Tennessee Nonresidential Buprenorphine Treatment Guidelines
December 21st, 2017

Dear Friends and Colleagues,

We are pleased to share with you the Tennessee Nonresidential Buprenorphine Treatment Guidelines (Guidelines) for 2018. In April 2017, when Public Chapter 112 was enacted directing the development of these Guidelines, there was widespread acknowledgement of the need for these treatment Guidelines due to the growing prevalence of individuals who have an opioid use disorder, an increased number of individuals using medication-assisted treatment with buprenorphine, and diversion issues associated with buprenorphine. Opioid use disorder is a chronic, relapsing disease and the use of medication-assisted treatment with buprenorphine has been proven to be a valuable tool in treating those with this disorder when used appropriately.

We joined with other Tennessee policymakers, health experts, and other interested members of the public, in order to develop a comprehensive strategy to help providers treat opioid use disorder using products containing buprenorphine. We understand this is a complex disorder and requires collaboration and partnership at every level. We hope through education, we can assist providers in helping patients. These treatment Guidelines are a very important iterative first step. As we learn more and as the evidence continues to be developed, undoubtedly we will need to make changes in the Guidelines to improve their effectiveness.

We would like to extend a special thanks to all of those involved in assisting with creating these Guidelines (See Page 3). Your time and commitment to this project was invaluable and resulted in an immense contribution to the development of these Guidelines.

As we continue to move forward, we will need your continued partnership. Through conscientious and responsible prescribing, providing therapy, screening for communicable diseases, discussing methods to prevent unintended pregnancy, and screening for additional substance use or mental health disorders; providers can partner with patients to achieve the best quality of care possible. We recommend providers using buprenorphine-containing products to treat those with an opioid use disorder in a nonresidential setting closely regard these Guidelines and incorporate them into your practice to ensure all patients are equipped with the tools necessary to engage and thrive in their recovery.

Sincerely,

Marie Williams, LCSW
Commissioner
TDMHSAS

Dr. John Dreyzehner, MD, MPH, FACOEM
Commissioner
TDH
The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) would like to extend special thanks to the members of Buprenorphine Treatment Guidelines Committee for the time and effort they put forth in developing these Guidelines on behalf of the organizations they represented. Members of the Buprenorphine Treatment Guidelines Workgroup are denoted by asterisks.

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Additional thanks goes to the following individuals for their contributions to these Guidelines.

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AN ACT to amend Tennessee Code Annotated, Title 63, Chapter 1, relative to treatment guidelines for the nonresidential use of buprenorphine.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 63, Chapter 1, Part 4, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Commissioners" means the commissioner of mental health and substance abuse services and the commissioner of health; and

(2) "Nonresidential buprenorphine treatment guidelines" means systematically developed standards to assist any practitioners authorized by the state to prescribe buprenorphine-containing products for the treatment of opioid use disorder as defined in the latest version of the Diagnostic and Statistical Manual of Mental Disorders.

(b)(1) By January 1, 2018, the commissioner of mental health and substance abuse services, in collaboration with the commissioner of health, shall develop recommended nonresidential treatment guidelines for the use of buprenorphine that can be used by prescribers in this state as a guide for caring for patients. This subsection (b) shall only apply to practitioners prescribing buprenorphine-containing products for the treatment of opioid use disorder in a nonresidential setting. The guidelines must be consistent with applicable state and federal laws.
(2) Guidelines from nationally recognized organizations, such as the American Society of Addiction Medicine, Substance Abuse and Mental Health Services Administration, and the American Board of Preventative Medicine, must serve as resources in the development of guidelines under this section.

(3) The commissioner of mental health and substance abuse services shall consult with appropriate physicians, alcohol and substance abuse counselors, and other experts to serve as resources in the development of guidelines under this section.

(c) Beginning in 2019, the commissioners shall review the nonresidential buprenorphine treatment guidelines by September 30 of each year and shall cause these guidelines to be posted on both the department of mental health and substance abuse services and the department of health's websites.

(d)(1) The commissioner of mental health and substance abuse services shall submit the nonresidential buprenorphine treatment guidelines to each health-related board that licenses any practitioner authorized by the state to prescribe buprenorphine-containing products for the treatment of an opioid use disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders and to the board of pharmacy.

(2) Each board shall review the nonresidential buprenorphine treatment guidelines and determine how the nonresidential buprenorphine treatment guidelines should be used by that board's licensees.

(3) Each board shall post the nonresidential buprenorphine guidelines and standards on the licensing board's website.

(e) The commissioner of mental health and substance abuse services shall provide a copy of any guidelines developed pursuant to this section and any revision to those guidelines developed pursuant to this section to the chairs of the health committee of the house of representatives and the health and welfare committee of the senate at the time the guidelines or the revisions are posted on websites of the department of mental health and substance abuse services and the department of health.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.
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These Guidelines are intended for providers using buprenorphine-containing products in a nonresidential setting. These Guidelines are not meant to dictate medical decision making. They are Guidelines of generally accepted medical practice rather than absolutes. Providers still have flexibility to deal with exceptional cases. Occasional deviation from these Guidelines for appropriate medical reasons is to be expected and documented.
A. ASSESSMENT AND DIAGNOSIS

1. All prospective patients must present valid identification (i.e. driver’s license, state-issued identification, etc.).

2. All prospective patients must be given an assessment to determine eligibility for treatment, to provide the basis for a treatment plan, and to establish a baseline measure for use in evaluating a patient’s response to treatment. Accordingly, the assessment should be designed to achieve the following:
   a. Establish and document that the prospective patient meets the diagnosis of opioid use disorder (See APPENDIX B), including the duration, pattern, and severity of opioid misuse; the patient’s level of tolerance; results of previous attempts to discontinue opioid use; past experience with agonist therapies; the nature and severity of previous episodes of withdrawal; and the time of last opioid use and current withdrawal status (See APPENDIX C as an example).
   b. Document the prospective patient’s use of non-opioid substances, including alcohol, and incorporate how the use of those substances will be managed into the treatment plan.
   c. Document the prospective patient’s process addictions, if any, and document how they can interfere with the prospective patient’s recovery from substance use.
   d. Assess comorbid medical and psychiatric conditions and disorders and to determine how, when, and where they will be addressed.
   e. Screen prospective patient for communicable diseases and address them as needed.
   f. Evaluate the prospective patient’s level of physical, psychological, and social functioning or impairment.
   g. Assess the prospective patient’s social supports, such as, family and friends, employment status, housing status, financial status, and any legal issues.
   h. Determine the prospective patient’s readiness to participate in treatment (See APPENDIX D.1 as an example).
   i. Determine the prospective patient’s wishes with respect to pregnancy.

3. The Controlled Substance Monitoring Database (CSMD) shall be checked prior to initiating buprenorphine treatment for all prospective patients. This check shall be documented.

4. The provider shall obtain a drug test for the prospective patient prior to initiating buprenorphine treatment and the results of this test shall be documented.

B. PATIENT SELECTION

1. Buprenorphine treatment may be appropriate for individuals meeting the following:
   a. Interested in opioid use disorder treatment (See Appendix D.1 as an example).
   b. Agreeable to buprenorphine treatment after reviewing treatment options.
   c. Demonstrates a willingness to follow buprenorphine treatment contract/agreement.
   d. Demonstrates a willingness to adhere to the treatment plan.
   e. Demonstrates no contraindications to buprenorphine treatment.
   f. Demonstrates an understanding of risks and benefits of buprenorphine treatment and other treatment options.
2. In cases where it is determined that buprenorphine treatment is not appropriate for, or agreeable to, the prospective patient, they shall be offered referral information regarding other forms of treatment.

3. Prospective patients who are pregnant may be given special consideration in the admissions process where applicable.

C. CONSENT TO RELEASE INFORMATION

1. Where applicable, the provider shall obtain informed consent to release information in order to ensure continuity of care. When applicable, the treating provider will consult with the patient’s other healthcare providers to ensure continuity of care and that the other providers are aware of the patient’s current treatment plan.
   a. Required elements of an informed consent to release of information document include:
      i. Person or entity permitted to make disclosure;
      ii. Person or entity to which the disclosure will be made;
      iii. Patient name;
      iv. Purpose of disclosure;
      v. Nature of the information to be disclosed;
      vi. Signature of patient;
      vii. Date on which the informed consent to release information document is signed;
      viii. Statement that the patient’s informed consent to release information can be revoked at any time except to the extent that the program has already acted on it; and
      ix. Date, event, or condition upon which the patient’s informed consent to release information will expire if not previously revoked.

2. See APPENDIX H for sample consent to release information document.

D. CONSENT TO TREATMENT

1. Except as otherwise authorized by law, no person shall be admitted for treatment without written consent from the patient and, if applicable, parent, guardian, or responsible party. When applicable, the treating provider will consult with the patient’s other healthcare providers to ensure continuity of care and that the other providers are aware of the patient’s current treatment plan. A documented, voluntary, written, program-specific informed consent to treatment from each patient at admission should include:
   a. Information about all treatment procedures, services, and other policies and regulation throughout the course of treatment, including clinic charges in the form of a fee agreement signed by the patient.
      i. This fee agreement should include an explanation of the financial aspects of treatment and the consequences of nonpayment of required fees, including the procedures for the patient (or patient’s legal representative) in the event they are unable to pay for treatment.
   b. Consent to the individualized, prescribed therapy before dosing begins, including information about potential interactions with and adverse reactions to other substances, including those reactions that might result from interactions and adverse reactions to alcohol, other prescribed or over-the-counter pharmacological agents, other medical procedures, and food.
c. Information regarding the possible risks of therapy and potential side effects, including potentially life-threatening drug interactions. See Subsection F below regarding requirements for benzodiazepine co-prescribing.

d. Information to each patient that the goal of opioid treatment is stabilization of functioning.

e. Acknowledgement that the patient has been informed of the provider’s rules regarding patient conduct and responsibilities, including policies regarding diversion mitigation and non-adherence to treatment plan.

f. Acknowledgement that the patient has been informed of his or her rights.

g. Information that at regular intervals, in full consultation with the patient, the program should discuss the patient's present level of functioning, course of treatment, and future goals.

h. Information that the patient may choose to withdraw from or be maintained on the medication as he or she desires unless medically contraindicated.

i. Acknowledgement of informed consent between provider and patient regarding the risk of an infant developing neonatal abstinence syndrome (NAS) while the mother is taking buprenorphine. This informed consent shall be signed by the patient and provider and documented in the patient’s medical record. The provider shall discuss the risk of developing NAS with the patient prior to signing. See Subsection E below regarding required elements for consent to treatment regarding pregnancy and NAS prevention.

j. Acknowledgement that women of child-bearing age and ability will provide a serum or observed urine pregnancy test upon initial visit.

2. See APPENDIX G for sample buprenorphine consent to treatment form.

E. Required Elements for Consent to Treatment Regarding Pregnancy and NAS Prevention

1. The provider should discuss a method to prevent unintended pregnancy with every woman of child-bearing age and ability before buprenorphine is initiated.

2. The provider should obtain a signature indicating that any woman who wishes to become or is at risk to become pregnant has been educated about the risks of opioid use, as well as, the risks and benefits of buprenorphine treatment during her pregnancy.

3. Women of child-bearing age and ability shall provide a serum or observed urine pregnancy test to determine pregnancy prior to receiving treatment initiation.

4. Women of child-bearing age and ability should be tested monthly for pregnancy and must be asked about the possibility of pregnancy at each visit and information from such an inquiry shall be documented in the patient’s chart. For women who wish to avoid unintended pregnancy, use of voluntary, reversible, long-acting contraception (VRLAC) shall be discussed, and, if after discussion, VRLAC is desired by the patient, the VRLAC service will be provided, or referral to appropriate VRLAC provider made.
F. Requirements for Benzodiazepine Co-Prescribing

1. Benzodiazepines should only be prescribed to a patient after careful evaluation while utilizing caution and good judgement. Benzodiazepines may be prescribed to a patient on buprenorphine or a buprenorphine and naloxone combination under the following conditions:

   a. Benzodiazepines should not be initiated with a patient with opioid use disorder or the disease of addiction who has never been prescribed these products or has a history of misusing or abusing these products.

   b. Patients who present with a longstanding prescription for benzodiazepines for a legitimate medical condition from another prescriber may be prescribed buprenorphine products by a physician with a DATA 2000 waiver. Contact should be initiated with the prescriber of the benzodiazepine to coordinate care and clear documentation should be recorded in the patient’s medical record.

   c. A provider may assume management of a patient’s benzodiazepine prescribing from another provider if the patient is willing to initiate a program of tapering.

   d. If a patient presents with a dual diagnosis of opioid use disorder and a clear history of benzodiazepine use disorder, the duration and extent of the abuse should be clearly documented in the medical record. A provider may prescribe a long acting benzodiazepine, such as clonazepam or its equivalent, under the following conditions:

   i. A patient may continue on benzodiazepine therapy as medically indicated as long as there is an ongoing effort to taper the patient to the lowest effective dose in order to prevent benzodiazepine withdrawal syndrome and clear documentation of this effort is made in the patient’s medical record.

      1) Prescribing more than two (2) milligrams of clonazepam or its equivalent daily is considered “high dose therapy”.

      2) Patients receiving high dose therapy should have justification for the dosing clearly documented in the patient’s medical record.

      3) Patients receiving high dose therapy should be tapered as rapidly as possible to two (2) milligrams or less of clonazepam or its equivalent daily, and if the taper is unsuccessful, the reason(s) shall be clearly documented in the patient’s medical record.

      4) Patients receiving high dose therapy for a period of longer than six (6) weeks shall be managed by a physician who is board certified in addiction medicine or who is board certified or fellowship trained in addiction psychiatry, or by a physician with a DATA 2000 waiver who has obtained a formal consult from a physician who is board certified in addiction medicine or who is board certified or fellowship trained in addiction psychiatry. The formal consult shall be clearly documented in the patient’s medical record.
Section II

Initiating Treatment
A. INDICATIONS FOR BUPRENORPHINE WITHOUT NALOXONE

1. Buprenorphine with naloxone product formulations are the treatment of choice for all patients except those who are pregnant, nursing, or have a documented adverse reaction or hypersensitivity to naloxone.
   a. An adverse reaction or hypersensitivity to a buprenorphine with naloxone product is rare. If a provider is prescribing buprenorphine without naloxone, due to adverse reaction or hypersensitivity, to more than 5% of their patients receiving a buprenorphine-containing product, the provider should reevaluate his/her practice habits and may be subject to review by the Boards of Medical Examiners or Osteopathic Examination. All patients receiving buprenorphine without naloxone shall have proper justification documented in the patient’s medical record.
   b. The consensus of the Buprenorphine Treatment Guidelines Committee is that the risks associated with buprenorphine, either with or without naloxone, are similar in nursing mothers and the prescriber should provide clear documentation for justifying the use of buprenorphine without naloxone to a nursing mother for more than 3 months.
   c. If the prescriber of buprenorphine without naloxone is treating a patient that is pregnant or nursing and is not the patient's obstetrical or gynecological provider, the prescriber shall consult with the patient's obstetrical or gynecological provider to the extent possible to determine whether the prescription is appropriate for the patient.

B. SELECTING A THERAPY

1. When to start buprenorphine, whether with or without naloxone.
   a. Patient will likely feel he/she is in early stages of withdrawal. Prescriber may consider suggesting that the patient return during opioid withdrawal.
   b. Dosage should be titrated based on an opioid withdrawal assessment, such as COWS score (See APPENDIX C).

2. Detoxification or medically supervised withdrawal can be used for patients on self-administered opioids as well as patients in opioid agonist treatment (e.g., methadone treatment). Patient dependence on short-acting or long-acting opioids should be considered in determining if detoxification will involve direct induction or buprenorphine tapering (See APPENDIX I).
   a. Patients converting from methadone to buprenorphine may require referral to, or consultation with, a physician board-certified in addiction medicine.

C. GENERAL DOSING GUIDELINES

1. For offices offering in-office induction: Induction should be conducted according to standards established by the American Society of Addiction Medicine and using the buprenorphine-containing product package insert (See APPENDIX I). Target buprenorphine dose range should be 6 mg to 12 mg (or equivalent) per day (See APPENDIX O).
D. PATIENT MANAGEMENT

1. Assessment of a patient
   a. An assessment of a patient shall include documentation of a physical exam by an appropriate provider (See APPENDIX J as an example).
   b. Patient shall receive communicable disease screening upon admission. If a practice does not have the proper resources to administer a disease screening, patients should be sent to the local health department (This is a mandatory referral).
      i. If risk factors are present, disease screening should, at a minimum, screen for the following: Tuberculosis, Hepatitis C, HIV, and STDs.
   c. An assessment of a patient shall include an evaluation of the need for trauma-informed care, including obtaining an Adverse Childhood Experiences (ACEs) score (See APPENDIX M).

2. Provider shall obtain a signed individualized treatment plan upon initiation of treatment, which shall be documented in the patient’s medical record.

3. Counseling
   a. See APPENDIX A for the definitions of a qualified provider.
   b. Counseling is essential and a qualified provider should determine the best counseling option for each individual patient based upon the patient's history and assessments, agreement of the patient, and the goals of the patient's individualized treatment plan (See APPENDIX N).
   c. The provider shall be responsible for determining and documenting that each patient is receiving counseling and that each patient is progressing towards meeting the goals listed in their individualized treatment plan. The provider should review and modify the individualized treatment plan if it is determined that a patient is not following through with counseling referrals.
   d. If the provider utilizes their own staff to provide counseling, staff should be sufficient in number and in training to:
      i. Allow for adequate:
         1) Psychosocial assessment;
         2) Treatment planning; and
         3) Individualized counseling.
      ii. Allow for regularly scheduled counseling sessions (See Subsection A of Section III); and
      iii. Allow patients access to their counselor if more frequent contact is merited by need or is requested by the patient.
   e. For providers referring patients for counseling, the provider should provide the patient, with the patient's consent, a list of available licensed treatment providers in the community and assist the patient in receiving these services by offering to make appointments on the patient's behalf and by coordinating care.
Section III

Ongoing Treatment
A. MAINTENANCE TREATMENT

Maintenance treatment consists of 3 phases: 1) induction, 2) stabilization, and 3) maintenance.

1. A patient in the induction or stabilization phases of treatment should:
   a. Have weekly scheduled office visits;
   b. Receive appropriate counseling sessions at least twice a month;
   c. Be subject to one (1) observed drug screen at least weekly; and
   d. Receive case management services weekly.

2. A patient in the maintenance phase of treatment for less than one (1) year should:
   a. Have a scheduled office visit at least every two (2) to four (4) weeks;
   b. Receive counseling sessions at least monthly;
   c. Be subject to a random observed drug screen at least twelve (12) times annually; and
   d. Receive case management services at least monthly.

3. A patient in the maintenance phase of treatment for one (1) year or more should:
   a. Have a scheduled office visit at least every two (2) months
   b. Receive counseling sessions at least monthly;
   c. Be subject to a random observed drug screen at least eight (8) times annually; and
   d. Receive case management services at least monthly.

4. The prescriber should document the patient’s current phase of treatment in the patient’s medical record. Changes in the patient’s phase of treatment should also be documented in the patient’s medical record.

B. MONITORING PARAMETERS

1. Providers, or their designated healthcare practitioner extenders, should check the CSMD at each patient visit and documentation of each such check should be made in each patient’s medical record. When checking the CSMD, providers should be cognizant of checking a patient’s prescription history in neighboring states.

2. Laboratory Monitoring
   a. Drug testing procedures should follow the American Society of Addiction Medicine’s “Appropriate Use of Drug Testing in Clinical Addiction Medicine.”
      i. See https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing
   b. Monthly serum or observed urine pregnancy test for women of child-bearing age and ability.

C. TAPERING TREATMENT

1. A provider shall weigh the risk of relapse with the benefit of tapering off of buprenorphine.

2. Similar to other disease states, tapering from the treatment medication shall only occur when clinically appropriate and in agreement with the patient. Tapering schedules and durations are patient specific.
D. RELAPSE INDICATORS

1. Patient may be in danger of relapse if any of the following occur:
   a. Patient is not adherent to buprenorphine as prescribed.
   b. Patient is still living in or around the “people, situations, places, and things” that were previously linked to poor behavior, specifically illicit drug use, and can sometimes include home environment.
   c. Patient is not engaged in a “recovery program” (e.g., as may be done through 12-step program, etc.), a sufficient support system, and/or is not using his/her recovery program and/or support system adequately.
   d. Patient displays difficulties managing stress.
   e. Patient inadequately manages and/or displays symptoms of an undiagnosed co-occurring mental disorder.
   f. Patient displays symptoms of untreated behavioral addictions (e.g., codependency, sex, gambling).
   g. Patient displays inadequate development of coping skills for triggers and cravings.
   h. Patient displays need for more intensive ancillary treatment (e.g., intensive outpatient counseling or treatment).
   i. Patient displays insufficient motivation for change or is not suitable for treatment with buprenorphine for a variety of reasons (This should be essentially a diagnosis of exclusion).
   j. The treating provider receives information from other healthcare sources (i.e. other physicians, pharmacists, etc.) regarding a patient’s non-adherence with treatment.
Section IV

Appendices
APPENDIX A – Definitions

Source: Adapted from TDMHSAS Rule Chapter 0940-05-35: Minimum Program Requirements for Nonresidential Office-Based Opiate Treatment Facilities.

1. “Buprenorphine” means a semi-synthetic opioid.

2. “Case Management/Care Coordination” means a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

3. “Controlled Substance Monitoring Database” or “CSMD” means a program administered by the Tennessee Department of Health to monitor the prescribing and dispensing of Schedule II, III, IV and V controlled substances as set forth by T.C.A. Title 53, Chapter 10, Part 3.

4. “Counseling” or “Counseling Session” means a face-to-face individual therapeutic counseling session lasting not less than twenty (20) minutes with a qualified provider, or a group educational session of no more than twenty (20) patients and lasting not less than fifty (50) minutes facilitated by a qualified provider. Counseling shall be focused on issues related to the patient’s opioid use disorder and shall not include discussions related to administrative procedures. Telehealth, pursuant to the Tennessee Code Annotated, may be utilized to facilitate counseling. Attendance of a 12-step program, such as Narcotics Anonymous, shall not be considered counseling. The provider shall document each counseling session in the patient’s medical chart.

5. “DATA 2000 Waiver” means the registered authority given to a qualified health care professional by the U.S. Drug Enforcement Administration to prescribe FDA-approved narcotic medication for opioid detoxification or maintenance treatment pursuant to 21 U.S.C. §823(g).

6. “DEA” means the United States Drug Enforcement Administration.

7. “Detoxification” or “Detoxification Treatment” means the dispensing of an opioid agonist treatment medication in decreasing doses to the patient to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or substantial use of an opioid drug and as a method of bringing the patient to a drug-free state within that period.

8. “FDA” means the United States Food and Drug Administration.

9. “Medical Record” or “Medical Chart” means medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations and other written electronics, or graphic data prepared, kept, made or maintained in a facility that pertains to services rendered to patients.

10. “Opiate/Opioid” means a drug that contains opium, derivatives of opium, or any of several semi-synthetic or synthetic drugs with agonist activity at the opioid receptor.
11. “Observed Drug Screen” or “Observed Urine Drug Screening” means a test used to determine the presence of illicit drugs in an individual’s body conducted by and in the presence of medical or lab staff or contracted medical or lab staff so as to ensure against the tampering with or falsification of the results.

12. “Patient” shall refer to an individual receiving treatment for opioid use disorder by a licensed provider.

13. “Phases of Treatment” means the induction, stabilization, and maintenance phases associated with office-based opioid treatment as described in the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: A Treatment Intervention Protocol published by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Treatment (CSAT).

14. “Qualified Provider” means a qualified mental health professional as defined in T.C.A. § 33-1-101(20), qualified alcohol and drug abuse treatment personnel as defined in TDMHSAS Rule Chapter 0940-05-01-.16(7), or treatment staff operating under the direct supervision of either a qualified mental health professional or qualified alcohol and drug abuse treatment personnel.

15. “Relapse” means a process in which an individual who has established abstinence or sobriety experiences a recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors.

16. “Treatment” or “Substance Abuse Treatment” means a broad range of services intended to assess status, reduce symptoms, or mitigate the effects of substance misuse, substance use disorders, or co-occurring disorders; reduce risk of relapse and associated harm; or restore or establish well-being for individuals and families; provided, that said practice may include, but not be limited to, care coordination, case management, medical, pharmacological, psychological, psycho-educational, rehabilitative or social services and therapies. The overall goals are to eliminate the substance abuse as a contributing factor to physical, psychological, and social dysfunction and to arrest or reverse the progress of any associated problems.

17. “Treatment program” or “Substance Abuse Treatment Program” means an organized system of services containing a mission, philosophy, and model of substance use disorder treatment designed to address the needs of clients.
**APPENDIX B - DSM-5 Diagnosis Chart for Opioid Use Disorder**

*Source: Adapted from DSM-5*

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>Meets criteria?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids taken over a longer time period than was intended and/or in larger amounts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsuccessful efforts or persistent desire to cut down or control opioid use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great deal of time spent in activities necessary to obtain or use the opioid or recover from its effects.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong desire or urge (craving) to use opioids.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use resulting in a failure to fulfill major role obligations at home, school, or work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued opioid use despite recurrent or persistent interpersonal or social problems exacerbated by the substance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Important social, recreational, or occupational activities reduced or given up because of opioid use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use in situations in which it is physically hazardous.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued opioid use despite knowledge of recurrent or persistent psychological or physical problem that is likely to have been exacerbated or caused by the substance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerance*, defined by markedly diminished effect with continued use of same amount of an opioid or need for markedly increased amounts of opioids to achieve desired effect or intoxication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal*, manifested by opioids (or closely related substance) taken to avoid or relieve withdrawal symptoms or characteristic opioid withdrawal syndrome.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Illness Severity**

<table>
<thead>
<tr>
<th>Number of Symptoms</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>6+</td>
<td>4-5</td>
<td>2-3</td>
</tr>
</tbody>
</table>
APPENDIX C - Clinical Opiate Withdrawal Scale (COWS)


<table>
<thead>
<tr>
<th>Resting Pulse Rate:</th>
<th>DATE/TIME:</th>
<th>DATE/TIME:</th>
<th>DATE/TIME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(record beats per minute) Measured after patient is sitting/lying for one minute.</td>
<td>0 pulse rate 80 or below</td>
<td>1 pulse rate 81-100</td>
<td>2 pulse rate 101-120</td>
</tr>
<tr>
<td>Sweating: Over past 1/2 hour not accounted for by room temperature or patient activity.</td>
<td>0 no report of chills of flushing</td>
<td>1 one subjective report of chills or flushing</td>
<td>2 flushed or observable moisture on face</td>
</tr>
<tr>
<td>Restlessness: Observation during assessment</td>
<td>0 able to sit still</td>
<td>1 report difficulty sitting still, but is able to do so</td>
<td>2 frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>Pupil Size:</td>
<td>0 pupils normal or normal size for room light</td>
<td>1 pupils possibly larger than usual for room light</td>
<td>2 pupils moderately dilated</td>
</tr>
<tr>
<td>Bone or Joint Aches: If patient was having pains previously, only the additional component attributed to opiate withdrawal is scored.</td>
<td>0 not present</td>
<td>1 mild diffuse discomfort</td>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>Runny nose or tearing: Not accounted for by cold symptoms or allergies.</td>
<td>0 not present</td>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td>2 nose running or tearing</td>
</tr>
<tr>
<td>GI Upset: Over last 1/2 hour</td>
<td>0 no GI symptoms</td>
<td>1 stomach cramps</td>
<td>2 nausea or loose stools</td>
</tr>
<tr>
<td>Tremor: Observation of outstretched hands</td>
<td>0 no tremor</td>
<td>1 tremor can be felt, but not observed</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>Yawning: Observation during assessment</td>
<td>0 no yawning</td>
<td>1 yawning once or twice during assessment</td>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>Anxiety or Irritability</td>
<td>0 none</td>
<td>1 patient reports increasing irritability or anxiety</td>
<td>2 patient obviously irritable, anxious</td>
</tr>
<tr>
<td>Gooseflesh skin</td>
<td>0 skin is smooth</td>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
<td>5 prominent piloerection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Total Score</strong></th>
<th><strong>Observers Initials</strong></th>
<th><strong>Blood Pressure/Pulse</strong></th>
<th><strong>Dose of Buprenorphine/naloxone Given</strong></th>
</tr>
</thead>
</table>

Note: Give first dose when COWS score ≥ 7

Score:
- 5-12 = MILD
- 13-24 = MODERATE
- 25-36 = MODERATELY SEVERE
- More than 36 = SEVERE WITHDRAWAL
INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I really want to make changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Sometimes I wonder if I am an addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. If I don't change my drug use soon, my problems are going to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I have already started making some changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I was using drugs too much at one time, but I’ve managed to change that.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Sometimes I wonder if my drug use is hurting other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I have a drug problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I’m not just thinking about changing my drug use; I’m already doing something about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I have serious problems with drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Sometimes I wonder if I am in control of my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My drug use is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drug problems that I had before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know that I have a drug problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. There are times when I wonder if I use drugs too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I am a drug addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I am working hard to change my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX D.2. - SOCRATES Scoring Form - 19-Item Versions 8.0  
Source: TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment. SAMHSA

SOCRATES Scoring Form - 19-Item Versions 8.0
Transfer the client’s answers from questionnaire (see note below):

<table>
<thead>
<tr>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ______</td>
<td>2 ______</td>
<td>4 _____</td>
</tr>
<tr>
<td>3 ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 _____</td>
<td>6 _____</td>
<td>8 _____</td>
</tr>
<tr>
<td>7 _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 _____</td>
<td>11 _____</td>
<td>13 _____</td>
</tr>
<tr>
<td>10 _____</td>
<td></td>
<td>18 _____</td>
</tr>
<tr>
<td>12 _____</td>
<td></td>
<td>19 _____</td>
</tr>
<tr>
<td>14 _____</td>
<td>16 _____</td>
<td></td>
</tr>
<tr>
<td>15 _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>Re _______</td>
<td>Am ________</td>
</tr>
</tbody>
</table>

Possible Range:  
7-35  4-20  8-40

INSTRUCTIONS: From the SOCRATES Scoring Form (19-Item Version) transfer the total scale scores into the empty boxes at the bottom of the Profile Sheet. Then for each scale, CIRCLE the same value above it to determine the decile range.

<table>
<thead>
<tr>
<th>DECILE SCORES</th>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 Very High</td>
<td>19-20</td>
<td>39-40</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>18</td>
<td>37-38</td>
<td></td>
</tr>
<tr>
<td>70 High</td>
<td>35</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>34</td>
<td>34-35</td>
<td></td>
</tr>
<tr>
<td>50 Medium</td>
<td>32-33</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>31</td>
<td>31-32</td>
<td></td>
</tr>
<tr>
<td>30 Low</td>
<td>29-30</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>27-28</td>
<td>26-29</td>
<td></td>
</tr>
<tr>
<td>10 Very Low</td>
<td>7-26</td>
<td>8-25</td>
<td></td>
</tr>
</tbody>
</table>

RAW SCORES (from Scoring Sheet)
Re=  
Am=  
Ts=

Version 1 – 2018
APPENDIX D.3. - Guidelines for Interpretation of SOCRATES-8 Scores
Source: TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment. SAMHSA

Using the SOCRATES Profile Sheet, circle the client’s raw score within each of the three scale columns. This provides information as to whether the client’s scores are low, average, or high relative to people already seeking treatment for alcohol problems. The following are provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information.

RECOGNITION

HIGH scorers directly acknowledge that they are having problems related to their drinking, tending to express a desire for change and to perceive that harm will continue if they do not change.

LOW scorers deny that alcohol is causing them serious problems, reject diagnostic labels such as “problem drinker” and “alcoholic,” and do not express a desire for change.

AMBIVALENCE

HIGH scorers say that they sometimes wonder if they are in control of their drinking, are drinking too much, are hurting other people, and/or are alcoholic. Thus a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be particularly expected in the contemplation stage of change.

LOW scorers say that they do not wonder whether they drink too much, are in control, are hurting others, or are alcoholic. Note that a person may score low on ambivalence either because they “know” their drinking is causing problems (high Recognition), or because they “know” that they do not have drinking problems (low Recognition). Thus a low Ambivalence score should be interpreted in relation to the Recognition score.

TAKING STEPS

HIGH scorers report that they are already doing things to make a positive change in their drinking, and may have experienced some success in this regard. Change is underway, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.

LOW scorers report that they are not currently doing things to change their drinking, and have not made such changes recently.
APPENDIX E - Assessment Process Chart
Provided by: Dr. Burley, Dr. Carter, and Dr. Villanueva - TDMHSAS

Disclaimer: The below chart is to be used as a general guide and not dictate patient placement criteria.
APPENDIX F – Sample Patient Agreement

Source: Dr. Richard Soper

PATIENT NAME: ___________________________________________

PRIMARY CARE PHYSICIAN/SITE: _______________________________

I understand that this agreement between myself; __ and (insert name of medical office/group) is intended to clarify the manner in which chronic (long-term) controlled substances will be used to manage my chronic pain. Chronic controlled substance therapy for patients who do not suffer from cancer pain is a controversial issue.

I understand that there are side effects to this therapy; these include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea and vomiting, loss of energy, decreased balance and falling, constipation, decreased sexual desire and function, potential for overdose and death. Care should be taken when operating machinery or driving a car while taking these medications. When controlled substances are used long-term, some particular concerns include the development of physical dependence and addiction. I understand these risks and have had my questions answered by my physician.

I understand that my (insert name of medical group) physician will prescribe controlled substances only if the following rules are adhered to:

• All controlled substance prescriptions must be obtained from your (insert name of medical group) primary care physician. If a new condition develops, such as trauma or surgery, then the physician caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify my primary care physician within 48-hours of my receiving a narcotic or any other controlled substance from any other physician or other licensed medical provider. For females only: If I become pregnant while taking this medicine, I will immediately inform my obstetrician and obtain counseling on risks to the baby.

• I will submit urine and/or blood on request for testing at any time without prior notification to detect the use of non-prescribed drugs and medications and confirm the use of prescribed ones. I will submit to pill counts without notice as per physician’s request. I will pay any portion of the costs associated with urine and blood testing that is not covered by my insurance.

• All requests for refills must be made by contacting my (insert name of medical group) primary care physician during business hours at least 3-workdays in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy, which is authorized to release a record of my medications to this office upon request. A copy of this agreement will be sent to my pharmacy.

• Pharmacy name/address/telephone: __________________________________________

• The daily dose may not be changed without my (insert name of medical group) primary care physician’s consent. This includes either increasing or decreasing the daily dose.

• Prescription refills will not be given prior to the planned refill date determined by the dose and quantity prescribed. I will accept generic medications.

• Accidental destruction, loss of medications or prescriptions will not be a reason to refill medications or rewrite prescriptions early. I will safeguard my controlled substance medications from use by family members, children or other unauthorized persons.
• You may be referred to an appropriate specialist to evaluate your physical condition.

• You may be asked to have an evaluation by either a psychiatrist or psychologist to help manage your medication needs.

• If your physician determines that you are not a good candidate to continue with the medication, you may be referred to a detoxification program or evaluation by a pain management center.

• These medications may be discontinued or adjusted at your physician’s discretion.

• I understand that it is my physician’s policy that all appointments must be kept or cancelled at least 2-working days in advance. I understand that the original bottle of each prescribed controlled substance medication must be brought to every visit.

I understand that I am responsible for meeting the terms of this agreement and that failure to do so will/may result in my discharge as a patient of (insert name of medical group). Grounds for dismissal from (insert name of medical group) include, but are not limited to: Evidence of recreational drug use, of drug diversion, of altering scripts (this may result in criminal prosecution), of obtaining controlled substance prescriptions from other doctors without notifying this office, abusive language toward staff, development of progressive tolerance, use of alcohol or intoxicants, engagement in criminal activities, etc.

________________________________________  ________________________________
Patient's Signature                        Witness' Signature

________________________________________  ________________________________
Date                                      Date
APPENDIX G - Sample Buprenorphine Consent to Treatment Form

Source: Dr. Richard Soper

Buprenorphine is a medication approved by the Food and Drug Administration (FDA) for treatment of people with opioid dependence. Qualified physicians can treat up to 30 patients for opiate dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

Buprenorphine itself is an opioid, but it is not as strong an opioid as heroin or morphine. Buprenorphine treatment can result in physical dependence of the opiate type. Buprenorphine withdrawal is generally less intense than with heroin or methadone. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more.

If you are dependent on opiates, you should be in as much withdrawal as possible when you take the first dose of buprenorphine. If you are not in withdrawal, buprenorphine may cause significant opioid withdrawal. For that reason, you should take the first dose in the office and remain in the office for observation. Within a few days, you will have a prescription for buprenorphine that will be filled in a pharmacy.

Some patients find that it takes several days to get used to the transition from the opioid they had been using to buprenorphine. During that time, any use of other opioids may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opioids will have less effect. Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with me first.

Combining buprenorphine with alcohol or some other medications may also be hazardous. The combination of buprenorphine with medication such as Valium, Librium, Ativan has resulted in deaths.

The form of buprenorphine you may be taking is a combination of buprenorphine with a short-acting opiate blocker (naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid, it could cause severe opiate withdrawal.

Buprenorphine tablets must be held under the tongue until they dissolve completely. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed.

Signature         Print Name         Date
APPENDIX H - Sample Consent for Release of Information

Adapted from: Permitted use of internal form used by Behavioral Health Group, 2017

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ________________________________ Patient ID: ________________________________

I, ________________________________, ________________________________, ________________________________, ________________________________, (name of patient) (Social security number) (date of birth)

Authorize To release to and obtain from: ________________________________ (name/address/phone # of receiving agency)

The information listed below is being released for the following purpose:

Release/Discharge Summary
- Assessments:
  - Nursing
  - Physical
  - Psychiatric
  - Psychosocial
  - Psychology

After Care
- Billing Records
- Discharge Plans
- Doctor Orders
- Lab Reports
- Letter of Admits And Release Dates
- Other – [List Specific Document(s)]

Medications
- Progress Notes
- Treatment Plans
- X-Rays

Date, Event, or Condition when Consent expires: ________________________________

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the release of information. I also understand that I, or my legally authorized representative, may revoke this consent in writing at any time unless action has already been taken based upon it. I freely and voluntarily give this consent.

I understand the records requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

THE INFORMATION I AUTHORIZE TO RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Patient Signature: ________________________________ Date: ________________________________

Witness Signature: ________________________________ Date: ________________________________
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ________________________________ Patient ID: ________________________________

Revocation:

Patient Signature: ________________________________ Date: ________________________________

Witness Signature: ________________________________ Date: ________________________________
APPENDIX I - Sample Induction for Patients Dependent on Short or Long-Acting Opioids

Source: Buppractice

### Day 1: Induction for Patients Physically Dependent on Short-Acting Opioids (e.g., Heroin)

<table>
<thead>
<tr>
<th>Patient dependent on short-acting opioids?</th>
<th>YES</th>
<th>Withdrawal symptoms present 12-24 hours after last use of opioids?</th>
<th>NO</th>
<th>Stop: patient not dependent on short-acting opioids</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give 4 mg buprenorphine and observe 2+ hours</td>
<td>YES</td>
<td>Withdrawal symptoms continue or return?</td>
<td>NO</td>
<td>Daily dose established</td>
<td>YES</td>
</tr>
<tr>
<td>Repeat dose up to 8-16mg for the first day</td>
<td>NO</td>
<td>Manage withdrawal symptomatically</td>
<td>YES</td>
<td>Follow Day 2+ induction guidelines for physically dependent patients (Figure 2)</td>
<td></td>
</tr>
<tr>
<td>Withdrawal symptoms relieved?</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily dose established</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Days 2+: Buprenorphine Induction for Patients Physically Dependent on Short- or Long-Acting Opioids

<table>
<thead>
<tr>
<th>Patient returns to the office on 8 mg</th>
<th>YES</th>
<th>Withdrawal symptoms present since last dose?</th>
<th>NO</th>
<th>Maintain patient on 8mg/day; daily dose established</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give buprenorphine 10-12 mg</td>
<td>YES</td>
<td>Withdrawal symptoms return?</td>
<td>NO</td>
<td>Daily dose established</td>
<td>YES</td>
</tr>
<tr>
<td>Withdrawal symptoms continue?</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administer 2-4 mg doses up to maximum 16mg total for second day</td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal symptoms relieved?</td>
<td>NO</td>
<td>Manage withdrawal symptomatically</td>
<td>YES</td>
<td>Return next day for continued induction; start with Day 2 total dose and increase by 2-4 mg increments [Max daily dose: 32mg]</td>
<td></td>
</tr>
<tr>
<td>Daily dose established</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient should not have had Methadone > 35 mg per day in the last week or ≤ 35 mg per day in the last 48 hours, or longer. Patient should be exhibiting withdrawal symptoms before dosing with buprenorphine.

Patient should not have taken benzodiazepines (BDZ) in the last 12-24 hours.

Patients on methadone should be tapered down to ≤ 30 mg per day for at least 1 week.

Buprenorphine can be started ≥ 24 hours, or longer, after patient’s last methadone dose. Patient should be exhibiting withdrawal symptoms before dosing with buprenorphine.
## APPENDIX J – Sample Physical Exam Form

*Adapted from: Permitted use of internal form used by Behavioral Health Group, 2017*

### PHYSICAL EXAM

Date: ________

Patient Name: ________________________________ Age: ________ DOB: ________ Patient ID: __________________

<table>
<thead>
<tr>
<th>VITAL SIGNS</th>
<th>Height: __________________</th>
<th>Weight: __________________</th>
<th>Temperature: ___________</th>
<th>Pulse: ___________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Respiration: __________________ Blood Pressure: ___________

### Patient Clinical and Medical History:

Dose: __________ mg(s) Code: ________

Check all that apply:

- □ HTN
- □ Hyperlipidemia
- □ Asthma
- □ AIDS / HIV
- □ Stomach ulcers/Reflux
- □ CAD
- □ Hepatitis
- □ Cancer
- □ Other

**Allergies:**

**Current Medication:**

**Surgeries:**

**Abnormal Labs:**

### Skin: General

- □ Normal
- □ Abnormal

[If Abnormal List Referral(s):]

**Appearance**

- □ Normal
- □ Abnormal

Check if present, and describe in IV Track Record:

- □ Tattoos/Distinguishing Marks:
- □ Thrombosis Veins
- □ Subcutaneous Abscesses: [Select One]
- □ Puffy Hand

<table>
<thead>
<tr>
<th>Tracks</th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forearm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See IV TRACK RECORD

### Eyes:

EOM: □ Normal □ Abnormal

[If Abnormal List Referral(s):]

Fund: □ Normal □ Abnormal

**Check Findings:**

- □ Sclera: Normal □ Icteric
- □ Nystagmus: Absent □ Present

Pupil Size

- □ Normal
- □ Myotic
- □ Mydriatic
- □ Nonreactive

- □ Left
- □ Right

Antecubital fossa

- □ Left
- □ Right

Hand

- □ Left
- □ Right
<table>
<thead>
<tr>
<th>Section IV: Appendices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ear Canal and Drums:</strong> Normal Abnormal [If Abnormal List Referral(s):]</td>
</tr>
<tr>
<td><strong>Nose:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Mouth and Throat:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Teeth:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Neck, including Thyroid:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Lymph Nodes:</strong></td>
</tr>
<tr>
<td>Cervical: Normal Abnormal [If Abnormal List Referral(s):]</td>
</tr>
<tr>
<td>Axillary: Normal Abnormal</td>
</tr>
<tr>
<td>Epitrochlear: Normal Abnormal</td>
</tr>
<tr>
<td>Inguinal: Normal Abnormal</td>
</tr>
<tr>
<td><strong>Heart:</strong> Normal Abnormal Referral needed for ECG? Yes No [If Abnormal List Referral(s):]</td>
</tr>
<tr>
<td><strong>Peripheral Pulses:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Lungs:</strong> Normal Abnormal [If Abnormal List Referral(s):]</td>
</tr>
<tr>
<td><strong>Abdomen:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Check Findings:</strong> Liver: Palpable Not Palpable Non-tender Tender Enlarged</td>
</tr>
<tr>
<td>Spleen: Palpable Not Palpable</td>
</tr>
<tr>
<td>Kidney: Palpable Not Palpable</td>
</tr>
<tr>
<td><strong>Joints:</strong> Normal Abnormal [If Abnormal or Yes List Referral(s):]</td>
</tr>
<tr>
<td><strong>Spine:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Extremities:</strong> Normal Abnormal</td>
</tr>
<tr>
<td><strong>Herniations:</strong> Yes No</td>
</tr>
<tr>
<td><strong>Edema:</strong> Yes No</td>
</tr>
<tr>
<td><strong>Varicosities, Thrombophlebitis:</strong> Yes No</td>
</tr>
<tr>
<td><strong>Neurological:</strong> Normal Abnormal [If Abnormal List Referral(s):]</td>
</tr>
<tr>
<td>(DTR's, Babinski, Romberg): Normal Abnormal</td>
</tr>
<tr>
<td>Cranial Nerves Normal Abnormal</td>
</tr>
<tr>
<td>Gait Normal Abnormal</td>
</tr>
<tr>
<td>Balance Normal Abnormal</td>
</tr>
<tr>
<td>Coordination Normal Abnormal</td>
</tr>
<tr>
<td>Motor Strength Normal Abnormal</td>
</tr>
<tr>
<td><strong>Check Findings:</strong> Mental Status: Alert Somnolent Noticeably High</td>
</tr>
<tr>
<td>Does not report any danger to self/others</td>
</tr>
<tr>
<td>Speech: Clear Slurred</td>
</tr>
</tbody>
</table>
SUMMARY DOCUMENTATION OF CURRENT PHYSIOLOGICAL ADDICTION

☐ Not Applicable for ANNUAL PHYSICAL - ONLY complete this section during ADMISSION PHYSICAL EXAMINATION or if

<table>
<thead>
<tr>
<th>Addictive Drug</th>
<th>Toxic State</th>
<th>Withdraw State (Check if present)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Heroin</td>
<td>☐ New Tracks</td>
<td>☐ Dilated Pupils</td>
</tr>
<tr>
<td>☐ Prescription Opiate Narcotics</td>
<td>☐ Contracted Pupila</td>
<td>☐ Rhinorrhea</td>
</tr>
<tr>
<td>☐ Street Opiate Narcotics</td>
<td>☐ Constipation Slurred</td>
<td>☐ Lacrimation</td>
</tr>
<tr>
<td>Daily Consumption:</td>
<td>☐ Speech</td>
<td>☐ Nausea/Vomiting</td>
</tr>
<tr>
<td>Time last used:</td>
<td>☐ Nystagmus</td>
<td>☐ Positive Romberg</td>
</tr>
<tr>
<td></td>
<td>☐ Staggering Gait</td>
<td>☐ Orthostatic Hypotension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ &quot;Gooseflesh&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Diarrhea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Tremulousness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Delirium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Diaphoresis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ (specify)&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Fever</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Insomnia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Convulsions</td>
</tr>
</tbody>
</table>

Provider Signature ____________________________ Date: ___________________

IV TRACK RECORD

X = Recent Tracks  0 = Old Tracks

Describe Tracks/Tattoos/ Distinguishing Marks:
**PAIN**

Patient complaint of current pain: Yes No Patient complaint of recent pain: Yes No
Patient complaint of CHRONIC PAIN Yes No

If the patient answers yes to either of these questions, then answer the following:

**What is the location of the pain?**

On a scale of 0 to 10 (0 being no pain and 10 being the worst pain imaginable), please rate the following:

Current pain intensity _____ Worst pain in few days _____ Least pain in past few days _____

Average pain over the past few days

What is the sensory quality of the pain: Stabbing Throbbing Aching Burning Shooting

Is the pain currently being treated? Yes No by whom: Clinic Private Doctor Other (specify)

**IMPRESSION:** Pain is associated with substance abuse or Pain is medically based

Further action needed to address pain related problems? Yes No Referral needed? Yes No

Referral:

**LABORATORY**

Laboratory Test Ordered: CBC with Diff Liver Profile RPR Urine Drug Screen
TB Skin Test Biological Pregnancy Test Micro UA

**PHYSICAL EXAMINATION SUMMARY**

Overall Impression of

Provider Signature: ___________________________ Date: ________________

**RECOMMENDATION**

Recommendation Based on Examination:

Provider Signature: ___________________________ Date: ________________

**COMMENTS**

General Impression of Patient:
Physical Completed [Date]

Provider Signature: ___________________________ Date: ________________
APPENDIX K - Suggested Sleep Hygiene

The relationship between Sleep Disturbances & Substance Use Disorders

Guidance on how to assess and treat sleep problems for patients in recovery

- Sleep problems vary by substance used & can include insomnia, sleep latency (the time it takes to fall asleep) disturbances in sleep cycles, or daytime sleepiness.
- People detoxing from opioids often report symptoms of insomnia, and 25-75% of people with alcohol use disorder (AUD) have symptoms before even entering treatment.
- Marijuana users may experience trouble sleeping from the first few days of withdrawal, up to weeks afterwards.
- In a study of college students, users of stimulants reported increased sleep disturbances & worse sleep quality.
- A study that objectively measured sleep in abstaining cocaine users found their sleep quality to be deteriorating, despite their perception that it was improving.
- Sleep loss can interfere with substance use treatment and have significant negative effects on the physical, mental, and emotional well-being of people in recovery.

What Providers Can Do:

- Screen for insomnia among people in recovery from substance use disorder (SUD). Rule out causes of sleep problems such as stress, mental and medical disorders, nicotine use, and medications that disturb sleep.

- Educate patients on good sleep hygiene & keeping a sleep diary.

- Conduct careful evaluations prior to prescribing sedative-hypnotic medications. Benzodiazepines and non-benzodiazepines have the potential for abuse and can interfere with SUD recovery.

- Medications without known abuse potential should be the first treatment option when drug therapy is necessary to treat insomnia during recovery. This includes the dietary supplement melatonin, as well as ramelteon and doxepin, the only unscheduled prescription medications approved by the FDA for the treatment of insomnia.

- Off-label meds without known abuse potential include trazodone, amitriptyline, mirtazapine, nefazodone, & nortriptyline.

GOOD SLEEP HYGIENE

Go to bed & get up at the same times each day. Use natural light to remind yourself when it’s time to be asleep & awake. Exercise regularly. Do not take naps after 5 PM. Do not eat or drink too much at bedtime. Avoid caffeine, nicotine, TV, & phones before bedtime. Try winding down before bed with a bath.

NON-DRUG THERAPY

- Mindfulness meditation
- Muscle relaxation
- Biofeedback practice
- CBT for insomnia
- Stimulus control exercises
- Sleep restriction therapy
- Bright light therapy
- Dental devices and continuous positive airway pressure machines for obstructive sleep apnea

Adapted from Treating Sleep Problems of People in Recovery from Substance Use Disorders. For more information, visit www.samhsa.gov.

APPENDIX L - Special Populations

Source: Adapted from TIP 40 with contributions from the Buprenorphine Treatment Guidelines Committee

L.1. ADOLESCENT TREATMENT (UNDER 18)

- Not all adolescents who use substances are, or will become, dependent. Programs and counselors must be careful not to prematurely diagnose or label adolescents or otherwise pressure them to accept that they have a disease: This may do more harm than good in the long run.
- Programs should make every effort to involve the adolescent client's family due to its possible role in the origins of the problematic behavior and its importance as an agent of change in the adolescent's environment.
- Using adult programs for treating adolescents is ill-advised. If this must occur, it should be done only with great caution and with alertness to the inherent complications that may threaten effective treatment for these young people.
- Treatment should include family therapy, a twelve-step based program, and assessment of causative factors.

L.2. BUPRENOPHINE AND PAIN

According to Tennessee Code 53-11-311(a), “Any product containing buprenorphine, whether with or without naloxone, may only be prescribed for a use recognized by the federal food and drug administration. This subsection (a) shall not apply to a person: (1) Who has a documented diagnosis of opiate addiction as shown in their medical record; (2) Who receives treatment from a provider practicing under 21 U.S.C. § 823(g)(2); and (3) Who is counted against the total number of patients allowed to the provider as set forth in 21 U.S.C. § 823(g)(2).” (See APPENDIX R)

Chronic pain and substance use disorders have similar physical, social, emotional, and economic effects on health and well-being. Patients with one or both of these conditions may report insomnia, depression, impaired functioning, and other symptoms. Effective chronic pain management in patients with, or in recovery from, substance use disorders must address both conditions simultaneously.

For all patients with pain, it is important that the correct diagnosis of pain etiology be made and that a suitable treatment be identified. Nonpharmacological treatments have been shown to be effective for pain (e.g., physical therapy) and may be considered.

If pharmacological treatment is considered, then nonnarcotic medications such as acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs) should be tried first. Adjunctive medications including anticonvulsants may be useful. Tricyclic antidepressants or combined norepinephrine-serotonin reuptake inhibitors may also be considered.

L.3. WOMEN WHO ARE PREGNANT OR BREASTFEEDING

Buprenorphine is classified by the FDA as a Pregnancy Category C medication. The available evidence does not show any causal adverse effects on pregnancy or neonatal outcomes from buprenorphine treatment.
Buprenorphine should be considered when the prescribing physician believes the benefits outweigh the risks.

Patients already maintained and stable on buprenorphine who become pregnant probably should continue it with close monitoring.

Clear documentation in the patient’s chart of the patient’s awareness that there is insufficient data about the safety of buprenorphine in pregnancy is essential.

Monthly drug screens should be performed during pregnancy. Emphasis should be made on maintaining documentation of drug screens in the patient’s record.

Coordination of care with OB/GYN, if different from buprenorphine provider, should be made. Buprenorphine provider should have documentation in patient’s chart documenting this coordination of care.

Patient’s pharmacist should be consulted to determine that patients are picking up their medications, including those for prenatal care (i.e. prenatal vitamins, etc.), to determine adherence to their treatment regimen.

Should a provider decide to not serve a pregnant patient, the provider should make every reasonable effort to refer the patient to available treatment resources.

Treatment with buprenorphine while pregnant is a decision between the patient and provider and should be made with the agreement and signed understanding that the patient will be treated at the lowest effective dose through pregnancy.

Breastfeeding: Sufficient evidence exists that buprenorphine products with or without naloxone are safe in breastfeeding. Medication selection for a nursing mother should be made that considers all patient-specific factors, including risk of diversion of buprenorphine mono product (See Subsection A.1.b. of Section II).

Providers should be aware the Safe Harbor provision pursuant to TCA § 33-10-104(f), regarding treating pregnant women prior to end of the 20th week of pregnancy and interactions with the Tennessee Department of Children’s Services.

L.4. CO-OCCURRING PSYCHIATRIC DISORDERS

Deliberation about what medications to prescribe to patients with active substance use disorders requires a careful consideration of their psychiatric diagnoses, their medical co-morbidities and overall health status, and how the specific substances they are using might interact with the medications being considered.

In the case of opioid use disorder, the most dangerous medications to recommend or prescribe are those that depress respiratory drive, such as the benzodiazepines.

L.5. PATIENTS WITH SIGNIFICANT MEDICAL COMORBIDITIES

Patients who have unstable or very severe cardiovascular disease, such as advanced heart failure or angina/coronary artery disease, may have difficulty tolerating the stress of induction onto buprenorphine. The same may be true for patients with severe lung disease, such as COPD. For this reason, these patients should be monitored very carefully throughout their treatment for any substance use disorder.
• These patients may need to undergo induction in an inpatient setting to allow for close monitoring, or may be better served by methadone treatment.
• Patients who have underlying conditions that increase somnolence, such as sleep apnea or narcolepsy, need close monitoring during early treatment to evaluate the effects of buprenorphine.

**L.6. BUPRENORPHINE AND LIVER DISEASE (INCLUDING HEPATITIS C)**
Current guidelines recommend that patients not be offered buprenorphine treatment if their transaminases (AST or ALT) are elevated more than three to five times the upper limit of normal. Patients infected with hepatitis C may need to be maintained on buprenorphine in order to withstand the stress of hepatitis C treatment. Studies have shown that these patients may do extremely well on treatment, particularly if they receive daily directly observed treatment with buprenorphine.

**L.7. BUPRENORPHINE AND HIV**
Treatment with methadone or buprenorphine has been shown to reduce frequency of drug use, and to reduce HIV risk behaviors; and methadone has been shown to reduce rates of HIV infection in those with injection drug misuse. Adherence to buprenorphine treatment is associated with greater likelihood of viral suppression and higher CD4 counts. Treatment of HIV infected patients with buprenorphine is associated with an approximately 50% decrease in opioid injection drug use, and this use decreases with increasing time on treatment.

• The addition of nontraditional treatment components--such as nutritional counseling, exercise regimens, education about testicular self-examination (for men), breast exams (for women), and ways to lower cholesterol--will greatly enhance the mental and physical health of persons with HIV/AIDS.
• Many HIV-infected substance abusers are unable to maintain total abstinence from substance abuse after the abrupt discontinuation at the start of treatment. In dealing with clients' ongoing substance abuse, treatment programs must find a balance between abstinence and public health approaches to substance abuse treatment.
APPENDIX M – Adverse Childhood Experiences (ACEs)

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes   No   If yes enter 1 __________

2. Did a parent or other adult in the household often or very often…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes   No   If yes enter 1 __________

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes   No   If yes enter 1 __________

4. Did you often or very often feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn’t look out for each other, feel close to each other, or support each other?
   Yes   No   If yes enter 1 __________

5. Did you often or very often feel that …
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes   No   If yes enter 1 __________

6. Were your parents ever separated or divorced?
   Yes   No   If yes enter 1 __________

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes   No   If yes enter 1 __________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes   No   If yes enter 1 __________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes  No          If yes enter 1 _______

10. Did a household member go to prison?
   Yes  No          If yes enter 1 _______

   Now add up your “Yes” answers: _______ This is your ACE Score.
Section IV: Appendices

APPENDIX N – Treatment Planning and Therapies
Source: Deborah Hillin & Dr. Richard Soper

Treatment Plans

Treatment plans need to utilize assessment information, describe client problems in behavioral terms, and specify in measurable steps the objectives that have been individually selected to help clients reach identified goals.

Treatment plans should assess the severity of the substance use disorder as well as any co-occurring disorders; should identify the client’s goals for treatment in measurable, time sensitive steps toward achieving the goals; address the motivation and readiness for change; and should incorporate a strength-based approach.

Use a Problem List to formulate treatment plans and develop:

– **Problem Statements** - information gathered from the assessment
– **Goals** based on Problem Statements
– **Objectives** based on Goals and specific to what the client will do
– **Interventions** based on Objectives and what the staff will be doing with client

These components need to reflect action steps of the client in measurable activities, etc.

Treatment plans should reflect the client’s strengths and active participation in the treatment planning.

Therapies

Therapies, including individual, family and group therapy, help people learn to increase their coping skills, manage high-risk situations, avoid substance-use triggers and control cravings. Therapies that have demonstrated effectiveness may include, but are not limited to:

- **Motivational interviewing and motivational enhancement therapy**: bolsters motivation to change substance use behaviors
- **Cognitive behavioral therapy**: helps identify, recognize and avoid thought processes, behaviors and situations associated with substance use; manage cravings and negative emotions; and develop better problem-solving and coping skills
- **Community reinforcement approach**: focuses on improving family relations, acquiring job skills, and developing alternative activities and associates to minimize substance use
- **Contingency management**: alters behavior by rewarding constructive behaviors and discouraging unhealthy behaviors
- **Behavioral couples/family therapy**: improves communication and support and reduces conflict between couples and families that have a member with a substance problem
- **Family therapy for adolescents**: addresses adolescent substance use and related problem behaviors in relation to individual, family, peer and community-level influences (examples include multidimensional family therapy, functional family therapy, multi-systemic therapy, brief strategic family therapy, integrated/combined treatments)
- **12-Step facilitation approach (Not the same as, but used in conjunction with, AA, NA, fellowship meeting)**: Therapy sessions are highly structured, following a similar format each week that includes symptoms inquiry, review and reinforcement for AA participation, introduction and explication of the week's theme, and setting goals for AA participation for the next week. Material introduced during treatment sessions is complemented by reading assignments from AA literature.
- **Acceptance and commitment therapy**: increases psychological flexibility, or the ability to enter the present moment more fully and either change or persist in behavior when doing so serves valued ends
APPENDIX O - Suggested Dosing for In-Office Induction

Source: Adapted from Vermont Buprenorphine Guidelines.

1. These general guidelines should be followed for patients physically dependent on opioids. Patient-specific factors such as: age, co-morbidities, other risks, etc. must be considered when dosing buprenorphine.
   a. Begin induction early in the week.
   b. Plan on a time table of 3-5 days for stable dosing.
   c. Patient’s last reported use should have been at least 6 hours prior to induction.
   d. Make sure the patient is not on methadone or other long-acting opioids as buprenorphine may precipitate withdrawal if it too closely follows long-acting opioids. (If patient is on methadone, see Subsection 2 below).
   e. Day 1: Give the patient a prescription for 2 doses of 2 mg (or equivalent) of buprenorphine with naloxone.
   f. Patient takes the prescription to the pharmacy and returns to the office with the medication.
   g. Patient self-administers the medication according to physician’s guidance and product instruction in office.
   h. Target buprenorphine dose range should be 6 mg to 12 mg (or equivalent) per day, with a recommended maximum of 16 mg daily.
   i. If more than an 8 mg (or equivalent) dose is needed, gradually increase the dose in 2 mg (or equivalent) increments over the next several days.
   j. The patient’s severity of withdrawal symptoms before the next scheduled dosing time is one of the best ways to assess adequacy of the dose. (See APPENDIX C).

2. For a more detailed regimen for patient’s dependent on short or long acting opioids, see APPENDIX I.
APPENDIX P – Guidelines for Pharmacists

Sources: College of Psychiatric & Neurologic Pharmacists, guideline, opioid use disorder, Suboxone® Medguide

Background

Being recognized by the American Psychiatric Association (APA) in their most recent Diagnostic and Statistical Manual of Mental Disorders, DSM-5, Opioid Use Disorder (OUD) should be recognized and treated as any other disorder. Community pharmacists have the responsibility of providing safe and appropriate access to treatment, while also protecting against misuse and abuse. One of the best methods for distinguishing legitimate use is by collaboration with prescribers.

Buprenorphine is the only opioid agonist medication in the United States that can be prescribed to treat OUD outside of an opioid treatment program. The Drug Addiction Treatment Act of 2000 (DATA 2000), limits prescriptive authority to prescribers that have obtained a waiver, distinguished by an “X” preceding their DEA number. This number along with their regular DEA number must be on the prescription.

Medication-assisted treatment encompasses opioid agonist treatment and opioid antagonist treatment. Buprenorphine can be prescribed to alleviate symptoms of opioid withdrawal, block opioid use, and allow the patient to begin to focus on improving their overall health. Relapse rates without MAT are substantial for opioid use disorder; therefore, long-term treatment may be the goal. Unlike other maintenance medications, buprenorphine may be prescribed in very limited quantities to ensure close follow up, particularly during the induction and stabilization phase. These frequent refills provide a high level of contact at the pharmacy and the opportunity for the pharmacist to actively participate in the patient’s treatment. Concerns, progress, and missed doses should be clearly communicated with the provider. Some patients may require more intensive monitoring including provider request for supervised dosing at the pharmacy. It is recommended for the pharmacist to record in the patient’s chart a note to prevent them from receiving other opioids without direct permission from their provider. This high level of care can make a significant difference in keeping patients engaged in treatment and achieving remission from OUD.

Pharmacists should review the following resource and incorporate these guidelines into their everyday practice: http://cpnp.org/guideline/opioid
APPENDIX Q - Available Buprenorphine Formulations

**Buprenorphine/Naloxone Products**

*Suboxone® SL film and Bunavail® only products indicated for induction therapy of opioid dependence; All products indicated for maintenance therapy*

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage Forms</th>
<th>Strengths Available (mg)</th>
<th>FDA-Labeled Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suboxone® SL</td>
<td>Sublingual Tablet</td>
<td>0.7/0.18, 1.4/0.36, 2.9/0.71, 5.7/1.4, 8.6/2.1, 11.4/2.9</td>
<td>Treatment of opioid dependence</td>
</tr>
<tr>
<td>Bunavail®</td>
<td>Buccal Film</td>
<td>2.1/0.3, 4.2/0.7, 6.3/1.0</td>
<td></td>
</tr>
<tr>
<td>Suboxone®</td>
<td>Sublingual Film</td>
<td>2.0/0.5, 4.0/1.0, 8.0/2.0, 12.0/3.0</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine/</td>
<td>Sublingual Tablet</td>
<td>2.0/0.5, 8.0/2.0</td>
<td></td>
</tr>
</tbody>
</table>

**Buprenorphine Products**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage Forms</th>
<th>Strengths Available</th>
<th>FDA-Labeled Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belbuca®</td>
<td>Buccal Film</td>
<td>75mcg, 150mcg, 300mcg, 450mcg, 600mcg, 750mcg, 900mcg</td>
<td>Chronic severe pain requiring long-term daily around-the-clock treatment</td>
</tr>
<tr>
<td>Butrans®</td>
<td>ER Transdermal patch</td>
<td>5mcg/hr, 7.5mcg/hr, 10mcg/hr, 15mcg/hr, 20mcg/hr</td>
<td>Chronic pain requiring around-the-clock treatment</td>
</tr>
<tr>
<td>Buprenex®</td>
<td>Injection (IM,IV)</td>
<td>0.3mg/mL</td>
<td>Moderate to severe pain</td>
</tr>
<tr>
<td>Buprenorphine HCl</td>
<td>Injection (IM,IV)</td>
<td>0.3mg/mL</td>
<td></td>
</tr>
<tr>
<td>Probuphine®</td>
<td>Sublingual Tablet</td>
<td>2mg, 8mg</td>
<td>Treatment of opioid dependence</td>
</tr>
<tr>
<td></td>
<td>Implant</td>
<td>74.2mg</td>
<td>Maintenance treatment of opioid dependence</td>
</tr>
</tbody>
</table>

References:
- LexiComp Drug Reference
- Micromedex Drug Reference
- Drugs@FDA: FDA Approved Drug Products
APPENDIX R – Tennessee Code Annotated § 53-11-311

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*** Current through 2017 Regular Session (Chapter 493). ***
Title 53 Food, Drugs And Cosmetics Chapter 11 Narcotic Drugs and Drug Control Part 3 Regulations and Registration

53-11-311. Use of buprenorphine products.

(a) Any product containing buprenorphine, whether with or without naloxone, may only be prescribed for a use recognized by the federal food and drug administration. This subsection (a) shall not apply to a person:

(1) Who has a documented diagnosis of opiate addiction as shown in their medical record;

(2) Who receives treatment from a provider practicing under 21 U.S.C. § 823(g)(2); and

(3) Who is counted against the total number of patients allowed to the provider as set forth in 21 U.S.C. § 823(g)(2).

(b) (1) Any prescription for buprenorphine mono or for buprenorphine without use of naloxone for the treatment of substance use disorder shall only be permitted to a patient who is:

(A) Pregnant;

(B) A nursing mother; or

(C) Has a documented history of an adverse reaction or hypersensitivity to naloxone.

(2) If the prescriber of buprenorphine mono or buprenorphine without use of naloxone for a patient under subdivision (b)(1)(A) or (b)(1)(B) is not the patient’s obstetrical or gynecological provider, the prescriber shall consult with the patient’s obstetrical or gynecological provider to the extent possible to determine whether the prescription is appropriate for the patient.

(c) (1) Notwithstanding any other provision of this title, a physician licensed under title 63, chapter 6 or 9, is the only healthcare provider authorized to prescribe any buprenorphine product for any federal food and drug administration approved use in recovery or medication-assisted treatment.

(2) Healthcare providers not licensed pursuant to title 63, chapter 6 or 9 and who are otherwise permitted to prescribe Schedule II or III drugs under this title, are prohibited from prescribing any buprenorphine product for treatment of opioid dependence. However, the providers may participate in the assessment and management of patients with an opiate addiction.

(d) (1) A prescriber who treats a patient with more than sixteen milligrams (16 mg) per day of buprenorphine or its therapeutic equivalent for more than thirty (30) consecutive days for treatment of opioid dependence shall clearly document in the patient’s medical record why the patient needs the higher dosage amounts of buprenorphine. A prescriber who does not meet the requirements established in the manner described in subdivision (d)(2) and treats a patient with more than twenty milligrams (20 mg) per day of buprenorphine or its therapeutic equivalent for more than thirty (30) consecutive days for treatment of opioid dependence shall, to the extent possible, either consult with an addiction specialist meeting the requirements established in the manner described in subdivision (d)(2) or refer the
patient to the addiction specialist for management of the patient's treatment plan. If a prescribing physician cannot make the required consultation or referral as outlined in this subsection (d), the reasons shall be set out in the medical record.

(2) The board of medical examiners and the board of osteopathic examination shall promulgate rules establishing the requirements for licensees to qualify as addiction specialists.

(e) This section shall not apply to perioperative surgery or ventilator sedation that is performed in a licensed healthcare facility set forth in § 68-11-201(3) or (26).

(f) When patients are admitted as inpatients of a hospital, or registered as outpatients of a hospital, prescribers may continue orders for these drug products as part of a medication reconciliation process to continue home medications as previously prescribed and without restrictions pertaining to the use of the product until the patient is discharged from the facility. However, prescriptions written upon discharge from the facility and intended to be filled by the patient at a retail pharmacy and consumed post-discharge shall follow the requirements of this section.