Buprenorphine Prescribing Protocol for Opioid Addiction:

Outpatient

Summary
Opioid addiction treatment as an outpatient medical provider, can be a very fulfilling aspect of practice and help you achieve excellent results for your patients with opioid use disorder (OUD). Medications for Opioid Use Disorder (MOUD), also known as Medications for Addiction Treatment (MAT) has strong validation and includes the medications naltrexone by depot injection, methadone delivered through an Opioid Treatment Program (OTP), and buprenorphine provided on an outpatient basis. There also is independent validation for addiction therapy and some, but less research support for mutual help programs such as Narcotic Anonymous. Although research does not (yet) show additional benefit to adding addiction counseling to MOUD, that is not to say that they are without value and may be due to methodological problems with previously conducted studies. The combination of MOUD and counseling is generally recommended by many in the field who, based on clinical experience, feel it may be the best means to establish early and durable recovery for those addicted to illicit and / or prescription opioids. The combination of medications and counseling is considered a "whole patient" approach. Addiction therapy focuses on recovery typically through cognitive behavioral therapy (CBT) and trigger management.

Mutual help programs like 12-step (Narcotics Anonymous [NA], Pills Anonymous, and Prescriptions Anonymous) are not facilitated by trained therapists but can be effective in supporting recovery. "12-Step Facilitation" (TSF) is the term used to indicate the professional component by which medical providers guide patients in the use of mutual help programs and is recommended. It is also recommended that providers who chose to use services of 12-step programs get to know their local programs, as many consider patients on MOUD as still actively using and there is stigma associated with that label that may interfere with a patient's medical treatment. Assuring that the mutual help program is supportive of the patient's treatment regimen and goals is essential.

This protocol makes the following assumptions:

1. Buprenorphine products will be used in your outpatient practice. While clinicians should also consider the use of methadone (via OTP referral) and naltrexone, these medications are not addressed here.
2. The use of mutual help programs and addiction therapy in combination with the use of buprenorphine. Since validation for mutual help and therapy has not been established, it is acceptable to not require it, although it may be deemed necessary based on the treatment system within which care is delivered.
3. The induction onto buprenorphine described here takes place in person, in an office setting. Home induction and micro-induction are not addressed here although resources for these types of inductions are available via the Compass Opioid Stewardship Program.

The protocol outlines how the medical provider(s) - addiction therapy team can initiate and maintain the patient on buprenorphine based on literature-based evidence and clinical experience. It is only meant to be a guide for the patients in an outpatient treatment setting. It is not intended to be applicable to all patients, clinical settings, and clinical circumstances. It can be used as a starting point, and each clinical setting should develop its own specific protocol, making adjustments based on current regulatory and health system requirements, resources available and the experience of the clinicians. All care should be personalized to the patient, and this protocol is not designed to be applicable to any one specific patient. The medical team must also address co-occurring addictions, psychiatric comorbidities, and other co-occurring medical conditions in order to optimize the chances for sustained recovery.

Opioid Addiction Treatment Protocol Overview

1. **Initial patient contact with the office**
2. **Patient initial evaluation with physician**
3. **Patient makes business arrangement for participation**
4. **Week 1 (after initial evaluation)**
    a. Buprenorphine induction in office "Day 1"
    b. Buprenorphine stabilization office visit "Day 2"
    c. Subsequent buprenorphine stabilization
    d. Addiction therapy, mutual help program referral
    e. Treatment and / or referral for co-occurring psychiatric or mood problems
5. **Buprenorphine maintenance and addiction recovery after Week 1**
    a. Patient follow-up with buprenorphine prescriber Q 1-3 months depending on clinical status
6. **Termination of buprenorphine therapy if indicated**
    a. Due to recurrent aberrancies or recurrent relapses
    b. When patient ready to stop buprenorphine in sustained, stable recovery

Opioid Addiction Process Detail

1. **Initial patient contact with the office**
    a. Welcome to the practice
    b. Introduce the basic office and program operations
    c. Invitation for an appointment with a physician if indicated
2. **Patient initial medical evaluation with buprenorphine prescriber (pre-induction)**
    a. Addiction evaluation
        + Establish presence of Opioid Use Disorder using DSM-5 criteria (Appendix A)
            + Obtain history, exam, corroboration, prescription database, body fluid drug testing
            + Record in the problem list indicating "mild", "moderate", or "severe" OUD
        + Identify use and relationship (salience) with other addiction-prone substances
            + Screen initially with the screening portion of Screening, Brief Intervention, and Referral to Treatment: Do you now or have you ever used _____ ?
            + Consider table in Appendix B to catalog current use or history of other substances
            + The following screening are useful to establish or qualify diagnosis of other use disorders:
                → Affirmative Tobacco → Fagerström Test
                → Affirmative Alcohol → AUDIT
                → Affirmative Cannabis → CUDIT-R
                → Affirmative Other Drugs → DAST-10
            + Obtain history, exam, corroboration, prescription database, body fluid drug testing
            + Establish presence of other Substance Use Disorder (SUD) using DSM-5 criteria
            + Record in the problem list indicating "mild, moderate, or severe" for each
    b. Establish if co-occurring psychiatric problems are present
        + Consider the following screening tools:
            + PHQ-2 For depressed and anxious mood
                → PHQ-9 if affirmative for depressed mood
                → GAD-7 if affirmative for anxiety
            + Adverse Childhood Experience questionnaire (ACE) for trauma
        + Other screeners when suggested by history or initial screeners
            + Post-Traumatic Stress Disorder: PTSD Check List (PCL-C)
            + Bipolar Disease: Mood Disorder Questionnaire (MDQ)
            + Attention Deficit Hyperactivity Disorder: Adult ADHD Self-Report Scale (ASRS)
            + Psychosis: Psychosis Screener (PS)
            + Insomnia: Sleep Condition Indicator (SCI)
            + Suicidality: Patient Safety Screener (PSS-3)
        + Refer, if indicated, for diagnostic clarity and / or co-managing to psychiatry or addiction medicine
        + Record in the problem list indicating "mild, moderate, or severe" for each
    c. Establish presence or not of other co-occurring medical problems
        + Obtain history, exam, corroboration
        + Lab: CBC, CMP, HIV, Hep B, Hep C, testosterone (men), HCG (women), PPD
        + Pain: Acute (up to 2 weeks), Subacute (2-12 weeks), Chronic (>12 weeks)
            + PEG-3 (Pain, Enjoyment, General Function)
        + Respiratory:
            + STOP-BANG for obstructive sleep apnea risk → sleep study if indicated
            + Pulmonary workup for established / suspected disease

        - Consider baseline nocturnal oximetry for all patients
    - Sign lab printout(s) for the chart and reference results in office visit note(s)
        - Respond to abnormalities, including referral / coordination with PCP / specialists
        - Note especially hepatic, respiratory, cognitive, psychomotor problems
d. Establish lowest necessary level of care for the patient
    - Using the ASAM Patient Placement Criteria **(Appendix C)**
    - Determine if outpatient treatment will meet the needs of the patient
e. Establish baseline functional status **(Appendix D)**
f. Estimate level of risk for return to opioid use: "Low" "Intermediate" "High"
    - Record in problem list and office visit note under "Assessment"
g. Determine personalized goals with the patient
    - Addiction prone substance abstinence (excepting buprenorphine)
        - ± Tobacco abstinence: indicate
    - Functional goals
    - Record in the office visit note under "Plan"

3. **Buprenorphine safe use Risk Baseline Evaluation (Appendix E)**
    c. Identify personal / family risk factors and resiliencies
        - Corroborate information with family, friends, medical records
        - Identify and list past medication-related aberrancies
    d. Online prescription database (Prescription Drug Monitoring Program [PDMP]) review
        - Sign printout(s) for chart, reference in office visit note, address results
    e. Definitive (Gas Chromatography / Mass Spectrometry [GC/MS] or Liquid Chromatography /Tandem Mass Spectrometry [LC/MS-MS]) body fluid drug testing (typically urine)
        - Sign printout(s) for chart, reference in office visit note, address results
    f. Determine Level of Risk for safe use of buprenorphine: "Low" "Intermediate" "High"
        - Consider frequency/intensity of prior episode(s) of opioid return to use
        - Record in problem list and office visit note under "Assessment"
    g. Establish Urine Drug Testing (UDT) plan based on level of risk
        - Initial frequency of routine and random evaluation
        - Initial frequency of in-office screening: Point-of-care (POC) immunoassay
        - Initial frequency of definitive testing: GC/MS or LC/MS-MS – establish with a vendor
    h. Establish initial frequency of PDMP review based on level of risk
    i. Establish initial frequency of product (tablet, film) counts based on level of risk
    j. Initiate a tracking mechanism (*e.g.,* flow sheet such as Appendix G) to record past and new aberrancies as they occur (if any)
4. **Risk Mitigation (Appendix F) - strategies to limit risks going forward**
    a. Informed consent regarding buprenorphine and other treatment approaches employed
    b. Review and have patient sign treatment agreement which outlines:
        - Expected behavior
        - Prohibited behavior
        - Consent for risk monitoring
        - Potential responses to aberrancies
    c. Provide buprenorphine secure storage and safe disposal instructions
    d. Consider which buprenorphine product to select – *i.e.,* with or without naloxone
    e. Naloxone prescription and overdose rescue instructions to include family and support network.
5. **Outline treatment plan with the patient**
    a. Treatment goals:
        - Addiction recovery goals
        - Functional goals
    b. Treatment schedule:

- Medical provider visit schedule
- Addiction therapy referral - therapist to establish schedule based on need
- Recommend mutual help (12-step) (*cf.*, Meeting locators: Appendix H)

c. Monitoring outline:
- Behavioral, PDMP and body fluid drug testing (Appendix E)

d. Buprenorphine use (document discussion in office visit notes)
- Traditional medication informed consent: Risks, Benefits, Alternatives
- Potential adverse reactions
- Buprenorphine induction procedure
- Proper buprenorphine use after induction

6. **Pre-induction process**

a. Patient to be off all opioids
- At least 24 hours for most opioids except:
  - Fentanyl at least 48 hours
  - Methadone at least 72 hours after being tapered down to 30 mg or less

b. Prescribe medications to ameliorate opioid withdrawal symptoms, considering these options:

Naproxen	**1 po q6h prn musculoskeletal pain OTC or**	**#20 RF0**
Cyclobenzaprine	**10 mg po q6h prn back spasm**	**#20 RF0**
Clonidine	**0.1 mg po q6h prn shakes / sweats**	**#20 RF0**
Hyoscyamine	**0.125 mg SL q6h prn abdominal cramps**	**#20 RF0**
Gabapentin	**300 mg 1 po qHS prn sleep**	**#20 RF0**

Avoid benzodiazepines, trazodone, Z drugs (Ambien, Lunesta)

7. **Patient makes business arrangements for participation, schedules induction, obtains withdrawal meds**
8. **Buprenorphine initiation: Week 1**

a. Buprenorphine induction in office: Day 1
- Patient is brought to and from office by a reliable attendant due to possible impairment
- Patient affirmed to be in significant withdrawal - use COWS scale
- Review buprenorphine induction risks, benefits, alternatives
- Patient questions answered and patient agrees to move forward with induction
- Patient's attendant obtains buprenorphine from pharmacy: 2 mg #40 RF0
  - Combination buprenorphine with naloxone highly recommended
    - → Except if coming off methadone - consider mono-agent buprenorphine
  - Complete prior authorization as necessary
- Initiate buprenorphine induction: 2-4 mg SL depending on withdrawal severity
- Recheck patient in 1.5 hours or prn: VS, symptoms
  - If still withdrawing (expected), give another 2 mg buprenorphine
  - If bad headache, hypotension, N/V: hold buprenorphine and monitor
- Recheck patient in 1.0 hours or prn: VS, symptoms
  - If still withdrawing (expected), give another 2 mg buprenorphine
  - If bad headache, hypotension, N/V: hold buprenorphine and monitor
- Recheck patient in 1.0 hours (after lunch) or prn: VS, symptoms
  - If still withdrawing and <8 mg buprenorphine already given, give 2mg buprenorphine
  - If bad headache, hypotension, N/V: hold buprenorphine and monitor
- Maximum dose of buprenorphine for day 1 Induction: 8 mg
  - This should improve but not necessarily eliminate opioid withdrawal
    - → Have patient continue prn withdrawal meds already prescribed
  - This should improve but not necessarily eliminate opioid craving

- → Have patient employ behavioral anti-craving measures

b. Buprenorphine stabilization office visit: Day 2
   - Patient takes total # mg buprenorphine taken on 1st day all at once on day 2 at home
   - Patient seen in office 2 hours after taking buprenorphine at home for VS, clinical status
   - If withdrawal / craving substantial, add buprenorphine in 2 mg increments q2h up to
     - Maximum dose 16 mg day 2

c. Buprenorphine stabilization: the rest of Week 1
   - Phone or virtual contact to adjust buprenorphine dose
   - Typical dose ranges 12 - 24 mg. Evidence that 16mg or greater has better treatment retention; rarely is 32 mg required
     - Caution: Increased risk of diversion, and 32 mg dose is not FDA approved
   - Office visits at least twice to address clinical status:
     - Addiction recovery
     - Abstinence determined by report, PDMP, definitive body fluid drug test
     - Addiction therapy, mutual help program(s) initiation (Appendix H)
     - Buprenorphine proper and safe use (Appendix G)
     - Buprenorphine efficacy / adverse events, if any
     - Behavioral aberrancy inquiry
     - On-line PDMP review
     - Definitive body fluid (typically urine) drug test

9. **Buprenorphine maintenance and addiction recovery: after week 1**
   a. Typical follow-up medical office visit frequency:
      - Weekly for the first month
      - Monthly thereafter
      - Over time every 2-3 months only if:
        - Confirmed abstinence
        - Confirmed safe use and absence of aberrancies
        - Craving is minimal and manageable
        - Buprenorphine adverse reactions are absent or manageable
        - Mood is stable and well managed:
          - → PHQ-2 For depressed and anxious mood
          - → PHQ-9 if affirmative for depressed mood
          - → GAD-7 if affirmative for anxiety
        - No new major stressors are present
        - Patient is actively involved and progressing in addiction therapy
        - Patient is participating in mutual help program(s) as recommended
   b. Continue to address other medical problems
   c. Consider monitoring nocturnal oximetry, testosterone (men), pregnancy test (women)
10. **If the patient returns to active opioid use**
    a. Return to use is frequent and should not automatically prompt dismissal from the practice
    b. Make return to recovery a positive learning experience
    c. Address urgent medical concerns: overdose, infection, suicidality, HIV/hepatitis testing
    d. Identify and address trigger(s) that led to return to use
    e. Consider medication alternatives to buprenorphine: methadone, depot naltrexone
    f. Consider consultation/referral to specialty care
       - Reassess level of care per ASAM PPC-2 criteria and plan accordingly
    g. Reinduction onto buprenorphine – consider increased dosage
    h. Increase therapies
    i. Increase monitoring
    j. Adjustment treatment plan otherwise as indicated

11. **Termination of buprenorphine therapy**
    a. If due to identified diversion
        - Do not refill buprenorphine
        - Withdrawal medications probably not needed
        - Terminate from practice following standard guidelines for proper dismissal
    b. Prior to considering termination due to frequent aberrancies, recurrent return to use
        - Consider undiagnosed or inadequately treated psychiatric problem and treat
            - Notably undiagnosed or inadequately treated PTSD due to sexual trauma
        - Review and update trigger management plan
        - Consider medication alternatives to buprenorphine: methadone, depot naltrexone
        - Refer to addictionologist for care following guidelines for dismissal from practice
            - Decide whether or not to bridge buprenorphine until seen by a new provider
    c. Tone of termination from practice to be that of a "therapeutic discharge"
        - To encourage adherence to Opioid Use Disorder treatment plan of the new provider
    d. Upon patient request or when buprenorphine is no longer felt necessary to help sustain abstinence / recovery
        - Ensure patient is quite stable in recovery and agrees to a tapering process
        - Ensure no current stressors that could precipitate return to use
        - Typically, do not try to taper until 9-12 months after starting buprenorphine
        - Reduce buprenorphine by 2 mg per month initially as tolerated
        - Reduce buprenorphine by 1 mg per month below 4 mg daily dose as tolerated
        - After 1 mg qd successful, reduce to q2d, then q3d, then q4d, then discontinue
        - If craving reappears, hold buprenorphine dose and engage the addiction therapist
        - If craving persists, return to previous buprenorphine dose with which craving absent
        - Manage withdrawal symptoms as indicated with medication and non-med strategies
        - Armodafinil (not addiction prone) may help if fatigue is pronounced and unrelenting
        - Encourage ongoing 12-step and addiction therapy as indicated
        - Continue to monitor for abstinence with history, exam, definitive drug testing, and PDMP
        - Communicate tapering plan / results to others involved in the patient's care
    e. Note that there is no limit to amount of time patients can be on buprenorphine, there are no studies that define when relapse risk decreases. If patients are stable on buprenorphine it is reasonable to continue care indefinitely. The decision to discontinue a patient who is stable is one that should be patient guided and done with shared decision making.

Appendix A
Diagnosis of Opioid Addiction

DSM-5 Diagnoses

- Opioid Use Disorder
- Opioid Intoxication
- Opioid Withdrawal
- Other Opioid-Induced Disorders
- Unspecified Opioid-Related Disorders

Opioid Use Disorder Diagnostic Criteria

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period. Check all that apply.

- ☐ Opioids are often taken in larger amounts or over a longer period of time than was intended.
- ☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ☐ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ☐ Craving, or a strong desire or urge to use opioids.
- ☐ Recurrent opioid use resulting in failure to fulfill major role obligations at work, school, or home.
- ☐ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ☐ Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- ☐ Recurrent opioid use in situations in which it is physically hazardous.
- ☐ Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- ☐ Tolerance*, as defined by with of the following:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of an opioid.
- ☐ Withdrawal*, as manifested by either of the following:
  - The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal.
  - Opioids (or a closely related substance are taken to relieve or avoid withdrawal symptoms

MILD = 2-3 | Moderate = 4-5 | Severe = 6 or more

*Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision, who may exhibit physiologic factors such as tolerance & withdrawal.

Specify if:

- In early remission: previously met criteria are no longer met for 3-12 months.
- In sustained remission: previously met criteria are no longer met for 12 months or more.
- On maintenance therapy: such as, buprenorphine, methadone, naltrexone

**Note there is no longer a diagnosis of "opioid abuse." Opioid Use Disorder criteria are intended to reflect a continuum: mild, moderate, and severe. The criteria above are not applicable to pain patients unable to cut down solely due to the level of pain.

Appendix B
Patient Experience Substance Experience Table

Patient Experience	Effect	Problems
Addiction Prone Substances, Behaviors		
Alcohol		
Amphetamine / Methamphetamine		
Anabolic steroids (Nandrolone, etc.)		
Barbiturates (Fioricet, Esgic, phenobarbital)		
Bath salts (mephedrone, MDPV)		
Benzodiazepines		
Betel-quid		
Carisoprodol (Soma)		
Cocaine		
Dextromethorphan (DM)		
Driving While Under the Influence		
Ecstasy (MDMA) / MDA		
Food		
Gambling		
GHB / GBL		
Hallucinogens (LSD, mushrooms, peyote)		
Inhalants (paint, glue, white out, gas, amyl nitrate, etc.)		
Internet / Video games		
Intravenous Drug Use		
K2		
Ketamine		
Khat (cathinone)		
Kratom		
Marijuana		
Methoxyetamine		
Methylphenidate (Ritalin, Concerta, Methylin, etc.)		
Nicotine / Tobacco		

Opioids (heroin, oxycodone, morphine, tramadol, etc.)		
Phencyclidine (PCP)		
Prescription Medications that are Controlled		
Propofol		
Quaaludes		
Rohypnol (date rape drug)		
Salvia		
Sex		
Shopping		
Spice (synthetic cannabinoids: JWH-018 etc.)		
Addiction Treatment		
Acomprosate (Campral)		
Alternative Medications		
Anticonvulsants		
Gabapentin (Neurontin)		
Topiramate (Topamax)		
Valproic acid / divalproex sodium (Depakote)		
Vigabatrin		
Buprenorphine combination with naloxone		
Buprenorphine alone without naloxone		
Buproprion (Wellbutrin)		
Disulfiram (Antabuse)		
Ibogaine		
Methadone (Dolophine)		
Modalities		
Addiction Therapy		
Cognitive Behavioral Therapy (CBT)		
Coercion / Drug Court		
Contingency		
Faith-based (Celebrate Recovery)		
Mutual Help (AA, CA, NA, PA, Rational Recovery)		
Rapid Detox under Anesthesia		

Residential / Inpatient		
Addiction Treatment		
Sober Living		
Naltrexone		
Oral (Trexan, Revia)		
Vivitrol intramuscular depot		
Nicotine Replacement Therapy (patch, gum, lozenge)		
Ondansetron (Zofran)		
Quetiapine (Seroquel)		
Varenecline (Chantix)		
Topiramate (Topamax)		
Withdrawal Medications		

Appendix C
American Society of Addiction Medicine
Patient Placement Criteria for the Treatment of Substance Related Disorders

ASAM Patient Placement Dimensional Assessment

Withdrawal potential / level of intoxication: _____
Supporting Data: _____

Biomedical Comorbidities: _____
Supporting Data: _____

Emotional / Behavioral: _____
Supporting Data: _____

Treatment Acceptance / Resistance _____
Supporting Data: _____

Relapse / Continued Use Potential: _____
Supporting Data: _____

Recovery Environment: _____
Supporting Data: _____

ASAM Placement Level (least restrictive): _____

Specific programs recommended: _____

ASAM PPC Levels

Level 0.5	Early intervention
Level I	Outpatient treatment
Level II	IOP/ Partial Hospitalization
Level III	Residential / Intensive Inpatient Treatment
Level IV	Medically Managed Intensive Inpatient Treatment

Appendix D
Personalized Functional Assessment and Goals

REMS Surveillance				**Goal Monitoring**							
Numerical Rating Scale 0 - 10:				0 = worst 10 = best				0 = best 10 = worst			
Energy				10 relationship				Anxiety			
Strength				Sexual function				Sadness			
Endurance				Social life				Insomnia			
Coordination				Memory				Sleepiness			
Exercise				Appetite				Accidents			
Ability work				Outlook				**Pain**			
Ability home				Enjoyment				**Med misuse**			
Personalized Function Goals				**Process**				**Outcome**			
1.											
2.											
3.											
Regarding pain level: 1st number is pain level before out of bed, 2nd number is level out of bed before meds settle in, 3rd number is best for the day after meds settle in.											

Appendix E
Risk Evaluation Baseline for Buprenorphine Safe Use

Risk Evaluation		Date Initiated:	
SBIRT Evaluation (current use)	Tobacco:		
	Alcohol:	Average # drinks / day:	Last time > 3, 4 drinks in a day:
	Illicit Drugs:		
	Prescription drug non-medical use:		
Patient History	Addiction:		
	Harmful Use:		
	Diversion:		
	Aberrancies:		
	Neuro:		
	Psych:		
	Trauma: Physical / Head / Sexual:		
Family History	Chronic intractable pain:		
	Substance Use Disorder:		
	Obesity:		
	Sudden death:		
	Neuro:		
	Psych:		
	Other:		
Risk Screening Tool			
Other Risks:			
Resiliency Factors:			
Medical Records:			

↑ increased **↓ decreased** **→ change to** **⊢ begun** **⊣ ended** **✓ present**

Risk Stratification taking into consideration all of the above elements:

1. Level of risk for opioid return to use: Low / Intermediate / High
2. Level of risk for safe buprenorphine use: Low / Intermediate / High

Appendix F
Risk Mitigation for Buprenorphine Safe Use

Risk Mitigation							
Designated Prescribers: Medication Prescribed:							
Informed Consent:		Medical Cannabis:					
Controlled Substances Agreement:	Signed on:	Nocturnal oximetry baseline:					
Secure Storage:		Safe Disposal:					
Patient Self-Management: Mutual Help:		Bowel Program:					
Addiction Therapy:		Other:					
Screening:		HIV		Hep B		Hep C	

Appendix G
Risk Monitoring for Buprenorphine Safe Use

Risk Monitoring				
Behavioral Aberrancies				
PDMP	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Consistent				
Inconsistent				
Drug Testing	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Consistent				
Inconsistent				
Date	**Testosterone level**	**ALT**	**Cr / eGFR**	**Nocturnal oximetry % time < 89% sat**
√ = OK				

Appendix H
12 Step Meeting Locators

Alanon	Alanon / Alateen
Alateen	Alanon / Alateen
Alcoholics Anonymous	AA
Cocaine Anonymous	CA
Codependents Anonymous	CODA
Gamblers Anonymous	GA
Marijuana Anonymous	MA
Narcotics Anonymous	NA
Pills Anonymous	PA
Sex Addicts Anonymous	SAA

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