

# Pregnancy Medical Home Program Care Pathway: Management of Substance Use in Pregnancy

April 2015

## Background

Substance use is a persistent challenge in our society across all demographic groups and raises specific concerns and complications in pregnancy. Screening, brief intervention and referral to treatment (SBIRT) is an evidence-based approach to addressing substance use in clinical practice and is endorsed in the obstetric setting.<sup>1</sup> Brief interventions in the prenatal care setting serve as teachable moments and may help women with substance use in pregnancy to reduce or eliminate use. For some women, the SBIRT approach will lead to treatment and recovery. The benefits of the pregnant woman's behavioral change have proven to be effective in improving birth outcomes for the newborn.

### 1. Use universal verbal/written screening with patients at the initial prenatal visit and across pregnancy<sup>1</sup>.

Urine drug screening is not recommended universally.

- a. **Establish a non-judgmental approach to addressing substance use.** See [Appendix E](#) for sample language.
- b. **Complete the [PMH Risk Screening Form](#)** with new OB patients at the beginning of the first prenatal visit. Questions 8-13 on the "patient" side of the form are standardized substance abuse screening questions, adapted from the Modified 5 P's instrument<sup>2</sup>.
  - i. A clinician (nurse, nurse practitioner, midwife, physician assistant or physician, per DMA Policy 1E6, Section 5.3.1) should review **both** sides of the screening form with the patient before the patient leaves and follow up on any positive responses in detail.
- c. **Gather additional information to assess the patient's risk for problems with drugs or alcohol** from the following sources or others as appropriate:
  - **Review the patient's current medication regimen** with the patient, including asking her about any misuse of prescription medications.

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<sup>1</sup> American College of Obstetricians and Gynecologists: At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice. Committee Opinion No.422. Obstet Gynecol 2008; 112; 1449-60.

<sup>2</sup> Kennedy C, Finkelstein N, Hutchins E, Mahoney J. Improving screening for alcohol use during pregnancy: the Massachusetts ASAP program. Maternal Child Health J. 2004 Sep;8(3):137-47.

- **Check the NC Controlled Substances Reporting System (NC CSRS) and CCNC’s Provider Portal** for prescription fill history to identify potential misuse of prescription drugs. See [Appendix D](#) for information about the use of the NC CSRS.
  - **Ask about any past or current substance abuse treatment**, including residential, outpatient, medication-assisted therapy for opioid use disorder, 12-step programs or other treatment modalities.
- d. **Record relevant information in the medical record.** See [Appendix G](#) for guidance related to the documentation and disclosure of substance use information.
- i. Federal regulations restricting the disclosure of substance abuse treatment information do not apply to patient self-disclosure to her provider or substance abuse information gathered from other medical providers.
  - ii. Providers should only include medically necessary and accurate information with no subjective comments when documenting and disclosing information related to substance use.
- e. **Refer to the [Pregnancy Medical Home Care Pathway on Perinatal Tobacco Use](#)** for guidance on the management of patients who report tobacco use during pregnancy on the PMH risk screening form.
2. **Complete further assessment based on information gathered above:** If patient answers “yes” to Risk Screening Form questions about current use of drugs or alcohol (question 13), about use of drugs or alcohol prior to pregnancy (question 12) or about past problems with drugs or alcohol (question 11), or screening findings indicate any potential concern about the patient’s use of drugs or alcohol or misuse of prescription drugs:
- a. Ask the patient to specify **what substance(s)** she was referring to when responding to these questions.
  - b. Ask about **frequency of use** (“What do you mean by rarely, sometimes, or frequently?”)
    - i. Ask the patient **how many days per week** on average she uses or was using each substance and about times when she may have used more.
    - ii. Ask the patient to specify **how much** of each substance she uses or was using at one time.
    - iii. Ask when the **last use** was for each substance.
  - c. For patients who report past problems with drugs or alcohol:
    - i. Ask the patient to describe her **past difficulties** with substance use
    - ii. Ask the patient to describe her experience with **substance use in previous pregnancies**
    - iii. **Offer support and referral** for further substance use assessment or treatment as needed.
    - iv. **Encourage the patient to disclose** to you any concerns about substance use at this time or during the pregnancy and let her know that you will be checking in with her about substance use during the pregnancy

3. **Offer a brief intervention to raise awareness of the risks of drug and alcohol use in pregnancy and to increase the patient’s motivation to acknowledge and address any problems related to use of these substances.**<sup>3</sup> Include a clear recommendation delivered in a non-judgmental, caring, and respectful manner to discontinue use of drugs and alcohol immediately for patients with any current use. See [Appendix E](#) for guidance on how to conduct a brief intervention. Patients on opioid therapy for chronic pain management or medication-assisted treatment for opioid dependence should not be advised to discontinue treatment; those using opioids illicitly should be referred for medication-assisted treatment. See [Appendix A](#) for further guidance on management of opioid dependence in pregnancy.
  - a. **Provide clear, accurate information to all patients** on possible effects of all common substances on the fetus.
    - i. Offer easy-to-read written materials and links to websites with reliable information for patients on substance use in pregnancy (see [Appendix H](#) for patient education resources)
    - ii. Encourage patients to bring questions about substance use to future prenatal visits.
  - b. **For patients without current or recent substance use and without a history of significant problems with drugs or alcohol:**
    - i. **Reinforce positive behavior** of abstaining from alcohol and drug use during pregnancy.
    - ii. **Reinforce benefits of avoiding drug and alcohol use** during pregnancy and for women’s health generally at subsequent visits.
    - iii. **Reassess drug and alcohol use once per trimester and at post-partum visit**, or if potential risk indicators are noted that warrant reassessment (see [Appendix B](#) for risk indicators).
  - c. **For patients who have a history of problems with drug or alcohol abuse but no current use:**
    - i. **Provide support for ongoing non-use** and reinforce positive behavior of abstaining from alcohol and drug use during pregnancy.
    - ii. Consider further assessment or treatment, if warranted.
    - iii. Schedule more frequent prenatal visits.
    - iv. Consider referral to pregnancy care manager, especially if there are concerns about the potential for relapse.
  - d. **For patients who have stopped using drugs or alcohol recently or since learning of the pregnancy:**
    - i. **Provide support for ongoing non-use** and reinforce positive behavior of abstaining from alcohol and drug use during pregnancy.
    - ii. Consider further assessment or treatment, especially for patients who have only recently discontinued substance use.
    - iii. Schedule more frequent prenatal visits.
    - iv. Ensure that the patient has a **pregnancy care manager**.

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<sup>3</sup> American College of Obstetricians and Gynecologists: Motivational Interviewing: A Tool for Behavior Change. Committee Opinion No.423. Obstet Gynecol 2009; 113: 243-6.

- v. **Discuss referral options with the patient;** see Section 4, Referral, below.
  - e. **For patients with current substance use (see [Appendix A](#) for guidance specific to patients with current opioid use):**
    - i. **Assess the patient's perception of problem and readiness to change her behavior,** including her desire to stop using drugs or alcohol and her willingness to accept a referral for substance abuse assessment and/or treatment.
    - ii. **Ensure that the patient has been referred to a pregnancy care manager.**
    - iii. **Schedule more frequent prenatal visits.**
    - iv. **Discuss referral options with patient;** see Section 4, Referral, below.
    - v. **For patients who do not agree to abstain from use** and who do not want a referral for substance abuse assessment or treatment:
      1. **Utilize motivational interviewing techniques** to engage the patient in ongoing discussion about her substance use.
      2. **Focus on strategies to reduce risk,** such as decreasing use, increasing safety around use, and promoting optimal self-care.
      3. **Regularly reassess the patient's readiness to change** and adjust the plan of care accordingly, including offering referral for substance abuse assessment and/or treatment again.
  - f. **Consider the use of urine drug screening for patients with a history of or with active substance abuse** (see [Appendix B](#) for urine drug screening considerations).
    1. Elicit the patient's permission to perform urine drug screening randomly during the pregnancy.
    2. Conduct urine drug screening once per trimester or more often for patients with active use during pregnancy.
- 4. Referral for Substance Abuse Assessment and Treatment:** Patients who may benefit from a referral to a behavioral health provider for a substance abuse assessment include:
- those who have tried to stop using alcohol or drugs in the past without success,
  - those who are currently using alcohol or drugs during pregnancy and are not confident in their ability to stop, and/or
  - those who are not ready to stop but who are willing to meet with a behavioral health provider for assessment.

For patients who are ready to enter a substance abuse treatment program or who are in need of acute stabilization, see Sections 5d and 5e below.

- a. Make a referral for substance abuse assessment for any patient who would benefit from this service. Explain that a substance abuse assessment with a behavioral health provider is a consultation with a specialist, as with any medical consultant, rather than a requirement that she enter substance abuse treatment.
- b. For outpatient or community behavioral health referrals for a substance abuse assessment, **if a behavioral health provider is known to the**

- practice**, make a referral directly to that provider, preferably by phone with the patient present, or using whatever existing local referral process is already in place.
- i. When speaking with the behavioral health provider, request an appointment for the patient to receive an assessment and for service recommendations (which are to be reported back to the prenatal care provider, per signed written consent).
  - ii. Prenatal care providers should establish pathways for referral and for coordination of care with local substance abuse treatment providers.
- c. **If the practice does not know of a behavioral health provider**, call the Local Management Entity/Managed Care Organization (LME/MCO) Screening, Triage, and Referral (STR) line with the patient present. The LME/MCO will conduct an assessment and link the patient to a behavioral health provider in the community. The LME/MCO STR phone numbers can be found here:  
<http://www.ncdhhs.gov/mhddsas/lmeonblue.htm>
- i. Pregnant patients who are uninsured or on Medicaid and are using substances are a priority population for the state LME/MCO system.
  - ii. When speaking with the LME/MCO, request an appointment for the patient to receive an assessment and for service recommendations (which are to be reported back to the prenatal care provider, per signed written consent).
- d. **For patients requesting a substance abuse treatment program:**
- i. Contact the NC Perinatal Substance Use Coordinator through the Alcohol/Drug Council of North Carolina at 800 688-4232 for assistance identifying a program or managing the referral process. See [Appendix K](#) for more information.
    1. The NC Perinatal and Maternal Substance Abuse Initiative and CASAWORKS for Families Residential Initiative coordinates 28 evidence-based, gender-specific substance abuse treatment programs for pregnant and parenting women across the state.
  - ii. Refer the patient directly to a community-based substance abuse treatment program **if a program that can meet the patient's current needs is known to the practice**.
    1. Prenatal care providers should be familiar with local substance abuse treatment providers, including having established pathways for referral to treatment and coordination of care.
- e. **For patients in need of acute stabilization prior to entry into a community-based and/or residential treatment program**, utilize available inpatient options, including the state-operated Alcohol and Drug Abuse Treatment Centers (ADATCs) or tertiary centers that manage pregnant patients with acute substance use treatment needs.
- i. The three state ADATCs all accept pregnant women from their catchment areas. Pregnant women are a priority population.
    1. The Julian F. Keith ADATC serves patients in the western counties of the state, and the R.J. Blackley ADATC covers the central part of the state.



- c. **Contact the treatment provider to coordinate care**, including reviewing medications being prescribed in both the behavioral health and prenatal settings.
- d. **Maintain contact with the treatment provider** over the course of the pregnancy and postpartum period
- e. **Identify and resolve barriers to treatment adherence.**
- f. Ensure the patient has a **pregnancy care manager**.



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## Appendices

- A. Management of Opioid Use in Pregnancy
- B. Urine Drug Screening Guidance
- C. Pain Contracts/Treatment Agreements
- D. Use of the North Carolina Controlled Substances Reporting System
- E. Strategies and Scripts for Brief Interventions and for discussing substance use with pregnant patients (FRAMES and Brief Negotiated Interview Script)
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- I. Provider resources
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- K. The NC Perinatal & Maternal Substance Abuse Initiative and the CASAWORKS for Families Residential Initiative
- L. Guidance on prescribing buprenorphine in pregnancy

## Appendix A: Management of Opioid Use in Pregnancy

- 1. Background:** Women of childbearing age may be taking opioids in a variety of circumstances, including:
  - By prescription for the treatment of pain,
  - Through medication-assisted therapy (either methadone or buprenorphine) for the management of opioid dependence,
  - Misuse of prescription medications (taking medications other than how they were prescribed, including medications that were prescribed for another person or that were obtained illegally), and/or
  - Using heroin or other illegal opioids.

People who take opioids, whether by prescription or illicitly, may have one or both of the following responses:

- **Physical dependence:** the person will experience unpleasant physical withdrawal symptoms if the opioid is abruptly discontinued.
- **Opioid use disorder/addiction:** the person is using opioids for the purpose of getting high and/or for their perceived impact on pain, stress, anxiety, depression or other conditions.

Pregnant patients on opioid therapy for chronic pain management or medication-assisted treatment (MAT) for opioid dependence should not be advised to discontinue treatment due to high risk of relapse and pregnancy complications associated with withdrawal (Kaltenback et al, 1998). Patients taking opioids illicitly should be referred for MAT, either to an opioid treatment program (for methadone or buprenorphine) or to a physician who has DEA approval to prescribe buprenorphine.

Patients who request opioid detoxification during pregnancy should be referred to an experienced consultant. No standard protocols exist for opioid detoxification in pregnancy. The American Society of Addiction Medicine recommends detoxification in the second trimester, if it is to be undertaken at all. For patients who choose this option, prenatal visits should include screening for relapse (patient report and urine drug screening), ongoing support, and willingness to revisit the use of MAT if the detoxification plan is not successful.

- 2. Guidance for working with all patients taking opioids during pregnancy:**
  - a. Provide education about the possibility of neonatal abstinence syndrome and its management.
  - b. Encourage to share their concerns with their prenatal care provider and opioid prescriber. Patients on opioid therapy may require more access to their provider to address their concerns about fetal opioid exposure.
  - c. Schedule more frequent prenatal visits.
  - d. Refer the patient to the pediatric team at the intended delivery facility during the third trimester to discuss the plan for neonatal assessment and management of neonatal abstinence symptoms, if present.
  - e. Work with the patient and the delivery facility to establish a plan for pain management during labor and delivery.

- f. Provide education about the value of breastfeeding for infants exposed to opioids during pregnancy. For more information, refer to the Academy of Breastfeeding Medicine Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman, available at:  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2989871/>

**3. Management of patients who are currently receiving medication-assisted treatment for opioid use disorder:**

- a. Patients on MAT for opioid use disorder should continue this treatment during pregnancy (ACOG 2012); doses may need to be adjusted due to metabolic changes of pregnancy. MAT medications should be managed by the current prescribing provider.
  - i. The prenatal care provider should obtain a thorough history of how long the patient has been on medication-assisted therapy, the dose, its effectiveness, her relationship with the treatment provider, and whether the treatment provider is aware of the pregnancy.
  - ii. Patients already stable on methadone treatment should not be encouraged to switch to buprenorphine during pregnancy.
- b. If current treatment is not meeting the patient's needs, work with the pregnancy care manager, LME/MCO, and/or the treatment provider as applicable to explore alternative treatment options.

**4. Management of patients in chronic pain treatment who are taking prescribed opioid medications:** The prenatal care provider should work collaboratively with the prescriber of the pain management regimen and other members of the care team (behavioral health, physical therapy, etc.) and should take the following steps (Meyer 2014):

- a. Obtain release of information so all members of the team may share clinical information.
- b. Work with the care team to determine if the patient will continue chronic opioid therapy during the pregnancy. Ensure that all care team members are aware of risks associated with withdrawal during pregnancy.
- c. For patients who will be continuing opioid treatment during pregnancy:
  - i. Establish who will prescribe the pain regimen during pregnancy, including dose and duration (e.g., limiting to 30-day supply).
  - ii. Establish which provider will check the Controlled Substances Reporting System (see [Appendix D](#)) for duplicate prescriptions or medications that increase risk when on opioid therapy (e.g., benzodiazepines, sedative hypnotics).
  - iii. The opioid prescriber should take responsibility for performing urine drug screening. (See [Appendix B](#) for UDS considerations.)
  - iv. Develop a plan for postpartum evaluation and treatment.
  - v. Ensure safe storage of opioid medications, including use of a lockbox if there are children present in the home.
  - vi. If the pain prescriber is not comfortable managing opioid therapy during pregnancy, the prenatal care provider may continue the current regimen, with

the understanding that the pain provider will reassume care following the pregnancy. The prenatal care provider should take the following steps:

1. Obtain records to confirm diagnosis, current medications and doses, and treatment history.
  2. If available, obtain a pain medicine consult to review the goals of chronic opioid therapy for pain management and to assess alternative medications or treatment modalities.
  3. Complete a work-up as appropriate for the pain disorder (e.g., renal ultrasound, x-ray, etc.).
  4. Treat with minimal opioids and investigate alternatives, such as lidocaine patches, cyclobenzaprine, gabapentin, acupuncture, trigger point injections, or physical therapy.
  5. Emphasize sleep hygiene.
  6. Refer for behavioral health consultation as appropriate.
  7. Consider written/verbal pain agreement (see [Appendix C](#)).
- d. For patients who will not be continuing opioid therapy for pain management during pregnancy:
- i. Determine who will manage the patient's discontinuation of treatment.
  - ii. Taper 10% of initial dose every 4-7 days
  - iii. Assess for physical withdrawal symptoms and for pain control.
  - iv. Emphasize alternative therapy, including behavioral health, and coping skills
  - v. Seek ongoing input from pain medicine for exacerbations.

**5. Management of patients in need of acute treatment for opioid use disorder:** Pregnant patients at risk for acute withdrawal due to discontinuation of opioid use may be managed in the inpatient or outpatient setting. Some patients admitted to the hospital in the antepartum period for other reasons may need management to address opioid withdrawal.

- a. Outpatient management for patients who accept MAT:
  1. Make a referral to a MAT provider that serves the patient's community. Instruct the patient to abstain from narcotics for 24 hours prior to intake, or follow guidance from the treatment provider.
  2. Prescribe as needed to cover the patient until the intake MAT appointment.
  3. Practices with a high volume of patients with opioid use disorder should consider having a provider within the practice become licensed to prescribe buprenorphine to facilitate access to treatment for pregnant patients (see [Appendix L](#) for more information on becoming a buprenorphine prescriber).
- b. Outpatient management for patients who do not accept MAT:
  1. Follow harm reduction guidance in [Section 3.e.v](#) of the Management of Substance Use in Pregnancy pathway, above.
  2. Assess the patient's willingness to be referred to a behavioral health provider for a substance abuse assessment ([Section 4](#) in pathway, above).
  3. See the patient for more frequent prenatal visits and assess readiness for treatment at each visit.

- ii. For patients with chronic pain treatment needs, see Section 3, above.
- c. Inpatient management:
  - i. Consider referral to a state-operated Alcohol and Drug Abuse Treatment Center (ADATC). The three state ADATCs, operated by the NC Division of State Operated Healthcare Facilities, accept pregnant women from their catchment areas. Pregnant women are a priority population.
    1. The Julian F. Keith ADATC serves patients in the western counties of the state, and the R.J. Blackley ADATC covers the central part of the state.
    2. In addition to serving women in eastern Carolina, Walter B. Jones ADATC in Greenville, NC accepts pregnant women statewide, including those with high-risk pregnancies, and is able to provide medication-assisted therapy for opioid use disorder on site.
    3. To refer to an ADATC, complete the Regional Referral Form available on the Department of State-Operated Healthcare Facilities (DSOHF) website:  
<http://www.ncdhhs.gov/dsohf/professionals/admissioncriteria-adatc.htm>.
    4. Fax the form to the number listed on the website for the ADATC to which the referral is being made, then follow up with a phone call to the Admissions Coordinator, whose number is also posted on the DSOHF website.
  - ii. Admit locally for stabilization while arranging follow-up with a MAT program. Seek expert consultation for assistance with methadone or buprenorphine induction, if needed.
- g. Utilize the NC Perinatal Substance Use Coordinator for assistance identifying a program or managing the referral process, including to an ADATC. The Coordinator can be reached through the Alcohol/Drug Council of North Carolina at 1-800-688-4232. See [Appendix K](#) for more information.
- h. Refer the patient for pregnancy care management if she does not already have a pregnancy care manager.

#### Appendix A. References

- American College of Obstetricians and Gynecologists: Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No.524. *Obstet Gynecol* 2012; 119: 1070-6
- Jones HE, Martin PR, Heil SH, Kaltenbach K, Shelby P, Coyle MG, et al.: Treatment of opioid-dependent pregnant women: clinical and research issues. *J Substance Abuse Treatment* 2008; 35(3):245-259
- Kandall SR, Albin S, Lowinson J, Berle B, Eidelman AI, Gartner LM: Differential effects of maternal heroin and methadone use on birthweight. *Pediatrics* 1976; 58(5): 681-6
- Kaltenbach K, Berghella V, Finnegan L: Opioid dependence during pregnancy: Effects and management. *Obstet Gynecol Clin N Am* 1998; 25 (1):139-151
- Meyer M. The Perils of Opioid Prescribing During Pregnancy. *Obstet Gynecol Clin N Am* 2014; 41:297-306

## Appendix B. Urine Drug Screening (UDS)

ACOG Statement: ACOG Committee Opinion No. 422 (2008) states that universal written/verbal substance use disorder (SUD) screening, brief intervention, and referral to treatment, rather than UDS, is best practice. UDS may be useful in specific clinical situations, including as follow up to a positive verbal screen.

Indications for UDS: UDS is useful in monitoring patients with or at high risk of SUD, as well as patients receiving controlled substances as part of pain management or SUD medication assisted treatment. The physician should be aware of metabolism pathways and careful with panel selection as some of the more common drugs of abuse are not part of the standard panel ([see video](#)). The physician should discuss the purpose, risks and benefits of the use of UDS with the patient and should stress that maternal and infant safety is the primary purpose.

If risk indicators are identified at any time during pregnancy or postpartum, rule out other identifiable causes, re-screen, test, or provide assessment as appropriate. Risk indicators include:

- Little or no prenatal care
- Inappropriate behavior (e.g., disorientation, somnolence, unfocused anger)
- Physical signs of substance abuse or withdrawal
- Smell of alcohol/chemicals
- Recent history of SUD or treatment

Positive UDS Results: Test results that suggest illicit drug use or prescribed medication misuse should be discussed with the patient. The discussion should occur in a positive, supportive fashion to strengthen the physician-patient relationship, encourage healthy behaviors, and produce behavioral change when needed and should include a referral to an addiction specialist.

If you believe a patient may be diverting a medication, she should be notified to come in to the office between scheduled appointments for a random pill count. If a random pill count reveals medication quantities that fall short of amounts expected from prescribing instructions, it is vital to perform a point of care urine drug screen (UDS) with confirmation. A UDS confirmation negative for the prescribed opioid and/or its metabolites is strong evidence of diversion and, the medication should be discontinued and alternative treatments initiated. If the physician believes the diversion represents a significant risk to public health, consideration should be given to reporting the individual to law enforcement or asking the NC Controlled Substance Reporting System (CSRS) for assistance.

UDS Reimbursement: The NC Medicaid code is G0434 (\$19.84). CPT codes 80100 (\$17.94) and 80101 (\$16.98) can be used for qualitative drug screening tests that use chromatographic methods for multiple (80100) and single (80101) drug classes. CLIA waived tests are highly recommended as they cost \$4-\$8 and require far less documentation than non-CLIA tests.

## Appendix C. Pain Contracts/Treatment Agreements

The North Carolina Medical Board (NCMB), in its “[Policy for the Use of Opiates for the Treatment of Pain](#)”, recommends the use of written informed consent and a treatment agreement when treating chronic pain with opioid medications. Agreements, or “pain contracts”, are signed by both the provider and patient and identify the goals of treatment.

The agreement typically addresses the patient’s responsibility to use the medication(s) safely, to only obtain opioids from one physician/practice, and to undergo periodic drug testing, and the physician’s responsibility to be available or have coverage for unforeseen problems and to prescribe scheduled refills. The agreement should include guidelines about prescription refills, how monitoring will occur (e.g. random pill counts and urine drug screening), and conditions under which drug therapy may be discontinued (e.g., violation of agreement).

A sample pain agreement can be found in CCNC’s Chronic Pain initiative toolkit for primary care providers (pages 19-20): <https://www.communitycarenc.org/media/related-downloads/pl-toolkit-pcps.pdf>



## Appendix D. Use of the North Carolina Controlled Substances Reporting System [www.nccsrs.org](http://www.nccsrs.org)

### What is the NC CSRS?

- A controlled substance prescription reporting system that allows registered dispensers and prescribing practitioners to review a patient's controlled substances prescription history on the web.

### How Does the System Work?

- All prescriptions for controlled substances, schedule II through V, dispensed in North Carolina are reported into the NC CSRS database. Pharmacies are required to report the data every 72 hours.
- Prescribers and pharmacists can register to gain access to the online system to look up a patient's controlled substances prescription history. Prescribers may legally query the system for their patients only.
- Registered prescribers can also delegate someone under their supervision to run queries for their patients. The delegate must register with the NC CSRS and will have their own login credentials. Guidelines and directions for setting up a delegate account can be found on the website ([www.nccsrs.org](http://www.nccsrs.org)).

### What Should I do with this Data?

- The NC CSRS is intended to assist you in providing better care to your patients through monitoring their safety and adherence to legally prescribed controlled substances. It is important that you inform your patients that you are using this system to ensure their well-being and quality of care. It is also important to assure your patients that the NC CSRS data is not openly shared with nonregistered providers and law enforcement or used as means to exclude them from future physical and behavioral health services.
- If the data reveal that the patient *may* be seeking, misusing, or diverting large quantities of controlled substances or seeking prescriptions from multiple providers, then the practitioner should discuss this with the patient in a nonjudgmental manner and contact the NC CSRS to discuss with a representative.
- If you believe the patient is abusing controlled substances, educate the patient about the risks and refer the patient to a behavioral health provider for substance misuse screening, assessment, and/or treatment if needed.

### What Shouldn't I do with this data?

- **The NC CSRS is not intended as a mechanism to exclude or discharge patients** without first offering intervention or referral to treatment for management of substance abuse and/or pain.
- **The NC CSRS is also not intended as a law enforcement investigative or reporting tool.** If you suspect the patient is inappropriately requesting controlled prescriptions from multiple providers, otherwise known as "doctor shopping", or committing prescription fraud please contact the NC CSRS program representatives for further guidance.

For more information, contact: 919.733.1765 or [NCControlSubstance.Reporting@dhhs.nc.gov](mailto:NCControlSubstance.Reporting@dhhs.nc.gov)

## Appendix E. Strategies and Scripts for Brief Interventions and for discussing substance use with pregnant patients (FRAMES and Brief Negotiated Interview script)

Being open, honest, non-judgmental and respectful is the first step in establishing rapport in order to talk with patients about substance use and help them take the next step towards addressing it.

- Keep messages clear, simple, and realistic.
- Don't predict the outcome of a particular pregnancy.
- Deliver personal, individually tailored messages.
- Stress the positive.
- Help women assess their risks.
- Motivate risk reduction and encourage ongoing hope.
- Be sensitive to legal implications.

Establish a non-judgmental approach to screening, such as by using the following script: "At this practice, we ask all of our patients about drug and alcohol use to make sure we are providing the best possible care for you and your baby. Your answers will not affect our commitment to ensuring you receive high quality prenatal care. What you tell us is confidential and used for medical care purposes only."

Find more detailed approaches in the 'Strategies to Communicate Risk' in Section 5 of the Perinatal Substance Use Manual available from the NC Division of Public Health Women's Health Branch: <http://whb.ncpublichealth.com/provPart/pubmanbro.htm>

There are various frameworks for structuring a brief intervention to address substance use. Below are the Brief Negotiated Interview/Active Referral to Treatment (BNI ART) Institute that summarizes the process of a brief intervention and referral for treatment and the FRAMES model, which is included in the ACOG Fetal Alcohol Spectrum Disorders Toolkit. This comprehensive toolkit can be accessed here: <http://mail.ny.acog.org/website/FASDToolkit.pdf>

### Brief Intervention Steps (with sample script below)

1. **Raise subject and ask permission**
  - a. acknowledge positives where applicable
  - b. ask to review lifestyle factor information gathered (use has already been established)

### Sample Script

- 1a. "I'm glad you came in today for prenatal care." (review positives: ex. overall health, lab results, early access of prenatal care)
- 1b. "I'd like to review lifestyle factors that may affect your health and the health of the baby, would that be ok?" <pause and listen>

## 2. Provide Feedback

- a. Review screening questions
- b. Make connection

### Sample Script

2a. “From what I understand you are currently using [insert substance].”

2b. “What do you know about [insert substance] effects on the health of the baby?” <pause and listen>

- <Reflective listening, state what she has said, ex: “Your understanding is that [insert substance] doesn’t have an effect on the baby.”>
- “What we do know about [insert substance] and the developing baby is that it can cause problems such as [insert medical information].”
- “What do you think about that information?” <pause and listen>

## 3. Enhance Motivation

- a. Explore pros and cons
  - Use reflective listening
  - Assess readiness to change
  - Reinforce positives
  - Develop discrepancy between ideal and present self

### Sample Script

3a. “Help me understand the good parts about [insert substance] for you?” <pause and listen>

- “And now we know about some not good parts for the pregnancy. Are there other parts of [insert substance] that have caused problems for you or that you don’t like?” <pause and listen>
- “On the one hand you said...<restate pros>”
- “On the other hand you said...<restate cons>”
- “Where does this leave you? On a scale of 1-10 of readiness to change, where would you put yourself?” <Show readiness ruler>
- “Why that number and not a lower one?” <pause and listen> “Are there other reasons to change?” <pause and listen>
- “How does this fit with where you see yourself in the future?” <pause and listen>

## 4. Negotiate and advise

- Negotiate goal
- Benefits of change
- Reinforce resilience/resources
- Summarize
- Provide handouts

## Sample Script

### 4. "What is the next step?"

- "If you do decide to stop using [insert substance], at least during your pregnancy, you have a better chance of having a healthy baby."
- "If you choose to make that decision I believe you can do it."  
<pause and listen> <if she expresses doubt about ability to make change offer help through a referral>
  - "It can be challenging to do alone, and you don't have to. I have someone I'd like to connect you with who has a lot of experience supporting women to make behavior change."
- Review plan for change, document, agree to check in on plan at next prenatal visit. Provide information sheet. Provide warm handoff for assessment and treatment referral.

## FRAMES:

### **F** Feedback

Compare the patient's level of drug or alcohol use with patterns that are not risky. She may not be aware that what she considers normal is actually risky. Inform the patient that any drug or alcohol use in pregnancy is considered risky. Check the patient's understanding of the effects of substance use on herself and her fetus and whether these effects are of concern to her.

### **R** Responsibility

Stress that it is her responsibility to make a change.

### **A** Advice

Give direct advice (not insistence) to change her behavior.

### **M** Menu

Identify situations that involve the use of drugs or alcohol and offer options for coping.

### **E** Empathy

Use a style of interaction that is understanding and involved.

### **S** Self-efficacy

Elicit and reinforce self-motivating statements such as, "I am confident that I can stop drinking". Encourage the patient to develop strategies, implement them, and commit to change.

## **Appendix F. Overview of Child Abuse Prevention and Treatment Act (CAPTA), reporting of substance-exposed pregnancies, and sample script for providers**

In North Carolina, substance use during pregnancy is not reportable to the Department of Social Services.

The Keeping Children and Families Safe Act (2003) Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized in 2003. This federal law requires states to create policies and procedures to address the needs of infants born and identified as being affected by illegal substance use or withdrawal symptoms resulting from prenatal drug exposure. This includes appropriate referrals to child protection service systems and for other appropriate services.

CAPTA includes a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants. North Carolina's policy and practice is consistent with this requirement, and includes prenatal alcohol exposure as cause to refer to child protective services.

Local Departments of Social Services (DSS) accept referrals for infants reported to have been exposed to substances prenatally, at the time of birth. When a referral is made by the health care provider, DSS utilizes a structured intake tool that includes the question, "Has the parent's alcohol/drug use resulted in a positive screening at the child's birth?". DSS's role is to assess the safety of the infant in the current family and living situation. The DSS assessment will indicate what response is necessary for the health and safety of the infant.

### Sources:

US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. "The Child Abuse Treatment and Prevention Act". June 2003.

North Carolina Department of Health and Human Services, Division of Social Services, Family Services Manual, Volume I: Children's Services, Chapter VIII: Child Protective Services. 19-65.

## **Appendix G. Guidance on documentation and disclosure of information related to substance use and its treatment**

Federal substance abuse confidentiality regulations (42 CFR, Part 2) do not apply to patient self-disclosure to her OB/GYN provider or to information gathered from anyone who is not a substance abuse treatment provider, such as a care manager, primary care physician, emergency department, etc. In the health record, OB/GYN providers should be careful, when documenting and disclosing information related to substance use, to include only medically necessary and accurate information with no subjective comments. ACOG Committee Opinion Number 422 (2008) states that “concerns about protection of confidentiality and nonmaleficence can be addressed most appropriately by including only medically necessary, accurate information in the medical record and informing the patient about the purpose of any disclosure.”

Any diagnosis or treatment information received from a “Part 2 facility” (i.e., a substance abuse treatment provider that is supported by federal funds) should be accompanied by a specific release of information form that will include language regarding 42 CFR, Part 2, as well as a written notice prohibiting redisclosure. This treatment information should be kept in a separate, secure file.

## Appendix H. Patient education resources

### [March of Dimes](#)

This website provides information for patients on the effects of tobacco, alcohol and drug use during pregnancy. There is information focused on how these substances may harm the patient as well as affect her pregnancy. There are also resources for those that would like help stopping use of these substances.

### [CDC: Alcohol Use in Pregnancy](#)

Website available in English and Spanish that provides information about why alcohol is dangerous in pregnancy, as well as how much and when. Resources are provided for those that are interested in help to quit drinking. Free posters and brochures on this topic are available to order or download on this [webpage](#).

### [ACOG FAQ on Tobacco, Alcohol, Drugs, and Pregnancy](#)

This fact sheet provides information on the how the use of various substances may affect the patient's pregnancy. Information about receiving treatment and why this is important is provided. Questions on why the patient should tell their health care provider about substance use is also included.

### [NIH: National Institute on Drug Abuse](#)

This website contains information about drugs of abuse. Under each of these is a webpage with specific information about these drugs, and some, such as marijuana and heroin, include specific information about the potential adverse effects of using the substance during pregnancy.

### [Alcohol Drug Council of North Carolina: Women's Services](#)

This is the webpage for the Women's Services section of the Alcohol/ Drug Council of North Carolina website, a statewide organization which can assist patients in finding a residential or outpatient treatment program. For information and help, call Judith Johnson-Hostler at (800) 688-4232 or email [jjones@alcoholdrughelp.org](mailto:jjones@alcoholdrughelp.org).

### [North Carolina Coalition Against Domestic Violence](#)

This is the website of the North Carolina Coalition Against Domestic Violence. Women who are involved with a controlling and/or abusive partner and may need assistance with information, shelter, and legal issues. The state program has information and connections to local programs across North Carolina. A list of NC Domestic Violence Service Providers statewide and by county is available under the "Get Help" tab. The NC Domestic Violence Hotline is 1-800-799-SAFE (7233). *If providing this information to a patient, note that not all of the pages open with the pop up box providing instruction on how to quickly navigate away from the site.*

### [UNC Horizons](#)

This is the website of UNC Horizons, one of the residential programs in North Carolina which serves pregnant and parenting women and their children. This website includes information about the services offered, FAQs, and success stories.

### [Intermountain Healthcare: Prescription Pain Medication in Pregnancy](#)

This patient education fact sheet from Intermountain Healthcare provides information on opioid pain medication. This includes a section on how this medication may affect the baby including the risk of NAS.

### [Intermountain Healthcare: Substance Use During Pregnancy](#)

This patient education fact sheet from Intermountain Healthcare provides information on various substances and their potential effects on pregnancy. Resources are listed for those that would like more information or help locating treatment for substance use.



**[MothertoBaby](#)**

Printable fact sheets in English and Spanish are available on this page on the effect of different substances such as cocaine and marijuana during pregnancy and beyond.

**[UCSF: Substance Use During Pregnancy](#)**

This patient education website from UCSF Medical Center provides a brief summary on the effect of different substances on the baby.

## Appendix I. Provider resources

### Substance Abuse and Mental Health Services Administration

This is the website of the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMSHA is a federal agency dedicated to developing effective programs for individuals and families struggling with mental health or substance use issues. Its website has thorough, reliable information on alcohol and drugs and free publications available for ordering or download. To download or order publications from the SAMHSA website, click [here](#).

Relevant publications include the following Treatment Improvement Protocols (TIPs):

- *TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment*  
Offers guidelines to help clinicians influence the change process in their clients by incorporating motivational interventions into substance abuse treatment programs. Describes different motivational interventions that can be used at all stages of change.
- *TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*  
Practice guidelines help physicians make decisions about using buprenorphine to treat opioid addiction. Includes information on patient assessment; protocols for opioid withdrawal; and the treatment of pregnant women, teens, and polysubstance users.
- *TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*  
Gives a detailed description of medication-assisted treatment for addiction to opioids, including comprehensive maintenance treatment, detoxification, and medically supervised withdrawal. Discusses screening, assessment, and administrative and ethical issues.

### NIH: National Institute on Drug Abuse

Website of the National Institute on Drug Abuse (NIDA). NIDA is part of the National Institutes of Health and focuses entirely on the use of alcohol, drugs and other substances. It also has great information and publications to share. This website contains information about drugs of abuse. Under each of these is a webpage with specific information about these drugs, and some, such as marijuana and heroin, include specific information about the potential adverse effects of using the substance during pregnancy.

### American Society of Addiction Medicine

This is the website of the American Society of Addiction Medicine; it has information of particular interest to physicians, including on the topic of Medication-Assisted Treatment (MAT).

### ACOG Committee Opinions

The following list of relevant ACOG Committee Opinions may be helpful as additional resources on each of these specific topics.

- [Committee Opinion No. 538: Non Medical Use of Prescription Drugs; October 2012, Reaffirmed 2014](#)
- [Committee Opinion No. 524: Opioid Abuse, Dependence and Addiction in Pregnancy; May 2012, Reaffirmed 2014](#)
- [Committee Opinion No. 496: At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications; August 2011, Reaffirmed 2013](#)
- [Committee Opinion No. 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist; January 2011, Reaffirmed 2014](#)
- [Committee Opinion No. 422: At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice, December 2008](#)

### **[North Carolina Pregnancy and Opioid Exposure Project](http://ncpoep.org/)**

<http://ncpoep.org/>

This is a new website on pregnancy and opioid exposure, sponsored by the NCDHHS. This website provides the new NC guidance on pregnancy and opioid exposure as well as other relevant informational materials. This website includes brief video vignettes about the NC Perinatal Substance Use program and a demonstration of a brief intervention with a pregnant woman about substance use in pregnancy.

### **[Alcohol Drug Council of North Carolina: Women's Services](http://www.alcoholdrugcouncil.org/women-services)**

This is the webpage for the Women's Services section of the Alcohol/ Drug Council of North Carolina website, a statewide organization which can assist patients in finding a residential or outpatient treatment program. For information and help, call the NC Perinatal Substance Use Specialist, Judith Johnson-Hostler, at (800) 688-4232 or email [jjones@alcoholdrughelp.org](mailto:jjones@alcoholdrughelp.org).

### **[NC Healthy Start: Perinatal Substance Use Project](http://www.ncperinatal.org/nc-healthy-start)**

Information about referrals to treatment and updated bed availability at NC facilities is linked on this site. There is also information on how to access training and technical assistance, as well as publications for professionals available through this website.

### **[North Carolina Coalition Against Domestic Violence](http://www.ncdvc.org)**

This is the website of the North Carolina Coalition Against Domestic Violence. Women who are involved with a controlling and/or abusive partner and may need assistance with information, shelter, and legal issues. This is our state program which has great information and connections to all our local programs. A list of NC Domestic Violence Service Providers statewide and by county is available under the "Get Help" tab. The NC Domestic Violence Hotline is 1-800-799-SAFE (7233).

### **[Health Cares About Intimate Partner Violence](http://www.nhrcc.org/health-cares)**

This website has resources for health care settings and includes links to technical assistance from the National Health Resource Center on Domestic Violence. There is a Screening and Counseling Toolkit for providers under "How To Screen". Under "Specific Setting - Reproductive Health", there is a list of resources, including [ACOG Committee Opinion No. 518 February 2012 on Intimate Partner Violence](http://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/518).

### **[UNC Horizons](http://www.unc-horizons.org)**

This is the website of UNC Horizons, one of the residential programs in North Carolina which serves pregnant and parenting women and their children. This website includes information about the services offered, FAQs, and success stories.

## Appendix J. Reimbursement and coverage of substance abuse services for pregnant women

### SBIRT counseling in the prenatal care setting:

North Carolina Medicaid covers two CPT codes associated with SBIRT counseling:

- CPT 99408 – Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services; 15-30 minutes
- CPT 99409 – Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services; greater than 30 minutes

These codes can be billed in addition to prenatal care services, including the global fee or other OB package codes, and in addition to tobacco cessation counseling codes. These codes can be billed by physicians, nurse practitioners, physician assistants, certified nurse midwives, and health departments. More information is available at the SBIRT NC website:

<http://www.sbirtnc.org/reimbursement-in-north-carolina/>

### Coverage of substance abuse treatment for pregnant patients:

Substance abuse and behavioral health services are covered for pregnant Medicaid beneficiaries, including for women in the Medicaid for Pregnant Women (MPW) category. All pregnant women with Medicaid coverage, regardless of coverage category, are exempt from co-payments for pregnancy-related services, including prescription drugs and behavioral health. For details, see the February 2013 NC DMA Provider Bulletin article “Psychiatric Services Available to Pregnant Medicaid Beneficiaries” at

<http://www.ncdhhs.gov/dma/bulletin/pdfbulletin/0213bulletin.pdf>

### Buprenorphine coverage:

North Carolina Medicaid covers buprenorphine as part of the pharmacy benefit. This medication requires prior approval. The simple, one-page “NC DMA Pharmacy Request for Prior Approval – Suboxone, Zubsolv and generic buprenorphine” form can be found on the NC Tracks website: <https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html> (listed under “Suboxone”). Therapy can be approved for up to 12 months at a time.

## Appendix K. The NC Perinatal & Maternal Substance Abuse Initiative and the CASAWORKS for Families Residential Initiative

The North Carolina Perinatal and Maternal Substance Abuse and CASAWORKS for Families Residential Initiatives (Initiatives) represent a nationally recognized statewide approach to the social and health challenges associated with family addiction. The [28 programs](#), located in 13 counties across the state, use evidence-based treatment models. All of the programs in the Initiatives are “cross-service area”, meaning they accept women from any part of the state; this helps to meet the need of pregnant and parenting women who do not have gender- or family-responsive treatment in their home communities.

More than 20 years of research show that women are motivated to engage with treatment and recovery by concern for their children or pregnancy but that they are often unwilling to seek treatment if it means leaving their children. The NC Initiatives address this by providing family-responsive care that includes, but is not limited to, behavioral health treatment services for pregnant and parenting women, parenting support, arrangement for treatment and prevention services for children, referral for and coordination with medical care for women, and referral and coordination for pediatric and developmental care for children. Job readiness and job coaching are key provisions in the 8 CASAWORKS for Families sites which have a primary goal of self-sufficiency.

Through a [capacity management system](#) with an online bed availability list, health care providers, Department of Social Services social workers, and treatment providers can refer women and their children to the services they need anywhere in the state. Women in need of services can also access this system to identify appropriate treatment resources statewide. Providers and women can contact the NC Perinatal Substance Use Coordinator at 1-800-688-4232 for assistance identifying a program or managing the referral process. A flyer describing the Perinatal Substance Use Coordinator’s services can be found [here](#).

## Appendix L. Guidance on prescribing buprenorphine in pregnancy

### What is buprenorphine?

- Buprenorphine is an opioid medication used to treat opioid addiction. Buprenorphine can be dispensed for take home use, by prescription. Physicians must take Waiver Training in order to prescribe or dispense.
- Buprenorphine is an opioid partial agonist. It produces typical opioid agonist effects and side effects, but its maximal effects are less than those of full agonists like heroin and methadone. At low doses buprenorphine produces sufficient agonist effect to block withdrawal symptoms. The agonist effects of buprenorphine increase linearly with increasing doses of the drug until at moderate doses there is a “ceiling effect.” Thus, buprenorphine carries a lower risk of abuse, addiction, and side effects compared to full opioid agonists.
- Buprenorphine is available in a variety of formulations including Suboxone®, Subutex®, Zubsolv® and can be a single ingredient product or it can be mixed with naloxone to create a combination ingredient product. Naloxone formulations render the combination product less conducive to misuse (e.g. injection).
- The following fact sheet from the National Institute of Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) provides an overview of buprenorphine treatment:  
[http://attcnetwork.org/projects/documents/poats/POATS\\_Buprenorphine\\_FactSheet.pdf](http://attcnetwork.org/projects/documents/poats/POATS_Buprenorphine_FactSheet.pdf)

### Is buprenorphine safe during pregnancy?

- Studies have found that treatment with buprenorphine has similar outcomes to methadone treatment during pregnancy.
  - <http://pcssmat.org/wp-content/uploads/2014/06/PCSS-MATGuidancePregnancy-and-Buprenorphine.Martin.pdf>
  - Meyer MC1, Johnston AM, Crocker AM, Heil SH. *J Addict Med.* 2015 Jan 22. [Epub ahead of print] Methadone and Buprenorphine for Opioid Dependence During Pregnancy: A Retrospective Cohort Study.

### Where can I find information on how to become a buprenorphine provider?

- Qualified physicians can receive a waiver from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid addiction treatment. This waiver allows qualifying physicians to prescribe medication-assisted treatment for opioid addiction with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration (FDA) which includes buprenorphine.
- Physician Waiver Qualifications can be found at [http://buprenorphine.samhsa.gov/waiver\\_qualifications.html](http://buprenorphine.samhsa.gov/waiver_qualifications.html)
- ASAM, APA, and AAAP all offer 8-hour online training for physicians to complete the training requirement for CSAT certification to prescribe buprenorphine in office-based treatment of opioid-dependent patients

### How can I find buprenorphine providers?

- SAMHSA has a Physician and Treatment Program Locator ([http://buprenorphine.samhsa.gov/bwns\\_locator/](http://buprenorphine.samhsa.gov/bwns_locator/))
- The National Alliance of Advocates for Buprenorphine Treatment offers a few different options for locating physicians and programs (<http://www.naabt.org/tl/buprenorphine-suboxone-treatment.cfm>)

### Links

- <http://buprenorphine.samhsa.gov/>
- <http://pcssmat.org/>
- <http://pcss-o.org/>
- <http://buprenorphine.samhsa.gov/otherlinks.html>