Below I have included what I have prepared for tomorrow- was planning on reading some/referencing but wanted to send your way in case it would be helpful. Thanks

Apologize for grammar errors, as this was mainly intended as guide for me .

Testimony
One of the most important aspects of MAT/treatment programs is that it is easily accessible. Our community has done tremendous work to reduce barriers in accessing life saving medication, but we still have some progress to make.

In my experience, the prior authorization process required for increasing doses above 16mg and switching to buprenorphine only product, creates unnecessary roadblocks that prevent patients from receiving the care they deserve.

I find myself tailoring my prescribing practices to what my patients can access the easiest and quickest- and this often doesn't align with what the best plan is or what is evidence based.

In re: to PA's for doses >16mg

- Based on older data that propose opt receptors are mostly blocked at this dose. Guidelines and research also established based on studies of people using heroin- for example, if a person is using 10 bags of heroin, the recommended "optimal dose" was thought to be 16mg. However, very few people are using just heroin anymore, as much of the drug supply is contaminated with fentanyl, which is more potent, thus potentially requiring larger doses of buprenorphine.
- Dose should be titrated based on clinical response and restrictions on max dose may impede progress in treatment
- Much of the population I serve has limited access to transportation and rely on ride they received to come to office visit to take them to pharmacy directly after appointment to pick up medication. Often, there is not time for patient to wait for paperwork to be approved ,so they may delay increasing the dose until next office visit ,which increases risk they will use illicit substances and subsequently be at higher risk of overdose.

In re: to Med Watch form

- Medication adherence is vital to a person's success in decreasing or abstaining from substance use
- Unfortunately, there are some adverse effects patient's experience fromc combo product beyond " minimal side effects" that are intolerable,and patients do not adhere to medication.
- For all other meds, the provider would be able to clinically evaluate the response to medication and switch to alternative formulation if needed.
- The med watch process required to switch a patient to buprenorphine is time consuming and puts a patient at unnecessary risk of additional adverse events that are already known and can be prevented
- I have had patients drop out of treatment program because they have found street buprenorphine more accessible than a prescription, due to the process of completing medwatch
- Additionally, when initiating treatment, most patients find the transition a little easier with monoproduct (some patients may absorb more of the naloxone in the combo product increasing risk of precipitated withdrawal ) I have talked with a few patients

that access syringe services regularly who are ambivalent about entering treatment , and they share they would be more ready to engage if they could start with monobup first- the fear precipitated withdrawal with Suboxone isa deterrent, and because we can't offer monobup immediately upon entrance to a treatment program, we fail to engage some in same day /rapid access to treatment

Some may argue that the PA's are approved quickly and within a few hours. However, for patients who are in survival mode living their lives minute to minute, sometimes just to stay alive, a minute to approve paperwork is too long for some to wait and exponentially increases their chance of not engaging in treatment, dropping out of treatment, or resorting to more rapidly accessible street drug which may result in overdose and death.

Best,

Jacqueline Bray, DNP FNP-C; RN
she/her
Howard Center
802.734.3536