Opioid Dependence Treatment with Buprenorphine/Naloxone: An Overview for Pharmacists and Physicians

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Legislation Passed Enabling Office-Based Treatment of Opioid Dependence

• Drug Addiction Treatment Act of 2000:
  - Gave “waiver authority for physicians who dispense or prescribe certain narcotic drugs for maintenance treatment or detoxification treatment”

H.R. 4365, Children’s Health Act of 2000
Amended Controlled Substances Act DATA 2000

- Revision in legislation allows a physician to prescribe narcotic drugs in schedules III, IV, V, or combinations of such drugs, for the treatment of opioid dependence

- Drugs and practitioners must meet certain requirements
Amended Controlled Substances Act DATA 2000

Narcotic drug requirements:

• Must be approved by the US FDA for use in maintenance or detoxification treatment of opioid dependence
• Schedule III, IV, or V
• Drugs or combinations of drugs
Amended Controlled Substances Act
DATA 2000

Practitioner requirements:

1. Must be a “Qualifying Physician” as defined in federal law

2. Must certify that they have the capacity to refer patients for appropriate counseling and ancillary services

3. Physicians must register with SAMHSA and DEA (i.e.: obtain the waiver to prescribe buprenorphine products for opioid dependence)
Practitioner requirements:

4. Patient Limit:
   - Year 1: No more than 30 patients per waived physician
   - After 1 year may petition to have patient limits up to 100 patients per individual waived physicians
   - Patient limit for waived physicians in group practices may be set by the Secretary
Amended Controlled Substances Act DATA 2000

Evaluation period:

• During the first three years following FDA approval of buprenorphine products, Department of Health and Human Services (DHHS) and Drug Enforcement Administration (DEA) evaluated safety and efficacy

• Safety included protection of the public against diversion of the drug
DHHS evaluated:

- Whether opioid dependence treatment is effective in the office setting
- Whether access to treatment was increased
- Whether there have been adverse consequences for the public health
Amended Controlled Substances Act
DATA 2000

DEA evaluated:

- Extent of violations of the 30/100 patient limit
- Extent of diversion of the medication
- Physician record keeping and security measures related to on-site medication storage
Amended Controlled Substances Act DATA 2000

- Buprenorphine was found to be a safe and effective treatment for opioid dependence
- DEA will continue to inspect practices in which physicians offer office-based treatment of opioid dependence
- Data on adverse events and deaths related to buprenorphine misuse are followed through national data collection and reported yearly (explained in more detail to follow)
Buprenorphine Characteristics

• Buprenorphine products are the only drugs currently FDA approved for office-based treatment of opioid dependence

• Buprenorphine is a mu opioid receptor partial agonist

• Buprenorphine exhibits ceiling effect on respiratory depression with increasing doses

• Therefore, buprenorphine is thought to be safer in overdose than other opioids
Buprenorphine Characteristics

• Buprenorphine/naloxone is the formulation which the federal government advises be used for treatment of opioid dependence

• Naloxone in the buprenorphine film helps to diminish the likelihood of diversion to injected abuse
Buprenorphine Advantages

• Buprenorphine is Schedule III
  - Methadone is Schedule II

• Methadone can only be prescribed for treatment of opioid dependence from specially regulated narcotic treatment programs
Treatment Modalities for Buprenorphine

- Office based treatment
  - Primary Care
  - Specialty Care (e.g. infectious disease, GI, Psychiatry)
- Substance abuse treatment clinics
- Methadone maintenance programs
Pharmacology of Full vs. Partial Mu Opioid Receptor Agonists

- **Full mu opioid receptor agonists:**
  - Bind to the mu receptor
  - Activate increasing numbers of mu receptors with increasing dose
  - Can fully activate mu receptors which can result in opioid toxicities at high doses

- **Full mu opioid receptor agonists include:**
  - Heroin, methadone, morphine, hydrocodone, oxycodone, oxymorphone, fentanyl, hydromorphone
Pharmacology of Full vs. Partial Mu Opioid Receptor Agonists

• Buprenorphine is a mu opioid receptor partial agonist that only partially activates the receptors; therefore, when it binds to the mu receptors, a net decrease in mu receptor activation occurs and withdrawal develops.

• Buprenorphine can precipitate opiate withdrawal if it displaces a full agonist from mu receptors.

![Graph showing the effects of drugs on mu receptor intrinsic activity.](image)
Buprenorphine
Dosage Forms and Approved Uses

• Buprenex® Injection: 0.3 mg/mL (1 mL vial)
  - Management of moderate-to-severe pain
• Buprenex® Sublingual tablet: 2 mg, 8 mg
  - Treatment of opioid dependence primarily during pregnancy
• Butrans® Transdermal patch: 5mcg/hr, 10mcg/hr, 20mcg/hr
  - Management of moderate-to-severe chronic pain in patients requiring an around-the-clock opioid analgesic for an extended period of time
Buprenorphine/Naloxone Dosage Forms

• **Suboxone® Sublingual Film**
  - Buprenorphine 2 mg and naloxone 0.5 mg
  - Buprenorphine 8 mg and naloxone 2 mg
  - lime flavor

• **Suboxone® Sublingual Tablets and Strips**
  - Buprenorphine 2 mg and naloxone 0.5 mg
  - Buprenorphine 8 mg and naloxone 2 mg
  - lemon-lime flavor
Buprenorphine/Naloxone Products

- Buprenorphine/naloxone combination developed specifically for treatment of opioid dependence
  - Developed to decrease diversion and prevent injection administration by those addicted to opioids
  - Preferred dosage form for opioid dependence treatment
  - Will precipitate withdrawal if administered to an opioid dependent person currently taking full mu agonist opioids
Buprenorphine/Naloxone Administration

• Sublingual film:
  - Film should be placed under the tongue
  - Keep under the tongue until film dissolves completely
  - Film should not be chewed, swallowed or moved after placement
  - If more than one film is needed, the additional film should be placed under the tongue on the opposite side from the first film

• Sublingual tablet:
  - Tablet should be placed under the tongue until dissolved
  - It should not be swallowed
  - If two or more tablets are needed per dose, up to 3 may be placed under the tongue at once
  - To ensure consistent bioavailability, subsequent doses should always be taken the same way
Buprenorphine/Naloxone Administration

• When administered sublingually:
  - Tablet dissolves in 3-10 minutes
  - Strips dissolve more rapidly
  - Taste is generally well tolerated
  - Strips reported to have better flavor
  - Monitor dissolution after dosing
  - Limit to two-three tablets/strips at one time to assure adequate absorption
Buprenorphine can be abused!!

Abuse of buprenorphine used parenterally

- Injected buprenorphine produces “high”
- Has relatively lower abuse risk as compared to full agonists (e.g. methadone)
- Injection of buprenorphine/naloxone is less preferred
  - Large dose of naloxone (an opioid antagonist) in buprenorphine tablets will displace full mu opioid agonist in those who have recently used a full mu agonist drug
  - Both buprenorphine and naloxone will also precipitate severe withdrawal in those with opioid dependence who have full mu opioid agonist on receptors
Buprenorphine Abuse Potential

Abuse potential of buprenorphine varies as function of:

- Level of physical dependence
  - Lower opioid physical dependence less likely to precipitate withdrawal; more likely to produce an agonist effect

- Time interval between last dose of opioid agonist and buprenorphine ingestion
  - The longer it has been since the last use of opioid; the more likely buprenorphine will give positive opioid effects

- Naloxone may diminish opioid effect
Two Types of Buprenorphine Treatment

1. Medical Withdrawal (detoxification)
2. Maintenance
   - Maintenance is the preferred treatment
   - Studies show that > 80% undergoing medical withdrawal will relapse in the year following treatment
Buprenorphine Maintenance

• Numerous outpatient clinical trials in people with opioid dependence compared efficacy with:
  - Methadone
  - LAAM (a long acting opioid no longer manufactured in the U.S. but previously used for opioid dependence treatment)
  - Placebo

• These trials reliably demonstrated that, in preventing relapse to heroin:
  - Buprenorphine is more effective than placebo
  - Buprenorphine is equally effective as moderate doses of methadone (e.g., 60 mg per day)
Buprenorphine Doses and Effect on Opiate Use

As the dose of buprenorphine increases, opioid use decreases as measured by urine drug screen.

(Ling et al., 1998)
Mean Heroin Craving
(16 Week Completers)

8 and 16 mg doses of buprenorphine associated with lower opioid craving over time

Mean Craving Score

1 mg
4 mg
8 mg
16 mg

Week of Study

(Ling et al., 1998)
Is there really significant difference between 4 mg and higher dosages after the 5th week?

Jeff Baldwin, 1/15/2013
Buprenorphine and methadone have equivalent retention in treatment over 16 weeks of therapy.

(Strain et al., 1994)
Delete this - already on the slide

Jeff Baldwin, 1/15/2013
Buprenorphine vs. Methadone
Opioid Urine Results

Both medications are associated with decreases in opioid positive urines which then begin to increase as dose is decreased (Weeks 16-20)

(Strain et al., 1994)
Buprenorphine Maintenance/Withdrawal Retention

Even with enhanced psychosocial services; those receiving withdrawal treatment (controls) had all left the study by 60 days (Kakko et al., 2003)
Starting Buprenorphine Treatment: Best Practices for Waivered Physicians

1. Confirm that the patient requesting buprenorphine treatment is opioid dependent
   • History/review previous treatment records if available
   • Look for physical signs
     - withdrawal, track marks
   • Urine drug screen positive for opioids (at least one positive screen)
     - Can check by dipstick whenever patient comes to your office
Starting Buprenorphine Treatment: Best Practices for Waivered Physicians

2. Check your state prescription drug monitoring program (PDMP)
   • Prior to starting buprenorphine and regularly thereafter
   • Understand how to interpret PDMP reports
     - May have some erroneous or confusing information
Ongoing Buprenorphine Treatment: Best Practices for Waivered Physicians

3. Once the patient is started on buprenorphine the prescriber must:
   - Continue to do random, regular urine drug screening to confirm that buprenorphine is present and to determine what other drug(s) are being used
     - Can use dipsticks and/or send to clinical lab for analysis
   - Check state PDMP periodically
   - Call patient back for random pill counts to decrease diversion risk
Ongoing Buprenorphine Treatment: Best Practices for Waivered Physicians

4. Every patient with opioid dependence must receive psychosocial treatments in addition to medication

- Aberrant behaviors of opioid dependence are not addressed by giving medication alone

- Therapies offered should include:
  - Individual counseling
  - Group counseling
  - Encourage attendance at 12 Step, mutual help groups

- Physicians agree to do this when they apply for waiver!
Ongoing Buprenorphine Treatment: Best Practices for Waivered Physicians

5. Document all aspects of substance abuse treatment

6. Do not give prescriptions for large quantities of buprenorphine/naloxone early in treatment
   • No more than one week at a time in the first few months until patient stabilizes and has stopped full agonist opioids or other illicit drug use
   • Shows regular treatment attendance
     - (Counseling, 12 step program)
   • PDMP confirms no other prescribers
Ongoing Buprenorphine Treatment: Best Practices for Waivered Physicians

7. Once stabilized, do not give more than a one month prescription
   - Physicians should be assessing patients at least once a month

8. Keep accurate and complete medical record documentation
   - *Remember: if it is not documented in the medical record; it didn’t happen!*

9. Make sure patient signs a 42 CFR compliant release of information before any treatment details are released/discussed with another provider
Buprenorphine: Side Effects

- Nausea/vomiting
  - consider precipitated withdrawal

- Diaphoresis

- Constipation

- Sedation
  - (generally mild with buprenorphine alone, but use of other sedating drugs or in those not currently dependent, but eligible for buprenorphine treatment by history, sedation is more common)

- Elevations in liver transaminases
  - (Hep C at higher risk; check baseline liver functions and as clinically indicated)

- Headache

- Vasodilatation

- Withdrawal Symptoms:
  - Precipitates withdrawal if given to a recent opioid user who is not in withdrawal
Induction: Procedure for use of buprenorphine/naloxone in opioid dependent patients on short acting opioids

**Day 1:**

- No opioids for at least 12 hours before induction
- Observe withdrawal before dosing;
  - Use standardized scale to determine severity (e.g.: use of Clinical Opiate Withdrawal Scale COWS)
- Initial dose: 2/0.5-4/1 mg
- May repeat dose after 1-2 hours if withdrawal symptoms not relieved;
- Maximum daily dose on day 1= 8/2 mg/day
Induction: Procedure for use of buprenorphine/naloxone in opioid dependent patients

Day 2:

• Assess patient
• Give previous dose from day 1 if no withdrawal symptoms present;
• If symptoms of withdrawal present, increase day 1 dose by 4/1-8/2 mg
• maximum daily dose on Day 2 = 16/4 mg/day
Induction: Procedure for use of buprenorphine/naloxone in opioid dependent patients

- Subsequent induction days:
- If withdrawal symptoms are not present, daily dose is established
- If withdrawal symptoms are present, increase dose in increments of 2/0.5 mg or 4/1 mg each day as needed for symptom relief
- Target daily dose by the end of the first week:
  - 12/3mg-16/4 mg/day; maximum daily dose: 24/6 mg/day
Induction – Special Considerations When Patient is on Methadone

- Methadone should be titrated down to \( \leq 30\text{mg/day} \) and patient should be experiencing withdrawal symptoms; usually takes at least 24 hours after last dose to observe withdrawal and can take 48 hours or longer in rare cases.

- TIP 40 states that initial treatment for days 1 and 2 may need to begin under close supervision using buprenorphine and that patients may be switched after 2 days to the combination product for maintenance and unsupervised therapy.

- Current practice is to only use buprenorphine/naloxone for inductions.

Induction Possible Complications: Precipitating Withdrawal Symptoms

• Check time of last use of opioids
• Occurs if buprenorphine/naloxone is administered before onset of withdrawal in person physically dependent on opioids
• Can be characterized by severe withdrawal (N/V, cramps, diarrhea, chills, myalgia, anxiety) within approx 15-30 minutes of buprenorphine/naloxone dose
Induction: Possible Complications: Precipitating Withdrawal Symptoms

- Consider medications for withdrawal symptoms (clonidine, antidiarrheals, antiemetics) and induction on a subsequent day or
- Monitor and re-dose with buprenorphine/naloxone after several hours (i.e. continue induction)

*Opiate withdrawal is generally not life threatening*
Maintenance Treatment

What is an “effective dose”? 

- Individual discontinues or substantially reduces opioid use
- Treatment retention
- Craving resolves
- Reduction/cessation of high risk, drug-related activities
- Doesn’t usually require doses over 16/4 mg/d (although patients will sometimes ask for more)
- 79-95% of mu receptors occupied at 16 mg/d

Zubiena et al, Neuropsychopharmacology, 2000
Greenwald et al. Neuropsychopharmacology, 2003
Medical Withdrawal

- Repeated administration of buprenorphine/naloxone produces and maintains physical dependence
- Can be substituted for heroin or other opioids and used as a withdrawal agent
- Degree of physical dependence is less than that produced by full agonist opioids
- Withdrawal syndrome less severe for buprenorphine/naloxone than for heroin, methadone or other opioids
Medical Withdrawal

• Initiate buprenorphine/naloxone up to 16/4 mg daily; then taper
• Withdrawal period can be over days to weeks
• Offer naltrexone (after 7 days free of buprenorphine/naloxone) to help prevent relapse
  - can use tablets or injectable
  - may start with a low (12.5-25 mg) dose of naltrexone (by splitting scored tablets)
Addressing Problems in Treatment: Use a Treatment Agreement with Every Patient

The agreement outlines the parameters under which buprenorphine will be provided.

- Describes goals of treatment
- Used to obtain informed consent
- Informs patient about risks/benefits of the medication
- Informs patient of behaviors that will not be allowed
- Informs patient of other aspects of treatment: urine drug screens, breath alcohol test if indicated, checking PDMP, pill counts
- Tells patient that you will medically withdraw/refer to higher level of care if noncompliant
Addressing Problems in Treatment: Continued Use of Opioids

• Can be a problem especially early in treatment
• Do not medically withdraw someone for one or even several uses
• If ongoing opioid use is chronic; most tox screens are positive; then (depending on circumstances):
  - Try requiring more counseling
  - Refer to a higher level of care (e.g.: methadone maintenance)
  - Medically withdraw and offer naltrexone or refer to a substance abuse treatment program that offers naltrexone
Polysubstance abuse is common

- **Danger of drug-drug life-threatening interactions**
  - e.g., benzodiazepines (sedative/hypnotics and anxiolytics) with buprenorphine (and with other opioids) have been associated with accidental deaths

- **However, benzodiazepines/sedative/hypnotic drugs may need to be used therapeutically in opioid-dependent, buprenorphine-maintained individuals. If so:**
  - Monitoring is required
  - Discussion of risks is required
  - If there is reason to believe the patient is abusing benzodiazepines, consider medical withdrawal and referral to a different/higher level of care.
  - If other illicit drugs are used and if the physician/clinicians believe use is harmful; consider discontinuation of buprenorphine/naloxone.
Addressing Problems in Treatment: Opioid Dependence with Mental Illness Comorbidity

• Not an absolute contraindication to buprenorphine/naloxone
• If patient is willing to participate in treatment for co-existing mental health disorders;
  - Buprenorphine/naloxone can be part of the care plan
• Try to avoid use of drugs likely to have drug interactions with buprenorphine/naloxone:
  - Fluoxetine inhibits CYP 3A4 and buprenorphine metabolism; interaction could be possible
  - Benzodiazepines will have pharmacodynamic interaction with CNS depressant effects
Addressing Problems in Treatment: Physical Illness

• All patients should have a primary care provider who is either:
  - The buprenorphine/naloxone prescriber or,
  - Who provides primary care and another physician (example: psychiatrist) prescribes buprenorphine/naloxone

• Primary and specialty (e.g. infectious disease, GI) can treat multiple medical issues in a patient with other physical illnesses
## Buprenorphine - Methadone Comparison

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<th>Buprenorphine/Naloxone</th>
<th>Methadone</th>
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<tbody>
<tr>
<td><strong>Regulation/Diversion</strong></td>
<td>- Partial agonist&lt;br&gt;- Combination: buprenorphine/naloxone&lt;br&gt;- Less diversion?&lt;br&gt;- Less regulation&lt;br&gt;- office-based opioid therapy (OBOT)</td>
<td>- Full agonist&lt;br&gt;- May be diverted-especially when prescribed in pain patients&lt;br&gt;- Toxicity risk greater&lt;br&gt;- Specialized treatment centers required</td>
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<tr>
<td><strong>Dose/Side Effects</strong></td>
<td>- Buprenorphine/naloxone preferred&lt;br&gt;- Side effects minor&lt;br&gt;- Precipitated withdrawal potential</td>
<td>- Relatively high dose required for tolerance induction; continued opiate effects, sedation</td>
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<td><strong>Ease of Use</strong></td>
<td>- Induction requires clinical monitoring&lt;br&gt;- Available by prescription&lt;br&gt;- Withdrawal easily tolerated&lt;br&gt;- One physician for patients with multiple illnesses</td>
<td>- Induction and dosing straightforward&lt;br&gt;- Withdrawal challenging; patients c/o significant discomfort&lt;br&gt;- Need for multiple providers&lt;br&gt;- Clinic visits may prevent full time employment</td>
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<td><strong>Toxicity</strong></td>
<td>- Few medically serious side effects</td>
<td>- Respiratory depression, altered mental status, QT prolongation, Torsades de Pointes</td>
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<td><strong>Drug Interactions</strong></td>
<td>- Few clinically significant with HIV meds to date; possibly atazanavir/ritonavir, rifampin, Benzodiazepine use is a concern</td>
<td>- Numerous, especially HIV meds, TB meds, anticonvulsants&lt;br&gt;- Benzodiazepine use is a concern</td>
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Who Should and Should Not Be Treated With Buprenorphine/Naloxone

- Serious medical illness: some may benefit (e.g. idoxuridine with HIV or Hepatitis C) from buprenorphine/naloxone treatment
- More functional patients: employment/employable benefit from buprenorphine/naloxone treatment
- Mental illness needs to be considered case by case:
  - No actively suicidal or psychotic individuals; treatment for serious depression or bipolar needs to be with an addiction psychiatrist or psychiatrist with experience treating co-occurring substance use disorders
- Patients who are benzodiazepine dependent should not receive buprenorphine/naloxone treatment
- Anxiety disorders: best if can be treated with SSRI
- Polysubstance Dependence: treatment must address all substances—not just opioids
Office-Based Treatment of Opioid Dependence

- Obtain the waiver to offer buprenorphine/naloxone treatment for your opioid dependent patients
- Get your staff on board with treating patients with substance use disorders
- Make sure all staff understand the confidentiality issues in treating substance use disorders
Office-Based Treatment of Opioid Dependence: Resources for Working with Buprenorphine-Maintained Patients

• Use the Physicians' Clinical Support System-Buprenorphine (PCSS-B) clinical tools in your practice

• (see www.pcssb.org):
  - Information for patients and families
  - Screening forms
  - Treatment agreements
  - History and Physical Examination Forms
  - 42 CFR compliant Consent Forms
  - Opiate Withdrawal Rating Scales
  - Example of Progress Notes

• Use the PCSS-B for help with questions.
What is Happening Now?

Cautionary Notes

Buprenorphine has become a highly prescribed drug in the United States

• Some states are trying to limit duration of use and dose in an effort to help control costs
• Have a structured treatment plan with clear goals and timelines
• Not everyone requires lifetime treatment: this decision should be based on the clinical needs of the patient; not assumed to be necessary as a rule of treatment of opioid addiction
• We do not have data on whether reducing dose and gradually shifting to naltrexone as progression in treatment occurs would produce good outcomes—many simply assume that everyone needs lifetime treatment which cannot be supported on current data
What is Happening Now?
Cautionary Notes

Buprenorphine is being widely diverted

- Most patients know that 8/2 mg will prevent withdrawal;
  - Higher doses while therapeutic can also be a source of illegal income

- Make sure urine tox screens are done regularly
- Make sure to test for presence of buprenorphine and other drugs
- Call patients back for random pill counts

*Refusal to cooperate with urine tox screens or pill counts is reason for discharge!*
Special Aspects for Pharmacists

• Pharmacist and technician education is essential regarding:
  - addiction
  - the patient population
  - buprenorphine/naloxone treatment

• Training allows pharmacists and technicians to be more comfortable and confident in providing pharmacy services to opioid-dependent patients being treated with buprenorphine/naloxone from an office-based opioid treatment (OBOT) setting.

• Prescribers of buprenorphine/naloxone from an OBOT must have either their DATA 2000 waiver ID number or "X" number on the prescriptions.

Raisch DW, Fudala PJ, Saxon AJ et al.
Special Aspects for Pharmacists

• Shared information and collaboration between prescriber and pharmacist enhances monitoring and positive outcomes
  - Sharing responsibility for checking PDMP reports
  - Understanding treatment plan

• Lack of availability of appropriate pharmacy services will impede the widespread implementation of buprenorphine/naloxone for treatment of opioid dependence.
  - Maintain an adequate supply of buprenorphine/naloxone so patient will not have a lapse in their treatment

Raisch DW, Fudala PJ, Saxon AJ et al.
Special Aspects for Pharmacists

• Buprenorphine/naloxone diversion or prescription forgery is not as big of a concern as with other controlled substances, however:
  - Pharmacists & technicians should be aware that buprenorphine/naloxone is misused/abused and diverted.
  - Watch for signs such as paying cash for prescriptions, track marks, appearance of being “high”, etc.

• Pharmacists working in concert with physicians and patients, can make a major contribution to alleviating the morbidity and mortality associated with this very serious disorder.

• Confidentiality is critical!

Raisch DW, Fudala PJ, Saxon AJ et al.
Ask a clinical question...

- Get a response from an expert PCSS mentor
- (888) 888-572-7724 (Buprenorphine) (855) 227-2776 (Opioids)

From [www.PCSSB.org](http://www.PCSSB.org) and [www.PCSS-O.org](http://www.PCSS-O.org)

- Download clinical tools,
  - helpful forms
  - concise guidance (FAQs) on specific questions regarding
    1. opioid dependence
    2. use of buprenorphine
    3. safe/effective use of opioids
  - information on training and peer support
Summary
Buprenorphine/Naloxone

• Buprenorphine is an opioid partial agonist with:
  - less opioid effects than heroin or methadone
  - less potential for toxicity
• Opioid dependence must be verified prior to starting buprenorphine/naloxone treatment
• Induction requires clinical observation
• Withdrawal is better tolerated than for other opioids
Summary
Buprenorphine/Naloxone

• Diversion is becoming an issue
  - need to train physicians not to increase dose without justification
  - do not assume anyone will need the highest FDA-approved dose or doses that exceed FDA upper limit
• Patients with benzodiazepine addiction should not receive buprenorphine/naloxone treatment
• Control medication days supply per prescription
• Require ongoing substance abuse psychosocial treatment including a 12 step program, as a contingency for receiving medication
Please Click the Link Below to Access the Post Test for the Online Module

Upon completion of the Post Test:

• You will receive an email detailing correct answers, explanations and references for each question.

• You will be directed to a module evaluation, upon completion of which you will be emailed your module Certificate of Completion.

http://www.cvent.com/d/dcq5mk