Why are doctors underusing a drug to treat opioid addiction?

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A drug approved for private physicians to treat opioid addiction is being underprescribed, and a survey of addiction specialists suggests that many of them are not willing to increase their use of it, despite an expanding opioid addiction epidemic in the United States, according to research presented at the 125th Annual Convention of the American Psychological Association.

Two opioid replacement medications are currently approved for opioid use disorder: methadone, which under federal law must be dispensed from authorized clinics, and buprenorphine, which can be used to treat opioid addiction in the privacy of a physician's office, so long as the physician has the proper waivers.

"Though it was widely believed that allowing physicians to prescribe this drug in a primary care setting would increase the number of patients receiving treatment, the number of physicians adopting this therapy has not kept pace with the magnitude of the opioid epidemic," said Andrew Huhn, PhD, of the Johns Hopkins University School of Medicine.

Buprenorphine was approved for the treatment of opioid use disorder in 2002 with the requirement that physicians apply for a waiver from the Substance Abuse and Mental Health Services Administration in order to prescribe the drug in primary care settings. Its mechanism of action is similar to methadone's but not quite as intense, hence it is less likely to be abused, but it still adequately suppresses withdrawal symptoms with daily doses. Physicians with waivers are allowed to treat up to 30 patients in the first year and 275 patients in each subsequent year.

Huhn and his colleagues surveyed 558 English-speaking physicians in the United States via email during the spring and summer of 2016. Participants were asked about perceived drawbacks associated with prescribing buprenorphine as well as possible resources that might encourage those who did not have the waiver to obtain it and those who did have the waiver to accept more new patients.

Only 74 respondents indicated they did not have waivers to prescribe the drug. Of those, approximately one-third said that nothing would increase their willingness to get a waiver. The most common reasons for not obtaining a waiver included not wanting to be inundated with patient requests for buprenorphine (29.7 percent) and concerns about patients

reselling their medication (25.7 percent).

More than half of respondents with waivers who were not prescribing to capacity indicated that nothing would increase their willingness to prescribe at that level. The most common reasons given for not prescribing at capacity included no time for more patients (36 percent) and insufficient reimbursement (15.4 percent).

Overall, survey respondents indicated that the resources most likely to increase their willingness either to obtain waivers or prescribe to capacity were receiving information about local counseling resources, being paired with an experienced provider and receiving more continuing medical education courses on opioid use disorder.

Government data published earlier this year estimated that 1.27 million people were hospitalized or sought help at an emergency room for opioid-related issues in 2014, a 64 percent increase for in-patient care and a 99 percent increase in emergency room visits compared with 2005.

"I think the two biggest takeaways from our research are that there are not enough physicians prescribing buprenorphine to meet patient demand, and access to counseling services for patients and mentoring services for physicians would make physicians more likely to take on new patients with opioid use disorder," said Huhn.

More information: Session 1239: "Why Don't Physicians with the SAMHSA Waiver Prescribe Buprenorphine to Capacity?" Paper Session, Thursday, Aug. 3, 1-1:50 p.m., EDT, Room 207B, Level 2, Walter E. Washington Convention Center, 801 Mount Vernon Pl., N.W., Washington, D.C.

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