PREVENTIVE CARE

MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

CONTINUATION OR MODIFICATION OF THERAPY

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE:

- Per ORS 689.645, a Pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.
    - Per ORS 689.698, a Pharmacist may prescribe, dispense and administer to a patient medication for the treatment of opioid use disorder in accordance with a statewide drug therapy management protocol developed, in consultation with a physician with a background in addiction medicine, by the Public Health and Pharmacy Formulary Advisory Committee convened under ORS 689.649 and adopted by State Board of Pharmacy rule pursuant to ORS 689.645
- Following all elements outlined in OAR 855-115-0330, a Pharmacist licensed and located in Oregon may prescribe an MOUD drug regimen.

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Continuation or Modification of Therapy Patient Intake Form (pg. 2-5)
- Utilize the standardized Continuation or Modification of Therapy Assessment and Treatment Care Pathway (pg. 6-8)

PHARMACIST TRAINING AND REGISTRATION REQUIREMENTS

- **Prior to using this protocol, the Pharmacist must:**
    - Complete a total of eight hours of ACPE-accredited (Accreditation Council for Pharmacy Education) training on Opioid Use Disorder (OUD) to include the prescribing of MOUDs, before newly applying for a registration from the DEA to prescribe Schedule III controlled MOUDs for the treatment of OUD.
    - Hold a current Drug Enforcement Agency (DEA) registration for Schedule III Controlled Substances.

RESOURCES

- Standardized Continuation or Modification of Therapy Prescription Template *optional* (pg. 9)
- Standardized Continuation or Modification of Therapy Provider Communication Template *optional* (pg. 10)
- American Society of Addiction Medicine (ASAM) National Treatment Guidelines for Treatment of OUD https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- Substance Abuse and Mental Health Services Association (SAMHSA) Tip 63: Medications for Opioid Use Disorder- Full Document https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
- American Pharmacist's Society: Neonatal Opioid Withdrawal Syndrome (NOWS) https://publications.ashp.org/downloadpdf/display/book/9781585287321/chapter21.pdf

MOUD Protocol- Patient Intake Form: Continuation or Modification of Therapy

(CONFIDENTIAL-Protected Health Information)

Date _____/_____/_____ Date of Birth _____/_____/_____ Age_____
Legal Name_____ Name _____
Sex Assigned at Birth (circle) M / F Gender Identification (circle) M / F / Other____
Preferred Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other_____
Street Address _____
Phone ( ) _____ Email Address _____
Primary Healthcare Provider Name Phone ( ) _____ Fax ( ) _____
_____
Do you have health insurance? Yes / No Insurance Provider Name _____
Any allergies to medications? Yes / No If yes, please list _____
Any allergies to foods (ex. soy, lactose)? Yes / No If yes, please list _____
_____

To Be Completed by Patient

Section 1- History with Medications for Opioid Use Disorder (MOUD)

1.	What medicine have you been taking for opioid use disorder that has been working for you? *Medication Name/Form (e.g., Suboxone tablet/film): _____ Dose (e.g., 8 mg/2 mg): _____ Frequency (e.g., twice daily): _____ Current Prescribing Provider and Location (e.g., pharmacy, doctor's office, etc.): _____ *If you are taking Methadone, or an injectable MOUD, we are unable to prescribe using this protocol. Please reconnect with your Methadone clinic, go to the Emergency Department, or seek care from another provider.	

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2.	Have there been any days lately when you couldn't take your medicine, or ran out? If yes, what do you think happened? _____ _____ When was the last time you were able to take a dose? _____ Have you taken any other opioids within the last 7 days? (for example, fentanyl, OxyContin®, Percocet®, oxycodone, hydrocodone, heroin, etc.) If yes, what were they? _____ _____ **Note:** If you have missed more than 3 to 5 days of your medicine for opioid use disorder, it may increase the risk of a certain kind of withdrawal if you were to restart therapy after taking other opioids.	□ **Yes** □ **No** □ **Yes** □ **No**
3.	Overall, how has the medicine and current dosage been working for you? **[ ]** Excellent - I feel stable and my cravings are well-managed. **[ ]** Good - It's working, but I still have some difficult moments. **[ ]** Poor/Fair - I am struggling with cravings or withdrawal symptoms. **Note:** This helps us understand your personal experience and whether your current dose is meeting your needs.	
4.	**Brief Substance Craving Scale (BSCS)** Please check the box that best describes your experience over the past week when you've been on the medicine: How often have you had cravings? **[ ]** Never **[ ]** Seldom **[ ]** Sometimes **[ ]** Often **[ ]** Constant How intense were the cravings? **[ ]** None **[ ]** Mild **[ ]** Moderate **[ ]** Severe **[ ]** Overwhelming How long did the cravings last? **[ ]** None **[ ]** <10 mins **[ ]** 10-30 mins **[ ]** 1-2 hours **[ ]** Most of the day **Note:** This helps us determine if you might benefit from a dose adjustment to reach full effect and help you get the most benefit out of your medicine.	

Section 2- Medical History

5.	Since your last follow-up with the prescriber of your medicine for opioid use disorder, have you been told you have liver failure, cirrhosis, or have you experienced "yellowing" of the eyes or skin? **Note:** We ask about your liver because this medication is processed there. We want to make sure your body can handle the medicine safely, without causing you any extra stress.	□ **Yes** □ **No**

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Section 3- Medication History

6.	Are you currently taking any prescription, over-the-counter (OTC), or herbal medicine? If yes, please list. _____ _____ _____ _____ **Note:** We ask this because some common medicines or supplements can change how your treatment works. We want to make sure everything you're taking works well together.	□ **Yes** □ **No**

Section 4- Health and Safety Resources

7.	To support your health during treatment, please indicate if you would like information or supplies regarding the following: (if yes, check all that apply) [ ] **Overdose Reversal:** Would you like a prescription for a medicine that might help reverse an opioid-related overdose (naloxone or nalmefene), or information on where to access it? [ ] **Supply Safety (Test Strips):** Would you like information on test strips that check for potentially lethal additives in the drug supply (like fentanyl and xylazine), or information on where to access them? [ ] **Infection Prevention:** Would you like information on the benefits of using sterile supplies and a safe disposal device, or information on where to access them (to prevent heart and skin infections)? [ ] **Safe Practices:** Would you like to discuss "Never Use Alone" resources or rescue breathing techniques?	□ **Yes** □ **No**
8.	Would you like information regarding any of the following services? (if yes, check all that apply) [ ] Residential treatment (inpatient/rehab) [ ] Outpatient counseling (drug and alcohol counseling, cognitive behavioral therapy, family or couples therapy, etc.) [ ] Peer support groups (narcotics anonymous, SMART recovery, peer coaching, etc.) [ ] Case management (help with housing, food, work, etc.) [ ] Medication management (tapering programs, medication therapy management (MTM) services, psychiatric medication management, etc.)	□ **Yes** □ **No**

Section 5- Patient Attestation

Patient Attestation: I certify that the information I have provided in this form is true and complete to the best of my knowledge. I understand that being honest about my medical history and drug use is essential for my own safety during treatment.

Patient Signature:_____ **Date:**_____

MOUD Protocol- Patient Intake Form: Continuation or Modification of Therapy

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To Be Completed by a Pharmacist

Section 6 – Pharmacist Verification of MOUD Therapy

	Pull and review patient's Prescription Drug Monitoring Program (PDMP) report, along with information provided in Question 1. Document the MOUD the patient is currently taking. Medication Name/Form:_____ Dose:_____ SIG: _____ Provider: _____ Date of Last Fill: _____ Last Sold Date: _____ **Source of information: (if PDMP report unavailable, please provide details about alternative information)** **[ ] PDMP Report** **[ ] Patient-provided _____** **[ ] Other _____**

MOUD Protocol- Assessment and Treatment Care Pathway: Continuation or Modification of Therapy

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Patient Demographic Information: D.O.B.

Is patient 18 years of age or older?

☐ Yes. Continue	☐ **No. DO NOT PRESCRIBE. Refer to another provider.**

Patient Demographic Information: Medication Allergies

Does patient have allergy to buprenorphine / naloxone, or any of its components?

☐ **Yes. DO NOT PRESCRIBE. Refer to another provider.**	☐ No. Continue

MOUD History (Questions 1 – 2 of Patient Intake Form)

Does patient history suggest current use of *buprenorphine and naloxone combination product without a **clinically significant gap?

□ **Yes** □ **No**

***** If patient is taking Methadone, or an injectable MOUD, we are unable to provide using this protocol. Please refer them to Methadone clinic, Emergency Department, or another provider.

**** Gap in buprenorphine and naloxone therapy could be clinically significant (or increase likelihood of precipitated withdrawal) if:**

- **2 days or more - <u>and</u> - used fentanyl or a substance that potentially contained fentanyl;**
- **3 days or more - <u>and</u> - used any opioids;**
- **5 days or more - and - patient was abstinent from all opioids.**

☐ Yes. Continue	☐ **No. DO NOT PRESCRIBE; refer to another provider or consider prescribing via induction protocol.**

PDMP Review

Did Pharmacist review patient's PDMP report, or relevant information from other sources?

☐ Yes. Continue	☐ **No. DO NOT PRESCRIBE.**

Stabilization (Question 4 of Patient Intake Form)

Based on answers to Question 4, is patient a candidate for a **<u>dose increase</u>** as outlined below?

BSCS Score	Risk Level	Recommendations
"Never" or "Seldom" / "None" or "Mild"	Low	Maintain Current Dose
"Sometimes" / "Moderate"	Moderate	Use rubric for **Moderate Dose Increase**
"Often" or "Constant" / "Severe" or "Overwhelming"	High	Use rubric for **Significant Dose Increase**

☐ Yes. Check the box below that corresponds to the appropriate "Recommendation" and continue. □ Moderate Increase □ Significant Increase	☐ No. Continue

MOUD Protocol- Assessment and Treatment Care Pathway: Continuation or Modification of Therapy

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Medical History (Question 5 of Patient Intake Form)

Since the patient's last appointment with their MOUD prescriber, have they been informed they have liver failure, cirrhosis, or have they experienced "yellowing" of the eyes or skin?

☐ **Yes. DO NOT PRESCRIBE. Refer to another provider.**	☐ No. Continue

Health and Safety Resources (Questions 7 - 8 on Patient Intake Form)

Did patient select any of the items below?

□ **Yes** □ **No**

If yes, check all that apply.

Health and Safety Resources

✓ all that apply	Topic	Tool
[ ]	**Overdose Reversal**	Short-acting Opioid Antagonist (Rx)
[ ]	**Supply Safety (Test Strips)**	Fentanyl / Xylazine Test Strips (information only)
[ ]	**Infection Prevention**	Sterile Syringes (information only)
[ ]	**Safe Practices:**	Alcohol Pads / Wound Kits (information only)

Would you like information regarding any of the following services? (if yes, check all that apply)

[ ] Residential treatment inpatient/rehab)
[ ] Outpatient counseling (drug and alcohol counseling, cognitive behavioral therapy, family or couples therapy, etc.)
[ ] Peer support groups (narcotics anonymous, SMART recovery, peer coaching, etc.)
[ ] Case management (help with housing, food, work, etc.)
[ ] Medication management (tapering programs, medication therapy management (MTM) services, psychiatric medication management, etc.)

☐ Yes. Act as indicated and continue	☐ No. Continue

Patient Attestation

Did patient sign and date attestation?

☐ Yes. Continue and prescribe continuation or modification of therapy.	☐ **No. Obtain signature, or DO NOT PRESCRIBE.**

MOUD Protocol- Assessment and Treatment Care Pathway: Continuation or Modification of Therapy

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Continuation or Modification of Therapy - Utilize answer from question 5 of Assessment and Treatment Care Pathway to prescribe via the corresponding pathway below.

May prescribe up to 30-day supply with 5 refills.

☐ **Continuing therapy**. Do not change:

- Medicine (including route of administration)
- SIG
- QTY (up to 30-day supply)

☐ **Modifying therapy**. See chart below for instructions on dose increase, but do not change:

- Medication (including route of administration)
- SIG (except for dose increase)
- QTY (up to 30-day supply)

MOUD Dose Escalation Rubric (for Buprenorphine/Naloxone SL films or tabs)

Current Daily Dose	Moderate Dose Increase (BSCS Risk = Moderate)	Significant Dose Increase (BSCS Risk = High)
2 mg to 12 mg	Increase total daily dose by **2 mg**	Increase total daily dose by **4 mg**
> 12 mg to < 32 mg	Increase total daily dose by **4 mg**, not to exceed *32 mg per day. (If taking 30 mg per day, increase total daily dose by 2 mg to achieve total daily dose of 32 mg per day)	Increase total daily dose by **8 mg**, not to exceed *32mg per day. (If taking 26 to 30 mg per day, increase total daily dose by 2, 4, or 6 mg to achieve dose of 32 mg per day)
≥ 32 mg	Do Not Increase; Refer to another provider.	Do Not Increase; Refer to another provider.

* Maximum daily dose is 32 mg. If patient requires higher dosage, refer to another provider.

Once prescription is determined, continue

Prescriber notification

Provide notification of care to the patient's most recent MOUD prescriber (may use **Provider Fax Template**).

RPH Name (Print):_____

RPH Signature:_____ **Date:** _____

MOUD Prescription Template- Continuation or Modification of Care

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:

Rx

☐ **Drug:** _____

- Directions: _____
- Quantity: _____
- Refills: _____

Written Date: _____

Prescriber Name:_____ Prescriber Signature: _____

Prescriber NPI:_____ Prescriber DEA#: _____

Prescriber Address:_____

Prescriber Phone: _____

Provider Notification - Medications for Opioid Use Disorder (MOUD)

Optional-May be used by pharmacy if desired

Pharmacy Name:_____Pharmacist Name: _____
Pharmacy Address:_____
Pharmacy Phone:_____Pharmacy Fax: _____

Dear Provider_____(name), (____)_____-_____(FAX)

Your patient_____(name)_____/_____/_____(DOB) was:

☐ **Prescribed and dispensed** a **Medication for Opioid Use Disorder (MOUD)** at our Pharmacy noted above on ____ / ____ / _____. The prescription issued and dispensed consisted of:

- Drug: _____
  - Directions: _____
  - Quantity: _____
  - Refills:_____

☐ **Prescribed and administered** a **Medication for Opioid Use Disorder (MOUD)** at our Pharmacy noted above on ____ / ____ / _____. The prescription issued and administered consisted of:

- Drug: _____
  - Directions: _____
  - Quantity: _____
  - Refills:_____

☐ **NOT prescribed, dispensed or administered** a **Medication for Opioid Use Disorder (MOUD)** at our Pharmacy noted above, because:

_____
_____

☐ **Referred to**: ☐ Primary care provider (PCP) ☐ Emergency department (ED) ☐ Urgent care for the following reasons:

_____
_____
_____
_____
_____

RPH Signature:_____RPH Name (Print:)_____ Date: _____

The prescription was issued pursuant to the Board of Pharmacy protocol authorized under OAR 855-115-0330.

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