Integration Academy
Integrating Behavioral Health & Primary Care

Quick Start Guide to Medications for Opioid Use Disorder

AHRQ
Agency for Healthcare Research and Quality

The authors of this report are responsible for its content. Statements in the report should not be construed as endorsement by the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Quick Start Guide
to Medications for Opioid Use Disorder

Prepared for

The Agency for Healthcare Research and Quality (AHRQ)
Contracting Officer's Representative (COR)
Jan DeLaMare
5600 Fishers Lane
Rockville, MD 20857
Jan.DeLaMare@ahrq.hhs.gov

Contract No. GS-00F-009DA
Order No. 75Q80124F80004

Prepared by

Wendy Kissin, PhD
Garrett Moran, PhD
Blake Fagan, MD
Sophia Tsakraklides, PhD
Danielle Durant, PhD, MS, MS, MBA
Alec Hester, PMP
Laurin Brown, MPH
Annaka Paradis, ScM
Tiffiany Portacio, MPH

Publication Number: AHRQ 26-0020
June 2026

Agency for Healthcare Research and Quality

Disclaimer Conflict of Interest

None of the investigators has any affiliations or financial involvement that conflicts with the material presented in this report.

Funding Statement

This project was funded under Contract Number GS-00F-009DA from AHRQ, U.S. Department of Health and Human Services. The opinions expressed in this document are those of the authors and do not reflect the official position of AHRQ or HHS.

Public Domain Notice

Suggested Citation

Kissin W, Moran G, Fagan B. et al. Quick Start Guide for Medications for Opioid Use Disorder. (Prepared by Westat under Contract Number GS-00F009DA, Task Order No. 75Q80124F80004) Rockville, MD: Agency for Healthcare Research and Quality; June 2026. Publication No. AHRQ 26-0020.

Contents

About the Quick Start Guide

This Quick Start section was designed to help motivate you to begin offering treatment medications for OUD, and to describe the basics of what is required. Look at topics in the Contents and go to those that seem relevant to your situation. The important thing is to begin offering this lifesaving MOUD treatment in a way that is feasible and sustainable in your setting.

Quick Start to Prescribing Buprenorphine for OUD

Buprenorphine saves lives, and any provider with a DEA license can prescribe it.

1. **Do you have patients with OUD in your practice or your community?**
   The need may be greater than you think.

2. **Does your practice include providers who are ready and willing to prescribe buprenorphine?**
   The only requirement is a DEA license.

3. **Is your leadership supportive of providing medications for OUD in your practice?**
   Identify internal champions.

Starting Buprenorphine

Medications to Treat OUD

The Food and Drug Administration (FDA) has approved three life-saving medications to treat OUD: methadone, buprenorphine, and naltrexone. In addition, naloxone is FDA-approved as an emergency antidote for opioid overdose, which is available without a prescription. Although methadone, naltrexone, and naloxone are described briefly below, **the focus of the Playbook is prescribing buprenorphine to treat OUD.**

Methadone is a full opioid agonist that completely binds to mu opioid receptors in the brain, activating the receptors and helping reduce withdrawal symptoms. Methadone carries a risk for diversion or overdose, so it can only be dispensed to treat OUD by opioid treatment programs (OTPs), which are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and registered with the U.S. Drug Enforcement Administration (DEA).

Buprenorphine is a partial opioid agonist that does not fully activate the mu opioid receptors, resulting in less euphoria and fewer breathing problems than full agonists like methadone. However, buprenorphine still carries some small risk of misuse or lethal overdose when combined with other sedating substances.

There is also a significant risk of diversion with the oral formulations of buprenorphine. To reduce the risk of misuse or diversion, providers often prescribe a medication that combines buprenorphine with naloxone, an antagonist that blocks mu opioid receptors when injected intravenously. When these **buprenorphine-naloxone** combination products are taken properly--either as a sublingual tablet or as a film placed sublingually (under the tongue)—the naloxone is minimally active. However, if someone tries to inject or snort the medication, the naloxone becomes more bioavailable, reducing the effects of the buprenorphine. However, some scholars have argued that the addition of naloxone may only delay the onset of euphoric symptoms.[1] In addition, some clinicians have expressed concern that the negative side-effects of naloxone in the combined product are underestimated.[2]

Buprenorphine treatment for OUD expands treatment access by enabling any medical provider with a DEA license to treat individuals with OUD in their practice. Different modes of administration provide flexibility to tailor treatment to the individual patient's needs. For example, long-acting buprenorphine injections can be administered weekly or monthly, which can improve adherence. These injections can be ideal and convenient for many patients, including those who are incarcerated or transitioning out of incarceration.

Naltrexone is an antagonist that blocks mu opioid receptors without activating them, preventing the rewarding effects (i.e., euphoria) of opioid use and potentially helping with cravings. There are no restrictions on the setting or qualifications needed to prescribe naltrexone as it does not carry a risk for misuse or overdose.

However, the field has shifted away from using naltrexone to treat OUD, with preference instead for buprenorphine and methadone. The primary limitation of naltrexone is that the patient must be opioid-free and have completed withdrawal before starting the medication. If naltrexone is given prematurely, it may cause precipitated withdrawal symptoms, making patients at risk for discontinuing treatment prematurely.[3] A recent systematic review also suggests LAI naltrexone is less acceptable to patients.[4] Though the Playbook focuses on buprenorphine, you can learn more about treating OUD with naltrexone from the National Institute on Drug Abuse (NIDA).

The table below summarizes medications used to treat OUD. The American Society for Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder includes another useful table (PDF - 10.4 MB) on buprenorphine formulations.

Table 1 – Medications Used to Treat OUD

Name	Mechanism of Action	Forms	Uses	Typical Maintenance Dosage[a]	Restrictions
Methadone (e.g., Methadose)	Agonist	Liquid Oral tablet	Withdrawal & treatment	Daily Tablet or liquid (60-120mg)	Dispensed in opioid treatment programs
Buprenorphine (e.g., Subutex, Sublocade, Brixadi, generic)	Partial agonist	Sublingual tablet, Sublingual film, Subcutaneous long-acting injectable	Withdrawal & treatment	Daily Tablet or film (<6-24mg)[a] Injection: Weekly (8-32mg) Monthly (64-128mg)	DEA licensed provider
Buprenorphine/ naloxone (e.g., Suboxone, Zubsolv, generic)	Combination	Sublingual tablet Sublingual film	Withdrawal & treatment	Daily Sublingual tab. (16/4mg) (buprenorphine/ naloxone)	DEA licensed provider
Naltrexone (e.g., ReVia, Vivitrol, Depade)	Antagonist	Injection (IM)	Treatment	Monthly injection (380mg)	None

[a] FDA changed package insert wording in late 2024 to make clear that, "daily maintenance dosages can be incrementally adjusted for each patient based upon their individual therapeutic need and that daily doses higher than 24 mg per day may be appropriate for some patients."[5] Recent discussion is that the dosing can and should go higher for those using fentanyl.[5] Doses as high as 32 to 40 mg have been suggested,[6] and higher doses have been associated with both better MOUD treatment retention[7] and lower urgent care utilization.[8]

Naloxone can reverse opioid overdose. Naloxone is a life-saving medication that rapidly reverses overdose symptoms. It can be purchased, carried, and administered by anyone in an emergency. Available without a prescription, naloxone can be found in stores, vending machines, and online, and it carries no risk of diversion. A helpful preventative measure is to encourage individuals with OUD and their families to carry naloxone, even if they are not receiving medications for OUD. The table below summarizes naloxone as an emergency medication.
If possible, provide your patients with naloxone when you first detect their OUD. Multiple forms of overdose reversal agents are available; be aware of the differences (PDF - 423 KB) so you can select the most appropriate agent.[9]

Table 2 – Medication Used to Reverse Opioid Overdose

Name	Mechanism of Action	Forms	Uses	Typical Maintenance Dosage[a]	Restrictions
Naloxone (e.g., Narcan, Rezenopy, Evzio, Kloxxado, RiVive, LifEMS Naloxone, Zimhi)	Antagonist	Nasal spray, Injection (IM, SQ)	Reverse opioid overdose	As needed Nasal spray (3-10mg), Injection (5mg/0.5ml, can give multiple)	None

Beginning the MOUD Treatment Process

The US Preventive Services Task Force (USPSTF) recommends that all adults age 18 or older be screened for substance use disorders by asking questions about unhealthy drug use.

Adults aged 18 years or older

The USPTF recommends screening by asking questions about unhealthy drug use in adults ages 18 years or older. Screening should be implemented when services ask for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens).[10]

If the initial screening indicates opioid misuse, you may want to determine if the person meets the DSM-5 diagnostic criteria for OUD. These diagnostic criteria are described under Diagnose OUD in this Playbook. More detailed presentations of the criteria and diagnostic process are included in the ASAM National Practice Guidelines and on this CDC page. The severity of OUD is assessed based on how many of the 11 diagnostic criteria are met, and persons who meet four or more criteria are potential candidates for MOUD. (Note that the tolerance and withdrawal criteria are not considered to be met for those taking opioids solely under appropriate medical supervision.) Your goal should be to inform the person about the benefits and risks associated with MOUD treatment and, using motivational interviewing, encourage them to start treatment.

Because of pervasive stigma about OUD and the use of medications to treat it, some patients may be hesitant to begin MOUD treatment.[11] In that case, you can inform them that MOUD is the standard of care[12] and that there is extensive research showing that it is MUCH more effective than drug-free treatment.[13] Their risk of illness, overdose and death will be much lower with MOUD than if they choose detoxification and drug-free treatment.[13] Ask about their reasons for seeking treatment and discuss how their odds of achieving recovery and their personal goals (e.g., return to family life, employment, etc.) will be much higher if they take buprenorphine or methadone.

The American Academy of Family Physicians notes that **"the goal when prescribing [buprenorphine] is not to keep a patient on the lowest dose. Rather, it is to find an adequate dose to treat the patient's cravings and withdrawals."**[14] Note that many patients with an OUD have prior experience with buprenorphine, either from previous treatment episodes or from other sources. Patients can be very knowledgeable about what dose or medication would be effective for them in preventing craving or withdrawal symptoms, and involving them in shared decision-making may promote their retention in MOUD treatment.[15]

The goal of low-threshold MOUD treatment is to begin providing the medication as soon as possible (same day as first contact, if possible) to minimize the risk of overdose and death. As with any other patient, you will want to complete a comprehensive clinical assessment to serve as the basis for a person-centered treatment plan based on shared decision-making. However, you don't have to complete that entire process before you begin MOUD treatment, and the comprehensive assessment can be performed over a series of visits. You will want to obtain a urine drug screen so you can assess the current substances in the patient's system and have a thorough understanding of other drug use and relevant health issues.

Regarding office-based buprenorphine treatment (OBOT), the American Society of Addiction Medicine's 2020 National Practice Guideline for the Treatment of Opioid Use Disorder states that:

> "Clinicians should consider a patient's psychosocial situation, co-occurring disorders, and opportunities for treatment retention versus risks of diversion when determining whether OTP or OBOT is most appropriate. Patients with active co-occurring alcohol, sedative, hypnotic, or anxiolytic use disorder (or who are in treatment for addiction involving the use of alcohol or other sedative drugs, including benzodiazepines or benzodiazepine receptor agonists) may need a more intensive level of care than can be provided in an office-based setting; this may also be true for persons who are regularly using alcohol or other sedatives, but do not meet the diagnostic criteria for a substance use disorder related to that class of drugs. **However, OBOT services should not be withheld if the patient does not have access to or is unwilling to participate in a more intensive level of care**. In these cases, the patient should be carefully monitored. [emphasis added]
>
> The use of benzodiazepines and other sedative-hypnotics should not be a reason to withhold or suspend treatment. According to the FDA, while the combined use of these drugs increases the risk of serious side effects, the harm caused by untreated opioid use disorder can outweigh these risks."[16]

This flowchart from SAMHSA (PDF - 25.2 MB) **outlines the management process from the patient entering the door throughout the treatment process.**

Buprenorphine Initiation (Induction)

As noted in this SAMHSA flowchart (25.2 MB), buprenorphine can be started either in the office or at home. The choice of location should be a shared decision made by you and the patient, considering such factors as patient preference and reliability, severity of OUD and comorbidities, access to a safe and private environment, travel limitations, and clinic resources and staffing.[17] Given the importance of starting the patient on MOUD as soon as possible, consider postponing paperwork or assessments that can wait until after the patient has started on medication.

Per the SAMHSA Quick Start Guide (PDF - 1.4 MB) *(which has not been recently updated so it is not recommended as a comprehensive resource)*, the starting dose of buprenorphine

> "depends on the severity of withdrawal symptoms, and the history of last opioid use …Long acting opioids, such as methadone, require at least 48-72 hours since last use before initiating buprenorphine. Short acting opioids (for example, heroin) require approximately 12 hours since last use for sufficient withdrawal to occur in order to safely initiate treatment. Some opioids such as fentanyl may require greater than 12 hours. Clinical presentation should guide this decision as individual presentations will vary."

An important goal is to minimize triggering precipitated withdrawal as that can be very unpleasant (although rarely life threatening) for the patient. Note that there are medications available to treat the withdrawal symptoms if they become too unpleasant. See discussion of Managing Withdrawal Symptoms in the Pharmacotherapy section of the Playbook.

You can assess the severity of withdrawal symptoms using the Clinical Opiate Withdrawal Scale (PDF - 606 KB) (COWS), an 11-item scale designed to be administered by a clinician. An alternative that may be used in the case of starting buprenorphine at home is the Subjective Opiate Withdrawal Scale, (SOWS) (PDF - 225 KB).

In the past, when the opioid epidemic was largely driven by prescription opioids and then later by heroin, the guidance was to wait until the patient had a COWS score of 12 or more, then provide an initial dose of 2 to 4 mg of buprenorphine. See the SAMHSA flowchart (PDF - 1.4 MB) of this process.18

Now that fentanyl and other synthetic opioids have become so widespread in the illicit drug supply, the dosing guidance has been updated, as presented in this 2025 AAFP publication, Treating Opioid Use Disorder as a Chronic Condition: A Practice Manual for Family Physicians (PDF - 1.0 MB):

"Buprenorphine induction protocols need to be altered for patients using fentanyl.[19] The drug's retention in adipose stores increases the risk of precipitated withdrawal after the initial buprenorphine dose. Buprenorphine initiation is possible with some changes. For more severe withdrawal symptoms, patients should be instructed to wait longer to initiate buprenorphine. At least 24 hours of abstinence from opiates and a COWs score of 12 or more are often recommended. It is difficult for patients to tolerate longer periods of severe withdrawal. Adjunctive medications such as clonidine 0.1-0.3 mg three times a day (depending on the severity of dependence or anticipated withdrawal) or antiemetics may help during this time.[20]

Patients accustomed to using fentanyl may require higher initial doses of buprenorphine to control cravings and withdrawal symptoms.[21] At least 8 mg is recommended as a first dose, and 16 mg should be considered. Patients routinely need 24 mg of buprenorphine daily and may need 32 mg per day or more to stabilize them early in treatment.[22]

Patients with suspected precipitated withdrawal symptoms who experience rapid worsening of withdrawal shortly after the first buprenorphine dose should be instructed to take another buprenorphine dose of 8-16 mg immediately.[23] While true precipitated withdrawal is probably rare, the risk causes anxiety and treatment reluctance in both providers and patients."

If you are not comfortable with the buprenorphine induction process, see the "Other Resources" section for free training and consultation options. Free training options are also listed on p. 13, Mentoring and Consultation.

Provide Naloxone for Overdose Reversal

Regardless of whether you are ready to prescribe medications for OUD, you can still screen your patients for OUD and, when appropriate, provide them with naloxone and educational materials. (See Resources.) **Naloxone is a life-saving medication that can reverse the effects of an opioid overdose**. Having it on hand is critical for preventing fatalities.[24–26]

Some studies have shown that just giving a naloxone prescription is not adequate and that it is most effective to put the naloxone in the hands of the patient or their family.[27] Depending on availability in your state, you may find free or low-cost naloxone kits.

MOUD in Primary Care

Why Offer MOUD in Primary Care?

- **You will be helping to keep people alive and addressing an important public health need:** Only about one fifth of people with OUD receive life-saving evidence-based treatment with FDA-approved medications. There are several reasons for this, but a shortage of willing providers is a major one. You can make a difference and help to save lives!
- **Buprenorphine, methadone, and naltrexone are approved by the FDA to treat OUD and are the standard of care.** Treatment with buprenorphine is a good fit for primary care. Medications are the standard of care for the treatment of OUD regardless of setting, and buprenorphine, specifically, is commonly, safely, and effectively delivered in primary care settings for many patients.[43] Once treatment is started, many patients with OUD can be managed in much the same way as patients with other chronic health conditions.
- **Many providers find that it is rewarding:** Many providers find treating patients with OUD to be highly rewarding, particularly when they see improvements in their patients' lives. Physicians providing OUD medication treatment in primary care have said,

"There aren't many illnesses where you can see actual change so quickly. It is so wonderful to help somebody in this manner, and you really get to see a profound change in your patients' lives."[29]

"People can get better and people can live a happy, healthy life. And not die. And we have the means to help them. We get to write prescriptions. Oh my G-d. I get to write prescriptions. I've got to do that."

– Subject Matter Expert

"I'm a family doc that delivered babies for ## years… One of the ladies that I delivered, she had two kids. She rolled into the ER, dead from an overdose and then it changed my life… I actually didn't know the medicine buprenorphine and I had all of the biases that you've probably heard, like if someone would have asked me to write the buprenorphine script prior to that, I would have said…I'm not going to do it."

– Subject Matter Expert

"I have stories from working, seeing patients and having lives change. Having people get kids back out of the foster care system. People that are pregnant and using fentanyl and stabilizing and having a delivery and having that dyad stay together, people going back to work."

– Subject Matter Expert

To see more success stories and examples, visit the Providers Clinical Support System (PCSS) to learn how primary care providers are making a difference with MOUD treatment. The FDA also has a page entitled Primary Care Providers Can Prescribe with Confidence that offers a range of helpful resources, including brief videos of MOUD prescriber experiences.

- **It allows you to meet the needs of patients you may already be treating (and potentially others in your community who may not have access to care):** Primary care practices are often a patient's first point of entry into the healthcare system.[30] Since primary care addresses most of a patient's healthcare needs, prescribing buprenorphine allows you to expand the scope of care you provide, addressing OUD in addition to other chronic health conditions your patients may have.
- **Many patients may prefer to be treated in primary care:** Individuals with OUD may prefer to receive treatment in primary care because they fear the stigma of seeking treatment in specialty substance use settings, or because the primary care setting is closer, more convenient, or already trusted.[31]

> "Buprenorphine is without a doubt, an effective, dignified, and private treatment option for the opioid dependent patient who wants both treatment and a return of their self esteem.[sic]"[3]
>
> **– Subject Matter Expert**

Does MOUD Work?

Medications for OUD are effective treatment by themselves, and they save lives. Research has demonstrated that medications for OUD can:

- Reduce opioid use and OUD-related symptoms;[33]
- Increase retention in treatment (with adequate **or higher**[7] MOUD dosing);[34]
- Decrease overdose-related and all-cause mortality;[35]
- Reduce the risk of infectious disease transmission;[36] and
- Reduce criminal behavior associated with drug use.[36]

Low-threshold Care for OUD

Provide medication first: The concept of low-threshold care for OUD involves prescribing buprenorphine without delays to reduce risk of overdose and death. Treating OUD with medications can be as simple as prescribing buprenorphine, either in-person or via telehealth. Medications like buprenorphine are the gold standard for treating OUD. These medications reduce cravings and withdrawal symptoms, stabilize brain chemistry, and, ultimately, save lives. Any primary care provider with a DEA license can prescribe buprenorphine, and the need for people to provide this evidence-based treatment for people with OUD is great.[37]

Hear from a family physician who treats OUD in his small primary care practice.

Ideally, treatment with medications for OUD is part of a comprehensive, whole-person care approach to recovery, addressing both the physical and psychological aspects of addiction. But even if your practice cannot provide the full range of services, you can provide life-saving medications and form partnerships with recovery organizations to provide further support to your patients.

- **Buprenorphine saves lives, even in the absence of other services:**[16,18,38] This means you should not delay prescribing based on whether a patient is attending counseling, has stopped their drug use, completed drug testing, or seen you in person or via telehealth.[39] While counseling can benefit many patients with OUD[40] and is associated with continuing MOUD treatment,[41] requiring it may create a barrier to care—especially for those who are unwilling or unable to participate.[42] Withholding medications for OUD puts your patients at an unnecessary risk for accidental overdose and death. Providing medications for OUD is an evidence-based, low-threshold approach that emphasizes immediate access to medication, often allowing for same-day treatment without extensive assessments or mandatory counseling.[43]
- **Primary care providers can save lives wherever they are able to be on the continuum of care:** On one end of the continuum is a low-threshold medication only approach—getting patients quick access to MOUD to minimize morbidity and mortality. At the other end is a more comprehensive model combining MOUD with whole-person care that addresses both the physical and psychological aspects of addiction. Once patients with OUD are stabilized on medication, many will benefit from having access to other services—including medical and mental health care, addiction counseling, and recovery supports--based on their needs and preferences.
- **Primary care providers are well situated to provide this life-saving treatment**, as they often serve as patients' first point of contact with the health care delivery system.

For a detailed description, see The Role of Low-Threshold Treatment for Patients with OUD in Primary Care | The Academy.

Background: The Problem

Overdose remains a leading cause of death for adults in the U.S.[44,45] In 2024, opioids were involved in 68% of all overdose deaths, 88% of which involved **synthetic opioids** such as fentanyl and its analogs (excluding methadone).[46]

Drug overdose deaths in the U.S. rose steadily during the first 20 years of the 21st century, followed by a recent downturn to close to 2019 levels. Peaking at 107,941 deaths in 2022,[47] drug overdose deaths fell to 79,384 in 2024 and an estimated 71,542 in 2025[48] (i.e., age-adjusted rates per 100,000 population were 32.6 in 202246 and 23.1 in 2024.) Similarly, the rate of overdose deaths involving synthetic opioids (other than methadone) decreased 35.6% from 22.2 per 100,000 in 2023 to 14.3 in 2024.[49]

Fentanyl is extremely potent—up to 50 times stronger than heroin and 100 times stronger than morphine,[50] with faster, deeper respiratory suppression.[51] It tends to be cheaper than other street opioids like heroin and is often mixed into other drugs. People using street drugs may not even realize they are taking fentanyl, or how much. This lack of awareness puts them at particularly high risk for overdose.[52] Synthetic substances, such as xylazine,[53] a veterinary tranquilizer not approved for human use, present additional dangers when combined with opioids like fentanyl.

The drug supply continues to evolve, as monitored by the National Drug Early Warning System (NDEWS) | National Institute on Drug Abuse (NIDA). For example, carfentanil has reemerged. Carfentanil is a particularly deadly fentanyl analogue that is 100 times stronger than fentanyl and 10,000 times more potent than morphine. Carfentanil was noted in a small but increasing number of overdose deaths: 29 deaths (January to June, 2023) to 238 deaths (January to June, 2024) and in the illegal drug supply of all but one state.[54]

In 2018, nearly 63% of opioid overdose deaths involved other substances, including cocaine, methamphetamine, or benzodiazepines.[55] From 2022 to 2024, almost 2.0 million emergency department visits involved opioids, specifically prescription opioids (excluding fentanyl) (34.2%), heroin (27.4%), fentanyl (25.7%) and unknown (20.2%). Distribution of these opioids varied by region. For example, fentanyl-involved emergency department visits were most common in the West (51.2%) followed by the South (25.9%), Northeast (13.8%) then the Midwest (9.2%), although these patterns are subject to constant change.[56]

According to the 2024 National Survey on Drug Use and Health (NSDUH), about 4.8 million people in the U.S. (1.7% of people 12 years and older) had an OUD.[57] However some studies have suggested that general population surveys like NSDUH cannot provide accurate estimates of the rate of a low-frequency condition like OUD and that the actual rate is much higher.[58–60] OUD is defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress."[61] Symptoms may include:[16]

- **Physical effects** (e.g., tolerance and withdrawal);
- **Difficulty reducing use;**
- **Risky use behaviors;**
- **Failure to fulfill obligations; and**
- **Social problems.**

In addition, opioid use disorder also contributes to other critical public health issues, including the spread of infectious diseases such as HIV and hepatitis C.[62,63]

Barriers to Treatment Access: Recent studies have estimated that 75 to 90 percent of people who could benefit from MOUD do NOT receive it.[64] Certain groups, including Black adults, women, unemployed people, and those living in nonmetropolitan areas are even less likely to receive MOUD.[65] There are several factors that limit access to treatment. Chief among them are:

- **Stigma** or negative attitudes toward people with OUD and toward the use of medications to treat OUD. These negative beliefs are founded on a lack of understanding of OUD as a chronic brain disorder that is subject to recurrence, and corresponding negative beliefs about the role MOUD plays in helping to restore the brain's reward centers to more normal functioning. Stigma is widespread among health care providers, in communities, and among people with OUD. Direct exposure to and information sharing regarding people in recovery can help overcome these inaccurate negative beliefs.[66,67]
- **A severe shortage of MOUD providers** that results from stigma, lack of education about treatment of addictions in general and OUD specifically, and too often, inadequate reimbursement for MOUD provision.[68,69]

Training

Do I Need Special Training?

- **Basic training is sufficient, and additional training and supports are available for free:** Like managing other chronic conditions such as diabetes, treating OUD involves medication management. Additional education on how to manage the disease is ideal but not essential for starting treatment.[70] Free training is available from several sources listed in Resources.
- **Specialization is not required, and consultation is available:** Treating patients with medications for OUD does not require specialized training. This is emphasized by the Centers for Disease Control and Prevention (CDC), NIDA, ASAM, and the FDA.[71] Consultation with addiction specialists can be available if needed for individual cases.
- **Treatment for many patients' OUD can be effectively managed in primary care settings:** Outcomes are comparable to those in specialty settings.[72,73]
- **A range of providers can prescribe medications for OUD:** Physicians, nurse practitioners, and physician assistants can prescribe medications for OUD once they have a DEA license. Non-physician prescribers may need to follow state-specific requirements, such as physician oversight, which apply to all Schedule III controlled medications, including buprenorphine.[74]

Mentoring and Consultation

- **Free mentoring and training are available** from several different organizations with funding from federal health agencies, including:
  - The University of California, San Francisco, operates the National Clinician Consultation Center for substance use management that offers phone and online case consultation
  - The PCSS Medications for Opioid Use Disorder program. With support from SAMHSA, these services are available to all free of charge, and PCSSNOW offers a broad range of training programs to meet various needs.
  - SAMHSA's Addiction Technology Transfer Centers also offer free training on the treatment of OUD.
  - The Opioid Response Network (ORN) offers free training and technical assistance programs led by the American Academy of Addiction Psychiatry in collaboration with a large national coalition with funding from SAMHSA. This coalition offers resources to address opioid, stimulant and all substance use disorders.
  - The CDC offers a free Addiction Medicine Toolkit with continuing education on addictions generally.
  - NIDA offers a range of free continuing medical education offerings relevant to treating opioid use disorder.
  - Many states, universities, and other organizations offer free virtual case-based learning sessions on how to treat people with OUD based on the Project ECHO model. For example, Project ECHO sessions in South Carolina are offered by the Medical University of South Carolina; in Wisconsin by the University of Wisconsin, and in West Virginia by West Virginia University. These sessions typically involve a brief didactic presentation by an expert, followed by the presentation of an individual case study, Q & A, and discussion.
  - In addition, ASAM and other professional organizations offers an extensive roster of relevant courses, including ones suitable to meet the DEA requirements, for modest fees.

- **A Collaborative Care approach may allow you to establish a consulting relationship with a psychiatrist or other addiction specialist:** This guide from the AIMS Center (PDF - 354 KB) at the University of Washington explains how to bill Medicare for office-based collaborative care for substance use disorders. Most (but not all) state Medicaid programs also allow billing for these or similar codes. The AIMS Center also offers guides for bundled payments for behavioral health integration (BHI) services (PDF - 336 KB), and CMS's Medicare Learning Network offers guides for BHI services in FQHCs (PDF - 2.8 MB) and rural health clinics (PDF - 1.8 MB).

Recovery Supports

Is Counseling Required?

Not necessarily. The primary focus of MOUD is stabilizing patients with medication. Medication is the only treatment that improves patient outcomes[75] and saves lives.[76] Once the patients are stabilized on medications for OUD, they may be more ready for counseling or other psychosocial supports.

Requiring counseling as a condition for treatment can create a barrier, especially for individuals who may be reluctant or unable to participate.[42] Withholding medications for OUD because a patient delays or refuses psychosocial interventions is not warranted. This approach only places patients at unnecessary risk for accidental overdose and death.

Community Resources

Office-based opioid treatment with buprenorphine is also appropriate as a "step down" from more intensive services; or for those who are stable on buprenorphine and for whom ongoing monitoring or disease management is appropriate. **There is a great need for prescribers to offer ongoing maintenance MOUD treatment.** Provision of this service fits well in primary care settings and can save lives. **Please consider offering ongoing maintenance MOUD.**

It is important to identify what resources are available in your community. Other organizations may be able to get people started on MOUD, after which you might provide ongoing MOUD maintenance. They may offer services that are beyond the scope of your primary care practice and be willing to accept referrals from you for patients needing a more intensive or higher level of care. Conversely, some of the substance use treatment specialty organizations lack the ability to address chronic medical conditions that are well within the scope of primary care. With telehealth and virtual treatment services, your community may be defined more broadly than through physical distance. Examples of the kinds of other organizations you might consider collaborating with include:

- **Pharmacies.** There has been a nationwide concern[77] about the hesitation or unwillingness of some pharmacies to fill buprenorphine prescriptions.[78–80] Some pharmacies stock a limited number of buprenorphine formulations, and others place severe limitations on the number of prescriptions they will fill. It is important to learn which community, national chain, or mail order pharmacies will fill the prescriptions you write for your patients. To address this issue, the National Association of Boards of Pharmacy and the National Community Pharmacists Association have collaborated to develop The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARM-OUD) Guideline, a resource that can be shared with local pharmacists.
- **Local or regional specialty substance use treatment programs:** As noted, these include OTPs that provide all three FDA-approved medications and counseling. Other substance use specialty programs might be offered through certified community behavioral health centers (CCBHCs) or other regional community behavioral health programs. There may also be independent treatment programs that offer residential treatment, intensive outpatient treatment, or inpatient care.

- **Local or regional hospitals that provide inpatient treatment for substance use disorders, or that have emergency departments that treat people who have experienced an overdose:** Some emergency departments now have developed protocols to initiate buprenorphine, sometimes with peer support, and they may have a need to identify community providers (which might be primary care providers) that could provide maintenance treatment with buprenorphine.
- **Federally Qualified Health Centers, Health Care for the Homeless programs, rural health, and other community health clinics:** The capabilities of these organizations vary widely, but some are larger and may have some level of behavioral health integration and the expertise needed to begin MOUD and provide a broader range of ongoing recovery supports.
- **Telehealth or virtual care providers:** Since the COVID-19 pandemic, we have seen dramatic growth in the number of organizations and companies that provide addiction treatment virtually, through telehealth or phone-based apps. Your state university system may provide telehealth treatment for people in remote areas. Several private for-profit companies also have business models to treat OUD, either in collaboration with a primary care provider, or independently. For example, CareConnect Telehealth Bridge Clinic is an urgent care clinic that provides same-day buprenorphine to patients and connects them with providers to continue MOUD treatment.[81] There are no independent evaluations of most of these services, so it is important to be cautious in developing collaborations with them, but the potential for them to meet patient needs beyond the capability of your primary care practice could be valuable. Some will provide and manage the MOUD maintenance, connect patients with self-help groups and peer counselors, offer cognitive behavioral therapy or contingency management, and other recovery support services.

- **Other community resources to enable access to treatment and support recovery:** For patients to participate in treatment for OUD over time they may need any of several types of support. There can be challenges associated with food, transportation, childcare, housing, education, employment, or legal issues, and any of these may effectively make it very difficult to continue in treatment for the year or longer that may be needed to achieve persistent recovery. It is probably beyond the scope of your primary care practice to address these needs, but you can build relationships with other organizations in your region that can help. Just giving the patient a list of resources is unlikely to result in solutions to the problems they face. It is best if you can develop an ongoing collaboration with these service organizations, with "closed loop" referrals and ongoing communication about patient progress, with appropriate patient consent.
- **Local or regional jails or prisons:** Many people with substance use disorders become involved in the criminal justice system, and risk for an overdose in the days and weeks following re-entry to the community is frighteningly high. To lessen this risk, these settings are increasingly starting to provide MOUD to people with an OUD, and then there is a need to identify providers who can continue the MOUD treatment when they are back in the community. In some places, there are peer counselors who work to assist with the orderly transition back to community settings. It is possible that some of these formerly incarcerated people could be appropriate candidates for lifesaving MOUD treatment in your primary care practice.

In addition to just looking around at what is in your community, there are on-line sources of information about providers and support services. For example, the advocacy group Shatterproof is attempting to develop a resource (Shatterproof Atlas) that lists treatment providers and uses patient and provider data to rate the quality of their services. It is not yet available in all states but may be available in yours. More complete listing coverage of mental health and substance use treatment programs (without quality ratings) is available through SAMHSA. Another national resource for information on a range of social services and support is from FindHelp.org that lists organizations that can assist with food, housing, transportation, care, etc.

Prescribing Medications to Treat OUD: Practice Guidelines

- Primary Care Providers Can Prescribe with Confidence | FDA (2024) – Useful information, resources, and videos where prescribers describe their experiences prescribing MOUD.
- Medications for Opioid Use Disorder – Michigan OPEN (2025) – Clearly presented information for using medications to treat patients with OUD.
- Buprenorphine Quick Start Guide | SAMHSA (PDF - 1.4 KB) and the abbreviated Buprenorphine Quick Start Pocket Guide | SAMHSA (PDF - 211 KB) (Both 2021)
- Treating Opioid Use Disorder as a Chronic Condition: A Practice Manual for Family Physicians, from the American Academy of Family Physicians (2025)
- Buprenorphine Implementation Toolkit 2020 | NIATx – UW–Madison (2020)
- Treatment Improvement Protocol 63: Medications for Opioid Use Disorder | SAMHSA (2021) – For Healthcare and Addiction Professionals, Policymakers, Patients, and Families
- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder – 2020 Focused Update – A thorough downloadable reference available free-of-charge.

Other Resources

Free Training Opportunities

- Practitioner Training and Resources: Substance Use Disorder | SAMHSA
- Training: Assessing and Addressing Opioid Use Disorder | Overdose Prevention | CDC
- Medications for Opioid Use Disorder (MOUD) - PCSS-MOUD – For both training and mentoring.

Naloxone and Overdose Instructions

- Next Distro: Free Naloxone Access for Impacted Communities — NEXT Distro (2023,) – How to obtain free naloxone by mail, naloxone administration guidelines, and other risk reduction resources.
- Opioid Overdose Rescue with Naloxone Nasal Spray 4mg: Patient Guide (2016) – Simple, detailed infographic that explains how a lay person can administer nasal naloxone and chest compressions. From U.S. Department of Veterans Affairs.
- How and When to Use Naloxone for an Opioid Overdose (n.d.) – CDC tip sheet describing symptoms and basic response to overdose.
- Prescribe To Prevent (2022) – Patient educational videos describing how to identify an overdose and how to use intranasal and intramuscular naloxone.
- SAMHSA Overdose Prevention and Response Toolkit (PDF - 666 KB) (2023) – General reading about overdose from opioids, stimulants, and other drugs with single-page appendices geared toward people who use prescription opioids, people who use drugs in general, and providers.

Principles of Person-Centered OUD Treatment

In this module we summarize six effective principles for OUD treatment, based on those developed for general substance use treatment by several organizations.[16,82,83] These principles inform the approach taken throughout the Playbook and should be helpful to keep in mind as you implement treatment for OUD, regardless of whether your practice only provides MOUD or is also able to offer additional services.

Principle #1: Implement Routine Screening to Identify Individuals with or at Risk for OUD

Universal screening for unhealthy drug use (including OUD) should be integrated into routine care in primary care and other ambulatory care settings for adults aged 18 or older:[84] Screening helps identify individuals at risk and allows for early intervention, potentially preventing further misuse. If symptoms of OUD are identified, patients should undergo further evaluation and begin medications for OUD as soon as possible.[6]

Principle #2: Facilitate Fast Access to Treatment

Treatment needs to be readily available and accessible to those who need it:[85] Addiction alters brain chemistry, impacting motivation, inhibition, and stress tolerance. Patients fear entering withdrawal and that plays a major role in their seeking opioids.[86,87] When patients are motivated or ready to engage in treatment for OUD, providing medication as soon as possible is crucial.[83] **Even a few days waiting can mean the difference between initiation and disengagement from medical care or loss of interest in seeking treatment.**

Starting patients on medications on the same day they are first seen by providers improves retention in treatment:[88] Buprenorphine does not need to be started in medical settings. Telehealth and home starts (i.e., inductions), when paired with adequate education, support, and communication, can be both safe and effective.[89] Additionally, you are encouraged to prescribe buprenorphine even if a patient is using stimulants, benzodiazepines, or other substances, as the potential harms of untreated OUD outweigh the risks of concurrent substance use.[89]

Principle #3: Recognize That Addiction is a Chronic, Recurring Brain Disease

Addiction is a complex, yet treatable disease that affects the brain:[90] Recurrence of symptoms (substance use, in this case) is a common part of a chronic disease like addiction. It does not mean these patients are inappropriate for or "failing" treatment, but rather that they need more support and possibly adjustments to their treatment plan.[91] As a primary care provider, you can view reductions in substance use as an indicator of progress toward treatment goals, rather than a reason to remove a patient from buprenorphine treatment.[92]

Many individuals with OUD also use alcohol and other drugs: Continued use of other substances should not be viewed as evidence that the medication for OUD is not effective. Instead, it is an opportunity to engage with the patient about additional services they might need. **Do NOT discontinue their MOUD treatment due to use of other substances.** Keep them in care by addressing their broader substance use needs, recognizing that referral to a more intensive or higher level of care may be necessary.[92]

Stigma is a major barrier to treatment, both within the healthcare system and the community: Patients with OUD may experience shame or judgment, which can prevent them from seeking care or continuing treatment. As a primary care provider, your role in creating a non-judgmental, supportive environment is crucial. By understanding addiction as a chronic disease, not a moral failing, you can help reduce stigma and foster a setting where patients feel safe and motivated to remain in treatment.

Principle #4: Support Long-Term Retention in Treatment

Continue buprenorphine treatment for as long as it benefits the patient: Staying in treatment for enough time is critical to the patient's long-term success and sustained recovery.[85] While there is no standard length for treatment with medications for OUD, prematurely discontinuing treatment can pose serious risks, including overdose and death.[73] Longer treatment retention is generally associated with better outcomes.[93–95] The probability of survival increases significantly when treatment continues for at least 12 months or longer.[96] Any decision to discontinue treatment should be a decision shared between you and your patient.[6] As patients' needs change over time, adjust the nature and intensity of their care accordingly.[6]

Principle #5: Take a Person-Centered Approach to Service Models and Care Plans

No single treatment approach is best for everyone:[97] Medication-only treatment for OUD is effective, even without other services.[97] Ideally, depending on the level of care your practice offers, treatment should consider each patient's unique social, mental, biological, and environmental needs,[83] and the types and intensity of services offered should be tailored accordingly.[82] Update treatment plans regularly to meet the patient's changing needs.[85] For example, someone in the early stages of treatment may want help meeting basic needs (e.g., housing and food stability) before engaging in regular counseling appointments.[82]

As you develop your approach to using medications to treat people with OUD, consider how to incorporate person-centered care principles: Person-centered care principles can be applied from the very start of treatment. Person-centered care includes helping patients choose the right medication for them and how best to help them start it. This also carries over to achieving the right dose for patients on buprenorphine and not limiting it based on arbitrary guidelines. Some patients are very knowledgeable about dosing and medications for OUD, so involving them in shared decision-making has the potential to increase retention in MOUD treatment.[15] Develop strategies to identify patients who may be at risk for leaving treatment prematurely, and address their unique barriers to care to keep them engaged in treatment.[82] Patient needs and preferences can help shape practice systems and workflows. For example, offering telehealth options can help patients manage travel and transportation challenges, and providing walk-in clinic hours or evening/weekend appointments can accommodate diverse schedules.[82] If your practice offers medication-only care, some patients may benefit from referrals to additional services or higher levels of care.

Principle #6: Address the Holistic Needs of the Patient to Support Recovery

If your patient needs more services and supports than your practice can provide, or if additional services are essential for their sustained recovery, it may be appropriate to refer them to a practice that can provide more intensive services, such as an opioid treatment program OTP, or to a higher level of care, such as intensive outpatient or partial hospitalization. Ideally, practices that provide MOUD will also connect patients with nonmedical recovery support services in the community,[83] such as peer services, self-help groups, supported education or employment services, and housing.

To the extent possible, OUD treatment addresses holistic needs of the individual, not just the substance use:[85] Many individuals with OUD have complex needs that benefit from treatment that goes beyond medication alone. Recognizing that many primary care settings may not have the resources or capabilities to address the full range of needs and concerns, please consider what is possible in your setting and what might be achieved through referral and collaboration with external resources.

As you are able, address the patient's medical needs as well: Most individuals who enter treatment for OUD also have co-occurring medical disorders. For example, individuals with OUD often present with physical health problems such as chronic pain, sleep disorders, infectious diseases, diabetes, or hypertension.[83] Testing for infectious diseases and providing targeted risk-reduction counseling, along with connecting patients to necessary treatment, is important.[85]

Ideally, treatment of the OUD and other co-occurring conditions would be delivered in an integrated health care system or through carefully coordinated care across different providers:[83] Practices that have already integrated behavioral health and primary care may have in place a team that can address a broad range of medical and behavioral health conditions. Behavioral therapies can be effectively combined with medication to address patients' unique behavioral health needs.[85] Many individuals with OUD have co-occurring mental health conditions,[85] such as depression, anxiety, and post-traumatic stress disorder (PTSD).[83] Behavioral therapies can help patients develop coping strategies and promote behavior change related to addiction while addressing their other mental health needs.

Not all patients need traditional counseling to achieve recovery or treatment goals: Patients have different needs and preferences related to behavioral therapies and recovery supports. Making counseling or therapy mandatory may not be practical or appropriate for some people with OUD and may result in their leaving treatment early. Some may need help with more basic needs, such as food and safe housing, before engaging in counseling. Depending on the phase of treatment, patients may also require different types or intensities of psychosocial support.[98] This being said, counseling is associated with greater continuity and retention in buprenorphine treatment.[41]

Sustained recovery may require practical and emotional support from family, friends, and the community:[83] Patients may struggle to maintain their recovery without positive relationships, stable housing, and having other basic needs met. While you may not be able to directly address these issues, consider these needs when developing treatment plans.

Avoiding Common Pitfalls

- Don't have a single fixed treatment design that every patient with OUD is expected to fit within.
- Don't forget to identify what is important to the individual patient and use motivational interviewing principles to encourage them to begin and remain in treatment.
- Don't expect all patients to progress at the same rate or treat them disrespectfully if they stumble and return to substance use.

Resources

- Principles of Drug Addiction: A Research-Based Guide (Third Edition) (PDF - 1.2 MB) (Revised 2018)
- Shatterproof National Principles of Care (2025)

References

1. Blazes CK, Morrow JD. Reconsidering the Usefulness of Adding Naloxone to Buprenorphine. *Front Psychiatry*. 2020;11. doi:10.3389/fpsyt.2020.549272
2. Gregg J, Hartley J, Lawrence D, Risser A, Blazes C. The Naloxone Component of Buprenorphine/Naloxone: Discouraging Misuse, but at What Cost? *Journal of Addiction Medicine*. 2023;17(1):7. doi:10.1097/ADM.0000000000001030
3. Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open*. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622
4. Kornør H, Lobmaier PPK, Kunøe N. Sustained-release naltrexone for opioid dependence. *Cochrane Database Syst Rev*. 2025;5(5):CD006140. doi:10.1002/14651858.CD006140.pub3
5. Center for Drug Evaluation and Research. FDA recommends changes to labeling for transmucosal buprenorphine products indicated to treat opioid use disorder. *FDA*. Published online December 26, 2024. Accessed June 4, 2025. https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-changes-labeling-transmucosal-buprenorphine-products-indicated-treat-opioid-use
6. Grande LA, Cundiff D, Greenwald MK, Murray M, Wright TE, Martin SA. Evidence on Buprenorphine Dose Limits: A Review. *J Addict Med*. 2023;17(5). doi:10.1097/ADM.0000000000001189
7. Harris R, Stracker N, Rice M, St. Clair A, Page K, Rosecrans A. Redefining low-threshold buprenorphine access in an integrated mobile clinic program: Factors associated with treatment retention. *Journal of Substance Use and Addiction Treatment*. 2025;169:209586. doi:10.1016/j.josat.2024.209586
8. Axeen S, Pacula RL, Merlin JS, Gordon AJ, Stein BD. Association of Daily Doses of Buprenorphine With Urgent Health Care Utilization. *JAMA Netw Open*. 2024;7(9):e2435478. doi:10.1001/jamanetworkopen.2024.35478
9. Bernosky-Smith K, Painter O, Butler S, Patel D, Clemency B, Lynch J. Intranasal overdose reversal formulations: a rapid review of available agents. *Pain Management*. 2025;15(2):105-113. doi:10.1080/17581869.2025.2461445
10. US Preventive Services Task Force, Krist AH, Davidson KW, et al. Screening for Unhealthy Drug Use: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2020;323(22). doi:10.1001/jama.2020.8020
11. Dickson-Gomez J, Spector A, Weeks M, Galletly C, McDonald M, Green Montaque HD. "You're Not Supposed to be on it Forever": Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids. *Subst Abuse*. 2022;16. doi:10.1177/11782218221103859
12. Buresh M, Stern R, Rastegar D. Treatment of opioid use disorder in primary care. *BMJ*. 2021;373. doi:10.1136/bmj.n784
13. Substance Abuse and Mental Health Services Administration. *TIP 63: Medications for Opioid Use Disorder*. SAMHSA; 2021:Part 3: Medications for Opioid Use Disorder for healthcare professionals. Accessed April 7, 2025. https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002

14. Bravata K, Cabello-De La Garza A, Earley A. Treating opioid use disorder as a chronic condition: A practice manual for family physicians. Published online 2018.
15. Almeida A, Conway M, Grelotti DJ, Gupta A, Frank D, Bórquez A. Medication experiences in the treatment of opioid use disorders: Insights from Reddit. *Addiction*. 2025;120(8):1610-1622. doi:10.1111/add.70022
16. American Society of Addiction Medicine. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *Journal of Addiction Medicine*. 2020;14(2S):1-91. doi:10.1097/ADM.0000000000000633
17. León-Barriera R, Zwiebel SJ, Modesto-Lowe V. A practical guide for buprenorphine initiation in the primary care setting. *CCJM.* 2023;90(9):557-564. doi:10.3949/ccjm.90a.23022
18. Substance Abuse and Mental Health Services Administration. *Buprenorphine Quick Start Guide*. 2021. https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf
19. Blevins D, Bramlette E, Burns A. Practice-Based Guidelines: Buprenorphine in the Age of Fentanyl. Published online 2023. Accessed May 30, 2025. https://pcssnow.org/wp-content/uploads/2023/05/PCSS-Fentanyl-Guidance-FINAL-1.pdf
20. Sigmon SC, Bisaga A, Nunes EV, O'Connor PG, Kosten T, Woody G. Opioid Detoxification and Naltrexone Induction Strategies: Recommendations for Clinical Practice. *Am J Drug Alcohol Abuse*. 2012;38(3). doi:10.3109/00952990.2011.653426
21. National Institute on Drug Abuse. Higher doses of buprenorphine may improve treatment outcomes for people with opioid use disorder | National Institute on Drug Abuse (NIDA). September 25, 2024. Accessed June 4, 2025. https://nida.nih.gov/news-events/news-releases/2024/09/higher-doses-of-buprenorphine-may-improve-treatment-outcomes-for-people-with-opioid-use-disorder
22. Herring AA, Vosooghi AA, Luftig J, et al. High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder. *JAMA Netw Open*. 2021;4(7). doi:10.1001/jamanetworkopen.2021.17128
23. Miller JC, Brooks MA, Wurzel KE, Cox EJ, Wurzel JF. A Guide to Expanding the Use of Buprenorphine Beyond Standard Initiations for Opioid Use Disorder. *Drugs R D*. 2023;23(4). doi:10.1007/s40268-023-00443-5
24. National Institute on Drug Abuse. How Naloxone Saves Lives in Opioid Overdose. NIDA. 2019. Accessed April 24, 2025. https://nida.nih.gov/videos/how-naloxone-saves-lives-in-opioid-overdose
25. CDC. Lifesaving Naloxone. Stop Overdose. 2024. Accessed April 24, 2025. https://www.cdc.gov/stop-overdose/caring/naloxone.html
26. Fischer LS, Asher A, Stein R, et al. Effectiveness of naloxone distribution in community settings to reduce opioid overdose deaths among people who use drugs: a systematic review and meta-analysis. *BMC Public Health*. 2025;25(1):1135. doi:10.1186/s12889-025-22210-8
27. Hardin J, Seltzer J, Galust H, et al. Emergency Department Take-Home Naloxone Improves Access Compared with Pharmacy-Dispensed Naloxone. *The Journal of Emergency Medicine*. 2024;66(4):e457-e462. doi:10.1016/j.jemermed.2023.11.020

28. Substance Abuse and Mental Health Services Administration. TIP 63: Medications for Opioid Use Disorder. SAMHSA Library. 2021. Accessed April 7, 2025. https://library.samhsa.gov/product/tip-63-medications-opioid-use-disorder/pep21-02-01-002
29. National Institute on Drug Abuse. Medication Treatment for Opioid Use Disorder in the Primary Care Setting. NIDA. 2023. Accessed April 18, 2025. https://nida.nih.gov/nidamed-medical-health-professionals/science-to-medicine/medication-treatment-opioid-use-disorder/in-primary-care-setting
30. U.S. Department of Health and Human Services. HHS is Taking Action to Strengthen Primary Care. Published online 2023. Accessed May 3, 2025. https://www.hhs.gov/sites/default/files/primary-care-issue-brief.pdf
31. Barry CL, Epstein AJ, Fiellin DA, Fraenkel L, Busch SH. Estimating Demand for Primary Care-Based Treatment for Substance and Alcohol Use Disorders. *Addiction*. 2016;111(8):1376-1384. doi:10.1111/add.13364
32. Thompson-Gargano K. What Buprenorphine Treatment is Like? The National Alliance of Advocates for Buprenorphine Treatment (NAABT). Accessed April 30, 2025. https://naabt.org/education/what_bt_like.cfm
33. National Institute on Drug Abuse. Medications for Opioid Use Disorder. NIDA. 2025. Accessed April 16, 2025. https://nida.nih.gov/research-topics/medications-opioid-use-disorder
34. Biondi BE, Vander Wyk B, Schlossberg EF, Shaw A, Springer SA. Factors associated with retention on medications for opioid use disorder among a cohort of adults seeking treatment in the community. *Addiction Science & Clinical Practice*. 2022;17(1):15. doi:10.1186/s13722-022-00299-1
35. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. doi:10.1136/bmj.j1550
36. American Society of Addiction Medicine. *Advancing Access To Addiction Medications: Implications for Opioid Addiction Treatment*. ASAM. Accessed December 17, 2024. https://www.asam.org/docs/default-source/advocacy/advancing-access-to-addiction-medications-report.pdf?sfvrsn=2aa870c2_0
37. Dowell D, Brown S, Gyawali S, et al. Treatment for Opioid Use Disorder: Population Estimates — United States, 2022. *MMWR Morb Mortal Wkly Rep*. 2024;73. doi:10.15585/mmwr.mm7325a1
38. Substance Abuse and Mental Health Services Administration. *Advisory: Low Barrier Models of Care for Substance Use Disorders*. SAMHSA; 2023. Accessed April 23, 2025. https://library.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf
39. Degenhardt L, Clark B, Macpherson G, et al. Buprenorphine versus methadone for the treatment of opioid dependence: a systematic review and meta-analysis of randomised and observational studies. *Lancet Psychiatry*. 2023;10(6):386-402. doi:10.1016/S2215-0366(23)00095-0
40. CDC. Treatment of Opioid Use Disorder. Overdose Prevention. August 12, 2024. Accessed February 26, 2025. https://www.cdc.gov/overdose-prevention/treatment/opioid-use-disorder.html
41. Zhu T, Noor-E-Alam Md, Hasan MM, Young LD, Young GJ. Counseling as a complement to buprenorphine treatment for opioid use disorder: A retrospective observational study of patient outcomes. *Journal of Substance Use and Addiction Treatment*. 2025;175:209719. doi:10.1016/j.josat.2025.209719

42. Sofuoglu M, DeVito EE, Carroll KM. Pharmacological and Behavioral Treatment of Opioid Use Disorder. PRCP. 2019;1(1):4-15. doi:10.1176/appi.prcp.20180006

43. Jakubowski A, Fox A. Defining Low-threshold Buprenorphine Treatment. *Journal of Addiction Medicine*. 2020;14(2):95-98. doi:10.1097/ADM.0000000000000555

44. Lippold KM, Jones CM, Olsen EO, Giroir BP. Racial/Ethnic and Age Group Differences in Opioid and Synthetic Opioid-Involved Overdose Deaths Among Adults Aged ≥18 Years in Metropolitan Areas - United States, 2015-2017. *MMWR Morb Mortal Wkly Rep*. 2019;68(43):967-973. doi:10.15585/mmwr.mm6843a3

45. CDC. CDC Reports Nearly 24% Decline in U.S. Drug Overdose Deaths. CDC Newsroom. February 25, 2025. Accessed March 16, 2025. https://www.cdc.gov/media/releases/2025/2025-cdc-reports-decline-in-us-drug-overdose-deaths.html

46. Overdose Lifeline. 2024 Opioid Overdose Data Report: Key Trends and Insights. Overdose Lifeline. September 29, 2025. Accessed March 25, 2026. https://www.overdoselifeline.org/news/2024-opioid-overdose-data-report-key-trends-and-insights/

47. CDC. Drug Overdose Deaths in the United States, 2003–2023. National Center for Health Statistics. 2024. doi:10.15620/cdc/170565

48. CDC. Data Resources. Overdose Prevention. September 18, 2025. Accessed October 3, 2025. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/index.html

49. Garnett M (CDC/DDPHSS/NCHS/DAE), Miniño AM. Drug Overdose Deaths in the United States, 2023–2024. CDC. 2026;(549).

50. Suzuki J, El-Haddad S. A review: Fentanyl and non-pharmaceutical fentanyls. *Drug and Alcohol Dependence*. 2017;171:107-116. doi:10.1016/j.drugalcdep.2016.11.033

51. Blevins D, Bramlette E, Burns A. *Practice-Based Guidelines: Buprenorphine in the Age of Fentanyl*. Providers Clinical Support System (PCSS); 2023. Accessed May 2, 2025. https://pcssnow.org/wp-content/uploads/2023/05/PCSS-Fentanyl-Guidance-FINAL-1.pdf

52. O'Donnell J, Tanz LJ, Gladden RM, Davis NL, Bitting J. Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls — United States, 2019–2020. *MMWR Morb Mortal Wkly Rep*. 2021;70(50):1740-1746. doi:10.15585/mmwr.mm7050e3

53. Jiang X, Connolly S, Strahan AE, et al. Reported Xylazine Use Among Adults Aged ≥18 Years Evaluated for Substance Use Treatment - United States, July 2022-September 2023. *MMWR Morb Mortal Wkly Rep*. 2024;73(26):594-599. doi:10.15585/mmwr.mm7326a2

54. Tanz LJ, Stewart A, Gladden RM, Ko JY, Owens L, O'Donnell J. Detection of Illegally Manufactured Fentanyls and Carfentanil in Drug Overdose Deaths — United States, 2021–2024. *MMWR Morb Mortal Wkly Rep.* 2024;73(48):1099-1105. doi:10.15585/mmwr.mm7348a2

55. Compton WM, Valentino RJ, DuPont RL. Polysubstance use in the U.S. opioid crisis. *Mol Psychiatry*. 2021;26(1):41-50. doi:10.1038/s41380-020-00949-3

56. Das S, Jones C, Donnelly N, Goulding D, Spark TL. *Trends in Opioid-Involved Emergency Department Visits: Overall and by Type of Opioid*, 2021–2024. Accessed April 14, 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56241/dawn-trends-opioid-ed-visits.pdf

57. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health*. 2025. Accessed October 3, 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

58. Keyes KM, Rutherford C, Hamilton A, et al. What is the prevalence of and trend in opioid use disorder in the United States from 2010 to 2019? Using multiplier approaches to estimate prevalence for an unknown population size. *Drug Alcohol Depend Rep*. 2022;3. doi:10.1016/j.dadr.2022.100052

59. Powell D, Jacobson M. Estimates of Illicit Opioid Use in the US. *JAMA Health Forum*. 2025;6(5). doi:10.1001/jamahealthforum.2025.0809

60. Reuter P, Caulkins JP, Midgette G. Heroin use cannot be measured adequately with a general population survey. *Addiction*. 2021;116(10):2600-2609. doi:10.1111/add.15458

61. First MB. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, and Clinical Utility. *The Journal of Nervous and Mental Disease*. 2013;201(9):541. doi:10.1097/NMD.0b013e3182a2168a

62. Puzhko S, Eisenberg MJ, Filion KB, et al. Effectiveness of Interventions for Prevention of Common Infections Among Opioid Users: A Systematic Review of Systematic Reviews. *Front Public Health*. 2022;10. doi:10.3389/fpubh.2022.749033

63. McNamara KF, Biondi BE, Hernández-Ramírez RU, Taweh N, Grimshaw AA, Springer SA. A Systematic Review and Meta-Analysis of Studies Evaluating the Effect of Medication Treatment for Opioid Use Disorder on Infectious Disease Outcomes. *Open Forum Infect Dis*. 2021;8(8):ofab289. doi:10.1093/ofid/ofab289

64. McGinty EE, White SA, Eisenberg MD, Palmer NR, Brown CH, Saloner BK. US payment policy for medications to treat opioid use disorder: landscape and opportunities. *Health Aff Sch*. 2024;2(3):qxae024. doi:10.1093/haschl/qxae024

65. Jones CM, Han B, Baldwin GT, Einstein EB, Compton WM. Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. *JAMA Network Open*. 2023;6(8):e2327488. doi:10.1001/jamanetworkopen.2023.27488

66. Madden EF, Prevedel S, Light T, Sulzer SH. Intervention Stigma toward Medications for Opioid Use Disorder: A Systematic Review. *Substance Use & Misuse*. 2021;56(14). doi:10.1080/10826084.2021.1975749

67. Cheetham A, Picco L, Barnett A, Lubman DI, Nielsen S. The Impact of Stigma on People with Opioid Use Disorder, Opioid Treatment, and Policy. *Subst Abuse Rehabil*. 2022;13. doi:10.2147/SAR.S304566

68. Ukaoma SC, Kedia SK, Regmi S, Entwistle C, Lee G, Dillon PJ. Barriers and facilitators to medications for Opioid Use prescribing in primary care in the United States: a scoping review. *Drugs: Education, Prevention and Policy*. doi:10.1080/09687637.2025.2456255

69. Brown AR. Health Professionals' Attitudes toward Medications for Opioid use Disorder. *Substance Abuse*. 2022;43(1):598-614. doi:10.1080/08897077.2021.1975872

70. PCSS-MOUD. PCSS - About. Providers Clinical Support System-Medications for Opioid Use Disorders. Accessed April 25, 2025. https://pcssnow.org/about/

71. Center for Drug Evaluation and Research. Primary Care Providers Can Prescribe with Confidence. FDA. 2024. Accessed April 24, 2025. https://www.fda.gov/drugs/prescribe-confidence/primary-care-providers-can-prescribe-confidence

72. Franz B, Dhanani LY, Hall OT, Brook DL, Simon JE, Miller WC. Differences in buprenorphine prescribing readiness among primary care professionals with and without X-waiver training in the US. *Harm Reduction Journal*. 2023;20(1):180. doi:10.1186/s12954-023-00918-3
73. Harris RA, Kearney M, Keddem S, et al. Organization of primary care and early MOUD discontinuation. *Addiction Science & Clinical Practice*. 2024;19(1):96. doi:10.1186/s13722-024-00527-w
74. Department of Health and Human Services. Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder. Federal Register. 2021. Accessed April 25, 2025. https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder
75. Heimer R, Black AC, Lin H, et al. Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17. *Drug and Alcohol Dependence*. 2024;254:111040. doi:10.1016/j.drugalcdep.2023.111040
76. Nguyen KL, Forbriger J, Forbriger A, Schwarz ES. Medications for Opioid Use Disorder Do Help Patients. *Mo Med*. 2022;119(3):271-276.
77. Varisco T, Fish H, Bolin J, et al. *The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARM-OUD) Guideline*. University of Houston; 2024. doi:10.52713/PhARM-OUD
78. Welsh JW, Yarbrough CR, Sitar SI, et al. Demographic and socioeconomic correlates to buprenorphine access in pharmacies. *J Am Pharm Assoc* (2003). 2023;63(3). doi:10.1016/j.japh.2022.12.015
79. Monico LB, Eastlick M, Michero D, Pielsticker P, Glasner S. Overcoming barriers to traditional care delivery and pharmacy challenges: a qualitative study of buprenorphine, telehealth, and a digital therapeutic for opioid use disorder. *Subst Abuse Treat Prev Policy*. 2025;20. doi:10.1186/s13011-024-00631-9
80. Major EG, Wilson CG, Carpenter DM, Harless JC, Marley GT, Ostrach B. Factors in rural community buprenorphine dispensing. *Explor Res Clin Soc Pharm*. 2023;9. doi:10.1016/j.rcsop.2022.100204
81. Aronowitz SV, Holliday-Davis M, French R, et al. Barriers and facilitators to implementing CareConnect: A telehealth, low-barrier buprenorphine bridge clinic in Philadelphia. *International Journal of Drug Policy*. 2024;133:104569. doi:10.1016/j.drugpo.2024.104569
82. University of Wisconsin-Madison. Buprenorphine Implementation Toolkit 2020. NIATx. 2020. Accessed April 21, 2025. https://niatx.wisc.edu/buprenorphineimplementationtoolkit2020/
83. Shatterproof. Shatterproof National Principles of Care. 2025. Accessed April 24, 2025. https://www.shatterproof.org/shatterproof-national-principles-care
84. U.S. Preventive Services Task Force. Unhealthy Drug Use: Screening. U.S. Preventive Services Task Force. 2020. Accessed May 4, 2025. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening
85. Substance Abuse and Mental Health Services Administration. Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). SAMHSA. February 5, 2021. Accessed April 21, 2025. https://www.samhsa.gov/resource/ebp/principles-drug-addiction-treatment-research-based-guide-third-edition
86. Monroe SC, Radke AK. Opioid withdrawal: role in addiction and neural mechanisms. *Psychopharmacology (Berl)*. 2023;240(7):1417-1433. doi:10.1007/s00213-023-06370-2

87. Crouch TB, Donovan E, Smith WR, Barth K, Becker WC, Svikis D. Patient Motivation to Reduce or Discontinue Opioids for Chronic Pain: Self-Efficacy, Barriers, and Readiness to Change. *Clin J Pain*. 2024;40(1):18-25. doi:10.1097/AJP.0000000000001167

88. Lee CS, Rosales R, Stein MD, et al. Brief Report: Low-Barrier Buprenorphine Initiation Predicts Treatment Retention Among Latinx and Non-Latinx Primary Care Patients. *Am J Addict*. 2019;28(5):409-412. doi:10.1111/ajad.12925

89. Cunninghma C, Fishman M. *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opiod Use*. American Society of Addiction Medicine; 2015. Accessed April 21, 2025. https://www.samhsa.gov/sites/default/files/sites/default/files/opioid-addiction-asam-use-of-medications-in-treatment.pdf?utm_source=chatgpt.com

90. National Institute on Drug Abuse. The Science of Drug Use and Addiction: The Basics. NIDA Archives. 2024. Accessed May 4, 2025. https://archives.nida.nih.gov/publications/media-guide/science-drug-use-addiction-basics

91. National Institute on Drug Abuse. Treatment and Recovery. NIDA. 2020. Accessed May 4, 2025. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

92. Danovitch I, Freedman KI, Frost MP, et al. *Engagement and Retention of Nonabstinent Patients in Substance Use Treatment*. American Society of Addiction Medicine.

93. Glanz JM, Binswanger IA, Clarke CL, et al. The association between buprenorphine treatment duration and mortality: a multi-site cohort study of people who discontinued treatment. *Addiction*. 2023;118(1):97-107. doi:10.1111/add.15998

94. Jiang X, GuyJr GP, Dever JA, et al. Association Between Length of Buprenorphine or Methadone Use and Nonprescribed Opioid Use Among Individuals with Opioid Use Disorder: A Cohort Study. *Substance Abuse*. 2025;46(2):266-279. doi:10.1177/29767342241266038

95. Burns M, Tang L, Chang CCH, et al. Duration of medication treatment for opioid-use disorder and risk of overdose among Medicaid enrollees in 11 states: a retrospective cohort study. *Addiction*. 2022;117(12):3079-3088. doi:10.1111/add.15959

96. Hasan MM, Noor-E-Alam M, Shi J, Young LD, Young GJ. Long-term patient outcomes following buprenorphine/naloxone treatment for opioid use disorder: a retrospective analysis in a commercially insured population. *Am J Drug Alcohol Abuse*. 2022;48(4):481-491. doi:10.1080/00952990.2022.2065638

97. Leshner AI, Mancher M, eds. *Medications for Opioid Use Disorder Save Lives*. National Academies Press; 2019. doi:10.17226/25310

98. Martin SA, Chiodo LM, Bosse JD, Wilson A. The Next Stage of Buprenorphine Care for Opioid Use Disorder. *Ann Intern Med*. 2018;169(9):628-635. doi:10.7326/M18-1652