Update on Prescribing MAT during the COVID-19 Public Health Emergency

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ASAM National Practice Guideline – 2020 Focused Update (published March 2020) – MAT updates

- Comprehensive patient assessment for treatment planning is critical; **completion of all assessments should not delay or preclude initiation of MAT for OUD** (new)
- **All FDA-approved medications should be available to all patients** (major revision)
- There is **no recommended time limit for pharmacologic treatment (new)**
- The **use of benzodiazepines or other sedative/hypnotics should not be a reason to withhold or suspend** methadone or buprenorphine; untreated OUD can outweigh the risk of serious side effects; conduct a risk-benefit analysis (major revision)
- Assess psychosocial needs and offer psychosocial treatment; a **patient decision to decline psychosocial treatment should not preclude or delay pharmacotherapy with appropriate MAT** (major revision)
- Opioid dosing guidelines developed for chronic pain (expressed in MME), are not applicable to medications used to treat OUD (new)
- Naloxone should be provided to patients being treated for, or with a history of, OUD. Train patients and family members/significant others (new)
- Opioid withdrawal management with buprenorphine should not be initiated until there are objective signs of opioid withdrawal; once in withdrawal, initiate buprenorphine dose sufficient to suppress withdrawal (and titrate up as needed) (major revision)
- Clonidine and lofexidine are safe and effective for opioid withdrawal; methadone and buprenorphine are more effective in reducing withdrawal symptoms, retaining patients in withdrawal management, and in supporting the completion of withdrawal management (major revision)
- Recommended initial dose of methadone ranges from 10 mg – 30 mg, reassess in 2 – 4 hours; use a lower than usual initial dose (2.5 mg – 10 mg for patients with no or low opioid tolerance (major revision)

https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

ASAM 2020 Focused Update – MAT updates

- Initial methadone dose range is 60 mg – 120 mg; titration should be based on assessment of patient response and the dose generally not increased daily; increase by no more than 10 mg about every 5 days based upon withdrawal symptoms and sedation (major revision)
- Buprenorphine is a recommended treatment for OUD for patients who can give informed consent and have no contraindication (new)
- Both office-based and home-based initiation are considered safe and effective for buprenorphine; assess the patient's past experience with buprenorphine and ability to manage initiation at home (major revision)
- To be effective, the buprenorphine dose should be sufficient for patients to discontinue illicit opioid use; there is limited effectiveness data relative to doses higher than 24 mg/day; higher doses may increase the risk of diversion (major revision)
- Several new dosage forms of buprenorphine have been FDA-approved; data about effectiveness is limited; clinicians should use these products as indicated and be mindful of emerging evidence (new)
- LAI naltrexone is recommended to prevent relapse in OUD for patients who are no longer physically dependent on opioids, able to give informed consent, and have no contraindications (new)
- **LAI naltrexone is intended to be administered IM every 4 weeks; some patients may metabolize naltrexone more rapidly and may benefit from dosing as often as every 3 weeks (new)**
- **Oral naltrexone is not recommended except under limited circumstances** (major revision)

https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

ASAM 2020 Update – Special Populations

Pregnancy

- The first priority in evaluating pregnant women for OUD is to identify emergent or urgent medical conditions for referral (new)
- Pregnant women with OUD should receive methadone or buprenorphine rather than withdrawal management or psychosocial treatment alone (major revision)
- A lack of completion of all assessments in pregnancy should not preclude or delay MAT; a woman's decision to decline psychosocial treatment or a lack of available psychosocial treatment should not preclude or delay MAT (major revision)
- In pregnancy, methadone should be initiated at a dose of 10 mg – 30 mg with incremental doses of 5 mg – 10 mg every 3 – 6 hours as needed to a maximum first day dose of 30 mg – 40 mg; increase the methadone dose by no more than 10 mg every 5 days (major revision)
- **If pregnancy occurs while receiving naltrexone, it may be appropriate to discontinue naltrexone if the risk of relapse is low; a decision to remain on naltrexone should be carefully considered; if discontinued and there is a risk for relapse; consider methadone or buprenorphine treatment** (major revision)

Pain

- For a patient taking methadone or buprenorphine, temporarily increasing the dose or dosing frequency may be effective for managing pain; for those who have acute pain refractory to treatment and requiring additional opioid-based analgesia; adding a short-acting full agonist opioid to methadone may be considered; the dose of the short-acting agent may be higher than anticipated to achieve adequate analgesia (major revision)
- Patients receiving buprenorphine for OUD who have moderate to severe acute pain may benefit from the addition of "as-needed" doses of buprenorphine (major revision)
- Buprenorphine or methadone may be discontinued the day before or the day of surgery; higher potency IV opioids can be used for perioperative analgesia; methadone or buprenorphine can be resumed postoperatively (major revision)
- The opioid blockade of naltrexone can be overcome when necessary with high potency full agonist opioids; the patient should be closely monitored in the emergency or hospital setting (new)

https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

ASAM 2020 Update – Special Populations

Adolescents

- The risk/benefit balance of pharmacologic treatment without concurrent psychosocial treatment should be discussed with the patient and parent/guardian as appropriate; this should not delay or preclude use of MAT (major revision)

Co-occurring Psychiatric Disorders

- Declining psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay MAT (major revision)

Justice-Involved Individuals

- All FDA-approved medications for OUD should be available to individuals receiving healthcare within the criminal justice system; the treatment plan, including choice of medications, should be based on the individual patient's clinical needs (new)
- Individuals entering the criminal justice system should not be subjected to forced opioid withdrawal; individuals in OUD treatment should continue their treatment; those who are not in treatment should be assessed and offered individualized pharmacotherapy and psychosocial treatment as appropriate (new)
- Initiation or maintenance of MAT for OUD is recommended; staff should coordinate care and access to MAT to avoid interruption in treatment; patients should not be forced to transition from methadone or buprenorphine to naltrexone (major revision)
- A patient decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay MAT (major revision)
- If OTP is not available, patients may be transitioned to buprenorphine to methadone by a provider experienced in this transition (new)
- Risk for relapse and overdose is high in the weeks following release, patients who are stabilized in the prison or jail should continue treatment after release; patient care on reentry should be individualized and coordinated with community treatment providers (major revision)
- Naloxone kits should be available within correctional facilities; individuals with OUD should be given a naloxone kit prior to release; family and significant others should be educated on the administration of naloxone (new)

https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

SAMHSA FAQs – March 19, 2020

- Can an OTP admit a new patient with OUD to an OTP using telehealth (including telephone interview)?
  - Federal law requires a complete physical prior to admission. For buprenorphine initiation, SAMHSA can grant exemptions and has exempted OTPs from the requirement to perform an in-person physical evaluation. **This does not apply to methadone – these patients still require an in-person medical evaluation. Methadone dose initiation and escalation can not be done at home.**
  - March 16 2020 guidance – States may request blanket exceptions for all stable patients in an OTP to receive 28 days of take-home doses; may also request up to 14 days of take-home medications for patients who are less stable, but the OTP believes the patient can safely handle this level of take-home medication (these can be dispensed based on telehealth evaluation)
- Can an OTP continue to treat an **existing OTP patient** using methadone or buprenorphine via telehealth (including telephone interview)?
  - Yes, an existing OTP patient taking methadone or buprenorphine can be treated via telehealth
- Can a DATA waivered provider working outside the context of an OTP treat **new and existing patients** with buprenorphine via telehealth?
  - Yes, if complying with all standards of care; patients treated via telehealth will count toward the patient limit.
- Can OTP mid-level practitioners continue to dispense and administer MAT at an TP if their supervising provider can no longer provide supervision?
  - **A pharmacist, registered nurse, licensed practical nurse, or any other healthcare professional authorized by Federal and State law to administer or dispense opioid drugs (i.e, a mid-level practitioner) can administer and dispense MAT absent direct supervision**
- An OTP may request an exemption in order to have a mid-level provider perform functions related to admitting patients, ordering unsupervised take home medications or changing medication doses if these functions are consistent with applicable state law and the mid-level provider's scope of practice
- This exemption applies to the mid-level practitioner role in general, the exemption does not need to be updated if the actual mid-level practitioner changes.

https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

SAMHSA Opioid FAQs - Updated April 21, 2020

- The following can be done by a mid-level provider independently without supervision (requires SAMHSA exemption)
- OTP Patient Admission Criteria
  - Ensure each patient voluntarily chooses maintenance treatment; all drug therapy is clearly explained to the patient, obtain informed consent (program physician)
  - Can **waive the requirement for 1-year history of addiction for patients released from corrections facilities (within 6 months of release), pregnant patients (confirm pregnancy), previously treated patients (within 2 years of discharge)**
- Make dosing and administration decisions
- Make OTP decisions on dispensing opioid treatment medications to patients for unsupervised use
- Considering take-home criteria
- These are all usually functions of either the program physician or the medical director

https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

SAMHSA OTP Guidance for Patients Quarantined at Home with COVID – Updated March 30, 2020

- Document that the patient is medically ordered to be under isolation or quarantine; ensure that the source of the information is confirmed and documentation is maintained in the patients' OTP record
- **Identify a person that the patient designates who is trustworthy and not infected to deliver medications** using the OTP's established chain of custody protocol for take home medication. It is recommended for OTPs to determine who this person might be for each OTP patient in the event of new infections.
- The OTP should prepare a **"doorstep" delivery** if the designated person is unavailable. Take home medications must be in an **approved lock box**
  - Call the patient prior to staff delivery departure to ensure they or their designee are available to receive the medication
  - Medication is delivered to the door of the residence; call to notify the patient that it is there
  - Move at least 6 feet away to observe that the medications are picked up; the OTP staff must ask the person who is getting the medications from the door to identify themselves and that the person is the patient or designee; document confirmation that the medication was picked up from the door by the patient or designee
  - **Do not leave medication in an unsecured area; remain until the medication is retrieved**
  - If the patient or designee is not at the designated location, attempt to reach the person
  - If they don't arrive in a reasonable time, staff must bring the medication back to the OTP for storage until a decision about a second delivery attempt is made
  - Any medication brought back to the OTP must be logged in
  - The medication delivery and pick up be the patient or designee or return of medication to the OTP must be documented in the patient's OTP record and pharmacy records.

https://www.samhsa.gov/sites/default/files/otp-covid-implementation-guidance.pdf

DEA Prescribing Guidance

How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency

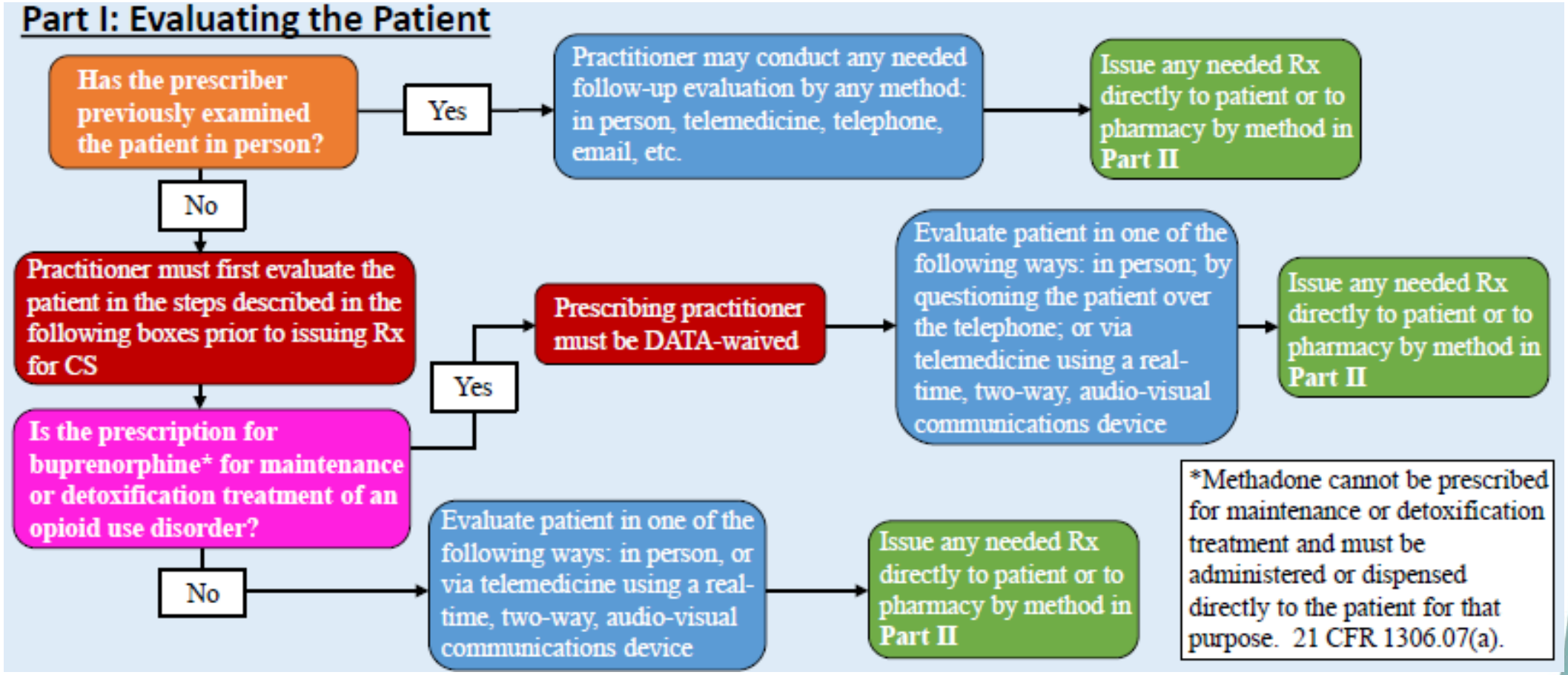
In response to the COVID-19 public health emergency declared by the Secretary of Health and Human Services, the Drug Enforcement Administration (DEA) has adopted policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients. This chart only addresses prescribing controlled substances and does not address administering or direct dispensing of controlled substances, including by narcotic treatment programs (OTPs) or hospitals. **These policies are effective beginning March 31, 2020, and will remain in effect for the duration of the public health emergency, unless DEA specifies an earlier date.**

This decision tree merely summarizes the policies for quick reference and does not provide a complete description of all requirements. Full details are on DEA's COVID-19 website (https://www.deadiversion.usdoj.gov/coronavirus.html), and codified in relevant law and regulations.

Under federal law, all controlled substance prescriptions must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his/her professional practice. 21 CFR 1306.04(a). In all circumstances when prescribing a controlled substance, including those summarized below, the practitioner must use his/her sound judgment to determine that s/he has sufficient information to conclude that the issuance of the prescription is for a bona fide medical purpose. Practitioners must also comply with applicable state law.

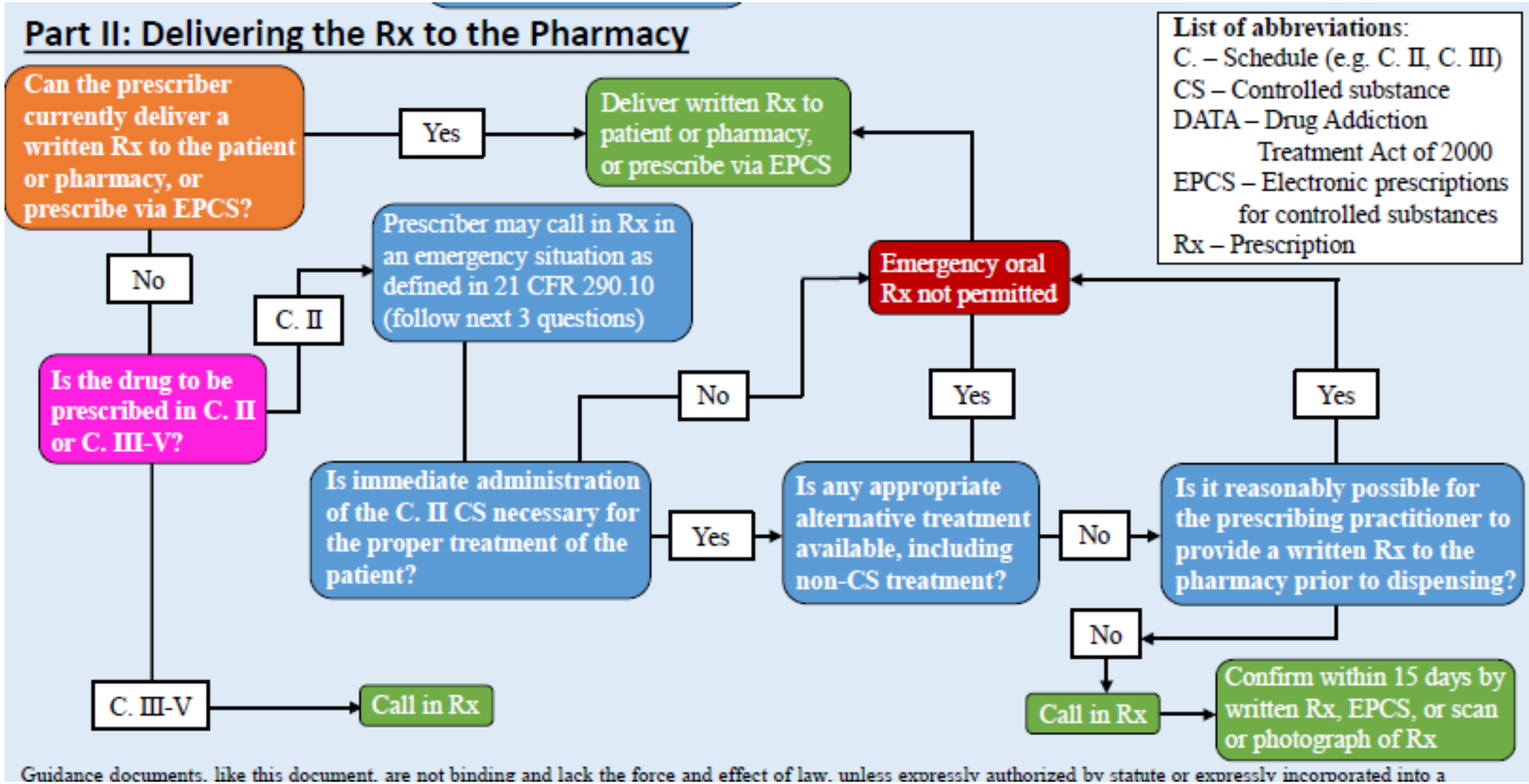
https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

DEA Decision Tree – Evaluating the Patient



https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

DEA Decision Tree – Delivering the Rx to the Pharmacy



https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

IHCP Bulletin – BT202042 – Apr 9, 2020
Revision of Policies for Behavioral Health Services

- Changes to admission, documentation, service, and prior authorization requirements for **ASAM levels 3.1 and 3.5**, intensive outpatient treatment, partial hospitalization programs, inpatient substance use disorder and psychiatric admission
- Modification of treatment requirements who are documented as in need of social isolation. Must document daily contact and ongoing support
  - New admission status, symptoms congruent with COVID-19, reported exposure to someone with COVID-19 or congruent symptoms
- Full clinical assessments will be completed within 7 calendar days; ASAM level 3.5 providers unable to complete subsequent follow-up visits in-person or virtually shall submit the following as an alternative:
  - Clinical update by a health service provider in psychology (HSPP), licensed mental health counselor (LMHC), licensed clinical social worker (LCSW), licensed clinical addiction counselor (LCAC)
  - Physical health update including vital signs, withdrawal symptoms, physical symptom changes, craving ratings with documentation of communication with a medical professional if there are increases in physical concerns including withdrawal symptoms. Changes to orders can be verbally given by the physician or advanced practice provider and documented in the record.
- ASAM Level 3.1 Services
  - Initial assessments – in-person or virtual healthcare questionnaire within 24 hours of intake that includes screening for COVID-19 as needed. Medical concerns warranting consultation with a medical professional should be documented.
  - Prior authorization – **Initial PAs for ASAM level 3.1 services will include 21 days**. Request for additional days will be due by the 21st day at the latest. Authorizations of 21 days only be provided for authorizations requested on or after April 9, 2020/

IHCP Bulletin – BT202042 – Apr 9, 2020
Revision of Policies for Behavioral Health Services

- **ASAM Level 3.5 Services**
  - Initial Assessments – If unable to complete the initial medical assessment within 48 hours in-person or virtually shall complete the following within 24 hours of intake:
  - Documented physical risk screen including substances used in the past month, current medications, medical history, vital signs, screening for urgent medical needs (diabetes, pregnancy, symptoms congruent with COVID-19)
  - Documentation must clearly confirm or deny symptoms in the above categories
  - Collaboration with physician or advanced practice provider via phone, telemedicine, or in-person consultation within 48 hours of admission must occur and be document in the record (documentation must also include treatment direction recommendations)
  - **Initial PAs for Level 3.5 will include 21 days**. Requests for additional days are due by the 21st day at the latest. Authorizations of 21 days will only be provided for requested on or after March 21, 2020
- Intensive outpatient treatment
  - Initial assessments in person or virtual healthcare questionnaire within 24 hours of intake, including COVID-19 screening as needed; document medical concerns warranting consultation with a medical professional. **PAs for IOT and PHP services will include 14 days**.
- Telemedicine
  - Providers are encouraged to use video-enabled technology; if these are not available, audio-only technology may be used and all service components must be met (use the most appropriate behavioral health procedure code(s) to describe the services rendered)
- Inpatient substance use disorder and psychiatric admissions
  - Initial Assessments in-person or by virtual healthcare questionnaire within 24 hours of intake, including screening for COVID-19 as needed. Document need for medical consultation.
  - PAs for inpatient SUD and psychiatric admissions will include 7 days. Request for additional days will be due by the 7th day at the latest. ****Opioid use disorder does not generally meet medical necessity criteria for inpatient SUD treatment – other treatment options should be considered****

http://provider.indianamedicaid.com/ihcp/Bulletins/BT202042.pdf

IHCP Bulletin – BT202044 – April 16, 2020

IHCP COVID-19 Response: IHCP makes updates to pharmacy benefits

In further response to the national public health emergency associated with the coronavirus disease 2019 (COVID-19) outbreak, the Indiana Health Coverage Programs (IHCP) is implementing the following additional changes regarding pharmacy benefits delivered under both the fee-for-service (FFS) and managed care delivery systems:

- Copays for all pharmacy claims are waived, effective April 1, 2020.
- Preference status of asthma and chronic obstructive pulmonary disease (COPD)-related metered dose inhalers (MDIs) has been suspended, effective April 1, 2020.
  - This change allows a member to receive a nonpreferred MDI without the need for an initial trial of a preferred MDI.
- Patient signature requirement for proof of delivery has been suspended (including patient pickup), effective March 1, 2020.
  - Pharmacy staff members are requested to complete the patient signature line with "COVID" in lieu of obtaining the patient's signature.
- Three-month extensions have been added to prior authorizations with expiration dates in April and May 2020 (excluding opioids and hepatitis C drugs).
  - This change requires no additional action by the member or pharmacy.

http://provider.indianamedicaid.com/ihcp/Bulletins/BT202044.pdf