Empowering Pharmacists to Preserve and Expand Access to Medications for Opioid Use Disorder Beyond the COVID-19 Pandemic

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Aim: The COVID-19 pandemic and its economic, social, and emotional consequences have exacerbated the opioid crisis. Rising overdose rates and decreasing access to treatment have highlighted the inequities in buprenorphine and methadone access for opioid use disorder (MOUD). MOUD saves lives, but rural, Black, and lower socioeconomic status patients have historically had limited access to buprenorphine and methadone. Pharmacies are located within 5 miles of 90% of every American. Pharmacist-based solutions are urgently needed to be implemented to sustain and expand access for these vulnerable groups.

Methods (Optional): Methadone is limited to opioid treatment programs (OTP) and while permitted to be dispensed from community pharmacies for treating pain, Drug Enforcement Administration (DEA) regulations do not permit dispensing for OUD treatment. This particularly affects rural patients who travel long distances, often daily, to OTPs instead of more convenient and accessible pharmacies, common in other countries. Pharmacies must be able to dispense methadone for OUD. Buprenorphine, though accessible through pharmacies, is over-regulated through training and waiver requirements, patient limits, community pharmacy dispensing

challenges, and widespread stigma and misinformation among patients, prescribers, and pharmacists. The DEA requirement for wholesalers to detect and report suspicious orders of all opioids have led pharmacists to unnecessarily limit buprenorphine dispensing. Removing buprenorphine from this requirement will encourage pharmacists to dispense without fear of DEA investigation. Patients must be able to initiate this medication through an authorized, willing, and known provider. Since the COVID-19 pandemic began in March 2020, buprenorphine can be initiated without an in-person assessment over an audio-only connection, lowering barriers for people to start treatment. In Rhode Island, these changes permitted an IRB-approved study to allow pharmacies to enroll patients and start home inductions performed using a collaborative practice agreement (CPA). These changes must be made permanent to maintain access using this tool. Recognizing and equitably reimbursing pharmacists to provide addiction pharmacotherapy services would further maintain low-barrier access to these essential medications and care.

Results (Optional): <blank>

Conclusions: A lack of trust, stigma, and fear of regulatory oversight hinders both patient access to MOUD and collaborative efforts among healthcare professionals to manage patients with OUD. The delivery of effective pharmacotherapy for patients struggling with OUD requires collaborative working relationships between physicians and community pharmacists, permanent changes to onerous federal regulations, and recognition of pharmacists as providers of addiction care.

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