Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction

Multiple Choice
Identify the choice that best completes the statement or answers the question.

1. Executive Summary
Which of the following is an accurate statement about the importance of the Drug Addiction Treatment Act of 2000 (DATA 2000)?
A. Prior to the enactment of DATA 2000, the use of opioid medications to treat opioid addiction was permissible only in federally approved Opioid Treatment Programs (OTPs)
B. Under the provisions of DATA 2000, qualifying physicians in the medical office may prescribe and/or dispense Schedule III, IV, and V opioid medications for the treatment of opioid addiction if such medications have been specifically approved by the Food and Drug Administration (FDA) for that indication
C. Buprenorphine has received FDA approval and office-based treatment with buprenorphine promises to bring opioid addiction care into the mainstream of medical practice, thereby greatly expanding access to treatment
D. All of the above are accurate statements

2. Buprenorphine offers new hope to many individuals, especially since pharmacotherapy alone has proven to be sufficient for the long-term successful treatment of opioid addiction.
A. True
B. False

3. The prevalence of heroin addiction in the United States is steadily increasing, and according to the Office of National Drug Control Policy (ONDCP), an estimated 810,000 to 1,000,000 individuals in the United States were addicted to heroin in the year 2000.
A. True
B. False

4. All of the following are accurate statements about the abuse potential of buprenorphine EXCEPT:
A. Buprenorphine is abusable, consistent with its agonist action at opioid receptors
B. The abuse potential of buprenorphine is higher in comparison with that of opioid full agonists
C. A formulation containing buprenorphine in combination with naltrexone has been developed to decrease the potential for abuse via the injection route
D. Physicians who prescribe or dispense buprenorphine should monitor for diversion of the medications

5. Patients with significant medical complications are likely to be inappropriate candidates for buprenorphine treatment of opioid addiction in an office-based setting.
A. True
B. False

6. Maintenance treatment with buprenorphine for opioid addiction consists of three phases, and helping patients begin the process of switching from the opioid of abuse to buprenorphine occurs in the ____________ phase.
A. Stabilization
B. Maintenance
C. Induction
D. Withdrawal
7. While methadone is currently the standard of care in the United States for the treatment of opioid addiction in pregnant women, if methadone maintenance treatment programs are unavailable, treatment with buprenorphine may be considered as an alternative.

A. True  
B. False

8. **Chapter One: Introduction**

In 1997 it was estimated that partly because of the stigma and inconvenience associated with receiving methadone maintenance treatment, the ___________ of the individuals with opioid addiction were receiving any form of treatment for it.

A. fewer than 25 percent  
B. fewer than 30 percent  
C. fewer than 35 percent  
D. fewer than 40 percent

9. All of the following are accurate statements about opioid addiction in the United States EXCEPT:

A. Opioid addiction is a neurobehavioral syndrome characterized by the repeated, compulsive seeking or use of an opioid despite adverse social, psychological, and/or physical consequences  
B. Addiction is always accompanied by physical dependence, a withdrawal syndrome, and tolerance  
C. The syndrome is often characterized by overactivity of the physiological functions that were suppressed by the drug and/or depression of the functions that were stimulated by the drug  
D. Factors contributing to the development of opioid addiction include the reinforcing properties and availability of opioids, family and peer influences, sociocultural environment, personality, and existing psychiatric disorders

10. In 2002, hydrocodone ranked among the 10 most common drugs related to deaths in 18 cities in the United States, while oxycodone ranked among the 10 most common drugs related to deaths in 19 cities in the United States.

A. True  
B. False

11. Pharmacotherapy and psychosocial therapy are two main modalities for the treatment of opioid addiction. Which of the following is NOT an example of pharmacotherapies now available for opioid addiction?

A. Antagonist maintenance using methadone  
B. Partial-agonist maintenance with buprenorphine or buprenorphine plus naloxone  
C. Antagonist maintenance using naltrexone  
D. The use of antiwithdrawal agents for brief periods, and in tapering doses, to facilitate entry into drug-free or antagonist treatment

12. Although at analgesic doses, buprenorphine is 20-50 times more potent than morphine, the agonist effects of buprenorphine reach a maximum and do not continue to increase linearly with increasing doses of the drug.

A. True  
B. False

13. The buprenorphine/naloxone combination tablet appears to have increased abuse potential compared with buprenorphine alone when studied in opioid-dependent populations.

A. True  
B. False

14. **Chapter Two: Pharmacology**

Which of the following is an accurate statement about opioid pharmacology and how opioids interact with receptors?

A. Drugs that activate receptors in the brain are termed agonists and they bind to receptors and block them  
B. Opioids with the greatest abuse potential are partial agonists  
C. Antagonists do not activate receptors, and they prevent receptors from being activated by agonist compounds  
D. All of the above are accurate statements
15. The two types of withdrawal that are associated with mu opioid agonists are spontaneous withdrawal and __________ withdrawal.
   A. Protracted  C. Acute
   B. Physical      D. Precipitated

16. The rate of onset of the pharmacological effects of a drug, and thereby its abuse potential, is determined by a number of factors including all of the following EXCEPT:
   A. The drug’s rate of association with receptors
   B. The drug's route of administration
   C. The drug’s half-life
   D. The drugs lipophilicity

17. Because it is a partial agonist, higher doses of buprenorphine can be given with fewer adverse effects than are seen with higher doses of full agonist opioids, and past a certain point, dose increases of buprenorphine do not further increase the pharmacological effects of the drug.
   A. True  B. False

18. The abuse potential of buprenorphine in individuals who are physically dependent on opioids varies as a function of all of the following factors EXCEPT:
   A. Time interval between administration of the full agonist and of buprenorphine
   B. Level of psychological addiction
   C. The dose of buprenorphine administered
   D. Level of physical dependence

19. The primary side effects of buprenorphine are similar to other mu opioid agonists (e.g., nausea, vomiting, constipation), but the intensity of these side effects is usually greater than that produced by full agonist opioids.
   A. True  B. False

20. Which of the following is an accurate statement about the use of buprenorphine in the treatment of opioid abuse?
   A. Medically supervised withdrawal (detoxification) from opioids has a much higher likelihood of long-term success than opioid maintenance treatment programs
   B. The immediate goal in starting buprenorphine is to ensure a schedule of withdrawal from the prescribed medication that the patient is addicted to
   C. Studies suggest that buprenorphine in a dose range of 8 to 16 mg a day sublingually is as clinically effective as approximately 60 mg a day of oral methadone
   D. Buprenorphine's partial mu agonist properties may discourage patient compliance with regular administration

21. Buprenorphine has unique qualities that make it an effective and safe addition to the available pharmacological treatments for opioid addiction and the combination of buprenorphine with the opioid antagonist naloxone further increases its safety and eliminates the likelihood of diversion and misuse.
   A. True  B. False

22. **Chapter Three: Patient Assessment**
   Although periodic and regular screening of all patients for substance use and substance-related problems is recommended, it was reported in by the National Center on Addiction and Substance Abuse in 2000 that fewer than one-third of physicians in the United States carefully screen for addiction.
   A. True  B. False

23. All of the following are accurate statements about the screening and assessment for substance abuse EXCEPT:
   A. Screenings are important in identifying individuals who are at risk for developing drug or alcohol related problems or who
   B. If screening indicates the presence of an opioid use disorder, further assessment is indicated to thoroughly
may have developed drug or alcohol related problems or addiction
delineate the patient's problem, to identify complicating medical or emotional conditions, and to determine the appropriate treatment setting

B. Laboratory evaluations and standardized assessments are the most effective means of gathering further information if substance abuse is suspected
D. The components of an assessment of a patient who is addicted to opioids should include a complete history, a physical examination, and a mental status examination

24. The approach and attitude the physician shows to patients who have an addiction are of paramount importance and it is the physician’s responsibility to deal appropriately with his or her own attitudes and biases as well as emotional reactions to a patient.
A. True         B. False

25. Which of the following is an accurate statement about interviewing patients regarding their substance abuse issues?
A. Simple, closed-ended-questions are the most effective for eliciting information
C. Questions should be asked in an indirect and subtle manner, as not to intimidate patients
B. Most patients are willing and able to provide reliable, factual information regarding their drug use and can articulate their reasons or motivation for using drugs
D. Assumptive or quantifiable questions such as "At what age did you first use alcohol or other drugs?" yield more accurate responses in the initial phases of an interview

26. All of the following are important components of a complete substance abuse assessment history EXCEPT:
A. Employment history and socio-economic status
B. Psychiatric history and readiness to change
C. Substance use and addiction treatment history
D. Medical and social history

27. Sensory impairment, myopathy, and cognitive deficits are examples of neurologic examination findings that could be suggestive of addiction or its complications.
A. True         B. False

28. Slurred speech, "nodding" or intermittently dozing, and memory impairment are all signs of opioid overdose.
A. True         B. False

29. Which of the following is a symptom of fully developed opioid withdrawal?
A. Insomnia     C. Muscle twitching
B. Abdominal pain D. Diarrhea and/or vomiting

30. Drug screenings are often used as part of opioid assessment and treatment. All of the following are accurate statements about drug screenings EXCEPT:
A. Tests for illicit drugs are not sufficient to diagnose addiction and cannot substitute for a clinical interview and medical evaluation of the patient
C. Physicians must decide which drug tests are necessary in each clinical setting, including office-based buprenorphine treatment
B. Testing for drugs can be performed on a number of bodily fluids and tissues, including urine, blood, saliva, sweat, and hair, and blood testing is the method most commonly employed
D. When a patient requests treatment with buprenorphine, a toxicology screen can help to establish that the patient is indeed using either a proscribed substance such as heroin or a prescribed substance such as
31. A DSM-IV-TR diagnosis of either opioid dependence or abuse is based on a cluster of behaviors and physiological effects occurring within a specific timeframe, and diagnosis of opioid dependence always takes precedence over that of opioid abuse.
A. True  B. False

32. Pulmonary medical disorders related to opiate use include which of the following?
A. Sinusitis  C. Upper airway obstruction
B. Pneumonia  D. Bronchospasm

33. Infectious diseases are more common among individuals who are addicted to opioids, individuals who are addicted to other drugs, and individuals who inject drugs, and in some areas, more than 50 percent of injection drug users may be HIV positive.
A. True  B. False

34. A patient who may be physiologically dependent on opioids and meets DSM-IV-TR criteria for abuse, but not for dependence, will generally be an excellent candidate for maintenance treatment with buprenorphine.
A. True  B. False

35. The physician should assess the patient for current signs of intoxication or withdrawal from opioids or other drugs as well as for the risk of severe withdrawal, as the risk of severe opioid withdrawal is a contraindication to buprenorphine treatment.
A. True  B. False

36. All of the following are accurate statements about patients with psychiatric issues and the use of buprenorphine for opioid addiction treatment EXCEPT:
A. A full psychiatric assessment is indicated for all patients who have significant psychiatric comorbidity before beginning buprenorphine treatment
B. Patients maintained on antipsychotic or mood-stabilizing agents such as lithium are usually good candidates for buprenorphine treatment
C. Psychiatric comorbidity requires appropriate management or referral as part of treatment
D. All of the above are accurate statements

37. Although multiple previous attempts at detoxification followed by relapse to opioid use are not a contradiction to maintenance with buprenorphine, such a history is a strong indication for maintenance treatment with pharmacotherapy.
A. True  B. False

38. Which of the following is an accurate statement about alcohol use and buprenorphine treatment?
A. Because alcohol is a sedative-hypnotic drug, patients should be advised to abstain from alcohol while taking buprenorphine
B. Buprenorphine may be used to control seizures caused by withdrawal from alcohol or other sedative-hypnotic substances
C. Rarely are individuals with active, current alcohol dependence appropriate candidates for office-based buprenorphine treatment
D. Both A and C above

39. Chapter Four: Treatment Protocols
All of the following are accurate statements about Opioid Withdrawal Syndrome With Buprenorphine Induction EXCEPT:

A. Because buprenorphine can precipitate an opioid withdrawal syndrome if administered to a patient who is opioid dependent and whose receptors are currently occupied by opioids, a patient should no longer be intoxicated or have any residual opioid effect from his or her last dose of opioid before receiving a first dose of buprenorphine.

B. Due to this required abstinence before initiating buprenorphine treatment, it is likely that patients will feel that they are experiencing the early stages of withdrawal when they present for buprenorphine induction treatment.

C. If a patient has early symptoms of withdrawal, then the opioid receptors are likely to be occupied fully and precipitated withdrawal from administration of buprenorphine will occur.

D. Before undertaking buprenorphine treatment of opioid addiction, physicians should be familiar with the signs, symptoms, and time course of the opioid withdrawal syndrome.

40. For most patients receiving buprenorphine treatment, it is usually appropriate to decide on the length of treatment during the initial evaluation.
   A. True  
   B. False

41. The duration of the induction phase of maintenance treatment with buprenorphine is usually:
   A. one week  
   B. two weeks  
   C. three weeks  
   D. four weeks

42. The goal of the induction phase of treatment is to find the minimum dose of buprenorphine at which the patient discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and no uncontrollable cravings for drugs of abuse.
   A. True  
   B. False

43. For patients taking methadone, the methadone dose should be tapered to ______ or less per day for a minimum of 1 week before initiating buprenorphine induction treatment.
   A. 10 mg/day  
   B. 20 mg/day  
   C. 30 mg/day  
   D. None of the above

44. Patients who are not physically dependent on opioids may still be good candidates for buprenorphine treatment if they:
   A. Have a known history of opioid addiction  
   B. Have failed other treatment modalities  
   C. Have a demonstrated need to cease the use of opioids  
   D. All of the above

45. All of the following are accurate statements about the stabilization phase of buprenorphine treatment EXCEPT:
   A. It is usually begun when the patient is experiencing no withdrawal symptoms, is experiencing minimal or no side effects, and no longer has uncontrollable cravings for opioid agonists.
   B. The usual duration is approximately two to three months.
   C. Dosage adjustments may be necessary during early stabilization, and frequent contact with patients increases the likelihood of compliance.
   D. If a patient continues to use illicit opioids during this phase despite the maximal treatment available in the physician's clinical setting, the physician should
consider referral to a more intensive therapeutic environment

46. The longest period that a patient is on buprenorphine is the period of stabilization, and this period may be indefinite.
   A. True  B. False

47. Patients with a desire to become opioid free and to engage in rehabilitation aimed at an opioid-free lifestyle can be detoxified over a 10 to 14 day period and this is considered:
   A. Long-period reduction  C. Short-period reduction
   B. Moderate-period reduction  D. None of the above

48. Although self-help groups may be beneficial for some patients with opioid addiction and should be considered as one adjunctive form of psychosocial treatment, it should be kept in mind that the acceptance of patients who are maintained on medication for opioid treatment is often challenged by many 12-Step groups.
   A. True  B. False

49. All of the following are accurate statements about monitoring of opioid treatment by physicians EXCEPT:
   A. During the stabilization phase, patients receiving maintenance treatment should be seen on at least a monthly basis to determine whether patients are adhering to the dosing regimen and handling their medications responsibly
   B. Patients and their physicians together need to reach agreement on the goals of treatment through a treatment plan that is based on assessment of the patient, treatment goals, and the conditions under which treatment is to be discontinued
   C. Whenever possible, significant others should be engaged in the treatment process, as their involvement is likely to have a positive effect on outcomes
   D. The initial plan should contain contingencies for treatment failure, such as referral to a more structured treatment modality

50. Discontinuation of medication should occur when a patient has achieved the maximum benefit from treatment and no longer requires continued treatment to maintain a drug-free lifestyle, and buprenorphine should be tapered slowly and appropriately while psychosocial services continue to be provided.
   A. True  B. False

51. **Chapter Five: Special Populations**
The presence of certain life circumstances or comorbid medical or psychosocial conditions warrant special attention during the evaluation and treatment of opioid addiction with buprenorphine. All of the following are accurate statements about treating these populations EXCEPT:
   A. Pregnant women, adolescents, geriatric patients, patients under the jurisdiction of the criminal justice system, and healthcare professionals who are addicted are all considered special populations
   B. Because of the unique issues presented by these circumstances, addiction treatment for these patients may require additional training or specialty care and consultation
   C. Although treatment of opioid addiction in patients with comorbid medical conditions rarely results in better outcomes for the comorbid condition, treatment of the substance use disorder is still critical for improving the patient’s lifestyle
   D. Pharmacological treatments of comorbid medical disorders may have important drug interactions with buprenorphine, which the physician must be aware of
52. Although research regarding the clinical use of buprenorphine for the maintenance treatment of opioid addiction in pregnant women is limited, when buprenorphine has been used, pregnancies have generally progressed normally, with low rates of prematurity or other problems.

A. True  
B. False

53. Which of the is an accurate statement about the use of buprenorphine for the treatment of opioid addiction in adolescents?

A. Many experts in the field of opioid addiction treatment believe that buprenorphine should be the treatment of choice for adolescent patients with long addiction histories  
B. Buprenorphine is not an appropriate treatment option for adolescent patients with histories of opioid abuse and addiction and multiple relapses who are not currently dependent on opioids  
C. Buprenorphine may be preferred to methadone for the treatment of opioid addiction in adolescents because of the relative ease of withdrawal from buprenorphine treatment  
D. All of the above

54. More than 70% of the states in the U.S. permit individuals younger than 18 years of age to consent to substance use disorder treatment without parental consent.

A. True  
B. False

55. The association of psychopathology and opioid addiction is well established and in 1997, a study of rates of psychiatric disorders among 716 patients addicted to opioids seeking treatment with methadone found a lifetime rate of ________, and a current rate of ________.

A. 57 percent; 49 percent  
B. 47 percent; 39 percent  
C. 37 percent; 29 percent  
D. 27 percent; 19 percent

56. The psychiatric disorders most commonly encountered in patients who are opioid addicted are other substance abuse disorders, depressive disorders, posttraumatic stress disorder, substance-induced psychiatric disorders, and antisocial and borderline personality disorders.

A. True  
B. False

57. All of the following are accurate statements about patients being treated for pain who become dependent on opioids EXCEPT:

A. Patients who need treatment for pain but not for addiction should be treated within the context of their regular medical or surgical setting  
B. It can be difficult to distinguish between the legitimate desire to use opioids for pain relief and the desire to procure them for purposes of obtaining a high  
C. Patients with pain who are addicted to opioids often escalate opioid dose without medical instruction  
D. Patients should be transferred to an opioid maintenance treatment program if they are being prescribed opioids and have become physically dependent on the opioids in the course of their medical treatment

58. Chapter Six: Policies and Procedures

Expertise in treating opioid addiction includes all of the following EXCEPT:

A. Familiarity with the evidence supporting the recommended treatments  
B. Specific knowledge of personality disorders including traits, how they effect  
C. Protocols for primary treatment or referral of patients with certain complicating conditions  
D. Knowledge of applicable practice standards or guidelines and of any
addiction, and treatment options applicable regulations or laws

59. Because patients addicted to opioids commonly have coexisting medical and psychiatric conditions, most physicians will need to establish linkages with other medical and mental health specialists, particularly those specializing in the evaluation and treatment of common comorbid conditions.
   A. True   B. False

60. The Substance Abuse and Mental Health Services Administration (SAMHSA) confidentiality regulation mandates that addiction treatment information in the possession of substance abuse treatment providers be handled with the same degree of confidentiality as general medical information.
   A. True   B. False

Matching

An Evaluation is Required for Each Course:

Please evaluate the course by choosing one of the responses below for each question. This data will help us to improve our program and meet certifying organization requirements. Thank you for allowing QUE to be your provider.

A. Excellent C. Average
   B. Above Average D. Below Average

61. The extent to which this course met the objectives
62. The adequacy of the author’s mastery of the subject
63. Efficiency of course mechanics
64. The applicability or usability of the information for you
65. Website functionality and ease of use
66. Availability of staff member (does the website provide adequate direction on how to access assistance)

Short Answer

67. Please provide us with any additional comments or suggestions that would help us to improve the quality of our program:

68. How did you find out about QUE?