# Complete Summary

## GUIDELINE TITLE

Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction.

## BIBLIOGRAPHIC SOURCE(S)

Center for Substance Abuse Treatment. Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2004. 171 p. (Treatment improvement protocol; no. TIP 40).

## GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

## SCOPE

### DISEASE/CONDITION(S)

- Opioid dependence
- Prescription opiate abuse

### GUIDELINE CATEGORY

Evaluation
Management
Screening
Treatment

## CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Psychiatry
Psychology

## INTENDED USERS

Nurses
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Substance Use Disorders Treatment Providers

## GUIDELINE OBJECTIVE(S)

- To provide physicians with step-by-step guidance through the opioid dependence treatment decision-making process
- Specifically, to enable physicians
    - To perform initial screening and assessment of patients with opioid addiction
    - To determine the appropriateness of buprenorphine treatment for patients with opioid dependence
    - To provide treatment of opioid dependence with buprenorphine according to established protocols
    - To assess for the presence of and arrange appropriate treatment services for comorbid medical and psychosocial conditions
    - To determine when to seek specialty addiction treatment referral or consultation

## TARGET POPULATION

Patients with dependence or addiction to opioids, including heroin and prescription pain medications, such as hydrocodone, oxycodone, and meperidine

## INTERVENTIONS AND PRACTICES CONSIDERED

### Screening/Evaluation

### Screening for Opioid Use

*Addiction Screening Tools for Drug Use*:

1. COWS (Clinical Opiate Withdrawal Scale)
2. SOWS (Subjective Opiate Withdrawal Scale)
3. DAST-10 (Drug Abuse Screening Test)
4. CINA (Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms)
5. CAGE-AID (CAGE Adapted to Include Drugs)
6. Narcotic Withdrawal Scale

**Assessment**

1. Complete history (including complete substance abuse assessment history)
2. Physical examination
3. Mental status examination
4. Relevant laboratory testing (including ongoing drug screening via urinalysis)
5. Additional laboratory evaluations, as indicated, including
    - Blood alcohol level (using a breath testing instrument or a blood sample)
    - Infectious disease evaluation
        - Human immunodeficiency virus (HIV) antibody testing
        - Hepatitis B virus (HBV) and hepatitis C virus (HCV) screens
        - Serology test for syphilis --Venereal Disease Research Laboratories (VDRL)
        - Purified protein derivative (PPD) test for tuberculosis, preferably with control skin tests treatment.
6. Formal psychiatric assessment, if indicated
7. Determination of patient appropriateness for buprenorphine treatment
    - Diagnosis of opioid-related disorders using *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR)
    - Assessment of common comorbid medical conditions

**Treatment/Management**

**Pharmacological Treatment**

*Maintenance*

1. Buprenorphine/naloxone combination for induction, stabilization, and maintenance phases for most patients
2. Buprenorphine monotherapy for induction phase for patients transferring from long-acting opioids

*Medically-Supervised Withdrawal ("Detoxification")*

1. Buprenorphine/naloxone combination for patients dependent on short-acting opioids
2. Buprenorphine monotherapy or buprenorphine/naloxone combination to taper off long-acting opioids only for patients with evidence of sustained medical and psychosocial stability, in conjunction with opioid treatment program

**Psychosocial Treatment**

1. Drug abuse counseling (individual or group)
2. Self-help programs
3. Patient monitoring to decrease the potential for abuse

**Treatment of Special Populations**

Modified approach to treatment of patients who have certain life circumstances or comorbid medical or behavioral conditions that warrant special consideration, including

- Patients with medical comorbidities
- Pregnant women and neonates
- Adolescents/young adults
- Geriatric patients
- Patients with significant psychiatric comorbidity
- Polysubstance abuse
- Patients with pain
- Patients recently discharged from controlled environments
- Health care professionals who are addicted to opioids

### MAJOR OUTCOMES CONSIDERED

- Abstinence from illicit opioids
- Relapse rate
- Treatment adherence
- Excessive opioid agonist symptoms
- Buprenorphine abuse rate
- Adverse events associated with buprenorphine or buprenorphine/naloxone
- Withdrawal symptoms
- Reduction in opioid positive toxicology specimens
- Reduction in cravings for illicit opioids
- Occurrence of neonatal abstinence syndrome
- Relief of pain

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

## METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic, the Center for Substance Abuse Treatment (CSAT) invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the Treatment Improvement Protocols (TIP). Then recommendations are communicated to a Consensus Panel composed of experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Cochairs) ensures that the guidelines mirror the results of the group´s collaboration.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

External Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of experts reviews the draft document closely (see Appendix J of the original guideline document for a list of field reviewers). The Buprenorphine Expert Panel, a distinguished group of substance abuse experts and professionals in such related fields as primary care, mental health, and social services, worked with the Consensus Panel Chair and the Center for Substance Abuse Treatment Division of Pharmacologic Therapies to generate new and updated changes to the subject matter for this Treatment Improvement Protocol based on the field´s current needs for information and guidance. Once the

changes recommended by the field reviewers have been incorporated, the Treatment Improvement Protocol is prepared for publication, in print and online.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

What follows is the executive summary of the guideline; for more detailed information on the recommendations, please see the original guideline document.

#### Patient Assessment

An approach to the screening, assessment, and diagnosis of opioid addiction problems, and for determining when buprenorphine is an appropriate option for treatment is provided in Chapter 3 of the original guideline document. The necessary first steps in the medical management of opioid addiction are (1) the use of validated screening tools to identify patients who may have an opioid use problem and (2) further assessment to clearly delineate the scope of an opioid addiction problem when one is identified. When treatment is indicated, consideration must be given to the appropriate treatment approach, treatment setting, and level of treatment intensity, based on a patient´s preferences, addiction history, presence of medical or psychiatric comorbidities, and readiness to change. Buprenorphine is a treatment option for many, but not for all.

#### Screening

The Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction Consensus Panel recommends that physicians periodically and regularly screen all patients for substance use and substance-related problems, not just those patients who fit the stereotypical picture of addiction. Several validated addiction or substance use dependence screening instruments are discussed. The full text of selected screening instruments is provided in Appendix B of the original guideline document, Assessment and Screening Instruments.

#### Assessment

If screening indicates the presence of an opioid use disorder, further assessment is indicated to thoroughly delineate the patient´s problem, to identify comorbid or complicating medical or emotional conditions, and to determine the appropriate treatment setting and level of treatment intensity for the patient. Complete assessment may require several office visits, but initial treatment should not be delayed during this period.

The Guidelines document provides recommendations on effective interviewing techniques and on the components of the complete history, physical examination, and recommended initial laboratory evaluation of patients with opioid addiction.

The consensus panel recommends that initial and ongoing drug screening should be used to detect or confirm the recent use of drugs (e.g., alcohol, benzodiazepines, barbiturates), which could complicate patient management.

Urine screening is the most commonly used and generally most cost-effective testing method.

**Diagnosis of Opioid-Related Disorders**

After a thorough assessment of a patient has been conducted, a formal diagnosis can be made. As a general rule, to be considered for buprenorphine maintenance, patients should have a diagnosis of opioid dependence, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR). This diagnosis is based not merely on physical dependence on opioids but rather on opioid addiction with compulsive use despite harm. (See DSM-IV-TR diagnostic criteria in Appendix C of the original guideline document, DSM-IV-TR Material.)

**Determining Appropriateness for Buprenorphine Treatment**

A detailed approach to determining the suitability of buprenorphine as a treatment option for patients with opioid addiction is included in the Guidelines. The evaluation includes determining if appropriate patient motivation exists and ruling out contraindicating medical and psychiatric comorbidities.

Patients for whom buprenorphine may be an appropriate treatment option are those who:

- Are interested in treatment for opioid dependence
- Have no contraindications to buprenorphine treatment
- Can be expected to be reasonably compliant with such treatment
- Understand the benefits and risks of buprenorphine treatment
- Are willing to follow safety precautions for buprenorphine treatment
- Agree to buprenorphine treatment after a review of treatment options

Patients less likely to be appropriate candidates for buprenorphine treatment of opioid addiction in an *office-based setting* are individuals whose circumstances or conditions include

- Comorbid dependence on high doses of benzodiazepines or other central nervous system depressants (including alcohol)
- Significant untreated psychiatric comorbidity
- Active or chronic suicidal or homicidal ideation or attempts
- Multiple previous treatments for drug abuse with frequent relapses (except that multiple previous detoxification attempts followed by relapse are a strong indication for long-term maintenance treatment)
- Poor response to previous treatment attempts with buprenorphine
- Significant medical complications

**Treatment Protocols**

Detailed protocols for the use of buprenorphine in the treatment of opioid addiction are provided in Chapter 4 of the original guideline document. A variety of clinical scenarios are addressed, including whether patients are addicted to long- versus short-acting opioids, and whether the approach selected is

maintenance treatment or medically supervised withdrawal (which must be followed by long-term drug-free or naltrexone treatment to be useful to the patient).

**Maintenance Treatment**

Maintenance treatment with buprenorphine for opioid dependence consists of three phases: (1) induction, (2) stabilization, and (3) maintenance. Induction is the first stage of buprenorphine treatment and involves helping patients begin the process of switching from the opioid of abuse to buprenorphine. The goal of the induction phase is to find the minimum dose of buprenorphine at which the patient discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and no craving for the drug of abuse. The consensus panel recommends that the buprenorphine/naloxone combination be used for induction treatment (and for stabilization and maintenance) for most patients. The consensus panel further recommends that initial induction doses be administered as observed treatment; further doses may be provided via prescription thereafter.

To minimize the chances of precipitated withdrawal, patients who are transferring from long-acting opioids (e.g., methadone, sustained release morphine, sustained release oxycodone) to buprenorphine should be inducted using buprenorphine monotherapy, but switched to buprenorphine/naloxone soon thereafter. Because of the potential for naloxone to precipitate withdrawal, pregnant women who are deemed to be appropriate candidates for buprenorphine treatment should be inducted and maintained on buprenorphine monotherapy.

The stabilization phase has begun when a patient is experiencing no withdrawal symptoms, is experiencing minimal or no side effects, and no longer has uncontrollable cravings for opioid agonists. Dosage adjustments may be necessary during early stabilization, and frequent contact with the patient increases the likelihood of compliance.

The longest period that a patient is on buprenorphine is the maintenance phase. This period may be indefinite. During the maintenance phase, attention must be focused on the psychosocial and family issues that have been identified during the course of treatment as contributing to a patient´s addiction.

**Medically Supervised Withdrawal ("Detoxification")**

Buprenorphine can be used for the medically supervised withdrawal of patients from both self-administered opioids and from opioid agonist treatment with methadone or levo-alpha-acetyl-methadol (LAAM). The goal of using buprenorphine for medically supervised withdrawal from opioids is to provide a transition from the state of physical dependence on opioids to an opioid-free state, while minimizing withdrawal symptoms (and avoiding side effects of buprenorphine).

Medically supervised withdrawal with buprenorphine consists of an induction phase and a dose-reduction phase. The consensus panel recommends that patients dependent on short-acting opioids (e.g., hydromorphone, oxycodone, heroin) who will be receiving medically supervised withdrawal be inducted directly

onto buprenorphine/naloxone tablets. The use of buprenorphine (either as buprenorphine monotherapy or buprenorphine/naloxone combination treatment) to taper off long-acting opioids should be considered only for those patients who have evidence of sustained medical and psychosocial stability, and should be undertaken in conjunction and in coordination with patients´ Opioid Treatment Programs (OTPs).

**Nonpharmacological Interventions**

Pharmacotherapy alone is rarely sufficient treatment for drug addiction. For most patients, drug abuse counseling—individual or group—and participation in self-help programs are necessary components of comprehensive addiction care. As part of training in the treatment of opioid addiction, physicians should at a minimum obtain some knowledge about the basic principles of brief intervention in case of relapse. Physicians considering providing opioid addiction care should ensure that they are capable of providing psychosocial services, either in their own practices or through referrals to behavioral health practitioners in their communities. In fact, DATA 2000 stipulates that when physicians submit notification to the Substance Abuse and Mental Health Services Administration (SAMHSA) to obtain the required waiver to practice opioid addiction treatment outside the OTP setting, they must attest to their capacity to refer such patients for appropriate counseling and other nonpharmacological therapies.

**Treatment Monitoring**

Patients and their physicians together need to reach agreement on the goals of treatment and develop a treatment plan based on the patient´s particular problems and needs. During the stabilization phase, patients receiving maintenance treatment should be seen on at least a weekly basis. Once a stable buprenorphine dose is reached and toxicologic samples are free of illicit opioids, the physician may determine that less frequent visits (biweekly or longer, up to 30 days) are acceptable. During opioid addiction treatment with buprenorphine, toxicology tests for relevant illicit drugs should be administered at least monthly.

**Special Populations**

The approach to patients who have certain life circumstances or comorbid medical or behavioral conditions that warrant special consideration during the assessment and treatment of opioid addiction is discussed in Chapter 5 of the original guideline document.

**Patients With Medical Comorbidities**

Patients who are addicted to opioids often have other medical comorbid problems as a consequence of both high-risk behaviors and of direct toxic effects of the active and inert ingredients in illicit drugs. In patients being treated with buprenorphine for opioid addiction, it is important to screen for and manage common comorbid medical conditions and to anticipate known and potential drug interactions.

**Pregnant Women and Neonates**

The scant evidence available does not show any causal adverse effects on pregnancy or neonatal outcomes from buprenorphine treatment, but this evidence is from case series, not from controlled studies. Methadone is currently the standard of care in the United States for the treatment of opioid addiction in pregnant women. Pregnant women who present for treatment of opioid addiction should be referred to specialized services in methadone maintenance treatment programs. If such specialized services are refused by a patient or are unavailable in the community, maintenance treatment with buprenorphine may be considered as an alternative.

**Adolescents/Young Adults**

Buprenorphine can be a useful option for the treatment of adolescents with opioid addiction problems. The treatment of addiction in adolescents, however, is complicated by a number of medical, legal, and ethical considerations. Physicians intending to treat addiction in adolescents should be thoroughly familiar with the laws in their States regarding parental consent. Physicians who do not specialize in the treatment of opioid addiction should strongly consider consulting with, or referring adolescent patients to, addiction specialists. Additionally, State child protection agencies can be a valuable resource when determining the proper disposition for adolescent patients addicted to opioids.

**Geriatric Patients**

Literature on the use of buprenorphine in geriatric patients is extremely limited. Due to potential differences in rates of metabolism and absorption compared to younger individuals, care should be exercised in the use of buprenorphine in geriatric patients.

**Patients With Significant Psychiatric Comorbidity**

The presence and severity of comorbid psychiatric conditions must be assessed prior to initiating buprenorphine treatment, and a determination made whether referral to specialized behavioral health services is necessary. The psychiatric disorders most commonly encountered in patients addicted to opioids are other substance abuse disorders, depressive disorders, posttraumatic stress disorder, substance-induced psychiatric disorders, and antisocial and borderline personality disorder.

As with medical comorbidities, it is important to explore the medications used to treat the other psychiatric conditions. Assessing for drug interactions is a critical part of the process.

**Polysubstance Abuse**

Abuse of multiple drugs (polysubstance abuse) by individuals addicted to opioids is common. Pharmacotherapy with buprenorphine for opioid addiction will not necessarily have a beneficial effect on an individual´s use of other drugs. Care in the prescribing of buprenorphine for patients who abuse alcohol and for those who abuse sedative/hypnotic drugs (especially benzodiazepines) must be exercised because of the documented potential for fatal interactions.

## Patients With Pain

Physicians may encounter particular complexities with regard to abuse and addiction in the use of opioids to treat patients with pain. Some patients move from needing prescription opioids for the treatment of pain to abusing them. Physicians concerned about this changing diagnostic picture now may legally use an opioid—buprenorphine—to help facilitate a controlled detoxification in order to manage the physical dependence of the patient who no longer has pain that requires an opioid, but who continues to take the opioid for its mood-altering effects.

Patients who need treatment for pain *but not for addiction* should be treated within the context of a medical or surgical setting. They should not be transferred to an opioid maintenance treatment program simply because they have become physically dependent on prescribed opioids in the course of medical treatment.

Patients who *are* being treated for addiction also may experience pain due to illness or injury unrelated to drug use. Pain in patients receiving buprenorphine treatment for opioid addiction should be treated initially with nonopioid analgesics when appropriate.

Patients maintained on buprenorphine whose acute pain is not relieved by nonopioid medications should receive the usual aggressive pain management, which may include the use of short-acting opioid pain relievers. While patients are taking opioid pain medications, the administration of buprenorphine generally should be discontinued. When restarting buprenorphine, to prevent acutely precipitating withdrawal, administration generally should not begin until sufficient time has elapsed for the opioid pain medication to have cleared from the patient´s system, as demonstrated by the onset of early withdrawal symptoms. Patients who are receiving long-acting opioids for chronic severe pain may not be good candidates for buprenorphine treatment because of the ceiling effect on buprenorphine´s analgesic properties.

## Patients Recently Discharged From Controlled Environments

A number of issues should be considered in determining the most appropriate treatment modalities for patients with addiction who are recently released from controlled environments (e.g., prison). Intensive buprenorphine monitoring activities are required, and treating physicians may be called upon to verify and explain treatment regimens (e.g., to parole and probation officers); to document patient compliance; and to interact with the legal system, employers, and others. If an OTP alternative is available, physicians should determine if any patient factors preclude referral.

## Healthcare Professionals Who Are Addicted to Opioids

There is a substantial problem of addiction to prescription opioids among physicians and other health professionals, especially within certain specialties. Prescription opioid addiction in health professionals should be viewed as an occupational hazard of the practice of medicine. Health professionals with substance abuse disorders often require specialized, extended care.

## CLINICAL ALGORITHM(S)

Clinical algorithms are provided in the original guideline document for buprenorphine induction in patients dependent on opioids: days 1–2, day 2 forward, and stabilization phase. Algorithms are also provided for detoxification from short-acting opioids and discontinuation of opioid agonist treatment (OAT) using buprenorphine.

# EVIDENCE SUPPORTING THE RECOMMENDATIONS

## TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

# BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

## POTENTIAL BENEFITS

- Appropriate management of patient opioid withdrawal and maintenance using buprenorphine
- Integration of psychosocial interventions with pharmacological treatment to maximize potential for the successful treatment of opioid addiction, including specialized addiction treatment if necessary
- Appropriate screening for and treatment of comorbid or psychosocial conditions

## POTENTIAL HARMS

- Primary side effects of buprenorphine include nausea, vomiting, and constipation.
- In higher doses, and under certain circumstances, antagonist properties of buprenorphine can cause the precipitation of acute withdrawal if administered to an individual who is physically dependent on opioids and maintained on a sufficient dose of a full agonist.
- Buprenorphine should be used cautiously in patients who are being treated for seizure disorders. When buprenorphine is used concurrently with antiseizure medications (e.g., phenytoin, carbamazepine, valproic acid, and others), metabolism of buprenorphine and/or the antiseizure medications may be altered. (See figure 2–3 of original guideline document.) In addition, the relative risk of interaction between buprenorphine and sedative-hypnotics (e.g., phenobarbital, clonazepam) should be kept in mind. Monitoring for therapeutic plasma levels of seizure medications should be considered.
- Buprenorphine should be used cautiously in combination with human immunodeficiency virus (HIV) antiretroviral medications that may inhibit, induce, or be metabolized by the cytochrome P450 3A4 enzyme system. (See figure 2–3 of original document.) Protease inhibitors inhibit cytochrome P450 3A4. Metabolism of buprenorphine and/or the antiretroviral medications may be altered when they are combined. In some cases, therapeutic blood levels may need to be monitored. Note that this is a caution, not a contraindication.

- Buprenorphine is classified by the Food and Drug Administration (FDA) as a Category C agent. Very few studies exist on the use of buprenorphine in pregnant women. If a patient is pregnant or is likely to become pregnant during the course of treatment with buprenorphine, the physician must consider whether buprenorphine is the appropriate treatment and must weigh the risks and benefits of buprenorphine treatment against all the risks associated with continued heroin or other opioid use.
- Abuse of or dependence on other drugs (e.g., alcohol, cocaine, stimulants, sedative-hypnotics, hallucinogens, inhalants) is common among individuals who are addicted to opioids, and such abuse or dependence may interfere with overall treatment adherence to buprenorphine.
- Epidemiological studies and human laboratory studies indicate that buprenorphine is abusable.
- Overdose of buprenorphine combined with other medications may increase morbidity and mortality.
- Some cases have been reported of respiratory depression induced by buprenorphine in individuals not physically dependent on opioids; in addition, buprenorphine, in combination with other sedative drugs, has been reported to produce respiratory depression.
- Buprenorphine can cause liver toxicity, including elevation of liver enzymes (aspartate aminotransferase (AST) and alanine aminotransferase (ALT).
- There have been case reports of deaths apparently associated with injections of buprenorphine combined with benzodiazepines and/or other central nervous system (CNS) depressants (e.g., alcohol)
- A case of fatal overdose has been reported in which buprenorphine and its metabolites, as well as the metabolites of flunitrazepam, were very high at the time of death.
- In some cases, drugs known to be metabolized by cytochrome P450 3A4 may either enhance or decrease buprenorphine´s effects through actions on the cytochrome P450 3A4 system.

## CONTRAINDICATIONS

### CONTRAINDICATIONS

Several medical conditions and medications, as well as concurrent abuse of other drugs and alcohol, necessitate caution or are relative contraindications to buprenorphine treatment.

#### Hypersensitivity

A history of hypersensitivity to buprenorphine is a contraindication to Subutex® and Suboxone® use. A history of hypersensitivity to naloxone is a contraindication to Suboxone® use.

#### Sedative-Hypnotics

The use of sedative-hypnotics (benzodiazepines, barbiturates, and others) is a relative contraindication to treatment with buprenorphine because the combination (especially in overdose) has been reported to be associated with deaths. The combination of buprenorphine and sedative-hypnotics may increase

depression of the central nervous system. If treatment with buprenorphine and sedative hypnotics is necessary, the doses of both medications may need to be lowered. Physicians must assess for use, intoxication, and withdrawal from sedative-hypnotics. Unfortunately, the use of certain benzodiazepines and other sedatives may not be detected on routine drug screens. Physicians must determine their laboratory´s specific parameters for detection of sedative-hypnotic use.

### Alcohol

Because alcohol is a sedative-hypnotic drug, patients should be advised to abstain from alcohol while taking buprenorphine. Rarely are individuals with active, current alcohol dependence appropriate candidates for office-based buprenorphine treatment. (It may be possible to treat such patients through initial, intensive services that effectively detoxify the patient from alcohol while concurrently starting buprenorphine [e.g., in an inpatient or residential setting].) Patients may present with withdrawal symptoms from other drugs at the same time they are experiencing opioid withdrawal symptoms. Buprenorphine will not control seizures caused by withdrawal from alcohol or other sedative-hypnotic substances. Benzodiazepines and barbiturates, the most commonly used pharmacological treatments for seizures caused by alcohol or other sedative-hypnotic withdrawal, should be used only with caution in combination with buprenorphine because of the increased risk of central nervous system and respiratory depression from the combination.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- The consensus panel notes that these guidelines represent one approach, but not necessarily the only approach, to the treatment of opioid addiction with buprenorphine. The panel considers these guidelines not as inflexible rules that must be applied in every instance, but rather as guidance to be considered in the evaluation and treatment of individual patients. Because each patient is unique, and because scientific knowledge and clinical best practices change over time, the application of these guidelines to the treatment of an individual patient must be informed by the needs of the patient, the changing body of scientific and clinical knowledge, and the clinical judgment of the physician.
- The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), or the Department of Health and Human Services (DHHS). No official support of or endorsement by CSAT, SAMHSA or DHHS for these opinions or for particular instruments, software, or resources described in this document are intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Chapter 6 of the original guideline document presents information on a number of administrative and regulatory issues pertaining to the use of controlled substances in the treatment of opioid addiction that are beyond the general medico-legal responsibilities that govern most other types of medical practice. Physicians should become thoroughly familiar with these issues prior to undertaking the treatment of opioid addiction.

#### The Drug Addiction Treatment Act of 2000 (DATA 2000) Waiver

To practice office-based treatment of opioid addiction under the auspices of Drug Addiction Treatment Act of 2000 (DATA 2000), physicians must first obtain a waiver from the special registration requirements established in the Narcotic Addict Treatment Act of 1974 and its enabling regulations. To obtain a DATA 2000 waiver, a physician must submit notification to Substance Abuse and Mental Health Services Administration (SAMHSA) of his or her intent to begin dispensing and/or prescribing this treatment. The Notification of Intent form must contain information on the physician´s qualifying credentials and must contain additional certifications, including that the physician (or the physician´s group practice) will not treat more than 30 patients for addiction at any one time. Notification of Intent forms can be filled out and submitted online at the SAMHSA Buprenorphine Web site at http://www.buprenorphine.samhsa.gov. Alternatively, the form can be printed out from the site and submitted via ground mail or fax. (The site contains detailed information about buprenorphine, the DATA 2000 paradigm, and the physician waiver process.) Physicians who meet the qualifications defined in DATA 2000 are issued a waiver by SAMHSA and a special identification number by the Drug Enforcement Administration (DEA).

To qualify for a DATA 2000 waiver, physicians must have completed at least 8 hours of approved training in the treatment of opioid addiction or have certain other qualifications as defined in the legislation (e.g., clinical research experience with the treatment medication, certification in addiction medicine) and must attest that they can provide or refer patients to the necessary, concurrent psychosocial services. The consensus panel recommends that all physicians who plan to practice opioid addiction treatment with buprenorphine attend a DATA 2000qualifying 8-hour training program on buprenorphine. SAMHSA maintains a list of upcoming DATA 2000-qualifying buprenorphine training sessions on the SAMHSA Buprenorphine Web site. Additional information about DATA 2000 and buprenorphine also can be obtained by contacting the SAMHSA Buprenorphine Information Center by phone at 866-BUP-CSAT (866-287-2728) or via e-mail at info@buprenorphine.samhsa.gov.

#### Preparing for Office-Based Opioid Treatment

Prior to embarking on the provision of office-based addiction treatment services, medical practices that will be new to this form of care should undertake certain preparations to ensure the highest quality experience for patients, providers, and staff. Providers and practice staff should have an appropriate level of training,

experience, and comfort with opioid addiction treatment. Linkages with other medical and mental health professionals should be established to ensure continuity of treatment and the availability of comprehensive, community-based, psychosocial services.

**Privacy and Confidentiality**

The privacy and confidentiality of individually identifiable drug or alcohol treatment information is protected by SAMHSA confidentiality regulation Title 42, Part 2 of the Code of Federal Regulations (42 C.F.R. Part 2). This regulation mandates that addiction treatment information in the possession of substance abuse treatment providers be handled with a greater degree of confidentiality than general medical information. Among other stipulations, regulation 42 C.F.R. Part 2 requires that physicians providing opioid addiction treatment obtain signed patient consent before disclosing individually identifiable addiction treatment information to any third party. The requirement for signed patient consent extends to activities such as telephoning or faxing addiction treatment prescriptions to pharmacies, as this information constitutes disclosure of the patient´s addiction treatment. A sample consent form with all the elements required by 42 C.F.R. Part 2 is included as Appendix D of the original guideline document, Consent to Release of Information Under 42 C.F.R. Part 2.

**Buprenorphine Use in Opioid Treatment Programs (OTPs)**

In May 2003, the Federal OTP regulations (42 C.F.R. Part 8) were amended to add Subutex® and Suboxone® to the list of approved opioid medications that may be used in federally certified and registered OTPs (i.e., methadone clinics). OTPs that choose to use Subutex® and Suboxone® in the treatment of opioid addiction must adhere to the same Federal treatment standards established for all medications under 42 C.F.R. Part 8.

## IMPLEMENTATION TOOLS

Clinical Algorithm

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better
Living with Illness

### IOM DOMAIN

Effectiveness
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Center for Substance Abuse Treatment. Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2004. 171 p. (Treatment improvement protocol; no. TIP 40).

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2004

### GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

### SOURCE(S) OF FUNDING

United States Government

### GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 40 Consensus Panel

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Panel Members*: Laura McNicholas, MD, PhD (*Chair*) Clinical Assistant Professor, Department of Psychiatry, University of Pennsylvania Treatment Research Center, Philadelphia, Pennsylvania; Tony Aguilar, LMFT, Legislative Consultant, California Department of Social Services, Sacramento, California; Daniel Alford, MD, MPH, Association for Medical Education and Research in Substance Abuse (AMERSA), Assistant Professor of Medicine, Boston University School of Medicine, Clinical Addiction Research and Education Unit, Boston, Massachusetts; Catherine T. Baca, MD, Clinical Supervisor, Center for Alcoholism, Substance Abuse and Addictions, Albuquerque, New Mexico; Thomas J. Croce, Jr., RPh, Senior Manager, Strategic Alliances, American Pharmaceutical Association, Philadelphia, Pennsylvania; George De Leon, PhD, Director, Center for Therapeutic Community Research of The National Development and Research Institutes, New York, New York; Elizabeth F. Howell, MD, Senior Medical Editor, Atlanta, Georgia; Martin Iguchi, PhD, Senior Behavioral Scientist, Director, Drug Policy Center, Rand Corporation, Santa Monica, California; Herbert D. Kleber, MD, Professor of Psychiatry, Director, The Division on Substance Abuse, Columbia University, New York, New York; Ervin Lewis, MD, Area Chief Medical Officer, Albuquerque Area Indian Health Service, Albuquerque, New Mexico; James J. Manlandro, DO, Medical Director,

Family Addiction Treatment Services, Rio Grande, New Jersey; Andrew Saxon, MD, Professor, Department of Psychiatry and Behavioral Sciences, University of Washington, Center of Excellence in Substance Abuse Treatment and Education, VA Puget Sound Health Care System, Seattle, Washington; Charles R. Schuster, PhD, Professor, Department of Psychiatry and Behavioral Neuroscience, Wayne State University School of Medicine, Detroit, Michigan; Audrey Sellers, MD, Medical Director, Bay Area Addiction Research and Treatment, Inc., San Francisco, California; Jann B. Skelton, RPh, MBA, Vice President, U.S. Wellness, Inc.; Gaithersburg, Maryland; David E. Smith, MD, President and Founder, Haight Ashbury Free Clinic, San Francisco, California; Eric C. Strain, MD, Professor, Johns Hopkins University School of Medicine, Baltimore, Maryland; Joycelyn Woods, MA, President, National Alliance of Methadone Advocates, New York, New York

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site. Also available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

## AVAILABILITY OF COMPANION DOCUMENTS

None available

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI on October 21, 2004. The information was verified by the guideline developer on November 19, 2004.

## COPYRIGHT STATEMENT

No copyright restrictions apply.

## DISCLAIMER

### NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 10/13/2008