Supplemental material for

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References:

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2. Federation of State Medical Boards. Model policy on DATA 2000 and treatment of opioid addiction in the medical office. Washington, DC: Federation of State Medical Boards, 2013. http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/2013_model_policy_treatment_opioid_addiction.pdf. Accessed August 14, 2017.

Appendix

MAHEC Family Health Center
Office Based Opioid Treatment (OBOT)

Policies and Procedures

I. Purpose

Opioid dependence is a chronic medical condition for which patients need ongoing treatment and support. As primary care providers, MAHEC providers are able to help patients access the treatment they need for opioid dependence within their medical home. MAHEC's Office Based Opioid Treatment (OBOT) was created in 2015 to provide patients with access to treatment of substance use disorder within their primary care home.

II. Scope

This policy & procedure applies to MAHEC patients who have a diagnosis of opioid dependency, request treatment for their substance use disorder through MAHEC's OBOT, and meet the eligibility criteria as described in this policy.

III. Responsibility

The OBOT Faculty Physician Lead (Blake Fagan), OBOT Director (Courtenay Wilson), OBOT APP (Carriedelle Fusco), OBOT Coordinator (Zach White), and OBOT scheduler (Monica Gonzalez) are responsible for this procedure. Other OBOT team members include: Faculty physicians with their DATA 2000 waivers, PGY3 residents, behavioral medicine faculty, pharmacy faculty, medical assistants, and schedulers.

IV. General

1. Patient Eligibility

- New or established MAHEC patient who is compliant with provider's plan of care for a minimum of three visits including initial OBOT intake visit.
- 18 years old or older.
- Meets the criteria for opioid dependence based on DSM V.
- Taking no more than 16mg/d of buprenorphine. If taking >16mg/d, must be willing to attempt to decrease to 16mg/d.
- No concurrent abuse of other medications or illicit substances or willing to discontinue use.
- Consents to required screens at initial consultation visit including but not limited to urine drug screen, alcohol screen, check of NCCSRS report.
- Signs Patient Consent and Patient Agreement.

- In good financial standing with MAHEC.

Conditions That Would Preclude a Patient as a Candidate for MAHEC's OBOT:

- Codependence on high doses of benzodiazepine or alcohol.
- Untreated mental health illness.
- Poor response to numerous previous well conducted attempts of buprenorphine treatments.
- Significant medical complications (especially end stage pulmonary diseases).
- Inability to follow treatment requirements.
- Physician discretion.

2. Initial Consultation Visit

All potential patients must have an initial consultation visit with the OBOT APP and/or OBOT Coordinator to determine if the patient meets the eligibility criteria. **No buprenorphine prescriptions will be given at the initial consultation visit.**

Components of the Initial Consultation visit:

- Education on opioid dependence and buprenorphine/naloxone treatment.
- Overview of the OBOT structure and expectations.
- Sign Patient Agreement and Consent for Treatment.
- Intake history.
- Urine drug screening.
- LFT's, hepatitis panel, HIV, Cr, urine hcg (females only).
- Review of North Carolina Controlled Substance Reporting System report.
- Consent to speak and obtain records from current & prior providers.

3. Determination of Eligibility

Based on the Initial Consultation Visit, the OBOT Director will determine if the patient meets eligibility criteria for MAHEC OBOT.

If accepted into the program, FM Scheduling department will be notified by the OBOT Coordinator to contact the patient to schedule the first visit with their assigned buprenorphine prescriber.

If not accepted into the program, the OBOT APP, OBOT Coordinator, or patient's assigned Primary Care Provider (PCP) will call the patient to explain why they were determined ineligible for enrollment in the program at this time.

4. First Visit with PCP

During the first visit, the PCP will assist the patient in developing goals for care, including duration of treatment, referrals to other support services, i.e. behavioral medicine, pharmacy, care management, etc.

5. Follow-up visits

To continue in the program, the patient must adhere to the treatment plan as outlined by the PCP.

If the assigned physician is not available, the patient is responsible for ensuring the OBOT visit is scheduled with the OBOT group. **No other physician may write for buprenorphine.** Refills will only be prescribed at clinic visits.

The patient is required to bring the buprenorphine/naloxone tablets/films to each visit. A drug screen and pill count will be performed at each visit. If the patient does not bring the medication, it will be considered an abnormal medication count.
Random pill/film counts and drug screens may be performed. If the patient fails to come to the clinic within 24 hours of notification of pill/film count and/or drug screen, this will be considered an abnormal count and drug screen.

6. Group Medical OBOT Visits
Group medical OBOT visits will be offered in the fall of 2016. These will be on Thursday afternoons. These will be facilitated by the OBOT Coordinator and buprenorphine prescriptions will be written by one of the OBOT physicians. All new patients will be required to attend the group medical visit at least once per month unless the primary OBOT physician determines otherwise. Existing patients as of September 2016, will be informed of the new group OBOT visit and will be encouraged to attend these visits as well.

7. Referral to more intensive treatment program
The physician may refer the patient to a more intensive treatment program for the following reasons:

- Ongoing opioid use despite adequate buprenorphine/naloxone dosing (no cravings, withdrawal and adequate narcotic blockage).
- Two unexpected drug screens.
- Failure to comply with random drug screens or pill counts.
- Ongoing abuse of higher doses of benzodiazepines, stimulants, or barbiturates causing impairment, sedation, overdose, medical illness, or hazardous unsafe behaviors despite interventions by the OBOT Team.
- Abuse of alcohol causing sedation, impairment, or hazardous unsafe behaviors despite interventions by the OBOT Team.
- Cocaine: Continued use despite intensifying treatment with more frequent OBOT visits and monitoring.
- Failure to follow agreed upon policies and procedures.

V. OBOT Team Meeting

The OBOT team meets on the fourth Tuesday of the month. The goals for this meeting are:

- To review patients for eligibility following their initial OBOT visit
- To ensure all active patients are meeting the requirements outlined in the Policies and Procedures.
- To address operational issues that may arise (EHR, scheduling, etc).
- To discuss clinical cases and share lessons learned.

VI. Patients with Pain

1. Acute Pain
Patients who are being treated for addiction also may experience pain due to illness or injury. Pain in patients receiving buprenorphine treatment for opioid addiction should be treated initially with non-opioid analgesics when appropriate. Once daily dosing of

buprenorphine often does not provide sufficiently sustained relief of pain. If buprenorphine is dosed once daily, the administration can be changed to divided doses while maintaining the same total daily dose.
Patients maintained on buprenorphine whose acute pain is not relieved by non-opioid medications or split daily dosing may require the use of short-acting opioid pain relievers. In such cases, the administration of buprenorphine generally should be discontinued. Higher doses of the opioid agonist may be required until the buprenorphine clears from they patient's system (24-36 hours). Non-combination opioid analgesics are generally preferred to avoid the risk of acetaminophen toxicity when combination products are used at the doses that are likely to be required for pain control in patients who have been maintained on buprenorphine. Analgesic dose requirements should be expected to decrease as buprenorphine clears the body.
When restarting buprenorphine, to prevent acutely precipitating withdrawal, administration generally should not begin until sufficient time has elapsed for the opioid pain medication to have cleared from the patient's system, as demonstrated by the onset of early withdrawal (see Induction Protocol below).

2. Chronic Pain
Buprenorphine may provide analgesic benefit for patients with addiction and chronic pain. Split dosing is generally preferred to provide sustained pain relief. If the patient continues to experience pain with split daily dosing, methadone may be required, which must be provided in an OTP. MAHEC does not prescribe buprenorphine for pain in the absence of addiction. MAHEC does not prescribe methadone for pain when there is a picture of addiction as well.

VII. Induction Protocol

1. Identification of Patient
When a provider identifies a patient who is a potential candidate for induction onto buprenorphine, the provider will send a patient message to FM Initial OBOT clinic inbox for review. The OBOT Coordinator is responsible for managing this inbox. First, the OBOT Coordinator will determine if the patient meets the eligibility criteria. If so, then the OBOT Coordinator, OBOT Director, and PCP will review the patient to determine if the induction should proceed. If the team agrees induction is in the patient's best interest, the OBOT Coordinator will notify the OBOT Scheduler to contact the patient to schedule the first visit with their assigned buprenorphine prescriber. If the team decides not to proceed with the induction, the OBOT Coordinator or PCP will notify the patient.

2. Intake Visit
The patient must complete an intake visit with the OBOT APP. The visit will include:

- Review of the induction protocol and the policies and procedures of MAHEC's OBOT.
- Education on buprenorphine including administration, dosing, potential side effects, and risks.
- Patient will be required to sign the consent for treatment and Patient Agreement.
- Patient will be given a prescription for two days' worth of buprenorphine/naloxone.

3. Induction

The goal of the induction is to find the minimum dose of buprenorphine at which the patient discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and no uncontrollable cravings for drugs of abuse.

There are three different induction protocols that will be used depending on the opioid of abuse. For all induction protocols, the process will be the same.

1) The patient will be scheduled with his/her assigned buprenorphine provider for at least two visits to begin the induction. The first visit must be on a Monday or Tuesday morning and the second visit must be the following day. The patient should also be scheduled for the group OBOT visit on Thursday afternoon the week of the induction.
2) The patient will bring the medication to clinic on the day of the induction.
3) The patient will remain in the exam room with the door open during the induction.
4) The medical assistant working with the physician will administer the SOWS as outlined in the protocol.

Protocol 1: Conversion from short/immediate acting opioids

Short Acting Opioids: Heroin; crushed Oxycontin; Immediate release formulations, including: Percocet, Vicoden, oxycodone, tramadol, etc.

Intermediate Acting Opioids: Oxycontin, other extended release formulations

Using TIP 40 induction protocol, Figure 4-1, proceed as follows:

Day 1:

1. Patient is instructed to take their last dose of opioid 12-24 hours before their induction visit. For intermediate acting opioids, period of abstinence should be 24 hours.
2. During the office visit the physician will assess the patient's status using the SOWS. The SOWS assessment will continue every 30 minutes until the SOWS is between 11-20 at which point the patient should be exhibiting early signs of opioid withdrawal (sweating, yawning, rhinorrhea, and lacrimation).
3. Once the SOWS is between 11-20, the physician will give the first dose of 2/0.5-4/1mg buprenorphine/naloxone. The patient will remain in the exam room and status will be monitored for two hours.
4. The MA will administer the SOWS two hours after the first dose and record the score on the flow sheet.
    a. If SOWS < 10, day one dose is established.
    b. If SOWS $\geq$ 10, repeat dose every two hours up to maximum 8/2mg for the first day.
        i. If SOWS remains $\geq$10 after the max dose of 8/2mg, consider managing withdrawal symptoms with clonidine, ondansetron, and/or NSAIDs.
    c. The total amount of buprenorphine administered in the first day should not exceed 8mg.

Day 2:

1. The MA will administer the SOWS and record the score in the flow sheet.
    a. If SOWS < 10, give the total dose administered in day one.

b. If SOWS $\geq$ 10, give dose equal to the total amount of buprenorphine/naloxone administered on day one plus an additional 4/1mg.
c. The patient will remain in the exam room and status monitored for two hours.

2. The MA will administer the SOWS two hours after the first dose.
    a. If SOWS < 10, day two dose is established.
    b. If SOWS $\geq$ 10, give dose an additional 4/1mg buprenorphine/naloxone. Repeat as needed every two hours until max dose of 16/4mg.
        i. If SOWS remains $\geq$10 after the max dose of 16/4mg, consider managing withdrawal symptoms with clonidine, ondansetron, and/or NSAIDs.
    d. The total amount of buprenorphine administered in the second day should not exceed 16mg.

Group Visit Day (Thursday, Day 3 or 4 of induction):

1. The MA will administer the SOWS and record the score in the flow sheet.
    a. If SOWS < 10, daily dose of buprenorphine/naloxone is established.
    b. If SOWS $\geq$ 10, give dose equal to the total amount of buprenorphine/naloxone administered on previous day plus an additional 4/1mg.
    c. The patient will remain in the exam room and status monitored for two hours.
2. The MA will administer the SOWS two hours after the first dose.
    a. If SOWS < 10, daily dose of buprenorphine/naloxone is established.
    b. If SOWS $\geq$ 10, give dose an additional 4/1mg buprenorphine/naloxone. Repeat as needed every two hours until max dose of 24/6mg.
        i. If SOWS remains $\geq$10 after the max dose of 24/6mg, consider managing withdrawal symptoms with clonidine, ondansetron, and/or NSAIDs.
    e. The total amount of buprenorphine administered should not exceed 24mg.

Week 2 and Beyond

1. Once the patient's daily dose of buprenorphine/naloxone is established, the patient should be seen weekly for 4 weeks and then monthly thereafter. These visits will preferably be conducted at the OBOT group visit. However, the patient may schedule individually with his/her physician at the physician's discretion.
2. If the patient has reached the maximum dose of buprenorphine/naloxone (24/6mg) and continues to have illicit opioid use, withdrawal symptoms, or compulsions to use, then the physician should increase intensity of nonpharmacological interventions, consider referral to OTP or other more intense level of treatment.

Protocol 2: Abstinence

Patients who are not physically dependent on opioids but who have a known history of opioid addiction, have failed other treatment modalities, and have a demonstrated need to cease the use of opioids, may be candidates for buprenorphine treatment. Other patients in this category would be those recently released from a controlled environment who have a known history of opioid addiction and a high potential for relapse.

These patients will not have withdrawal when they present since they are not currently opioid-dependent; thus, the SOWS does not guide dosing.

Day 1

1. The physician will administer 2/0.5mg of buprenorphine/naloxone.
2. The patient will remain in the exam room and status will be monitored for at least 2 hours.

Day 2

1. If patient has no illicit opioid use or compulsion to use, then daily dose of buprenorphine/naloxone is established.
2. If patient does have illicit opioid use or compulsion to use, the physician will administer 4/1mg of buprenorphine/naloxone.
    a. The patient will remain in the exam room and status will be monitored for at least 2 hours.

Group Visit Day (Thursday, Day 3 or 4 of induction):

1. If patient has no illicit opioid use or compulsion to use, then daily dose of buprenorphine/naloxone is established.
2. If patient does have illicit opioid use or compulsion to use, the physician will administer 6/1.5mg of buprenorphine/naloxone.
    a. The patient will remain in the exam room and status will be monitored for at least 2 hours.

Week 2 and Beyond

1. The patient should return to clinic every 2-3 days until the daily dose of buprenorphine/naloxone is established as evidenced by a lack of illicit opioid use or compulsion to use. The dose may be increased at an interval of 2/0.5mg daily to a maximum dose of 24/6mg.
2. Once the patient's daily dose of buprenorphine/naloxone is established, the patient should be seen weekly for 4 weeks and then monthly thereafter. These visits will preferably be conducted at the OBOT group visit. However, the patient may schedule individually with his/her physician at the physician's discretion.
3. If the patient has reached the maximum dose of buprenorphine/naloxone (24/6mg) and continues to have illicit opioid use or compulsions to use, then the physician should increase intensity of nonpharmacological interventions, consider referral to OTP or other more intense level of treatment.

Protocol 3: Conversion from methadone

Patient must be on methadone dose of 30mg or less per day for a minimum of one week before initiating buprenorphine induction treatment. Patients should not receive buprenorphine until at least 24 hours after the last dose of methadone.

During the initial consultation visit, the OBOT Coordinator will receive signed consent to communicate with the patient's Opioid Treatment Program (OTP). The OBOT Coordinator will then contact the patient's OTP to determine the methadone dosage levels and time of last dose.

Using TIP 40 induction protocol, Figure 4-1, proceed as follows:

Day 1

1. Patient is instructed to take their last dose of methadone 24-36 hours before their induction visit.

2. During the office visit the physician will assess the patient's status using the SOWS. The SOWS assessment will continue every 30 minutes until the SOWS is between 11-20 at which point the patient should be exhibiting early signs of opioid withdrawal (sweating, yawning, rhinorrhea, and lacrimation).
3. Once the SOWS is between 11-20, the physician will give the first dose of buprenorphine 2mg. The patient will remain in the exam room and status will be monitored for two hours.
4. The MA will administer the SOWS two hours after the first dose and record the score on the flow sheet.
    a. If SOWS < 10, day one dose is established.
    b. If SOWS $\geq$ 10, repeat dose every two hours up to maximum 8mg for the first day.
        i. If SOWS remains $\geq$10 after the max dose of 8mg, consider managing withdrawal symptoms with clonidine, ondansetron, and/or NSAIDs.
    c. The total amount of buprenorphine administered in the first day should not exceed 8mg.

Day 2

1. On Day 2, the buprenorphine monotherapy should be switched to buprenorphine/naloxone.
2. The MA will administer the SOWS and record the score in the flow sheet.
    a. If SOWS < 10, give the total dose administered in day one.
    b. If SOWS $\geq$ 10, give dose equal to the total amount of buprenorphine administered on day one plus an additional 4/1mg.
    c. The patient will remain in the exam room and status monitored for two hours.
3. The MA will administer the SOWS two hours after the first dose.
    a. If SOWS < 10, day two dose is established.
    b. If SOWS $\geq$ 10, give dose an additional 4/1mg buprenorphine/naloxone. Repeat as needed every two hours until max dose of 16/4mg.
        i. If SOWS remains $\geq$10 after the max dose of 16/4mg, consider managing withdrawal symptoms with clonidine, ondansetron, and/or NSAIDs.
    f. The total amount of buprenorphine administered in the second day should not exceed 16mg.

Group Visit Day (Thursday, Day 3 or 4 of induction):

1. The MA will administer the SOWS and record the score in the flow sheet.
    a. If SOWS < 10, daily dose of buprenorphine/naloxone is established.
    b. If SOWS $\geq$ 10, give dose equal to the total amount of buprenorphine/naloxone administered on previous day plus an additional 4/1mg.
    c. The patient will remain in the exam room and status monitored for two hours.
2. The MA will administer the SOWS two hours after the first dose.
    a. If SOWS < 10, daily dose of buprenorphine/naloxone is established.

b. If SOWS $\geq$ 10, give dose an additional 4/1mg buprenorphine/naloxone. Repeat as needed every two hours until max dose of 24/6mg.
    i. If SOWS remains $\geq$10 after the max dose of 24/6mg, consider managing withdrawal symptoms with clonidine, ondansetron, and/or NSAIDs.

g. The total amount of buprenorphine administered should not exceed 24mg.

Week 2 and Beyond

1. Once the patient's daily dose of buprenorphine/naloxone is established, the patient should be seen weekly for 4 weeks and then monthly thereafter. These visits will preferably be conducted at the OBOT group visit. However, the patient may schedule individually with his/her physician at the physician's discretion.
2. If the patient has reached the maximum dose of buprenorphine/naloxone (24/6mg) and continues to have illicit opioid use, withdrawal symptoms, or compulsions to use, then the physician should increase intensity of nonpharmacological interventions, consider referral to OTP or other more intense level of treatment.

MAHEC Family Health Center
Office Based Opioid Treatment (OBOT)

PATIENT CONSENT FORM for
Treatment with Buprenorphine

Buprenorphine is an FDA-approved medication for treatment of opiate dependence which can be used for detoxification or maintenance therapy. Buprenorphine is a partial opioid agonist that blocks cravings for and withdrawal from opioids.

I understand that the induction period is when I am started on buprenorphine. This phase may take one to two weeks. The stabilization phase follows the induction phase and may last for one to three months. I understand that maintenance therapy can continue as long as medically necessary and is estimated to continue for at least six (6) months.

I understand that side effects of buprenorphine may include headache and constipation.

I understand buprenorphine treatment can result in physical dependence of an opioid.

I understand stopping buprenorphine suddenly may result in symptoms such as muscle aches, stomach cramps, and/or diarrhea which may last several days. If I decide to stop taking buprenorphine, I understand the amount I take should be slowly decreased over several weeks.

I further understand if I am dependent on opioids at the time of induction of buprenorphine, I should be in as much withdrawal as possible. If not in withdrawal, I may experience severe opioid withdrawal.

I further understand, once I am stabilized on buprenorphine, the use of other opioids will have less effect and taking additional opioids could result in an overdose.

I understand if I take buprenorphine while I am pregnant, the baby will likely be dependent on buprenorphine and will need to stay in the hospital for a few days and may need medication for withdrawal. I understand that continued substance use while pregnant may result in preeclampsia, miscarriage, premature delivery, intrauterine growth restriction, neonatal abstinence syndrome, and fetal death.

I understand using alcohol or other drugs such as but not limited to Klonopin, Valium, Haldol, Librium and Ativan while I am taking buprenorphine is hazardous and may result in death.

I understand –

- My provider may require me to attend either individual or group counseling sessions.
- I must complete an intake visit with a MAHEC provider before beginning induction.

- For induction, I will be given a prescription for two days' of buprenorphine product which I must bring to the clinic on the day of induction.
- I must return to the clinic the day following the induction.
- Following induction, I must remain in the clinic for two hours.
- Buprenorphine tablets (or film) must be held under the tongue until completely dissolved and will not be absorbed if swallowed whole.
- I must be assessed for any reactions by the clinical staff before leaving the clinic and will be required to be evaluated by the provider in the event of any reaction, including overdose or withdrawal if the dose is too high or too low, respectively. Side effects of buprenorphine may include headache and constipation.
- If I fail to comply with the 2 hour waiting period, I will not be eligible to receive buprenorphine at a MAHEC facility.
- I must inform the clinical staff before receiving the buprenorphine if I am taking any new medication, especially medication for HIV or Hepatitis C due to significant drug interactions.
- I must inform the clinical staff before receiving the buprenorphine if I am pregnant.
- Precautions consistent with the standard medical protocols will be carried out to protect me against adverse reactions.

I agree if I have an allergic reaction to buprenorphine, the physician-in-charge has permission to treat the reaction. I understand that signs of an allergic reaction include difficulty breathing, tightness of the throat, and hives.

I have read and understand the above information including the risks and have been given the opportunity to discuss any questions with the provider.

PATIENT_____ DATE_____

PARENT or LEGAL GUARDIAN_____ DATE _____

MAHEC Family Health Center
Office Based Opioid Treatment (OBOT)

Patient Agreement

The purpose of this agreement is to prevent misunderstandings about buprenorphine-containing medications (Subutex and Suboxone). I understand that this medication may be helpful to treat opioid abuse and dependence. I freely and voluntarily agree to accept this treatment agreement, as follows:

General Policies:

- I agree to keep, and be on time to, all my scheduled appointments with my physician and other team members, and to conduct myself in a courteous manner in the clinic.
- If an emergency or a schedule change creates a conflict with my appointment, I will contact MAHEC at 257-4730 as soon as possible to address the situation and reschedule the appointment.
- I agree not to arrive at the clinic intoxicated or under the influence of drugs. If I do, the physician or other team member may not see me, and I will not be given any medication until my next scheduled appointment. I may be required to arrange for alternate transportation if my physician or a member of the OBOT team deems me unfit to drive. Additional therapy sessions may be required in order to help me effectively communicate/interact in the environment.
- I will keep MAHEC updated on any changes in medications or medical issues including: surgery, hospitalizations, need for acute pain treatment, or problems with my buprenorphine-containing medication.
- I understand that any medical treatment is initially a trial. If there is no improvement in my daily function or quality of life with buprenorphine-containing medication, my medication may be discontinued and/or tapered off as prescribed by the provider.
- I understand that I must remain in good financial standing with MAHEC in order to receive care.

Medications:

At the time of the OBOT visit, the physician will give a written prescription for no more than a 30 day supply. Prescription records are maintained in the electronic medical record for review by clinicians as needed and for DEA regulatory purposes.

- I agree that my prescriptions can be given to me only at my regularly scheduled office visit. Missed appointments may result in me not being able to get medication until the next scheduled visit.
- I understand that prescription refills will only be filled 30 days at a time.
- I agree to take my medicine correctly. I agree to take the medication only as prescribed and to contact my provider or the clinic BEFORE making any changes.
- I understand that prescription refills will not be written if I run out early. I am responsible for taking the medication in the dose prescribed and for keeping track of

the amount left in the bottle. **I understand that I will not be issued a refill until the next period for refills.**

- I understand that if my prescription is lost, stolen, destroyed, and/or damaged before it is filled, it will not be replaced. I will have to wait until my next scheduled appointment to get another prescription. Early prescriptions will not be given for lost, stolen, destroyed, damaged prescriptions.
- I agree that the medication I receive is my responsibility and that I will keep it in a safe and secure place. I agree that lost/stolen/destroyed/damaged medication will not be replaced regardless of the reasons for such a loss.
- In all of these events: lost, stolen, destroyed, or damaged medications, I understand that my physician may require me to undergo counseling by an OBOT team member to prevent these events from reoccurring.
- I understand that if I continue to experience events of lost, stolen, destroyed or damaged medications, I may be referred to a more intense treatment program.
- I agree to use only the following pharmacy for prescription refills. If I have a legitimate need to change my pharmacy, for example because of moving or transportation problems, I must notify my provider before doing so.

  Pharmacy: _____

  Phone: _____

- I understand that it is my responsibility to communicate with the pharmacy my ongoing need for this medication. I will give the pharmacy sufficient time to fill my prescription.
- I will not ask for or accept controlled substances from any other provider or individual while I am receiving medication from MAHEC. I will tell any other providers I may see outside of MAHEC the medications I am taking, including pain/anxiety medications, sleeping pills, muscle relaxers, or allergy pills.
- I understand that only my assigned physician or the OBOT group physician will prescribe my buprenorphine-containing medication. Every effort should be made to schedule with my assigned physician, even if that means being seen earlier than required. However, if my assigned physician is not available, then it is my responsibility to schedule my OBOT visit in OBOT group. My assigned physician is:

  Assigned: _____

- I understand I should not drink alcohol or use medicines containing alcohol.
- I understand that mixing buprenorphine with other medications, especially benzodiazepines such as Klonopin, Ativan, Valium, Xanax and other drugs can be dangerous. I understand that a number of deaths have been reported among persons mixing buprenorphine with benzodiazepines.

- I understand MAHEC will routinely access the North Carolina Controlled Substance Reporting System (NCCSRS) to review medication profiles on all patients to assure patients are not receiving other controlled substances from other providers. If patients are found to be accessing prescriptions from other providers, this finding will be reviewed by the OBOT team. If it is determined that the medications obtained by other non-MAHEC providers are in violation of the treatment agreement, MAHEC will evaluate the situation and I may not be able to continue receiving office based opioid treatment.
- I understand I cannot use any recreational and/or illicit substances while using buprenorphine-containing medications. I understand that should I choose to abuse illicit substances, this issue will be addressed through changes in my treatment plan to help me address these issues. If I continue to struggle with ongoing drug use this could be grounds for transfer to a more intense treatment program.
- I agree not to sell, share, give, or trade any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
- I agree not to deal, steal, or conduct any other illegal or disruptive activities in the clinic or on MAHEC grounds as this is grounds for immediate discharge.

Drug Screen and Pill Counts

- I agree to scheduled and random drug screens and pill counts.
- I will bring my buprenorphine-containing medication to every visit.
- I will bring in my remaining buprenorphine-containing medication when requested by an OBOT team member within 24 hours of being called. Refusal of screening is grounds for transfer to a more intensive treatment program.
- I understand that if the results of two drug screens fail to be positive for norbuprenorphine, the metabolite of buprenorphine, or are positive for other opioids or illegal substances, the OBOT team may take one or more of the following actions: I may be monitored more closely. I may be required to attend additional therapy sessions to address my failure to follow the requirements of the OBOT. I may be discharged and transferred to a more intense treatment program.
- I agree not to tamper with drug screens and if I do so, this may be immediate grounds for referral to a more extensive treatment program.
- I agree not to consume poppy seeds while receiving office based opioid treatment. Poppy seed consumption will not be accepted as an excuse for a positive opioid screen.
- I understand that I need to have a working telephone and contacts that are updated. When called for random drug screen or pill count, I need to respond within 24 hours by telephone. A non-response to call backs will be considered the same as a drug screen that does not meet the above criteria (positive for norbuprenorphine and negative for other opioids and illegal substances) and/or pill count. This is grounds

for closer monitoring, more frequent appointments, or transfer to a more intensive treatment program.

Other

- If I am female and of child bearing age it is strongly recommended that I utilize contraceptives while on treatment. If I chose to try to become pregnant or if I become pregnant while on buprenorphine/naloxone, I will alert my health provider immediately so they can assist me in the proper steps and treatment to keep me and my unborn baby safe.
- If at any time I am discharged from this OBOT, I may be reconsidered at a future time to see if office based treatment may be an option for me.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in substance use counseling and relapse prevention programs. Individual and/or group therapy will be mandated while I receive office based opioid treatment.
- I understand that my records, course of treatment, and medical care will be kept in an electronic medical record.
- I understand that MAHEC participates in Mission Hospitals' Health Information Exchange (HIE) and in the North Carolina HIE (NC HIE) which may result in another healthcare provider having the ability to view my substance abuse records.
- I understand that if I do not follow any of the above conditions, I may (at my provider's discretion) no longer receive buprenorphine-containing medication.
- I also understand if I have a problem or question with any of the above paragraphs, I must make an appointment to discuss this with my provider and receive clarification before a problem arises.

I have read the above information (or it has been read to me), have received a copy of the contract and all my questions regarding the treatment of substance abuse and dependence with buprenorphine-containing medication has been answered to my satisfaction. I hereby give my consent to participate in MAHEC OBOT.

_____	_____
Patient Name (print)	Medical Record Number
_____	_____
Patient Signature	Date
_____	_____
Provider Signature	Date