



ASAM

The Voice of Addiction Medicine
American Society of Addiction Medicine

Public Policy Statement on Pharmacological Therapies for Opioid Use Disorder

Background

Addiction involving opioids, as is the case for addiction overall, is a chronic disease of brain reward, motivation, memory and related circuitry. It can be complicated by comorbid physical and psychological conditions and influenced by genetic and environmental elements. While no two individuals suffer from addiction in exactly the same way, most patients require acute intervention followed by appropriate disease-specific treatment and then life-long continuing care to achieve and maintain remission of illness. In each case, therapy should be individually tailored to address the primary illness and all comorbidities. For most, opioid use disorderⁱ treatment requires chronic disease management that includes a combination of psychotherapeutic and, often, pharmacological interventions, administered in a variety of treatment settings and over a time frame sufficient to monitor relapse, stability and remission.ⁱⁱ The determination of which therapies will yield the best outcomes for persons with addiction involving opioids should be made only by knowledgeable and skilled physicians, in whom patients have placed their trust and well-being.ⁱⁱⁱ

Persons with addiction involving opioids can achieve and maintain long-term abstinence and recovery from their opioid use disorder using psychosocial interventions alone. However, some clinical outcomes research on specific populations of patients with opioid use disorder shows that mortality is significantly reduced when pharmacological therapy is included in the treatment plan. Currently, the US Food and Drug Administration has approved several opioid agonists, partial agonists and antagonist for use in “medication-assisted opioid therapy.” As of today, these medications include: buprenorphine, buprenorphine/naloxone, methadone, and extended-release injectable naltrexone. Federal, state, third-party and other laws, policies, rules and procedures that would limit a patient’s access to any potentially life-saving interventions, including pharmacological therapies for opioid use disorder, would have profound public health effects on the patient, their family, their community and the nation. Limited or discontinued opioid use disorder treatment, as a response to arbitrarily set government or third-party payer policies rather than to the guidance of the treatment provider, often leads to patient relapse, overdose, or death; disruption in family, work and community relationships; and criminally-involved drug-seeking behavior. Every effort should be made by the patient, the treatment provider, policy-makers and payers to maintain the optimal level of treatment for patients with an opioid use disorder, for the benefit of the patient, their family, the community and our society.

Recommendations:

The American Society of Addiction Medicine recommends:

- A. Treatment for any patient with an opioid use disorder should be based on a thorough evaluation of the patient by a knowledgeable and skilled physician, and designed in an individualized manner to best meet that patient's needs. Multidimensional assessment of the primary condition and co-occurring conditions should lead to initiation of and ongoing engagement in treatment.**
- B. Pharmacological therapy can be a part of effective professional treatment for opioid use disorder, and should be delivered by physicians appropriately trained and qualified in the treatment of opioid withdrawal and opioid addiction.^{iv,v} Furthermore, pharmacological therapy is best accompanied by and provided in conjunction with evidence-based psychosocial treatments and recovery support interventions as described in the ASAM Patient Placement Criteria.**
- C. Decisions about the appropriate type, modality and duration of treatment should remain the purview of the treatment provider and the patient, working in collaboration to achieve shared treatment goals.**
- D. Arbitrary limitations on the duration of treatment, medication dosage or on levels of care^{vi}, that are not supported by medical evidence, are not appropriate can be specifically detrimental to the wellbeing of the patient and his/her community. Thus, such arbitrary treatment limitations should not be imposed by law, regulation, or health insurance practices.**
- E. Arbitrary limits on the number of patients who can be treated by a physician or the number and variety of pharmacologic and/or psychosocial therapies that may be used for treatment should not be imposed by law, regulation, or health insurance practices.**
- F. Prior authorization requirements, medical necessity criteria tests, patient copays or in/out-of-network provider requirements for opioid use disorder treatment should be on par with similar requirements for other chronic medical illnesses.**
- G. Pharmacological therapy guidelines for use by treatment providers in the care of patients with opioid use disorder should be developed by addiction physician specialists^{vii}, in partnership with the U.S. Department of Health and Human Services and other federal, state and local public-private partnerships.**
- H. Long-term prospective studies aimed toward defining best practices should be developed and funded.**

Adopted by the ASAM Board of Directors on April 24, 2013.

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ⁱ The “Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V),” no longer uses the term “opioid dependence.” Rather this latest edition refers to addiction involving opioid dependence as “opioid use disorders.”

ⁱⁱ “ASAM Public Policy Statement on Effective Treatment of Addictive Disorders.” Adopted April 1, 1997, <http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/16/effective-treatment-of-addictive-disorders>.

ⁱⁱⁱ “ASAM Public Policy Statement on How to Identify a Physician Recognized for Expertness in the Diagnosis and Treatment of Addiction and Substance-related Health Conditions.” Revised January 15, 2010, <http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/16/how-to-identify-a-physician-recognized-for-expertness-in-the-diagnosis-and-treatment-of-addiction-and-substance-related-health-conditions>.

^{iv} “ASAM Public Policy Statement on Buprenorphine for Opioid Dependence and Withdrawal.” Revised May 1, 2006, <http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/buprenorphine-for-opiate-dependence-and-withdrawal>.

^v “ASAM Public Policy Statement on Methadone Treatment of Addiction.” Revised October 1, 2006, <http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/methadone-treatment-of-addiction>.

^{vi} Mee-Lee D, Shulman GD, Fishman M, Gastfriend, DR, and Griffith JH, eds. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R)*. Chevy Chase, MD: American Society of Addiction Medicine, Inc.

^{vii} As certified by the American Board of Addiction Medicine, the American Society of Addiction Medicine, the American Board of Psychiatry and Neurology, or the American Association of Osteopath Addiction Medicine.