Maine Opioid Response Clinical Advisory Committee

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To: Primary care and substance use treatment providers, pharmacy communities, and hospital and policy leaders

The Maine Opioid Response Clinical Advisory Committee consists of approximately 30 leaders in substance use disorder prevention, treatment and harm reduction in Maine including both prescribers and pharmacists. As part of our efforts, we have been working on developing clinical recommendations related to the management of patients with substance use disorders, particularly as they encounter barriers within the existing health care delivery system.

The primary goal behind creating a clinical guidance document for treating stable patients on buprenorphine is to provide healthcare providers with an evidence-based framework to manage stable patients in a consistent manner as continuous, long-term buprenorphine therapy significantly reduces all-cause mortality. Primary care is often the ideal setting to treat stable patients on buprenorphine since the focus is on maximizing long-term treatment retention and overall health. By providing a clinical framework, we hope that this consensus document encourages primary care clinics and community health centers to integrate buprenorphine into standard practice. This approach can help patients maintain their employment, childcare, and everyday lives without the burden of excessive clinic visits.

These recommendations are intended to enhance your care and should not replace your own clinical judgement. If you have any questions, please do not hesitate to contact us.

Sincerely,

Maine Opioid Response Clinical Advisory Committee

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Maine Opioid Response Clinical Advisory Committee (CAC): Consensus Statement on the Care of "Stable" Adult Patients Treated with Buprenorphine for Opioid Use Disorder

Background: Buprenorphine is an evidence-based, lifesaving medication for opioid use disorder (OUD). As individuals stabilize in treatment, monitoring practices (visit frequency, toxicology testing, and other adherence/diversion safeguards) should balance patient safety, access to care, stigma reduction, feasibility in rural settings, and cost-conscious stewardship of healthcare resources. National guidance supports decreasing visit frequency for carefully selected stable patients and individualizing care but provides limited specificity regarding optimal cadence of follow-up and toxicology testing, resulting in wide variation in practice.

Purpose/Goal: The purpose of this document is to provide recommendations for a baseline approach to follow-up visit frequency and toxicology testing for clinically stable patients receiving buprenorphine for OUD in outpatient settings. We aim to support high-quality, patient-centered care while promoting feasible, scalable monitoring standards across Maine.

Defining "Clinical Stability" on Buprenorphine: Determination of stability should be individualized and based on clinical judgment, informed by objective and patient-reported indicators. Potential indicators of stability include:

- Time from last non-prescribed opioid use
- Absence of ongoing high-risk substance use (including alcohol or other non-prescribed substances) or a clear plan to address it
- Adherence to medication and appointments
- Toxicology testing results generally consistent with the expected clinical picture
- Prescription Drug Monitoring Program (PDMP) checks and medication counts as clinically indicated and feasible
- Stable medical and psychiatric status
- Functional stability (e.g., occupational, social, caregiving responsibilities) as applicable
- Engagement with recovery-oriented supports when desired/available

We recognize that stability may fluctuate over time and may change in the setting of acute stressors, medical illness, changes in housing, or return to use. Monitoring intensity should be increased when clinically indicated. For instance, patients who are on a combination of controlled substances, such as buprenorphine and benzodiazepines or stimulants, may require more frequent monitoring to ensure there are no substantive interactions, or incentive salience that may increase risk of a return to use. Other controlled substances may be prescribed by another provider, which would warrant care coordination, and may allow for less frequent visits by the buprenorphine prescriber.

All patients with substance use disorder, regardless of their level of stability, remain at an increased risk of overdose and overdose death. All should be provided with education about overdose prevention, harm reduction strategies, as well as access to naloxone.

Proposed Recommendations for Monitoring "Stable" Patients on Buprenorphine:

1) Visit frequency

- Patients should be seen more frequently during treatment initiation and dose adjustment, then less frequently once stability is achieved.
- Many stable patients may appropriately be seen every two months after one to two years of monthly visits, with the option to extend to every three months after a period of time for carefully selected patients with sustained stability and adequate supports, particularly when travel distance, work constraints, caregiving responsibilities, or rural access barriers make more frequent visits burdensome. In exigent circumstances, visit frequency may occur outside these parameters. In that case, rationale and risk mitigation should be carefully documented in the chart.
- Patients who are actively tapering buprenorphine, experiencing new/worsening mental health symptoms, returning to use, or otherwise showing signs of instability should have increased visit frequency until stability is re-established.

2) Toxicology testing

- Toxicology testing should be used to support clinical care (not punitive enforcement) and should be paired with trauma informed consent including transparent communication, non-stigmatizing language, and a plan for responding to unexpected results.
- For stable patients, a minimum of **4 toxicology tests per year** is a reasonable baseline, with an emphasis on **random** (not purely scheduled) testing when feasible.
- Testing frequency should increase based on clinical indication (e.g., early in treatment, return to use, higher-risk co-occurring substance use, concerning PDMP findings, lost medications, or other safety concerns).
- We recognize feasibility challenges for random testing and medication counts in rural areas; providers should offer practical options (e.g., flexibility in lab locations/hours, coordination with local laboratories, or other patient-centered approaches).

3) Additional monitoring and diversion-mitigation strategies (as clinically indicated)

- PDMP checks at intervals consistent with state requirements and clinical judgment.
- Medication counts, transition to extended release buprenorphine, and observed dosing when there are diversion concerns, recognizing that these practices may not be feasible for all patients and settings.
- Use of visit-based counseling, care management, peer support, and/or behavioral health supports when available and desired by the patient.

4) Documentation and response to instability

- Providers should have clear, written protocols for how monitoring is performed and how unexpected toxicology results or return to use are addressed, prioritizing patient safety, retention in care, and harm reduction.
- Return to use should prompt reassessment of treatment needs (including visit frequency, counseling supports, harm reduction, and consideration of long-acting buprenorphine formulations when appropriate), rather than automatic discharge from treatment.

Policy Considerations (MaineCare): Current MaineCare rules cited in the CAC review require a minimum of eight (8) toxicology tests per year for maintenance treatment, with additional limitations on laboratory billing in certain circumstances. As of October 2026, the MaineCare benefits manual is under revision. Based on national guidance, local practice patterns, and the goal of cost-conscious, feasible care for stable patients, the CAC supports consideration of policy changes that would:

- Reduce the minimum toxicology testing requirement for stable maintenance patients from **8 per year** to **4 per year**, while preserving clinician discretion to increase testing when clinically indicated.
- Maintain an expectation that testing occurs **randomly** over time to support clinical utility.
- Encourage providers/organizations to maintain written toxicology testing policies and procedures.

Rationale and Implementation Considerations: Aligning monitoring requirements with evidence-informed practice may reduce unnecessary visits and laboratory utilization for stable patients, improving access and reducing burden while maintaining patient safety. In rural settings, requirements for random testing and medication counts should be implemented in ways that do not unintentionally create barriers to treatment engagement.

Selected Guidance and Resources Reviewed by the CAC (non-exhaustive):

- SAMHSA Treatment Improvement Protocol (TIP) 63: *Medications for Opioid Use Disorder* (guidance supporting less frequent visits for carefully selected stable patients).
- American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Focused Update).
- ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine (consensus guidance for OBOT testing frequency and individualized adjustment based on stability).
- Local practice input from Maine outpatient buprenorphine prescribers and CAC member survey (as presented to the CAC).
- https://elearning.asam.org/products/buprenorphine-mini-course-building-on-federal-prescribing-guidance

Notes:

This consensus statement specifically applies to adults (≥ 18 years); modifications to these recommendations may be needed for pediatric or adolescent patients.

This document is intended to guide baseline expectations and support consistent, patient-centered practice; it does not replace clinical judgment or individualized care planning.