



ASAM American Society of
Addiction Medicine

Caring for Patients During the COVID-19 Pandemic

ASAM COVID-19 Task Force Recommendations

Supporting Access to Buprenorphine in Office-Based Settings During the COVID-19 Pandemic

Purpose of the document

Buprenorphine is a life-sustaining medication. Abrupt discontinuation can lead to relapse to substance use, overdose, and overdose death. The anxiety and stress associated with the COVID-19 pandemic, and the societal response to it, may exacerbate symptoms of opioid use disorder. In addition, the “stay-at-home” orders and the restrictions on border crossings may reduce the drug supply and increase the need for treatment. Every effort should be made to ensure that patients currently taking buprenorphine have timely access to refills of this medication, and that any new patients in need of treatment for opioid use disorder can initiate treatment in a timely manner.

These materials seek to provide guidance to ambulatory addiction treatment providers, including those working in primary care, and programs as they strive to ensure that patients continue to have appropriate access to buprenorphine¹ during the COVID-19 pandemic.

Topics

1. [Reopening Considerations](#)
2. [Leveraging Telehealth](#)
3. [Refills](#)
4. [Access to drug testing](#)
5. [Psychosocial treatment](#)
6. [Ensuring adequate supply of buprenorphine](#)
7. [Harm reduction, including naloxone distribution](#)
8. [Considerations for high risk patients](#)

¹Throughout this document, the term ‘buprenorphine’ will be used to refer to any formulation of buprenorphine including those containing both buprenorphine and naloxone.

1. Reopening Considerations

While many places across the country are starting to relax physical distancing restrictions, the COVID-19 pandemic is not over. Communities and treatment programs across the country remain at risk for increasing population prevalence over time. Providers and programs should continue to implement policies and procedures to reduce the risk for coronavirus transmission, based on national scientific guidance and informed by the available data and guidance in their state and local areas. In addition, clinicians and clinical programs should prepare for potential spikes in transmission in their community and program. Programs and providers should consider:

- Maintaining or implementing an incident command structure to prepare for and address any issues that arise due to COVID-19
- Reviewing current infection control processes, including the extent to which staff and patients are adhering to them.
- Assessing what worked well in your initial response and where there may be room for improvement, updating related policies and procedures as needed.
- Assessing your program or practices' potential needs related to:
 - Personal protective equipment and other supplies needed to control and mitigate the spread of the coronavirus.
 - Staff training
 - Staff support
 - Technology to support telehealth
- Addressing the evolving phases of the epidemic and how to prepare for the next stages in your community.

2. Leveraging Telehealth

Providers and programs should take steps to minimize in-person interactions throughout the COVID-19 crisis, as this is likely to reduce the risk of acquiring or transmitting the COVID-19 virus. Telehealth is an important tool for maintaining patient access to treatment while minimizing the risks associated with COVID-19. This section is intended to provide guidance to providers and programs in developing policies and practices to leverage telemedicine to provide buprenorphine treatment. Also see ASAM's [Access to Telehealth Guidance](#) which provides an overview of recent federal and state policy changes to enable telehealth during the COVID-19 crisis.

Recommendation

Telemedicine or telephonic visits should be used whenever possible and appropriate to provide buprenorphine treatment to patients.

Typically, a prescription for a controlled substance must be predicated on an in-person medical evaluation. However, federal policy makers have enabled exceptions during this public health emergency (which was declared on January 21, 2020). In addition, as of March 15, 2020, sanctions and penalties have been temporarily waived for healthcare providers that do not comply with certain provisions of the HIPAA Privacy Rule which may enable use of non-HIPAA compliant telemedicine applications that are widely available such as FaceTime or Skype. **(See [Telehealth Guidance Document](#)).**

Telemedicine communication conducted using an audio-visual, real-time, two-way interactive communication system is preferred but some telephone-based visits may also be considered. For example, some patients may not have the technical capabilities available for video visits.

For stable patients, the risk of in-person visits is likely to outweigh the benefits of in-person

visits. Patients who are unstable, or patients that do not have reliable access to a telephone (e.g. homeless patients) may still benefit from in-person visits. Providers and programs should consider infection mitigation strategies for in person visits. See [Infection Mitigation: Outpatient](#) guidance.

Resources

- AMA Quick Guide to Telemedicine in Practice: <https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice>
- American Psychiatric Association: Telepsychiatry and COVID-19: <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19>
- CMS General Provider Toolkit: <https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>
- National Consortium of Telehealth Resource Centers: <https://www.telehealthresourcecenter.org/>
- National Council Resources for COVID-19: <https://www.thenationalcouncil.org/covid19/>

2. Prescriptions and Refills

Providing refills without requiring in-person visits is another strategy for reducing risk of exposure to COVID-19. Given the safety profile of buprenorphine, the benefits of providing refills is greater than the risk of providing refills given the risk of severe adverse events like fatal overdoses are uncommon.² This section is intended to provide guidance to providers and programs in developing policies and practices regarding buprenorphine refills.

The Centers for Disease Control recommends that individuals maintain a 2-week supply of prescription medications as part of a “household plan of action in case of illness in the household or disruption of daily activities” due to COVID-19. Social distancing, including limiting exposure to groups of people larger than 10, is key to reducing the spread of COVID-19.

SAMHSA and the DEA have released guidance to facilitate e-prescribing of controlled substances, including buprenorphine without an in-person medical evaluation during this public health emergency. The DEA also issued an [Exception to Separate Registration Requirements Across State Lines](#). This exception applies to the prescription of controlled substances via telemedicine. Subject to the conditions of the DEA letter’s temporary exception (see Resources below), DEA-registered practitioners may prescribe controlled substances to patients via telemedicine in states in which they are not registered with DEA. See ASAM’s [Telehealth Guidance](#) for more information.

Buprenorphine prescribers typically provide 1-4 week prescriptions for sublingual buprenorphine/naloxone formulations for their patients with opioid use disorder. As prescribers respond to recommendations for decreased in-person, face-to-face visits and other CDC COVID-19 guidance, ASAM recommends a thoughtful approach to changing buprenorphine prescribing to ensure three goals:

- 1) Continued patient access to buprenorphine medications outside of emergency departments and hospitals
- 2) Protect the safety of patients
- 3) Minimize unintended exposures to buprenorphine, especially of children and pets.

Recommendation

Provide buprenorphine refills to stable patients, without requiring in-person visits or urine toxicology testing. Patients who are unstable may benefit from having less medication on hand and more frequent contact with providers (e.g. remote or in-person visits). However, for stable patients, the benefits of buprenorphine refills are likely to outweigh the risks of buprenorphine refills.

Providers may be concerned about the possibility of diversion if they provide patients with buprenorphine refills. While diversion happens, relative to other opioid agonists, diversion of

² Paone D, Tuazon E, Stajic M, et al. Buprenorphine infrequently found in fatal overdose in New York City. *Drug Alcohol Depend.* 2015;155:298–301. doi:10.1016/j.drugalcdep.2015.08.007

buprenorphine is much lower.³ In addition, diversion often occurs for the purpose of self-treating opioid withdrawal rather than achieving euphoria.⁴

Policies or practices to consider

Considerations for clinicians when deciding upon durations of buprenorphine prescriptions for the treatment of opioid use disorder include:

- 1) Does the patient fall into a high-risk group for severe COVID-19 illness either due to age or underlying health conditions as outlined by the CDC? Coming to clinics and pharmacies more often increases their risk for COVID-19 infection and ensuing risks to providers and the public.
- 2) Is the patient under quarantine or isolation, either due to symptoms concerning for COVID-19 disease or confirmed positive? Access to clinic and pharmacies may be impacted. Patients need access to medication continuity to support recommended quarantine or isolation.
- 3) What capability does the patient have for safely and securely storing different quantities of sublingual buprenorphine/naloxone formulations? Without access to safe storage, less medication may be preferable.
- 4) Who has potential access to medications in the home, including children, pets, or neighbors? While buprenorphine is associated with relatively less respiratory depression risk compared with methadone, opioid-naïve individuals, especially children, can be harmed from unexpected exposure. Clinicians should co-prescribe or assure naloxone is in the home. If naloxone access is limited, prioritize patients in households with children and adolescents or others who would poorly tolerate reductions in respiratory function.
- 5) How stable is the patient's opioid use disorder and/or other substance use disorders, if present? Less medication and more frequent monitoring by telehealth or audio-only check in may be preferable for patients at higher risk of overdose due to co-occurring alcohol or sedative/hypnotic misuse.

Under the updated guidance from DEA and SAMHSA, buprenorphine can be prescribed through telehealth (including for new patients).

³ Cicero TJ, Surratt HL, Inciardi J. Use and misuse of buprenorphine in the management of opioid addiction. *J Opioid Manag.* 2007;3(6):302–308. doi:10.5055/jom.2007.0018

⁴ Fox AD, Chamberlain D, Sohler NL, Frost T, Cunningham CO. Illicit buprenorphine use, interest in and access to buprenorphine treatment among syringe exchange participants. *J Subst Abuse Treat.* 2015 Jan;48(1):112-6. PMC4250323

Resources

- Provision of Telemedicine While Providing MAT (May 2018): https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf
- DEA Information on Telemedicine: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telemedicine.pdf
- FAQs: Provision of Methadone and Buprenorphine for the Treatment of OUD in the COVID-19 Emergency: <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf>
- **DEA Policy: Exception to Separate Registration Requirements Across State Lines**
[https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-018\)\(DEA067\)%20DEA%20state%20reciprocity%20\(final\)\(Signed\).pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf)

3. Psychosocial treatment

ASAM's recently released [National Practice Guideline for the Treatment of Opioid Use Disorder](#) recommends that “a patient’s decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management.”⁵ This guidance is even more applicable right now when patients may need to be under self-quarantine or have other risk factors that lead them to want to minimize external interactions.

While some patients are likely to benefit from psychosocial counseling depending on their specific conditions and scenarios, four randomized trials found that enhanced psychosocial counseling provided no additional benefit than typical medical management that occurs during routine office-based visits for many patients ([R Weiss 2011](#); [D Fiellin 2006](#); [Brigham 2014](#); [Ruetsch 2012](#); [J Tetrault 2012](#)).

This section provides guidance to providers and programs in developing policies and practices regarding psychosocial treatment during the COVID-19 crisis.

Recommendation

Psychosocial counseling should not be required as part of buprenorphine treatment. However, for some, maintaining access to psychosocial treatments during a time of increased anxiety and stress such as the COVID pandemic may be important for preventing substance use and minimizing patient mental health risks.

Individual therapy, when needed, may be continued through a telehealth when possible. Guided group therapy with a licensed therapist (e.g. “Seeking Safety”) may also be continued when possible through telehealth. Some patients may also benefit from virtual support groups (See ASAM’s COVID-19 [Support Group guidance](#)).

⁵ <https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline>

Policies or practices to consider

- Do not require patients to participate in counseling – virtual or in-person – in order to access medication. This is a generally recommended practice and particularly important during the COVID-19 pandemic.
- Consider which therapies are possible to convert to a virtual platform.
- Limit physical, in-person groups to no more than 10 individuals, preferable in a larger room where social distancing of 6 feet between individuals is possible.

Resources

ASAM's [National Practice Guideline for the Treatment of Opioid Use Disorder](#)

"Taking Care of Your Behavioral Health" <https://www.samhsa.gov/sites/default/files/tips-social-distancing-quarantine-isolation-031620.pdf>

4. Ensuring adequate supply of buprenorphine

Buprenorphine is a life-sustaining medication. Abrupt discontinuation can lead to relapse to substance use, overdose, and overdose death. Every effort should be made to ensure that all patients have timely access to this medication.

Recommendation

Providers and programs should take steps to ensure that all patients currently taking buprenorphine for addiction treatment continue to have timely access to this medication. Providers should consider how each patient will continue to access their medications if they are under quarantine or otherwise unable to leave the house.

Policies or practices to consider

- Consider longer duration prescriptions as safe and appropriate to minimize community exposure retrieving prescriptions from pharmacies.
- Consider appropriateness of mail-order pharmacies, as covered by insurance.
- Consider assigning a staff member to routinely follow up with patients to ensure they are able to obtain their refill on time.

Resources

5. Harm reduction, including naloxone distribution

The current COVID-19 crisis may put patients at greater risk for harms related to substance use. The anxiety and stress associated with this pandemic, as well as the social isolation, may exacerbate addiction and mental health related symptoms. In addition, social distancing and “stay-at-home” orders may make it more difficult for individuals who use drugs to access sterile supplies. The restrictions on travel and U.S. border crossings are also likely to impact the drug supply.

To minimize the harms associated with these circumstances, providers and programs should consider implementation of additional harm reduction strategies.

Recommendation

Ensure patients have access to naloxone. Naloxone is a life-saving medication in the event of an overdose and needs to remain easily accessible to persons who are at risk of an overdose themselves or of witnessing an overdose by someone else. First responders’ availability to respond to an overdose may be diminished due to other acute needs. As a result, prescribing or distributing additional doses of naloxone is warranted.

Educate patients about the potential risks during this crisis:

- Persons who may have difficulty accessing opioids for a period of time due to quarantine status as individuals or as a community, may have decreased tolerance upon access to drug supply, public service announcements reinforcing the importance of test injections should be considered.
- Highlighting the importance of having naloxone on hand, at this time. As noted, first responders’ availability to respond to an overdose may be diminished during this crisis.
- Provide information on safer drug use practices.

Policies or practices to consider

- Partnering with pharmacies in your community to ensure they have naloxone on hand so patient prescriptions can be filled.
- Partnering with community naloxone distribution programs to keep naloxone available to distribute to patients and community members.

6. Considerations for High Risk Patients

According to the CDC individuals who are at higher risk for severe illness from COVID-19 include:

- People aged 65 and older
- People with chronic health conditions including
 - Serious heart conditions
 - Lung disease or moderate to severe asthma
 - People who are immunocompromised or on immune suppressing drugs
 - Severe obesity (BMI \geq 40)

The CDC also notes that, “people who are pregnant should be monitored since they are known to be at risk with severe viral illness, however, to date data on COVID-19 has not shown increased risk”.

This guidance is focused on helping providers and programs to establish recommendations for continuing to offer high risk patients appropriate care while minimizing their risk for exposure to COVID-19.

Recommendation

High risk patients should continue to have access to appropriate addiction treatment, which may need to include some capacity for face-to-face treatment. However, every effort should be made to minimize in-person interactions. Telehealth services should be used whenever possible (see [Telehealth Guidance](#)).

Policies or practices to consider

- Consider risk stratifying patients further based on level of individual risk, stage of disease, ability to access telehealth services and recent history of non-prescribed substance use.
- Consider extending prescriptions beyond usual practice to allow for fewer in-person healthcare touches including at pharmacies where additional exposure may occur.

Resources

<https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/people-at-higher-risk.html>

<https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf>