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POSITION STATEMENT

ACMT Position Statement: Remove the Waiver Requirement for Prescribing Buprenorphine for Opioid Use Disorder

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The position of the American College of Medical Toxicology (ACMT), endorsed by the American Academy of Clinical Toxicology, the American Academy of Emergency Medicine, and the American College of Emergency Physicians is as follows: To increase access for patients to receive treatment for opioid use disorder in the United States, we strongly recommend removing the waiver ("X-waiver") requirement for buprenorphine prescribing.

Background

Current US law requires prescribers to obtain a waiver ("X-waiver") for outpatient prescription of buprenorphine [1]. The ongoing epidemic of opioid overdose deaths in North America represents a major public health crisis, with more than 48,000 Americans estimated to have died from opioid overdose in 2017 alone [2]. Opioid use disorder (OUD) is a chronic medical condition that can be treated with pharmacological therapies. In response to growing evidence, there is consensus within the healthcare community that opioid agonist therapy (OAT) is the best practice for the management of OUD [3]. Therapy with buprenorphine, a form of OAT, reduces the risk of death in patients with OUD [4], prevents complications from nonfatal opioid overdose [5], prevents injection-associated infections, improves overall functional status [4, 6], and is cost-effective [7].

Prescribing Regulations

The 1970 Controlled Substances Act restricts OAT of patients with OUD to federally regulated opioid treatment programs (OTP) [1]. Methadone has been used for OAT since 1972, but its widespread use is complicated by the limited availability of registered treatment centers [8]. In the US, buprenorphine (formulated in combination with naloxone) has been FDA-approved for the outpatient treatment of opioid use disorder since 2002 [1, 9]. Available for prescription from offices, clinic-based practices, or emergency departments, buprenorphine is dispensed from conventional pharmacies. The Drug Addiction Treatment Act of 2000 (DATA 2000) allows prescription of buprenorphine for OUD outside of an OTP under certain conditions [1]. Prescribers of buprenorphine for OUD must complete an approved training and submit an application to Substance Abuse and Mental Health Services Administration. Once approved, the Drug Enforcement Agency issues a registration number beginning

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with X (the so-called "X-waiver") for outpatient prescribing of buprenorphine [1].

Buprenorphine is scheduled by the DEA under the Controlled Substances Act as a schedule III medication, indicating accepted medical use with "moderate to low" potential for physical and psychological dependence. This is less restrictive than methadone and other full-agonist opioids prescribed for pain [10], which are all schedule II.

Buprenorphine Safety

FDA approval requires proof that a medication is both safe and effective, both of which have been confirmed in the years following approval. Buprenorphine has pharmacological advantages over other opioids [11]. Unlike most therapeutic opioids, which are full mu opioid receptor agonists and used primarily for pain relief, buprenorphine is a partial agonist of the mu opioid receptor. This property confers a "ceiling effect" on respiratory depression (in adults) and reduced euphoria, the former accounting for the safety and the latter for the low rate of buprenorphine abuse compared with full agonists [12]. Buprenorphine also has exceptionally high affinity for the mu opioid receptor, limiting both the euphoric and the potentially lethal effects of full-agonist opioids [13].

Unlike methadone, buprenorphine does not predispose to serious cardiac arrhythmias. It is associated with fewer adverse gastrointestinal effects, less cognitive impairment, and a lower risk of adverse endocrine effects compared with other opioids [14]. Clinicians do not need to adjust buprenorphine dose in patients with kidney disease [15]. Although we recognize the risk for diversion, current evidence suggests that illicitly obtained buprenorphine is used to avoid symptoms of withdrawal [16]. Due to these properties, buprenorphine has been used safely by millions of patients in nations where buprenorphine prescription for opioid use does not require a special waiver [17, 18], such as Canada and France.

Increasing Buprenorphine Access

Prescribing regulations currently limit access to the effective treatment of OUD. Although the DATA 2000 legislation was intended to facilitate outpatient buprenorphine treatment of OUD, the waiver requirement serves as a major barrier to prescribing and, therefore, access. Prescribers must undergo training and are limited to treating 30 patients or fewer at a time in the first year of training. This can be increased in subsequent years to a maximum of 275. The need for a waiver, when other opioids can be prescribed for pain without a waiver, contributes to the misconception that buprenorphine is riskier than other opioids [19] and perpetuates the stigma associated with evidence-based treatment of OUD.

Today, fewer than 5% of eligible prescribers in the US have a waiver to prescribe buprenorphine [8, 20]. Limits on buprenorphine prescribing result in decreased accessibility [21]; nearly 30% of rural Americans live in a county without a buprenorphine prescriber [20]. Areas with decreased buprenorphine prescriber availability demonstrate increased mortality [22]. By removing the waiver requirement for outpatient buprenorphine prescription, we would increase the number of eligible prescribers by a factor as high as 20 [8, 20].

The Emergency Department (ED) is a logical setting to begin OAT because of its role in caring for patients with overdose, withdrawal, and other complications of OUD, especially for patients who may not otherwise have contact with the healthcare system. Although current rules permit non-waivered ED clinicians to administer a daily dose of buprenorphine, this is limited to only 72 h of medication. A survey of emergency physicians without the DATA 2000 waiver found that the inconvenience of the waiver process and the burden of obtaining extra training outside of work were the two largest barriers to obtaining the waiver in order to prescribe buprenorphine [23].

ACMT Recommends Removing the Waiver Requirement for Buprenorphine Prescribing for OUD

The waiver requirement is not justified by the pharmacology of buprenorphine and is not consistent with DEA scheduling of the drug. We share concern that increased access to buprenorphine may increase diversion or misuse, but believe these behaviors are less likely than with full agonists such as oxycodone and these risks are greatly outweighed by the benefit of increased access to OAT.

We recognize that removing the formal training requirement may present new challenges. As with prescribers of any medication, buprenorphine prescribers should be familiar with risks and contraindications associated with that drug. Principles of addiction medicine should be incorporated into medical school curricula, residency training, and continuing medical education.

The original intent of the DATA 2000 waiver was to expand opportunities for OUD treatment while controlling buprenorphine prescribing to ensure safety. We have now had nearly two decades of experience with buprenorphine prescribing with an excellent safety record. Buprenorphine has been demonstrated to be safe, cost-effective, and lifesaving.

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Compliance with Ethical Standards

Conflict of Interest None.

Disclaimer While individual practices may differ, this is the position of the American College of Medical Toxicology at the time written, after a review of the issue and pertinent literature.

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