

Board Opinion Relating to the Use of Suboxone (Buprenorphine/Naloxone) and Subutex (Buprenorphine) for the Treatment of Opiate Dependency

LEGAL AUTHORITY

This is a Board opinion issued pursuant to the Board's statute, KRS 311.602, to assist licensees in determining what actions would constitute unacceptable conduct under the provisions of KRS 311.595. The Board has decided to publish this opinion because it addresses issues of significant public and medical interest.

This opinion is not a statute or regulation, and does not have the force of law.

STANDARDS OF ACCEPTABLE AND PREVAILING MEDICAL/OSTEOPATHIC PRACTICE RELATING TO THE USE OF SUBOXONE (BUPRENORPHINE/NALOXONE) AND SUBUTEX (BUPRENORPHINE) FOR THE TREATMENT OF OPIATE DEPENDENCY

The Board has determined that the following principles constitute the standards of acceptable and prevailing medical practice relating to a physician's use of Suboxone and Subutex:

1. The physician should complete a full evaluation of the patient prior to treatment. That full evaluation should include, but not be limited to: history, physical examination, appropriate laboratory tests (drug screen, HIV, CMP, lipids, urinalysis, and hepatitis serology), and incorporation of clinic opioid withdrawal scale (COWS).
2. The physician should not provide more than 8 mgs. of Suboxone induction per the manufacturer's recommendation on the initial date of treatment.
3. The physician should limit patients' prescriptions to weekly for the first month of treatment, every two weeks for the second month of treatment, and then monthly as indicated.
4. The physician should not authorize refills on any individual prescription.
5. The physician should not provide refills prior to the formulated time and if a patient requests replacement of previous medication the physician must meet with the patient in order to determine the appropriate course of action.
6. The physician should allow dose adjustments to be made per physician recommendation only.
7. The physician should not undertake the treatment of chronic pain patients while they are in a Suboxone program.
8. The physician should not use benzodiazepines or any other sedative-hypnotics concomitantly with Suboxone. Any sedative-hypnotics, if necessary, are to be initiated and maintained by a psychiatric consultant.
9. The physician should refer patients with psychiatric co-morbidity for psychiatric evaluation and continued care as necessary.
10. The physician should refer patients with polysubstance use disorder to more intensive treatment programs (with or without suboxone).

11. The physician should not prescribe additional opiates for pain management to patients enrolled in a Suboxone Treatment Program for Opiate Dependency.
12. The physician should use prescription Suboxone as a primary opiate for Opiate Agonist Treatment (“OAT”). The physician should not combine Subutex with Suboxone.
13. The physician could use Buprenorphine for pregnant patients only after cautiously considering the risk/benefit issues involved.
14. The physician should use Buprenorphine only after the patient has been educated concerning it, and shall use it only after other treatment options have been considered.
15. The physician should proceed with re-induction for any patient who lapses in treatment and then returns to treatment.
16. The physician should prescribe Suboxone so that the patient’s use of it shall be limited to once a day.
17. The physician should obtain regular drug screens at each appointment, review the results with the patient, and utilize Gas Chromatography-Mass Spectrometry (“GCMS”) as necessary.
18. The physician should obtain pill counts randomly.
19. The physician should routinely request and appropriately utilize KASPER reports for all Kentucky patients consistent with the Board Opinion regarding Use of Controlled Substances in Pain Treatment, published by the Board on October 10, 2008.
20. The physician and any associate(s) should not employ any patients they have treated.
21. The physician should take suboxone certification at an American Society of Addiction Medicine (“ASAM”) sponsored review course, and that training should be completed through personal attendance.

These standards will be utilized by the Board and its consultants in their review of any grievance or investigation involving the use of Suboxone and/or Buprenorphine. Furthermore, these standards will be offered into evidence for use by the assigned Hearing Officer in any proceeding to enforce the provisions of KRS 311.595(9), as illustrated by KRS 311.597(3) and/or (4).

Adopted: December 17, 2009
Modified: June 16, 2011