BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Networking researchers, educators & care providers

Did you know?

BUPRENORPHINE/NALOXONE

There have been changes to provincial regulations for prescribing buprenorphine/naloxone that all primary care providers need to know:

1. A methadone exemption is no longer required to prescribe buprenorphine/naloxone. Any licensed BC physician can prescribe this medication for treatment of opioid use disorder.
2. Health Canada has removed the two-month minimum of supervised daily dispensing for this medication. Due to its relative safety profile, take-home doses of buprenorphine/naloxone can be provided as soon as the patient is deemed clinically stable by the treating clinician.
3. Buprenorphine/naloxone is a first-line benefit under BC PharmaCare and the Non-Insured Health Benefits program. Patients are no longer required to "fail" methadone first.

The new Provincial Guideline for Clinical Management of Opioid Use Disorder recommends buprenorphine/naloxone as the preferred first-line treatment for opioid use disorder. Buprenorphine/naloxone is a 4:1 combined formulation administered as a sublingual tablet.

1. Buprenorphine, a partial opioid agonist, treats opioid addiction by preventing opioid withdrawal and drug cravings, leading to cessation or reduction in opioid use.
2. Naloxone, an opioid antagonist, deters non-medical use ('diversion') by inducing withdrawal symptoms if the drug is misused and injected intravenously.

Research has shown that treatment outcomes (i.e., retention, reduction in opioid use) are similar to methadone, but buprenorphine/naloxone has fewer side effects and important safety advantages:[1,2]

1. A "ceiling effect" on respiratory depression, making fatal overdose much less likely
2. A lower risk of adverse events including cardiac arrhythmias
3. Fewer drug–drug interactions (e.g., with antibiotics, antidepressants, and HIV medications)
4. A potentially lower risk of diversion due to co-formulation with naloxone

Moreover, research demonstrates that patients can achieve similar or improved treatment outcomes in primary care compared to specialized addiction treatment clinics.[3] Other advantages include:[4–7]

i. A single prescriber model that supports safe prescribing strategies
ii. Patients may experience less stigma and fewer barriers to accessing treatment
iii. A pre-existing therapeutic relationship may improve engagement and continuity of care
iv. Addiction treatment can be provided within a comprehensive framework of care and support

FOR NEW PRESCRIBERS

It is recommended to complete an online CME course in buprenorphine/naloxone treatment. Additionally, new prescribers can consult with an experienced addiction medicine clinician or the Rapid Access to Consultative Expertise (RACE) line. Please see above for Resources and RACE line contact information. MSP billing codes are on the back of this bulletin.

Online Resources for Clinicians

- Provincial Guideline for Clinical Management of Opioid Use Disorder - provincial guideline for BC starting June 5, 2017
- Until June 5, 2017, the above guideline is provided for educational purposes. Prescribers may refer to the CPSBC's Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder
- The Suboxone® Continued Medical Education Program: www.suboxonetrainingprogram.ca
- Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians: www.camh.ca/en/education/about/AZCourses/Pages/BUP.aspx

Rapid Access to Consultative Expertise (RACE) Line

- The RACE line allows primary care practitioners to rapidly connect with and receive treatment advice from a specialist, often eliminating the need for a face-to-face specialist or emergency department referral. To connect with an Addiction Medicine specialist, call the RACE line (604.682.2344) or download the RACE app at www.raceconnect.ca/race-app
- Primary care physicians may be eligible to receive CME "Linking Learning to Practice" credit for using RACE in patient care.
- Visit www.raceconnect.ca for more information on how to implement RACE in your practice.

St. Paul's Hospital
608 - 1081 Burrard Street
Vancouver, BC Canada V5Z 1Y6
TEL: 604.806.8477 FAX: 604.806.8464

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Updates to BC PharmaCare Coverage for Buprenorphine/Naloxone

- As of **February 1, 2017**, buprenorphine/naloxone is fully covered under PharmaCare's Psychiatric Medications Plan (Plan G). Plan G is available to those with a family adjusted net income below $42,000 per year (plus $3,000 per dependent) who meet the clinical criteria. Application forms for Plan G can be accessed online at: http://www2.gov.bc.ca/assets/gov/health/forms/3497fil.pdf.
- Coverage is already available to individuals receiving B.C. Income Assistance (i.e., covered under Plan C), those with no deductible or family maximum under Fair PharmaCare, and to registrants of the Non-Insured Health Benefits Plan

MSC Payment Schedule Information

The following information has been excerpted "as is" from the current MSC Payment Schedule, effective April 26, 2017.

T00039 Oral opioid agonist treatment $23.19/week

T00039 is the only fee payable for any visit or medically necessary service associated with methadone or buprenorphine/naloxone agonist therapy. Payable once per week per patient regardless of the number of visits per week.

NOTES

i. The physician does not necessarily have to have direct face-to-face contact with the patient for these fees to be paid.

ii. 00039 is the only fee payable for any visit or medically necessary service associated with oral opioid agonist treatment, including but not limited to the following:

a) At least one visit per week with the patient during the induction of opioid agonist treatment.

b) At least one visit per month with the patient after induction/stabilization on oral opioid agonist treatment is complete. Exceptions to this criterion are where the patient resides/works in an isolated locale which is a significant distance from the prescribing physician.

c) Case management/treatment planning with the care team.

d) Supervised urine drug screening and interpretation of results.

e) Counselling by a physician.

f) Communication with a non-physician counsellor, (g) dispensing/supervising pharmacist, (h) primary care physician, or (i) hospital-based physician when patient admitted to hospital.

j) Completion and submission of documentation relating to registration, termination or transfer.

iii. Claims for visit fees are not payable in addition.

iv. This fee is payable once per week per patient regardless of number of visits per week.

v. This fee is not payable with out of office hours premiums.

vi. Eligibility to submit claims for this fee item is limited to physicians who are actively supervising the patient's continuing use of oral opioid agonist medications for treatment of opioid use disorder.

vii. This payment stops when the patient stops oral opioid agonist treatment.

P15039 GP Point of Care (POC) testing for opioid agonist treatment $12.53/biweekly

NOTES

i. Restricted to patients in opioid agonist treatment.

ii. Maximum billable: 26 claims per patient per annum.

iii. Confirmatory testing (reanalyzing a specimen which is positive on the initial POC test using a different analytic method) is expensive and seldom necessary once a patient is in treatment for opioid use disorder; confirmatory testing should be used only when medically necessary, i.e., when a confirmed result would have significant impact on patient management.

iv. The fee for POC testing includes the adulteration test.

v. Only POC urine testing kits that meet Health Canada Standards are to be used.

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3. Kraus ML, Alford DP, Kotz MM, et al. Statement of the American Society of Addiction Medicine Consensus Panel on the Use of Buprenorphine in Office-Based Treatment of Opioid Addiction. Journal of Addiction Medicine. 2011;5(4):254–263.
4. Basu S, Rohrberg DS, Bruce RD, Altice FL. Models for Integrating Buprenorphine Therapy into the Primary HIV Care Setting. Clinical Infectious Diseases. 2006;42(5):716–721.
5. Krantz MJ, Mehler PS. Treating opioid dependence. Growing implications for primary care. Archives of Internal Medicine. 2004;164(3):277–288.
6. Mintzer IL, Eisenberg M, Terra M, MacVane C, Himmelstein DU, Woolhandler S. Treating Opioid Addiction With Buprenorphine-Naloxone in Community-Based Primary Care Settings. Annals of Family Medicine. 2007;5(2):146–150.
7. Fiellin DA, Pantalon MV, Pakes JP, O'Connor PG, Chawarski M, Schottenfeld RS. Treatment of heroin dependence with buprenorphine in primary care. The American Journal of Drug and Alcohol Abuse. 2002;28(2):231–241.

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