MYTHS AND FACTS ABOUT BUPRENORPHINE

MYTH	FACT
1. Prescribing buprenorphine for opioid use disorder (OUD) replaces one addiction for another.	OUD is a chronic condition and medication is the most effective way to prevent worsening symptoms and death.[1] Taking daily medication to maintain health is not substance use disorder.[2,3]
2. A commitment to abstinence will prevent opioid overdose more than buprenorphine will.	OUD is a chronic condition; relapse is common. Abstinence-based treatment reduces tolerance to opioids and is associated with substantial risk for relapse, overdose and death.[4] Buprenorphine limits or blocks the effects of illicit opioids, reducing overdose risk.[5,6]
3. Buprenorphine can be misused and, therefore, prescribers should strictly control access.	Any medication can be misused. However, buprenorphine is not a drug of choice to get high because it limits feelings of euphoria and reward.[5] Buprenorphine misuse is usually associated with self-treatment of withdrawal symptoms and lack of access to buprenorphine treatment.[7,8]
4. Prescribing buprenorphine comes with more legal liability than prescribing other medications, or will make the Drug Enforcement Administration (DEA) target the prescriber or practice.	Like with all medications, protection against liability depends on good patient assessment, provider education and documentation.[5] The DEA conducts routine, unannounced visits to verify that prescribers practice within their patient limits authorized by the Substance Abuse and Mental Health Services Administration (SAMHSA) (the maximum number of active patients that prescribers can treat with buprenorphine at one time).
5. Starting to prescribe buprenorphine will lead to a large number of people asking for prescriptions.	This has generally not been true of primary care practices supported by the Philadelphia Department of Public Health. The DEA limits the number of patients providers can treat with buprenorphine, but providers can choose within those limits how many people to treat. Providers can also decide the level of care they provide.
6. A person must be completely abstinent and have a completely negative urine screen to receive buprenorphine.	People do not need to be completely abstinent to be treated with buprenorphine. People with OUD commonly use multiple drugs, often to maintain a consistent high or reduce withdrawals and cravings. Buprenorphine can stabilize this cycle, reducing the need for additional substances.[9] Imperfect abstinence does not eliminate buprenorphine treatment benefits.[5]
7. The ideal length of treatment with buprenorphine is six months or less. Treatment success means patients will become drug-free, including from buprenorphine and methadone.	Individuals should continue buprenorphine treatment as long as they continue to benefit. This can be for years or even a lifetime.[5,10] Stopping medication for OUD treatment, even after long periods of treatment, can lead to relapse.[5] Treatment success for someone with OUD is measured by improved quality of life, rather than being free of medications.[11]
8. Outpatient therapy or counseling is mandatory for clinical improvement.	The Drug Addiction Treatment Act of 2000 (DATA 2000) mandates that buprenorphine prescribers must be able to refer patients for behavioral health services. Behavioral health support will benefit many patients, but it is not mandatory for the provider to refer all patients, or for patients to attend counseling. In rare cases, health insurance plans may require outpatient counseling for buprenorphine treatment.
9. All Philadelphians have equal access to treatment for OUD.	In Philadelphia, access to treatment for OUD is not equal by demographics or geographically. Together with the Health Department, you can help create equitable access to care and decrease existing treatment disparities by offering buprenorphine to all patients who may need it.

For more information about buprenorphine prescribing resources, visit https://dbhids.org/MAT.

City of Philadelphia

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