Challenging Clinical Scenarios in MAT

Early Refills

Lost or Stolen Meds

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December 18, 2020

Disclosure

* I do not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Action Period Assignments from 10/23

1. Go online, including YouTube and Google, and find 2-3 popular urine adulterants that are being marketed and that you would like to share with the group during the next session.
    - Were you surprised at what you discovered? Will this change your practice in any way? If so, how?

2. How would you respond to a patient who asks: "Why do I have to provide these drug screens?"
    - Come up with a brief narrative that you can implement into your practice which explains to the patient why you're obtaining drug screens.

Objectives

- To identify the common reasons why patients may request early refills for buprenorphine.
- Learn how to implement effective clinical questioning and interventions when managing an early refill request.
- To become familiar with the common buprenorphine dosage requirements in patients with OUD.

Resources

1. TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Treatment Improvement Protocol (TIP) Series 40

http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

2. National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

3. Providers Clinical Support System (PCSS): Buprenorphine Induction

https://pcssnow.org/wp-content/uploads/2014/02/PCSS-MATGuidanceBuprenorphineInduction.Casadonte.pdf

Common Challenges with Buprenorphine Patients

* Precipitated withdrawal during home inductions
* Early refill requests
* Patient reports using more than prescribed.
* UDS is positive for other opioids
* UDS does not show buprenorphine
* Patient reports regular cannabis or alcohol use
* Strong suspicion that patient is selling the prescribed buprenorphine

MAT High Risk and Complex Patients

- **Are less ideal for management in a primary care setting.**
- Simultaneous SUD diagnoses in addition to OUD.
  - Ex. Patient has severe alcohol addiction and begins drinking again during buprenorphine treatment.
- Refractory OUD
  - Previous failed trials on bup and/or methadone
  - Continued active disease despite multiple inpatient and/or long-term residential programs.
- Complex psychiatric history.
  - Multiple inpatient psychiatric hospitalizations.
  - Multiple psychiatric medications with poor therapeutic efficacy
  - Simultaneous prescribed use of benzodiazepines in the unstable patient.

Ideal Patients for a Primary Care Setting

- Presence of OUD in the absence of other substance use disorders.
- No prior history of failed buprenorphine trials
- Any current psychiatric conditions are reasonably stable and well controlled.
- Benzodiazepines:
  - Patient is prescribed a reasonable therapeutic dose and is stable and doing on the medication.
  - No evidence of sedative addiction or benzodiazepine misuse.

Managing Bup Patients in a Primary Care Setting

- **Team approach**
  - Nurses, medical assistants, front desk staff.
  - Care team should all be educated on the basics of MAT
  - Regular meetings (weekly or monthly) to discuss complex patients and other clinic or patient concerns.
  - Appropriate delegation of responsibilities
    - Ex: MA manages incoming calls, discusses with RN, who communicates with the prescribing clinician (NP, PA, MD/DO).
- Provide patient with treatment agreement, which outlines expectations (templates are available online).
  - Note: this is NOT a contract

Early Refill Requests: Clinical Points

- Early refill requests are COMMON in buprenorphine medication management and do NOT always represent aberrant behavior.
- Patients often self-titrate dosages without telling you or inform you only when their Rx runs out.
- An early refill request may be a SIGN that the patient is not doing well and needs your help.
- Clinicians should manage an early refill request as a SYMTPOM which requires further investigation.

Reasons for Early Refill Requests

- **Patient is using more than the prescribed quantity**
  - Most commonly to mitigate cravings and/or withdrawal.
  - Refill requests are often 5-10 days early.
- **Patient is using the prescribed buprenorphine in an addictive manner, which is consistent with their misuse of other opioids.**
  - 30-day supply may be exhausted in 1-2 weeks.
- **Patient is selling a portion of their prescribed quantity.**
- **Medication was stolen or lost.**
  - YES, this does happen.

Early Refill: Assessment

* EVERY patient should be contacted regarding an early refill request.
* Assessment can be conducted by clinic support staff (RN, NP, PA) who have a basic understanding of MAT and can communicate findings to the prescribing clinician.
* Ideally, prescribing clinician should communicate with the patient, especially if the situation is somewhat complex.
* **NEVER authorize an early refill without investigating this issue and documenting that the patient was contacted.**

Early Refill: Assessment

* **1. Inquire:** *Tell me what happened?*
* **2. Validate**: *I'm sorry to hear about that. Are you doing OK?*
* **3. Explain**: *This is controlled substance, so there're certain things we need to do, and your treatment plan may temporarily change.*
* **4. Investigate**: UDS, MAPS
  * Ask for photos in relevant situations (i.e., report of destroyed meds or house fire).
* **5. Action**:
  * Increase dose
  * Refill original dose
  * Do not refill
  * Discontinue buprenorphine
* **6. Monitor and treat:** Schedule follow-up

Early Refills: Inquire

Let the patient know you're concerned that they may be using more than what is prescribed

* *"I'm sorry your meds got stolen but I'm concerned that something else may be going on. In my experience, some patients use more than what I'm prescribing and will have difficulty telling me about it. I'm wondering if this may be going with you? It's okay if that's the case, I just need to know so I can help you through this."*

Early Refills: Reasons to Increase Dosage

* Diversion is not suspected.
* Patient has demonstrated a reasonable degree of therapeutic efficacy on buprenorphine
* Patient reports increased cravings and feels current dosage "isn't enough."
* Patient has been reasonably compliant.
* UDS and MAPS report are unremarkable

Early Refills
Patient sub-optimally dosed

- **Increase bup dosage, if patient is taking less than 16 mg daily.**
  - **If patient is on 2-8 mg:** consider dosage increase by 4-8 mg.
  - **If patient is on 16 mg:** consider dosage increase to 20 mg.
  - **If patient is on 20 mg:** cautiously consider dosage increase to 24 mg.
    - Patient is recovery minded, is working a strong program, and is reliable and compliant.
  - **If patient is on 24 mg**: reconsider efficacy of medication and refer to higher level of care.

- **Consider non-pharmacological interventions:** care escalation to IOP, encourage community support meetings, step work, other psychological interventions.

Lost or Stolen Meds

- **Obtaining a police report should be at the discretion of the patient, not mandated by a clinic**: opinions vary on this issue.
- **If patient's report is within reason:**
  - **Option 1**: Do not issue another Rx and help patient manage withdrawal
  - **Option 2**: Provide patient with another prescription.
    - Patient and clinician will experience pushback from pharmacy and/or insurance provider.
    - Patient will likely have to pay cash
    - Pharmacy should be contacted by clinician, explaining situation.
    - Even with physician authorization, some pharmacies will not dispense med before due date.
- **Patients should be educated on appropriate medication storage.**
  - Purchase a safe
  - Do not carry meds in car, purse, or other personal belongings.

Early Refills: Diversion/Drug selling

- **A conclusion of diversion or selling is typically only made through clinical suspicion, circumstantial evidence, and clinician's intuition.**
  - Patients will never admit to you that they're selling their prescription medications and this accusation is very difficulty to prove. inicalition.
- **Although a criminal act, diversion may be a SIGN that the patient is not doing well and needs more intensive treatment.**
- **UDS may be helpful (negative for buprenorphine).**
- **If diversion is highly suspected, clinicians can do the following:**
  - Discontinue buprenorphine and consider alternative treatment (monthly naltrexone injections).
  - Discharge patient from practice: Addiction **is not** the primary problem (behavior is more criminally motivated).
  - Refer patient to a higher level of care: Addiction **is** the primary problem.
    - Long term residential treatment would be most appropriate.

Case 1

* 37-year-old female with a history of Rx opiate addiction (morphine and hydromorphone) was placed on buprenorphine 32 days ago.
* She has been maintained on 8 mg daily and has been doing reasonably well.
* She has provided 5 drug screens, which have all been unremarkable, including verified compliance with buprenorphine.
* She calls your office requesting a refill 8 days early: She reports that she recently turned in a rent-a-car but left the remainder of her medication in the vehicle.

Case 1: Discussion

* What will you do?
* What additional information would you like to do?

Case 1: Discussion with patient

- *"I'm sorry you lost your medications, but I'm concerned that something else may be going on. In my experience, it's quite common for a patient to use more than what is prescribed due to many factors, and then report that their meds were lost. My role here is to be helpful and in order to that, I need to know what's going on. If you've used more, I can understand that, but you need to be honest with me so I can help you."*

Case 1: What NOT to do

- **Immediately discharge patient from practice.**
  - This will not help anyone and will only make a bad situation worse.
- **Discontinue buprenorphine**
- **Take "my way or the highway" approach.**
- **Take a punitive stance.**
- **Shame the patient**
  - "I can't believe you're doing this to yourself."
- **Remember, your initial approach is to <u>treat this as a symptom and not as a failure.</u>**

Case 1: Takeaways

* Reasonable to suspect that her story is disingenuous.
* Diversion? Maybe, but you'll never you. **You must do what's in the best interest of the patient and not act on unfounded suspicion.**
* Patient is likely sub optimally dosed.
* Appropriate to increase dosage to 12 or 16 mg daily.
* Relapse should be ruled out.
  * **Patient should be drug tested ASAP**
  * **Review MAPS report**
* In the absence of any concerns, patient should be provided a dosage increase, a new Rx, and a follow-up visit within 5-7 days.

Case 1: Plan

- Increase buprenorphine to 12 or 16 mg daily
- Provide ONE WEEK SUPPLY ONLY, given patient's early refill request.
  - This allows you to follow the patient more closely and helps keep the patient accountable.
- Drug screen patient on that day, or at earliest possible time.
  - Screen may be positive for other opioids: very likely for patients to use if prescription runs out.
  - Important to ask about use of other substances in an unintimidating manner: "*Have you used anything to make you feel better?*"
  - It patient has used other opioids, explain home induction process in restarting buprenorphine, if patient is still actively using.
- Schedule follow-up appointment in 5-7 days.

Case 2

* 44-year-old female presents to our office reporting a history of heroin addiction for the last 10 years.
* You feel buprenorphine would be a reasonable treatment and the patient completes a home induction without incident.
* Over 7 days, the patient's dose is up-titrated to 16 mg daily.
* The drug screen obtained at the patient's 2nd follow-up visit (day 14) is unremarkable and is also negative for buprenorphine and norbuprenorphine.
* **What are the next steps?**

Case 2: Discussion with patient

- Discuss results with patient, but FIRST ask when they last ingested buprenorphine.
  - **YOU (Step 1)**: *I'm just following up on our appointment from Wednesday. There was some information I forgot to ask you: Can you please let me know when you last took buprenorphine and if you're taking the medication regularly?*
  - **PATIENT**: *I take it exactly as you told me to, and I haven't missed a day.*
  - **YOU (Step 2)**: *"Ok, thank you for providing that. I'd also like to share the results from your drug screen. It shows that buprenorphine was not in your urine and was wondering if you had any explanation for that?"*

Case 2: Discussion with patient

* **PATIENT**: *I don't understand, that has to be a mistake.*
* **YOU**: *We rarely see errors in this testing, and I don't think that's the case here. When I see this type or result, it makes me concerned that the patient is not taking the medication as it's prescribed or may be selling it to others What do you think?.*
* **PATIENT**: *Oh no Doctor, not me!*
* **YOU (option 1)**: *Well, for me to better understand what may be going on, we need to change your treatment plan.*
* **YOU (option 2)**: *Given the information that I have, I don't think you're using Suboxone in way it's intended to be used and It's no longer appropriate for me to prescribe this to you. I'm willing to discuss other treatment options.*

Case 2: Clinical Points

- If discharge is a consideration, obtaining a 2nd UDS may be helpful and can help confirm the patient is not taking the drug.
  - Request 2nd UDS before informing patient that 1st UDS did not contain buprenorphine. Example: "There was a concern with your drug screen on Monday and we need to test you again."
- Remember that diversion and not taking the prescribed buprenorphine (in the absence of pure criminal intent) is still a strong indication that the patient is not doing well and is at high risk for OD and possibly death.

Case 3

* A 22-year-old male with a history of heroin addiction was placed on buprenorphine by your office 4 weeks ago and has been maintained on 16 mg daily.
* He has been given 1-week prescriptions for the first 21 days.
* On the fourth week, he's given a 2-week supply, but calls you on day 6 of the Rx, reporting that he is out and has been using 32 mg per day.
* The patient states: "that dose works for me" and is asking for you to provide this dosage.

Case 3: Discussion

* What would you do?

Case 3: Discussion

- Is he addicted to buprenorphine?
- Should buprenorphine be continued?
- Action items:
  - UDS
  - MAPS report
  - In-office assessment
  - Consider higher level of care

Summary

- Early refills request are very common, do not always reflect aberrant behaviors. and may indicate a suboptimal dosing of buprenorphine.
- Early refills requests may also be indicative of resumption of addictive behaviors and clinicians may need to escalate the patient's care to IOP or long-term residential treatment.
- Early refill requests should never result in the immediate discharge of a patient or buprenorphine discontinuation.
- Diversion, while a criminal act, is often indicative of a poor clinical prognosis and treatment efforts should still be undertaken.

Action Period Assignments

1. As we discussed, the diversion of buprenorphine is rarely definitively proven in a clinical setting. How do you detect diversion and what actions, or clinic policies could you implement to help mitigate this behavior?

2. What clinical interventions and/or office policies could you implement in your practice to help reduce the likelihood o early refill requests?

Thank You!

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