Diversion and misuse of opioids that lead to drug poisoning and death can be mitigated by increased access to treatment for opioid use disorder*

*Access to **treatment**: not simply access to buprenorphine. The provision of buprenorphine is not synonymous with providing treatment.

Patient went to the ER in withdrawal- was started on buprenorphine per our protocol and referred to our office. His PCP learned of the visit, and offered the patient a 30 day prescription for buprenorphine, sight unseen so he "didn't have to deal with [treatment provider's office]"

DEA proposed rule would require

1) In person evaluation of the patient w/in 30 days of the initial prescription by the prescriber or
2) Telemedicine evaluation by the prescriber while the patient is in the physical presence of another DEA registered practitioner participating in the audio-visual encounter or
3) The in-person evaluation requirement may be satisfied by acceptance of a referral from another practitioner who has a relationship with the patient and who has already performed an in person evaluation

Why is this important?

- It is difficult to judge withdrawal, relief or withdrawal over a telemedicine connection. Objective evidence is completely lacking over the phone.
- There are numerous other co-morbidities accompanying IV/IN drug use that must be evaluated by physical examination:
    - Infective endocarditis: heart murmur
    - Injection site infections
    - Hepatitis
    - Poor dentition
    - Nasal septal defects (caused by product laced with cocaine that causes ischemia from vasoconstriction
- Full agonist opioids require an in person evaluation as does methadone.

The bill:

1) Needle collection sites- this is a very good idea. Aside from syringe service locations there are few if any (at least In Windsor) places to dispose of used needles, principally because there is no way to safely dispose of them (WFD's issue, hospital doesn't want them)
    a. Be careful to assure that the cost of disposal is taken into account and not necessarily passed on to consumers
2) Drug Collection: between "drug take back days", kiosks in pharmacies and municipal locations, and various office locations like ours, this is pretty robust. Providing continued incentive to maintain this is good.
3) Distribution of naloxone, education and other harm reduction: again, through the efforts of the Vermont Center on Rural Addiction (CORA). Local coalitions such as the Windsor County

Substance use Disorder Collaborative, grant funded consortia such as CVAR, Central Vermont Hospital's coalition etc. naloxone is very available. Any means to continue to fund and otherwise support this effort is worthwhile.

4) Removing, once and for all, harm reduction materials, e.g. syringes obtained from syringe services, fentanyl test strips, naloxone, from the category of "drug paraphernalia" is critically important.
   Similarly, indemnifying practitioners and others who provide naloxone and test strips, and individuals who, in good faith, administer naloxone to a poisoning subject needs to not only be codified but resources continued to be provided to trumpet this fact to the general public.
   Note our education effort "why call 911"
5) Med watch form: unnecessary a this point and an obstacle to timely treatment. Intended for medical devices or newly approved drugs. Bupe has been around long enough that the side effect profile is pretty well know.
6) Prior auths: Should not be done away with entirely. Remove up to 16 mg of combination product. Reasonable beyond that. Should NOT be required for dose decreases. Continue to require for monoproduct- diversion. High street value causes patients to demand "24 mg" right away. Many practitioners start patients on 24 mg inappropriately.
   Abolition of the X waiver is not necessarily a good thing
   the X waiver, in my opinion was not the problem. It was a convenient excuse for those who did not want to treat addiction.
   Even with the X waiver, there are practitioners who do not follow the ASAM practice recommendations for buprenorphine. Without it, I fear there will be more practitioners who have an insufficient fund of knowledge to competently use this medication.
   NESAM meeting 2/27 was in agreement with this.
7) Making a patient trial a med is generally not a great idea. Requiring attempts to mitigate a side effect when simply changing formulation will work is ridiculous.
8) Buprenorphine should be reimbursed for pain management.