opioid analgesics (including tramadol).
  - Cough, diarrhea, or other medications that contain codeine or other opioids.
  - Methadone.
  - Buprenorphine.
- Seek immediate medical help if symptoms of allergic reaction or anaphylaxis occur, such as:
  - Itching.
  - Swelling.
  - Hives.
  - Shortness of breath.
  - Throat tightness.
- Do not try to override the opioid blockade with large amounts of opioids, which could result in overdose.
- Understand the risk of overdose from using opioids near the time of the next injection, after missing a dose, or after stopping medications.
- Report injection site reactions including:
  - Pain.
  - Hardening.
  - Lumps.
  - Blisters.
  - Blackening.
  - Scabs.
  - An open wound.

  Some of these reactions could require surgery to repair (rarely).
- Report signs and symptoms of hepatitis.
- Report depression or suicidal thoughts. Seek immediate medical attention if these symptoms appear.
- Seek medical help if symptoms of pneumonia appear (e.g., shortness of breath, fever).
- Tell providers of naltrexone treatment, as treatment differs for various types of pneumonia.
- Inform all healthcare professionals of XR-NTX treatment.
- Report pregnancy.
- Inform providers of any upcoming medical procedures that may require pain medication.
- Understand that taking naltrexone may result in difficulty achieving adequate pain control if acute medical illness or trauma causes severe acute pain.
- Wear medical alert jewelry and carry a medical alert card indicating you are taking XR-NTX. A patient wallet card or medical alert bracelet can be ordered at 1-800-848-4876.

Medication Management for Patients With Respiratory or Hepatic Impairment Who Take Buprenorphine

CONTRAINDICATION/CAUTION	MANAGEMENT
Compromised respiratory function (e.g., chronic obstructive pulmonary disease, decreased respiratory reserve, hypoxia, hypercapnia [abnormally elevated blood levels of carbon dioxide], preexisting respiratory depression).	• Prescribe with caution; monitor closely. • Warn patients about the risk of using benzodiazepines or other depressants while taking buprenorphine.[20] • Support patients in their attempts to discontinue tobacco use.
Hepatic impairment Buprenorphine and naloxone are extensively metabolized by the liver. Moderate to severe impairment results in decreased clearance, increased overall exposure to both medications, and higher risk of buprenorphine toxicity and precipitated withdrawal from naloxone. These effects have not been observed in patients with mild hepatic impairment.[21,22]	• Mild impairment (Child-Pugh score of 5–6):[23] No dose adjustment needed. • Moderate impairment (Child-Pugh score of 7–9):[24] Combination products are not recommended; they may precipitate withdrawal. *Use combination products cautiously for maintenance treatment in patients who've been inducted with a monoproduct;[25,26] monitor for signs and symptoms of buprenorphine toxicity or overdose.[27] Naloxone may interfere with buprenorphine's efficacy.[28,29] • Severe impairment (Child-Pugh score of 10–15):[30] Do not use the combination product.[31] For monoproduct, consider halving the starting and titration doses used in patients with normal liver function; monitor for signs and symptoms of toxicity or overdose caused by increased buprenorphine levels.[32]

*Moderate to severe impairment results in much more reduced clearance of naloxone than of buprenorphine. Nasser et al.[33] found that moderate impairment doubled or tripled exposure (compared with subjects with no or mild impairment) for both medications. In subjects with severe impairment, buprenorphine exposure was two to three times higher; naloxone exposure increased more than tenfold.

Adapted from material in the public domain.[34]

Monitoring Recovery Activities

At medical management visits, do not simply ask about attendance at recovery support meetings; explore the level of participation and engagement in those activities. Some activities include:

- Finding and working closely with a sponsor.
- "Working" the 12 Steps at 12-Step meetings and with a sponsor.
- Doing service at meetings (e.g., setting up chairs, making coffee, going on a "commitment" to speak at a meeting in a jail or an inpatient drug and alcohol program).
- Having and frequently attending a regular "home" group.[35]

Remember this statement from recovery experts A. Thomas McLellan and William White: "Recovery status is best defined by factors other than medication status. Neither medication-assisted treatment of opioid addiction nor the cessation of such treatment by itself constitutes recovery. Recovery status instead hinges on broader achievements in health and social functioning—with or without medication support."[36]

OUD Medications: An Overview[37,38]

CATEGORY	BUPRENORPHINE*	METHADONE	XR-NTX**
Appropriate patients	Typically for patients with OUD who are physiologically dependent on opioids	Typically for patients with OUD who are physiologically dependent on opioids and who meet federal criteria for OTP admission	Typically for patients with OUD who have abstained from short-acting opioids for at least 7–10 days and long-acting opioids for at least 10–14 days
Pharmacology	**Opioid receptor partial agonist** Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.	**Opioid receptor agonist** Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.	**Opioid receptor antagonist** Blocks euphoric effects of self-administered illicit opioids through opioid receptor occupancy. Causes no opioid effects.
Patient Education	**Tell patients:** • That they will need to be in opioid withdrawal to receive their first dose to avoid buprenorphine-precipitated opioid withdrawal. • About the risk of overdose with concurrent benzodiazepine or alcohol use, with injecting buprenorphine, and after stopping the medication.	**Tell patients:** • That their dose will start low and build up slowly to avoid oversedation; it takes several days for a given dose to have its full effect. • About overdose risk in the first 2 weeks of treatment, especially with concurrent benzodiazepine or alcohol use, and after stopping the medication.	**Tell patients:** • That they will need to be opioid free for at least 7–10 days for short-acting and at least 10–14 days for long-acting opioids before their first dose to avoid XR-NTX-precipitated opioid withdrawal (which may require hospitalization). • About the risk of overdose after stopping the medication.
Administration	Daily (or off-label less-than-daily dosing regimens) administration of sublingual or buccal tablet or film. Subdermal implants every 6 months, for up to 1 year, for stable patients. Monthly subcutaneous injection of extended-release formulation in abdominal region for patients treated with transmucosal buprenorphine for at least 1 week.	Daily oral administration as liquid concentrate, tablet, or oral solution from dispersible tablet or powder (unless patients can take some home).	Every 4 weeks or once-per-month intramuscular injection.
Prescribing	Physicians, NPs, and PAs need a waiver to prescribe. Any pharmacy can fill a prescription for sublingual or buccal formulations. OTPs can administer/dispense by OTP physician order without a waiver.	SAMHSA-certified OTPs can provide methadone for daily onsite administration or at-home self-administration for stable patients.	Physicians, NPs, or PAs prescribe or order administration by qualified healthcare professionals.

*Long-acting buprenorphine implants (every 6 months) for patients on a stable dose of buprenorphine are also available through implanters and prescribers with additional training and certification through the Probuphine REMS Program. Extended-release buprenorphine monthly subcutaneous injections are available only through prescribers and pharmacies registered with the Sublocade REMS Program.

**Naltrexone hydrochloride tablets (50 mg each) are also available for daily oral dosing but have not been shown to be more effective than treatment without medication or placebo because of poor patient adherence.

OUD Medications: Comparison To Guide Shared Decision Making

CATEGORY	BUPRENORPHINE	METHADONE	NALTREXONE
Appropriate patients	Typically for patients with OUD who are physiologically dependent on opioids	Typically for patients with OUD who are physiologically dependent on opioids and who meet federal criteria for OTP admission	Typically for patients with OUD who are abstinent from short-acting opioids for 7 days and long-acting opioids for 10–14 days
Outcome: Retention in treatment	Higher than treatment without medication and treatment with placebo[39]	Higher than treatment without OUD medication and treatment with placebo[40]	Treatment retention with oral naltrexone is no better than with placebo or no medication;[41] for XR-NTX, treatment retention is higher than for treatment without OUD medication and treatment with placebo;[42,43] treatment retention is lower than with opioid receptor agonist treatment
Outcome: Suppression of illicit opioid use	Effective	Effective	Effective
Outcome: Overdose mortality	Lower for people in treatment than for those not in it	Lower for people in treatment than for those not in it	Unknown
Location/ frequency of office visits	**Office/clinic:** Begins daily to weekly, then tailored to patient's needs **OTP:** Can treat with buprenorphine 6–7 days/ week initially; take-homes are allowed without the time-in-treatment requirements of methadone	**OTP only:** 6–7 days/week initially; take-homes are allowed based on time in treatment and patient progress	**Office/clinic:** Varies from weekly to monthly
Who can prescribe/order?	Physicians, NPs,* and PAs* possessing federal waiver can prescribe and dispense; can be dispensed by a community pharmacy or an OTP	OTP physicians order the medication; nurses and pharmacists administer and dispense it	Physicians, NPs,* and PAs*

*NPs and PAs should check with their state to determine whether prescribing buprenorphine, naltrexone, or both is within their allowable scope of practice.

Continued on next page

OUD Medications: Comparison To Guide Shared Decision Making (continued)

CATEGORY	BUPRENORPHINE	METHADONE	NALTREXONE
Administration	Sublingual/buccal; implant by specially trained provider, and only for stabilized patients	Oral	Oral or intramuscular (Note: Oral naltrexone is less effective than the other OUD medications.)
Misuse/diversion potential	Low in OTPs or other settings with observed dose administration; moderate for take-home doses; risk can be mitigated by providing take-homes to stable patients and a diversion control plan	Low in OTPs with directly observed therapy; moderate for take-home doses; risk can be mitigated by a diversion control plan	None
Sedation	Low unless concurrent substances are present (e.g., alcohol, benzodiazepines)	Low unless dose titration is too quick or dose is not adjusted for the presence of concurrent substances (e.g., alcohol, benzodiazepines)	None
Risk of medication-induced respiratory depression	Very rare; lower than methadone	Rare, although higher than buprenorphine; may be elevated during the first 2 weeks of treatment or in combination with other sedating substances	None
Risk of precipitated withdrawal when starting medication	Can occur if started too prematurely after recent use of other opioids	None	Severe withdrawal is possible if period of abstinence is inadequate before starting medication
Withdrawal symptoms on discontinuation	Present; lower than methadone if abruptly discontinued	Present; higher than buprenorphine if abruptly discontinued	None
Most common side effects	Constipation, vomiting, headache, sweating, insomnia, blurred vision	Constipation, vomiting, sweating, dizziness, sedation	Difficulty sleeping, anxiety, nausea, vomiting, low energy, joint and muscle pain, headache, liver enzyme elevation XR-NTX: Injection site pain, nasopharyngitis, insomnia, toothache

D. Coffa, December 2017 (personal communication). Adapted with permission.

OUD Medications: Formulations[44,45]

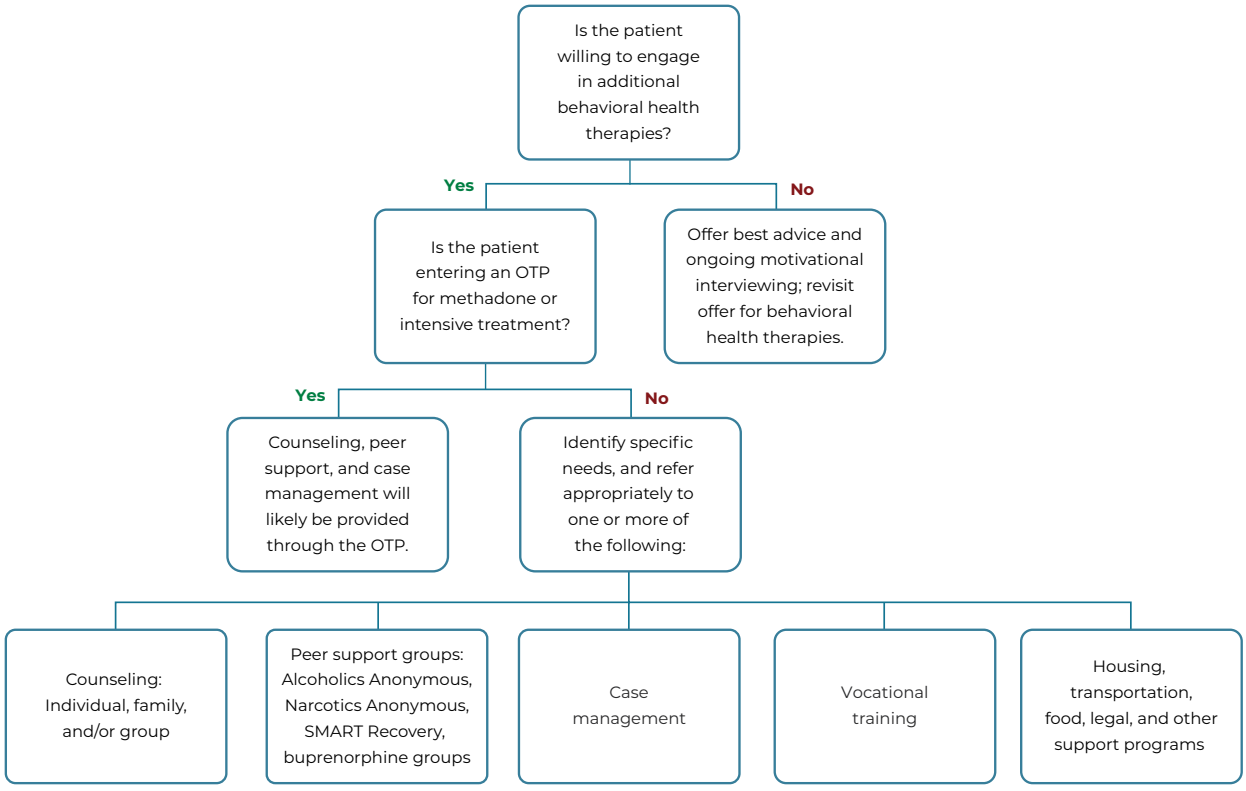
GENERIC/ TRADE NAME	FORMULATIONS	ACTION AT THE RECEPTOR	FDA INDICATIONS	DOSING REGIMEN
Methadone (Methadose, Dolophine)	Orally as liquid concentrate, tablet, or oral solution of powder or dispersible tablet	Mu-opioid receptor full agonist	Medically supervised withdrawal and maintenance treatment of opioid dependence; additional formulations FDA-approved for pain are not a focus of this TIP	Once daily (also off-label dosing regimens if appropriate, such as split dose twice daily)
Generic buprenorphine monoproduct	Sublingual tablet	Mu-opioid receptor partial agonist	Treatment of opioid dependence; additional formulations FDA-approved for pain are not a focus of this TIP	Once daily (also alternative off-label regimens)
Generic combination product (buprenorphine/ naloxone)	Sublingual tablet	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)
Buprenorphine/ naloxone (Zubsolv)	Sublingual tablet	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)
Buprenorphine/ naloxone (Bunavail)	Buccal film	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)
Buprenorphine/ naloxone (Suboxone)	Sublingual film; may also be administered buccally	Mu-opioid receptor partial agonist combined with mu-opioid receptor antagonist; the latter is not absorbed sublingually	Treatment of opioid dependence	Once daily (also alternative off-label regimens)

Continued on next page

OUD Medications: Formulations (continued)

GENERIC/ TRADE NAME	FORMULATIONS	ACTION AT THE RECEPTOR	FDA INDICATIONS	DOSING REGIMEN
Buprenorphine (Probuphine)	Implants	Mu-opioid receptor partial agonist	Maintenance treatment of opioid dependence in clinically stable patients taking 8 mg/ day or less of Suboxone equivalents	Implants last for 6 months and are then removed, after which a second set can be inserted
Extended-release injection buprenorphine (Sublocade)	Subcutaneous injection in the abdominal region	Mu-opioid receptor partial agonist	Treatment of moderate-to-severe OUD among patients initiated and taking transmucosal buprenorphine for at least 7 days	Monthly
Oral naltrexone (Revia)	Oral tablet	Mu-opioid receptor antagonist	Block the effects of administered opioid agonists	Once daily (also alternative off-label regimens)
XR-NTX (Vivitrol)	Intramuscular injection	Mu-opioid receptor antagonist	Prevent return to opioid dependence after medically supervised opioid withdrawal	Once monthly by injection

Referring Patients Who Receive OUD Pharmacotherapy to Behavioral Health Therapies



Strategies for Managing Benzodiazepine Use by Patients in OUD Treatment

- **Carefully assess the patient's benzodiazepine use,** including:
  - Intent of use.
  - Source (check the state's PDMP).
  - Amount and route of use.
  - Binge use.
  - Prior overdoses.
  - Harms (e.g., car crashes, criminal acts, sleep trouble).
  - Co-use with other substances that further increase risk for respiratory depression and overdose.
  - Withdrawal history (e.g., seizures, delirium).
- **Also assess the following:**
  - Psychiatric and medical comorbidity
  - Motivation for change
  - Psychosocial support system (obtain history from a significant other if the patient permits)
- **Gauge level of care and setting needed** (e.g., residential, outpatient). Inpatient treatment may be best for patients with poor motivation, limited psychosocial support, serious or complicated comorbidity, or injection or binge use.
- **Coordinate with other prescribers.** Some patients may have taken appropriately prescribed benzodiazepines for years with limited or no evidence of misuse. For such patients, tapering benzodiazepines may be contraindicated and unrealistic.
- **Address comorbid mental disorders (e.g., anxiety, depression)** with other medications or psychosocial treatments, when feasible.
- **Provide medically supervised withdrawal** from benzodiazepines or refer to specialty care for same.
- **Create a treatment plan with built-in conditions** (e.g., urine testing, more frequent visits, short medication supply).
- **Frequently review patient progress and objective outcomes,** such as:
  - Urine drug testing.
  - PDMP reports.
  - Psychosocial functioning.
  - Reports from significant others.
- **Revise treatment plans** as needed, and document the rationale for treatment decisions.

Adapted with permission.[46]

Sample Provider Forms

General forms

Goal-Setting Form

Patient's Name: _____ **Date:** _____

GOAL CATEGORY	CURRENT SITUATION SCORE 10 = major problems and 0 = no problems	What would need to change to decrease this score?	PRIORITY SCORE 10 = highest priority ("I really want to work on this") and 1 = lowest priority ("I really do not want to work on this")
Opioid use			
Other illicit drug use: _____			
Alcohol use			
Tobacco use			
Physical health			
Mental health			
Legal/court issues			
Finances			
Job/employment			
Hobbies			
Family relations			
Partner relations			
Supportive drug-free network			
Education			
Keeping medication safe (e.g., not giving it away, selling it, having it stolen)			
Other			
Other			

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Goal Sheet and Coping Strategies Form

Goals are things you would like to accomplish.

Patient's Name: _____ **Date:** _____

3-MONTH GOALS

1 _____

2 _____

3 _____

6-MONTH GOALS

1 _____

2 _____

3 _____

1-YEAR GOALS

1 _____

2 _____

3 _____

List of Triggers to Using Drugs

People To Stay Away From

Places To Stay Away From

Ways To Cope or Manage Stress Without Using Drugs

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Medical Management Visit Form

Patient's Name: _____ **ID#**_____

Date: _____ **Week#:** _____ **Dose:** _____ mg ☐ No Show

Heroin/cocaine or other illicit drug use since last visit?

_____

Symptoms or signs that might indicate return to use (e.g., changes in mood, physical appearance)?

_____

Since the last visit, are there any problems with the following:

			If yes, explain
Drug Use	☐ Yes	☐ No	_____
Alcohol Use	☐ Yes	☐ No	_____
Psychiatric	☐ Yes	☐ No	_____
Medical	☐ Yes	☐ No	_____
Employment	☐ Yes	☐ No	_____
Social/Family	☐ Yes	☐ No	_____
Legal	☐ Yes	☐ No	_____

Any new problem to add to Treatment Plan Review? ☐ Yes ☐ No

_____

Plan to address any new problem _____

_____

Participation in Narcotics Anonymous or Alcoholics Anonymous since last visit? ☐ Yes ☐ No

Length of Session: _____ Healthcare Professional Signature: _____

D. Fiellin, December 3, 2016 (personal communication). Adapted with permission.

Patient Urine Drug Screen and Medication Count Monitoring Form

Patient's Name: _____ **Dates To Be Called:** _____

Called for:

☐ Urine Drug Screen

☐ Medication Count at ☐ Office or ☐ Pharmacy FOR: _____

☐ Buprenorphine/Naloxone

☐ Other (list drug: _____, _____, _____)

Documentation of Phone Call to Patient

Patient was called at _____ (insert phone #) on _____ (date) at _____:_____ (time) and informed of monitoring required (described above) within the next _____ hours.

Check One:

☐ I spoke with patient

☐ Message left on answering machine/voicemail

☐ Message left with _____

☐ Other _____

Signature of Staff Member Making Phone Call: _____

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Pharmacy Tablet/Film Count Form

(Note: Before sending this form, discuss with the pharmacist first to explain goals and procedures and to ensure agreement and understanding.)

Date: _____

To: Pharmacists @ _____ Pharmacy

From: Healthcare Provider: _____

Clinic Address: _____

Phone Number: _____

My patient, _____, is starting office-based buprenorphine treatment for opioid dependence.

As part of monitoring this treatment, we ask the patient to do buprenorphine tablet/film counts at random times (we call the patient when it's time for a pill/film count).

The above-named patient lives much closer to your pharmacy than to our treatment clinic. It would be a big help to me and this patient if you would be able to perform periodic tablet/film counts on his/her buprenorphine and then fax this form to us.

On the days we call the patient for a random tablet/film count, the patient would come to your pharmacy with his or her pill bottle. When we call the patient to go for a random tablet/film count, we will fax this form to you. We would appreciate if you could record the tablet/film count results on this form and fax it back to us the same day. This would be a real help to me in monitoring my patient's treatment and also a great service to the patient.

Thank you very much for your help with this! Sincerely,

_____
Signature

Buprenorphine/naloxone formulation: _____

Dose per tablet/film: _____

Total # of tablets/films remaining in bottle: _____ Fill date on bottle: _____

Total # of tablets/films dispensed on fill date: _____ Tablet/film count correct? ☐Yes ☐No

Please fax this back to: _____

Thank You!

M. Lofwall, February 27, 2017 (personal communication). Adapted with permission.

Standard Consent to Opioid Maintenance Treatment Form for OTPs

CONSENT TO PARTICIPATE IN METHADONE OR BUPRENORPHINE TREATMENT

Patient's Name: _____ **Date:** _____

I authorize and give voluntary consent to _____ [insert name of program] to dispense and administer medications—including methadone or buprenorphine—to treat my opioid use disorder. Treatment procedures have been explained to me, and I understand that I should take my medication at the schedule determined by the program physician, or his/her designee, in accordance with federal and state regulations.

I understand that, like all other medications, methadone or buprenorphine can be harmful if not taken as prescribed. It has been explained to me that I must safeguard these medications and not share them with anyone because they can be fatal to children and adults if taken without medical supervision.

I also understand that methadone and buprenorphine produce physical opioid dependence.

Like all medications, they may have side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical and psychiatric provider who may treat me that I am enrolled in an opioid treatment program. In this way, the provider will be aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my treatment with methadone or buprenorphine or my recovery.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of these medications at any time. If I choose this option, I understand I will be offered medically supervised withdrawal.

For women of childbearing age: Pregnant women treated with methadone or buprenorphine have better outcomes than pregnant women not in treatment who continue to use opioid drugs. Newborns of mothers who are receiving methadone or buprenorphine treatment may have opioid withdrawal symptoms (i.e., neonatal abstinence syndrome). The delivery hospital may require babies who are exposed to opioids before birth to spend a number of days in the hospital for monitoring of withdrawal symptoms. Some babies may also need medication to stop withdrawal. If I am or become pregnant, I understand that I should tell the medical staff of the OTP right away so I can receive or be referred to prenatal care. I understand that there are ways to maximize the healthy course of my pregnancy while I am taking methadone or buprenorphine.

Signature of Patient: _____ **Date of Birth:** _____

Date: _____ **Witness:** _____

Adapted from material in the public domain.[47]

Buprenorphine Forms

Buprenorphine Diversion Control Policy

XYZ Medical Practice
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 professionals 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. Healthcare professionals should use their personal and professional judgment in interpreting these guidelines and applying them to the particular 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.

Preamble: Healthcare professionals can now treat up to 275 patients with buprenorphine. This increased access may contribute to increased diversion, misuse, and related harms. Signs that a patient is misusing or diverting buprenorphine include (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 or intolerant to naloxone and requesting monotherapy; (5) nonhealing or fresh track marks; or (5) police reports of selling on the streets. Likewise, there are a range of reasons for diversion and misuse (e.g., diverting to family/friends with untreated opioid addiction with the intent of trying to "help" convince them to also get treatment; diverting to family/friends on a treatment waiting list; selling some or all of the medication to pay off old drug debts/purchase preferred opioid of misuse/pay for treatment in places where there are inadequate addiction treatment professionals taking private insurance or Medicaid for such reasons as inadequate reimbursement/no reimbursement/burdensome prior authorization process).

The safety and health of patients and others in the community could be at risk if misuse and diversion are not addressed proactively 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 other than for whom it was intended (including sharing or selling a prescribed medication); *misuse* includes taking medication in a manner, by route or by dose, other than prescribed.[48]

Purpose: Misuse and diversion should be defined and discussed with patients at the time of treatment entry; periodically throughout treatment, particularly when there have been returns to illicit drug use; and when suspected (e.g., incorrect buprenorphine pill/film count) or confirmed. These procedures will establish the steps to be taken to prevent, monitor, and respond to misuse and diversion of buprenorphine. The response should be therapeutic and matched to the patients' needs, as untreated opioid use disorder and treatment dropout/administrative discharges may lead to increased patient morbidity and mortality and further use of diverted medications or illicit opioids associated with overdose death.

Procedures for Prevention:

- Use buprenorphine/naloxone combination products when medically indicated and cost is not an issue. Reserve the daily buprenorphine monoproducts for pregnant patients and patients who could not afford treatment if the combination product were required, who have a history of stability in treatment and low diversion risk, or who have arrangements for observed dosing. Buprenorphine monoproducts are recommended for pregnant women.
- Counsel patients on safe storage of, and nonsharing 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 locked devices and avoiding storage in parts of the home frequented by visitors (e.g., do not recommend storage in the kitchen or common bathrooms). Proactively discuss how medication should be stored and 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 healthcare professional; for example, they may not crush or inject the medication.
- Check the prescription drug monitoring program for new patients and check regularly thereafter. Prescription drug monitoring program reports can be a useful resource when there is little history available or when there is a concern based on observation. Check for prescriptions that interact with buprenorphine and for other buprenorphine prescribers.

- Prescribe a therapeutic dose that is tailored to the patient's needs. Do not routinely provide an additional supply "just in case." Question patients who say they need a significantly higher dose, particularly when they are already at 24 mg per day of buprenorphine equivalents.
- Make sure the patient understands the practice's treatment agreement and prescription policies. The XYZ Medical Practice's treatment agreement and other documentation are clear about policies regarding number of doses in each prescription, refills, and rules on "lost" prescriptions. Review the policies in person with the patient. Offer an opportunity for questions. Patient and provider must sign the agreement. Review the policies again with the patient at subsequent appointments. See Sample Buprenorphine Treatment Agreement or Sample XR-NTX Treatment Agreement as needed.

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 supports nonadherence. Testing for buprenorphine metabolites (which are present only if buprenorphine is metabolized) should periodically 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 (e.g., purses, backpacks) in the bathroom; (3) turning off running water and coloring toilet water to eliminate the 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 at initial or subsequent appointments to bring in their medication containers 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 time period (e.g., 24 hours) after the phone call. If the patient doesn't show, then the provider should consider this as a positive indicator of misuse or diversion.
- Directly observe ingestion. Patients take medication in front of the healthcare professional or another qualified clinician and are observed until the medication dissolves in the mouth (transmucosal [sublingual or buccal] absorption). Patients who are having difficulty adhering to their buprenorphine 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 not practical, short prescription time spans can be used (e.g., weekly, 3 days at a time).

Procedures To Respond to Misuse or Diversion: Misuse or diversion doesn't mean automatic discharge from the practice. However, it will require consideration of one or more of the following procedures:

- Evaluate the misuse and diversion. For instance, describe the incident of misuse (e.g., "the patient took the prescribed dose on three or more occasions by intravenous route immediately after starting treatment, stating that she believed the dose would not be adequate by sublingual route; she has just initiated treatment") or diversion ("the patient gave half of dose to his wife, who is still using heroin and was withdrawing, because he did not want her to have to buy heroin off the street; she is on a waiting list for treatment") and tailor the response to the behavior (e.g., reeducation of the patient on buprenorphine pharmacology in the first example above; assistance with treatment entry for the spouse in the second example). Reassess the treatment plan and patient progress. Strongly consider smaller supplies of medication and supervised dosing for any patient who is taking medication intravenously or intranasally or diverting, regardless of reason. Treatment structure may need to be increased, including more frequent appointments, supervised administration, and increased psychosocial support.
- Intensify treatment or level of care, if needed. Some patients may require an alternative treatment setting or pharmacotherapy such as methadone. The clinician will discuss these alternatives with the patient to ensure optimal patient outcome. This should be discussed at treatment onset so the patient is aware of the consequences of misuse and diversion.
- Document and describe the misuse and diversion incident. Also document the clinical thinking that supports the clinical response, which should be aimed at minimizing risk of diversion and misuse and treating the patient's opioid use disorder at the level of care needed.

Policy adapted from ASAM's *Office-Based Opioid Use Disorder Policy and Procedure Manual*, which is updated periodically; the most current version is available online (https://www.asam.org/docs/default-source/advocacy/sample-diversion-policy.pdf?sfvrsn=6).

Adapted with permission.[49]

Buprenorphine Induction and Maintenance Appropriate Use Checklists

Patient Name: _____

BTOD|REMS

APPROPRIATE USE CHECKLIST:
BUPRENORPHINE-CONTAINING TRANSMUCOSAL PRODUCTS FOR OPIOID DEPENDENCE

This checklist is a useful reminder of the safe use conditions and monitoring requirements for prescribing buprenorphine-containing transmucosal products for opioid dependence.

Requirements to address during each patient's appointment include:

- understanding and reinforcement of safe use conditions
- the importance of psychosocial counseling
- screening and monitoring patients to determine progress towards treatment goals

If a patient continues to abuse various drugs or is unresponsive to treatment, including psychosocial intervention, it is important that you assess the need to refer the patient to a specialist and/or a more intensive behavioral treatment environment.

Additional resource: Physician Clinical Support System: http://pcssb.org/

This checklist may be used during the induction period and filed in patient's medical record to document safe use conditions. Once a maintenance dose has been established, use the maintenance checklist.

MEASUREMENT TO ENSURE APPROPRIATE USE	NOTES
Date:	
INDUCTION	
☐ Verified patient meets appropriate diagnostic criteria for opioid dependence	
☐ Discussed risks described in professional labeling and Medication Guide with patient	
☐ Explained or reviewed conditions of safe storage of medication, including keeping it out of the sight and reach of children	
☐ Provided induction doses under appropriate supervision	
☐ Prescribed limited amount of medication at first visit	
☐ Scheduled next visit at interval commensurate with patient stability • Weekly, or more frequent visits recommended for the first month	

1

Continued on next page

Patient Name: _____

BTOD|REMS

APPROPRIATE USE CHECKLIST:

BUPRENORPHINE-CONTAINING TRANSMUCOSAL PRODUCTS FOR OPIOID DEPENDENCE

This checklist may be used for visits following the induction period and filed in patient's medical record to document safe use conditions.

MEASUREMENT TO ENSURE APPROPRIATE USE	NOTES
Date: **Visit #**	
MAINTENANCE	
☐ **Assessed and encouraged patient to take medication as prescribed** • Consider pill/film count/dose reconciliation	

☐ **Assessed appropriateness of dosage**
• Buprenorphine combined with naloxone is recommended for maintenance:
  • Buprenorphine/Naloxone SL tablet and film (Suboxone®): doses ranging from 12 mg to 16 mg of buprenorphine are recommended for maintenance
  • Buprenorphine/Naloxone SL tablet (Zubsolv®): a target dose of 11.4 mg buprenorphine is recommended for maintenance
  • Buprenorphine/Naloxone Buccal Film (Bunavail®): a target dose of 8.4 mg of buprenorphine is recommended for maintenance
• Doses higher than this should be an exception
• The need for higher dose should be carefully evaluated	

☐ **Conduct urine drug screens as appropriate to assess use of illicit substances**	
☐ **Assessed participation in professional counseling and support services**	
☐ **Assessed whether benefits of treatment with buprenorphine-containing products outweigh risks associated with buprenorphine-containing products**	
☐ **Assessed whether patient is making adequate progress toward treatment goals** • Considered results of urine drug screens as part of the evidence of the patient complying with the treatment program • Consider referral to more intensive forms of treatment for patients not making progress	
☐ **Scheduled next visit at interval commensurate with patient stability** • Weekly, or more frequent visits are recommended for the first month	

2

Available online (www.accessdata.fda.gov/drugsatfda_docs/rems/BTOD_2017-01-23_Appropriate_Use_Checklist.pdf). *Reprinted from material in the public domain.*[50]

Buprenorphine Treatment Agreement

This form is for educational/informational purposes only. It doesn't establish a legal or medical standard of care. Healthcare professionals should use their judgment in interpreting this form and applying it in the 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.

TREATMENT AGREEMENT

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

1. The risks and benefits of buprenorphine treatment have been explained to me.
2. The risks and benefits of other treatment for opioid use disorder (including methadone, naltrexone, and nonmedication treatments) have been explained to me.
3. I will keep my medication in a safe, secure place away from children (for example, in a lockbox). My plan is to store it [describe where and how _____].
4. I will take the medication exactly as my healthcare provider prescribes. If I want to change my medication dose, I will speak with my healthcare provider first. Taking more medication than my healthcare provider prescribes or taking it more than once daily as my healthcare provider 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 my healthcare provider's evaluation.
5. I will be on time to my appointments and respectful to the office staff and other patients.
6. I will keep my healthcare provider informed of all my medications (including herbs and vitamins) and medical problems.
7. I agree not to obtain or take prescription opioid medications prescribed by any other healthcare provider without consulting my buprenorphine prescriber.
8. If I am going to have a medical procedure that will cause pain, I will let my healthcare provider know in advance so that my pain will be adequately treated.
9. 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.
10. If I come to the office intoxicated, I understand that my healthcare provider 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.
11. I understand that it's 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 the clinic, and/or a change in medication based on my healthcare provider's evaluation.
12. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from the clinic.
13. 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.
14. I understand that I will be called at random times to bring my medication container into the office for a pill or film count. Missing medication doses could result in supervised dosing or referral to a higher level of care at this clinic or potentially at another treatment provider based on my individual needs.
15. 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.
16. I can be seen every 2 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.
17. I will go back to weekly visits if I have a positive drug test. I can go back to visits every 2 weeks when I have two negative drug tests in a row again.
18. I may be seen less than every 2 weeks based on goals made by my healthcare provider and me.
19. I understand that people have died by mixing buprenorphine with alcohol and other drugs like benzodiazepines (drugs like Valium, Klonopin, and Xanax).

Continued on next page

20. I understand that treatment of opioid use disorder involves more than just taking medication. I agree to comply with my healthcare provider's recommendations for additional counseling and/or for help with other problems.
21. I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is for me to stop using all illicit drugs and become successful in all aspects of my life.
22. I understand that I may experience opioid withdrawal symptoms when I stop taking buprenorphine.
23. I have been educated about the other two FDA-approved medications used for opioid dependence treatment, methadone and naltrexone.
24. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and been informed about methods for preventing pregnancy.

Other specific items unique to my treatment include:

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

This form is adapted from the American Society of Addiction Medicine's Sample Treatment Agreement, which is updated periodically; the most current version of the agreement is available online (https://www.asam.org/docs/default-source/advocacy/sample-treatment-agreement30fa159472bc604ca5b7ff000030b21a.pdf?sfvrsn=bd4675c2_0).

Adapted with permission.[51]

Naltrexone forms

Key Techniques for Reducing Injection Site Reactions[52]

To reduce severe injection site reactions when administering XR-NTX via intramuscular injection, use the following techniques:

- **Use one of the administration needles provided with the XR-NTX kit to ensure that the injection reaches the gluteal muscle.** Use the 2-inch needle for patients who have more subcutaneous adipose tissue. Use the 1.5-inch needle for patients with less subcutaneous adipose tissue. Either needle is appropriate for use with patients who have average amounts of subcutaneous adipose tissue.
- **Use aseptic technique when administering intramuscularly.** Using a circular motion, clean the injection site with an alcohol swab. Let the area dry before administering the injection. Do not touch this area again before administration.
- **Use proper deep intramuscular injection technique into the gluteal muscle.** XR-NTX must not be injected intravenously, subcutaneously, or into adipose tissue. Accidental subcutaneous injection may increase the risk of severe injection site reactions.
  - **Administer the suspension by deep intramuscular injection into the upper outer quadrant of gluteal muscle,** alternating buttocks per monthly injection.
  - **Remember to aspirate for blood before injection.** If blood aspirates or the needle clogs, do not inject. Change to the spare needle provided in the package and administer into an adjacent site in the same gluteal region, again aspirating for blood before injection.
  - **Inject the suspension in a smooth, continuous motion.**

A patient counseling tool is available to help you counsel your patients before administration about the serious risks associated with XR-NTX.

The above information is a selection of key safety information about the XR-NTX injection. For complete safety information, refer to the directions for use and the prescribing information provided in the medication kit. You can also obtain this information online (www.vivitrolrems.com) or by calling 1-800-VIVITROL.

Available online (www.vivitrolrems.com/content/pdf/patinfo-injection-poster.pdf).

Patient Counseling Tool for XR-NTX

Patient Counseling Tool

VIVITROL® (naltrexone for extended-release injectable suspension)

Risk of sudden opioid withdrawal during initiation and re-initiation of VIVITROL

Using any type of opioid including street drugs, prescription pain medicines, cough, cold or diarrhea medicines that contain opioids, or opioid dependence treatments buprenorphine or methadone, in the 7 to 14 days before starting VIVITROL may cause severe and potentially dangerous sudden opioid withdrawal.

Risk of opioid overdose

Patients may be more sensitive to the effects of lower amounts of opioids:

- After stopping opioids (detoxification)
- When the next VIVITROL dose is due
- If a dose of VIVITROL is missed
- After VIVITROL treatment stops

Patients should tell their family and people close to them about the increased sensitivity to opioids and the risk of overdose even when using lower doses of opioids or amounts that they used before treatment. Using large amounts of opioids, such as prescription pain pills or heroin, to overcome effects of VIVITROL can lead to serious injury, coma, and death.

Risk of severe reactions at the injection site

Remind patients of these **possible** symptoms at the **injection site:**

- Intense pain
- The area feels hard
- Large areas of swelling
- Lumps
- Blisters
- Open wound
- Dark scab

Some of these injection site reactions have required surgery.
Tell your patients to contact a healthcare provider if they have any reactions at the injection site.

Risk of liver injury, including liver damage or hepatitis

Remind patients of the possible symptoms of liver damage or hepatitis.

- Stomach area pain lasting more than a few days
- Dark urine
- Yellowing of the whites of eyes
- Tiredness

Patients may not feel the therapeutic effects of opioid-containing medicines for pain, cough or cold, or diarrhea while taking VIVITROL.

Patients should carry written information with them at all times to alert healthcare providers that they are taking VIVITROL, so they can be treated properly in an emergency.

A Patient Wallet Card or Medical Alert Bracelet can be ordered from: 1-800-848-4876, Option #1.

PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE.

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Available online (www.vivitrolrems.com/content/pdf/patinfo-counseling-tool.pdf).
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Sample XR-NTX Treatment Agreement

This form is for educational/informational purposes only. It doesn't establish a legal or medical standard of care. Healthcare professionals should use their judgment in interpreting this form and applying it in the 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.

TREATMENT AGREEMENT

I agree to accept the following treatment agreement for extended-release injectable naltrexone office-based opioid use disorder treatment:

1. The risks and benefits of extended-release injectable naltrexone treatment have been explained to me.
2. The risks and benefits of other treatment for opioid use disorder (including methadone, buprenorphine, and nonmedication treatments) have been explained to me.
3. I will be on time to my appointments and respectful to the office staff and other patients.
4. I will keep my healthcare provider 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 healthcare provider.
6. If I am going to have a medical procedure that will cause pain, I will let my healthcare provider know in advance so that my pain will be adequately treated.
7. If I miss a scheduled appointment for my next extended-release naltrexone injection, I understand that I should reschedule the appointment as soon as possible because it is important to receive the medication on time to reduce the risk of opioid overdose should I return to use.
8. If I come to the office intoxicated, I understand that my healthcare provider will not see me.
9. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from the clinic.
10. 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.
11. I understand that initially I will have weekly office visits until my condition is stable.
12. I can be seen every 2 weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row.
13. I may be seen less than every 2 weeks based on goals made by my healthcare provider and me.
14. I understand that people have died trying to overcome the opioid blockade by taking large amounts of opioids.
15. I understand that treatment of opioid use disorder involves more than just taking medication. I agree to follow my healthcare provider's recommendations for additional counseling and/or for help with other problems.
16. I understand that there is no fixed time for being on naltrexone and that the goal of treatment is for me to stop using all illicit drugs and become successful in all aspects of my life.
17. I understand that my risk of overdose increases if I go back to using opioids after stopping naltrexone.
18. I have been educated about the other two FDA-approved medications used to treat opioid use disorder, methadone and buprenorphine, and I prefer to receive treatment with naltrexone.
19. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting naltrexone treatment and have been informed about methods for preventing pregnancy.
20. I have been informed that if I become pregnant during naltrexone treatment, I should inform my provider and have a discussion about the risks and benefits of continuing to take naltrexone.

Other specific items unique to my treatment include:

Patient Name (print): _____

Patient Signature: _____ Date: _____

This form is adapted from ASAM's Sample Treatment Agreement, which is updated periodically; the most current version of the agreement is available online (www.asam.org/docs/default-source/advocacy/sample-treatment-agreement30fa159472bc604ca5b7ff000030b21a.pdf?sfvrsn=0).

Adapted with permission.[54]

Glossary of TIP Terminology

Abuse liability: The likelihood that a medication with central nervous system activity will cause desirable psychological effects, such as euphoria or mood changes, that promote the medication's misuse.

Addiction: As defined by ASAM,[55] "a primary, chronic disease of brain reward, motivation, memory, and related circuitry." It is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of **relapse** and **remission**. The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition[56] (DSM-5), does not use the term for diagnostic purposes, but it commonly describes the more severe forms of opioid use disorder.

Bioavailability: Proportion of medication administered that reaches the bloodstream.

Care provider: Encompasses both **healthcare professionals** and other professionals who do not provide medical services, such as counselors or providers of supportive services. Often shortened to "provider."

Cross-tolerance: Potential for people tolerant to one opioid (e.g., heroin) to be tolerant to another (e.g., methadone).

Dissociation: Rate at which a drug uncouples from the receptor. A drug with a longer dissociation rate will have a longer duration of action than a drug with a shorter dissociation rate.

Half-life: Rate of removal of a drug from the body. One half-life removes 50 percent from the plasma. After a drug is stopped, it takes five half-lives to remove about 95 percent from the plasma. If a drug is continued at the same dose, its plasma level will continue to rise until it reaches steady state concentrations after about five half-lives.

Healthcare professionals: Physicians, nurse practitioners, physician assistants, and other medical service professionals who are eligible to prescribe medications for and treat patients with OUD. The term "**prescribers**" also refers to these healthcare professionals.

Induction: Process of initial dosing with medication for OUD treatment until the patient reaches a state of stability; also called initiation.

Intrinsic activity: The degree of receptor activation attributable to drug binding. **Full agonist, partial agonist**, and **antagonist** are terms that describe the intrinsic activity of a drug.

Maintenance treatment: Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint (as with the typical standard of care in medical and psychiatric treatment of other chronic illnesses).

Medically supervised withdrawal (formerly called detoxification): Using an opioid agonist (or an alpha-2 adrenergic agonist if opioid agonist is not available) in tapering doses or other medications to help a patient discontinue illicit or prescription opioids.

Medical management: Process whereby healthcare professionals provide medication, basic brief supportive counseling, monitoring of drug use and medication adherence, and referrals, when necessary, to addiction counseling and other services to address the patient's medical, mental health, comorbid addiction, and psychosocial needs.

Mutual-help groups: Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as AA and NA are the most

widespread and well-researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART Recovery, Women for Sobriety).

Office-based opioid treatment (OBOT): Providing medication for OUD in settings other than certified OTPs.

Opiates: A subclass of opioids derived from opium (e.g., morphine, codeine, thebaine).

Opioid misuse: The use of prescription opioids in any way other than as directed by a prescriber; the use of any opioid in a manner, situation, amount, or frequency that can cause harm to self or others.[57]

Opioid receptor agonist: A substance that has an affinity for and stimulates physiological activity at cell receptors in the central nervous system that are normally stimulated by opioids. **Mu-opioid receptor full agonists** (e.g., methadone) bind to the mu-opioid receptor and produce actions similar to those produced by the endogenous opioid beta-endorphin. Increasing the dose increases the effect. **Mu-opioid receptor partial agonists** (e.g., buprenorphine) bind to the mu-opioid receptor. Unlike with full agonists, increasing their dose may not produce additional effects once they have reached their maximal effect. At low doses, partial agonists may produce effects similar to those of full agonists.

Opioid receptor antagonist: A substance that has an affinity for opioid receptors in the central nervous system without producing the physiological effects of opioid agonists. Mu-opioid receptor antagonists (e.g., naltrexone) can block the effects of exogenously administered opioids.

Opioid receptor blockade: Blunting or blocking of the euphoric effects of an opioid through opioid receptor occupancy by an opioid agonist (e.g., methadone, buprenorphine) or antagonist (e.g., naltrexone).

Opioids: All natural, synthetic, and semisynthetic substances that have effects similar to morphine. They can be used as medications having such effects (e.g., methadone, buprenorphine, oxycodone).

Opioid treatment program (OTP): An accredited treatment program with SAMHSA certification and DEA registration to administer and dispense opioid agonist medications that are approved by FDA to treat opioid addiction. Currently, these include methadone and buprenorphine products. Other pharmacotherapies, such as naltrexone, may be provided but are not subject to these regulations. OTPs must provide adequate medical, counseling, vocational, educational, and other assessment and treatment services either onsite or by referral to an outside agency or practitioner through a formal agreement.[58]

Opioid use disorder (OUD): Per DSM-5,[59] a disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. Tolerance and withdrawal do not count toward the diagnosis in people experiencing these symptoms when using opioids under appropriate medical supervision. OUD covers a range of severity and replaces what the DSM-IV termed "opioid abuse" and "opioid dependence." An OUD diagnosis is applicable to a person who uses opioids and experiences at least 2 of the 11 symptoms in a 12-month period. (See Exhibit 2.11 in Part 2 for full DSM-5 diagnostic criteria for OUD.)

Peer support: The use of peer support specialists in recovery to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.

Peer support specialist: Someone in recovery who has lived experience in addiction plus skills learned in formal training. Peer support specialists may be paid professionals or volunteers. They are distinguished from members of mutual-

help groups because they maintain contact with treatment staff. They offer experiential knowledge that treatment staff often lack.

Prescribers: Healthcare professionals who are eligible to prescribe medications for OUD.

Psychosocial support: Ancillary services to enhance a patient's overall functioning and well-being, including recovery support services, case management, housing, employment, and educational services.

Psychosocial treatment: Interventions that seek to enhance a patient's social and mental functioning, including addiction counseling, contingency management, and mental health services.

Receptor affinity: Strength of the bond between a medication and its receptor. A medication with high mu-opioid receptor affinity requires lower concentrations to occupy the same number of mu-opioid receptors as a drug with lower mu-opioid receptor affinity. Drugs with high mu-opioid receptor affinity may displace drugs with lower affinity.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their SUDs and regain health and social function. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature. Patients taking FDA-approved medication to treat OUD can be considered in recovery.

Recovery capital: The sum of the internal (e.g., motivation, self-efficacy, spirituality) and external (e.g., access to health care, employment, family support) resources that an individual can draw on to begin and sustain recovery from SUDs.

Recovery-oriented care: A service orientation that supports individuals with behavioral health conditions in a process of change through which they can improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Relapse: A process in which a person with OUD who has been in **remission** experiences a return of symptoms or loss of remission. A relapse is different from a **return to opioid use** in that it involves more than a single incident of use. Relapses occur over a period of time and can be interrupted. Relapse need not be long lasting. The TIP uses relapse to describe relapse prevention, a common treatment modality.

Remission: A medical term meaning a disappearance of signs and symptoms of the disease.[60] DSM-5 defines remission as present in people who previously met OUD criteria but no longer meet any OUD criteria (with the possible exception of craving).[61] Remission is an essential element of **recovery**.

Return to opioid use: One or more instances of **opioid misuse** without a return of symptoms of OUD. A return to opioid use may lead to **relapse**.

Tolerance: Alteration of the body's responsiveness to alcohol or other drugs (including opioids) such that higher doses are required to produce the same effect achieved during initial use. See also **medically supervised withdrawal**.

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