Date

Regarding Rule Proposed Amendment

4731-33-93: Office-Based Treatment for Addiction

4731-33-04: Medication-Assisted Treatment Using Naltrexone

4730-4-03 (PA): Office-Based Treatment for Addiction

4730-4-04 (PA): Medication-Assisted Treatment Using Naltrexone

Dear State Medical Board of Ohio,

My name is (**your first and last name**), and I am a (physician in primary care practices) who works in (Dayton in a private practice). The regulation of addiction treatment impacts my practice and patients.

I have reviewed the proposed amendment to the above-mentioned rules and strongly support removing the physician and physician assistant regulations for office-based addiction treatment and medication-assisted treatment using naltrexone. With the removal of the X-waiver, any individual with a DEA can now prescribe buprenorphine for opioid use disorder (OUD). Removing outpatient addiction treatment regulations on buprenorphine and naltrexone in Ohio is vital to combating the opioid crisis and promoting effective addiction treatment.

It is crucial we remove these rules for the following reasons:

1. **Buprenorphine and Naltrexone are safe and effective for OUD:** These evidence-based medications are safe and effective to treat OUD. In studies, the harms associated with diversion have been minimal, with most individuals using diverted buprenorphine for therapeutic purposes[1]. Recent flexibility in buprenorphine regulations through telehealth as a result of the COVID-19 pandemic did not result in an increase in buprenorphine overdoses, suggesting that removing our state regulations will not increase harm to our communities.[2]
2. **Empowerment of Healthcare Providers:** Removing state regulations empowers healthcare providers to prescribe buprenorphine without onerous documentation and will increase the number of individuals prescribing buprenorphine. When the X-wavier was in place, only 10% of eligible primary care prescribers could prescribe buprenorphine, now, with its removal, it is essential we continue to remove prescribing barriers for healthcare providers.[3]
3. **Increased Access to Treatment:** Removing regulations will increase the number of clinicians providing this life-saving medication. This will significantly expand treatment access across our state, particularly in rural areas.
4. **Stigma Reduction and Normalization of Treatment**: Restrictive regulations perpetuate the stigma associated with addiction treatment. Removing these barriers sends a strong message that addiction is a medical condition deserving the same compassion and treatment as any other health issue. Normalizing the accessibility of buprenorphine can help reduce the stigma surrounding medication treatment for OUD, encouraging more individuals to seek help without fear of judgment or discrimination. This shift can significantly impact public perception and

attitudes towards addiction, fostering a more empathetic and supportive community for those in recovery.

As a busy primary care clinician, the current regulations have deterred me from prescribing buprenorphine in my practice. Removing these regulations would empower me to prescribe it to my primary care patients who need treatment for their OUD. Furthermore, I find these regulations attempt to codify medical practices such as visit frequency and urine drug test monitoring when they should be determined based on a patient's medical stability, clinic capacity, and social circumstances. The way current regulations could place patients at risk of missing an appointment and losing a life-saving medication, and I, as a clinician, require flexibility in determining what is the most appropriate for my patient.

If the rules must remain in place, then I strongly recommend the board increase the flexibility, in all the listed procedures. There should be an opportunity for the patient to defer components of the assessment treatment plan, and for the physician to have the flexibility to continue MOUD treatment in their clinical judgment. The same should be allowed for physicians to adjust the care plan based on the clinical scenario for items such as toxicology testing, script supply, visit frequency, method of buprenorphine induction, withdrawal protocols, and their methods for decreasing the diversion risk of controlled substances. The documentation requirements in this document are heavy, and I would recommend documentation requirements for only the following scenarios (in addition to the routine HPI): 1) if the use of mono-product buprenorphine is selected, a reason should be documented 2) Naloxone script offered and document if pt deferred 3) counseling and attempted care coordination of with the prescribing physician if a patient is being co-prescribed another controlled substance.

I appreciate your consideration of my comments. Feel free to reach out to me with any additional questions or concerns. I genuinely support removing these rules, and it would safely expand life-saving addiction treatment across our state for our communities.

Sincerely

Name

Contact Information

References:

1. Schuman-Olivier Z, Albanese M, Nelson SE, et al. Self-treatment: illicit buprenorphine use by opioid-dependent treatment seekers. *J Subst Abuse Treat*. 2010;39(1):41-50.
2. Krawczyk N, Rivera BD, King C, Dooling BCE. Pandemic telehealth flexibilities for buprenorphine treatment: A synthesis of evidence and policy implications for expanding opioid use disorder care in the U.S. *medRxiv*. Mar 17 2023;doi:10.1101/2023.03.16.23287373

3. McBain RK, Dick A, Sorbero M, Stein BD. Growth and distribution of buprenorphine-waivered providers in the United States, 2007–2017. *Ann Intern Med*. 2020;172(7):504-506.