

Clinical Pharmacy Services in Medication-Assisted Treatment for Substance Use Disorder

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Pharmacy Forward: Advancing Practice for a
Healthier Tomorrow!

OPA Annual Conference & Trade Show April 9-11, 2026



Disclosure Statement

- Lauren Spoltman has no relevant financial relationships with ineligible companies to disclose.
and
- None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.





Learning Objectives

At the completion of this activity, the participant will be able to:

1. Describe the pharmacologic mechanisms, indications, and safety profiles of agents used in medication-assisted treatment (MAT) for opioid and alcohol use disorder;
2. Identify federal and state regulatory requirements governing pharmacist involvement in MAT services;
3. Discuss barriers and facilitators to implementing clinical pharmacy services in MAT settings; and
4. Explain the clinical pharmacist's role within interprofessional MAT programs to support evidence-based addiction care.

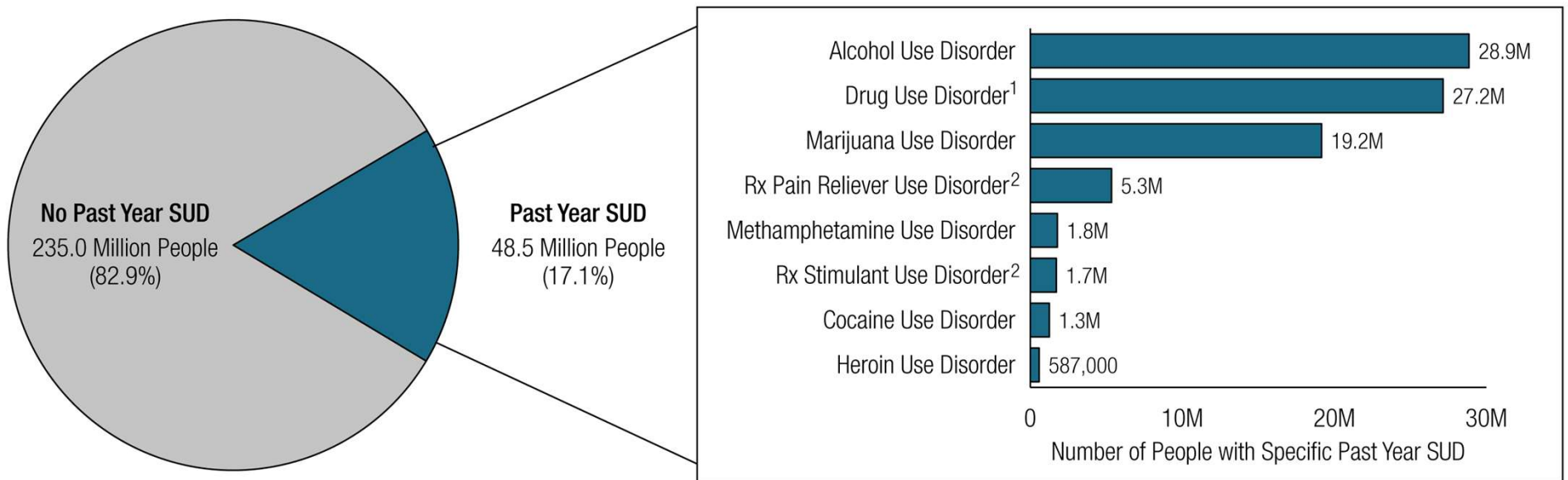
Substance Use Disorder (SUD)

- Substance Abuse and Mental Health Services Administration (SAMHSA) definition: “...**recurrent use of alcohol and/or drugs causes clinically significant impairment**, including health problems, disability, and failure to meet major responsibilities at work, school, or home.”

<https://www.samhsa.gov/substance-use/treatment/co-occurring-disorders>



Past Year SUD Among People Aged 12 and Older (2023)



Rx = prescription.

Note: The estimated numbers of people with SUDs are not mutually exclusive because people could have use disorders for more than one substance.

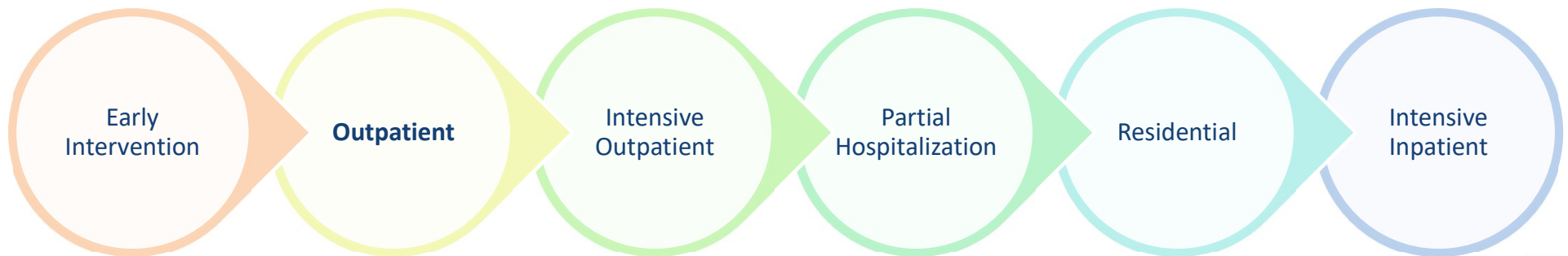
¹ Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).

² Includes data from all past year users of the specific prescription drug.



Treatment Approach for SUD

- American Society of Addiction Medicine (ASAM) process takes a **whole-person approach**
 - Based on clinical severity, medical and behavioral health needs, social and environmental factors, and risk of relapse



<https://www.asam.org/asam-criteria/about-the-asam-criteria>

<https://americanaddictioncenters.org/rehab-guide/asam-criteria-levels-of-care>



Treatment of SUD

- Recovery is “a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.”



<https://www.samhsa.gov/substance-use/recovery>



Alcohol Use Disorder (AUD)

	American Psychiatric Association (2018)	VA/DoD (2021)
First Line	Naltrexone Acamprosate	Naltrexone Topiramate*
Second Line	Disulfiram Topiramate* Gabapentin*	Disulfiram Acamprosate Gabapentin*

*Off label use

VA/DoD SUD Guidelines 2021
APA. 2018;175(1):86-90
SAMHSA Medication for the Treatment of AUD Brief Guide



Assessment Question 1

A 52-year-old man with alcohol use disorder wants medication to help reduce heavy drinking. He has a history of opioid use disorder in sustained remission and currently takes buprenorphine/naloxone. His liver enzymes are mildly elevated (AST 68 U/L, ALT 72 U/L). He has normal renal function.

- Which of the following is the most appropriate pharmacologic option?
 - A. Oral naltrexone
 - B. Extended-release injectable naltrexone
 - C. Acamprosate
 - D. Disulfiram



AUD Pharmacotherapy

Medication	Reduction	Abstinence	Return to drinking	Drinking days	Heavy drinking	Cravings
Naltrexone	X	+	X	X	X	X
Topiramate*	X	X		X	X	X
Acamprosate		X	X	X		
Gabapentin*	X	X	X		X	X
Disulfiram		X	?	?		

*Off label use

JAMA. 2006;295(17):2003-17

APA. 2018;175(1):86-90

VA/DoD SUD Guidelines 2021

Alcohol Clin Exp Res. 2023 Jul;47(7):1224-1237

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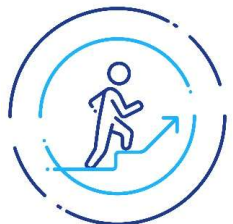
AUD Treatment in Pregnancy

- None of the medications used to treat AUD have been shown in clinical trials to be absolutely safe for pregnant or nursing women
 - Benefit versus risk
- Referral to addiction specialist or specialist managing high-risk pregnancies



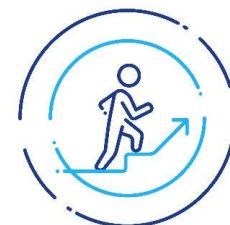
Naltrexone

- **Mechanism**: opioid antagonist acting on the reward pathway
 - Decreases subjective experience of cravings and reward of drinking
 - Reduces likelihood of returning to drinking/heavy drinking
- **Indication**: AUD (oral and injection) *and* opioid use disorder (OUD) (injection > oral)
- Must be opioid free for 7-14 days



Naltrexone Safety

- **Adverse effects**: nausea and vomiting (most common), headache, dizziness, fatigue, anxiety, somnolence, injection site reactions (injection)
- **Drug interactions**: cough and cold medications, antidiarrheals, thioridazine, yohimbine, and NSAIDs
- **Contraindications**: acute hepatitis or liver function tests (LFTs) >3x normal, concomitant opioids, acute opioid withdrawal
- **Monitoring**: urine drug screen and LFTs
- **Counseling**: recommend wallet card; contraindicated with opioid pain medications



Acamprosate

- **Mechanism**: glutamate modulator, thought to restore GABA/glutamate balance
- **Adverse effects**: diarrhea (most common)
 - Rare but serious: mood changes (suicidal ideation and attempts)
- **Drug interactions**: no major
- **Contraindication**: severe renal impairment (CrCl <30 mL/min)
- **Monitoring**: renal function



Disulfiram

- **Mechanism**: inhibits alcohol metabolism, causing disulfiram reaction (flushing, nausea, vomiting, chest pain, weakness, sweating, confusion) if alcohol is consumed



Disulfiram Safety

- **Adverse effects**: metallic taste, skin conditions, sweating, headache, fatigue, impotence
- **Drug interactions**: several (ex. Benzodiazepines, warfarin, tricyclic antidepressants, phenytoin, etc.)
- **Contraindications**: psychosis, severe myocardial disease or coronary occlusion, pregnant or lactating women
- **Monitoring**: adherence, LFTs
- **Counseling**: caution with other alcohol-containing products (cough syrup, mouth wash, cologne, diclofenac gel)



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OUD

Medication	Alleviate cravings	Withdrawal management	Reduces overdose death risk
Buprenorphine	X	X	X
Methadone	X	X	X
Naltrexone ER	X		?

First Line = Buprenorphine and Methadone



OUD Treatment in Pregnancy

- Standard of care = Methadone or Buprenorphine
- **Prefer opioid agonists + psychosocial treatment** versus withdrawal management or psychosocial treatment alone
- Buprenorphine monotherapy versus combination with naloxone
 - Limited evidence
 - Combination therapy considered safe and effective
 - Naloxone is minimally absorbed



Assessment Question 2

A 32-year-old man with opioid use disorder presents 12 hours after last using heroin. He has yawning, diaphoresis, mydriasis, and a COWS score of 12. The provider plans to start buprenorphine/naloxone.

- Which of the following best explains why buprenorphine must be initiated when the patient is in moderate withdrawal?
 - A. It is a full agonist and may cause overdose if given early
 - B. It is a partial agonist with high receptor affinity and can precipitate withdrawal if opioids are still present
 - C. It blocks NMDA receptors and worsens sedation
 - D. It increases alcohol cravings if given too soon



Additional Therapies for OUD

Opioid Overdose Reversal

- Naloxone
- Nalmefene

Withdrawal Management

- Methadone
- Buprenorphine
- Clonidine*
- Lofexidine
- Others?

*Off label use



Methadone

- **Mechanism**: full opioid agonist
- Barrier to care: access to opioid treatment programs and frequency of visits



Methadone Safety

- **Adverse effects**: QT prolongation, physical dependence, respiratory depression, sedation, nausea, vomiting, constipation, itching
- **Drug interactions**: many (CYP450 enzymes, QT prolongation)
- **Contraindications**: respiratory depression, severe bronchial asthma or hypercapnia, paralytic ileus
- **Monitoring**: EKG, LFTs



Buprenorphine

- **Mechanism**: partial opioid agonist with strong affinity for opioid receptors
- Available in sublingual tablet or film (with or without naloxone) and subcutaneous injectable forms



Buprenorphine Safety

- **Adverse effects**: sedation, physical dependence, constipation, headache, injection site reactions (injectable)
- **Drug interactions**: alcohol and other CNS depressants, CYP450 enzymes
- **Monitoring**: LFTs, gum/teeth hygiene (oral)
- REMS program for injectables
- **Counseling**: appropriate administration

ASAM OUD Guideline 2020

<https://www.sublocadehcp.com/>

<https://www.brixadi.com/>



Naltrexone

- **Mechanism**: opioid antagonist acting on the reward pathway; blocks subjective experience of opioids upon relapse
- **Indication**: AUD (oral and injection) *and* OUD (injection > oral)
 - Oral not as effective as injection, so only used for limited cases
- Must be opioid free for 7-14 days



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Assessment Question 3

A clinical pharmacist in a primary care clinic wants to begin managing buprenorphine therapy for patients with OUD under a collaborative practice agreement. The pharmacist asks whether prescribers in the clinic still need an X-waiver to prescribe buprenorphine.

- Which of the following is the most accurate response?
 - A. An X-waiver is still required for all buprenorphine prescriptions
 - B. Only psychiatrists are exempt from the X-waiver
 - C. The federal X-waiver requirement has been eliminated, but DEA registration is still required
 - D. Pharmacists may independently prescribe buprenorphine nationwide without state authorization



Federal Regulations

- Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill)
 - Removal of DATA-2000 (“X”) waiver for buprenorphine prescribing
 - Required 8 hours of training from certain organizations on opioid or other substance use disorders
- DEA licensure for prescribing of controlled substances
- Telehealth rules

<https://www.samhsa.gov/substance-use/treatment/resources/mat-act>
<https://www.federalregister.gov/>



State Regulations

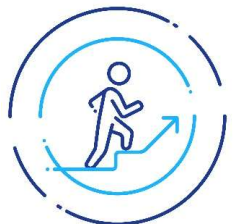
- Collaborative practice agreement (CPA)
- Ohio Automated Rx Reporting System (OARRS)
- Long-acting injectable training

Ohio Administrative Code 4729:1-6 and 4729:1-3-03
Ohio Revised Code 4729.39 and 4729.45
BOP Pharmacist Consult Agreements with Providers 2023
BOP Administration of Injections by Pharmacists 2025



State Regulations

- Ohio Board of Pharmacy (BOP) Controlled Substance Prescriber endorsement
 - As of fiscal year 2025, there were **24,073 active pharmacists**
 - As of 2/5/2026, a **total of 30 controlled substance prescriber endorsements have been issued**, and **23 are currently active**



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Assessment Question 4

A primary care clinic plans to expand its MAT clinic by adding a clinical pharmacist to manage medication titration, adherence counseling, and naloxone distribution. After 6 months, leadership questions the sustainability of the position due to limited direct billing revenue.

- Which of the following best describes the primary implementation barrier in this scenario?
 - A. Poor evidence supporting MAT
 - B. Regulatory prohibition of pharmacist involvement
 - C. Limited reimbursement mechanisms for pharmacist clinical services
 - D. Lack of effective MAT medications



Barriers of Implementation

Stigma with
SUD

Reimbursement
and billing

Workforce
shortages

Regulatory and
administrative
complexity



Facilitators of Implementation

Removal of
DATA 2000
waiver

Provider
status

Collaborative
practice
agreements

Collaboration
with medical
providers

Telehealth
expanded
access



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 - B. Regulatory prohibition of pharmacist involvement
 - C. Limited reimbursement mechanisms for pharmacist clinical services**
 - D. Lack of effective MAT medications



Assessment Question 5

A 45-year-old woman with alcohol use disorder is started on naltrexone. She also takes oxycodone for chronic back pain prescribed by another provider. During a medication review, the clinical pharmacist identifies a concern.

- What is the most appropriate pharmacist action?
 - A. Dispense naltrexone and advise the patient to stop oxycodone abruptly
 - B. Recommend avoiding naltrexone due to risk of precipitated opioid withdrawal and coordinate with the care team
 - C. Increase the oxycodone dose to overcome receptor blockade
 - D. Switch naltrexone to methadone for alcohol cravings



Clinical Pharmacist Role

- Patient education and motivational interviewing
- Medication management and/or administration
- Overdose prevention strategies
- Management of other comorbid conditions
- Coordinating care with medical providers and counselors
- Supporting harm reduction initiatives



Assessment Question 5

A 45-year-old woman with alcohol use disorder is interested in starting naltrexone. She also takes oxycodone for chronic back pain prescribed by another provider. During a medication review, the clinical pharmacist identifies a concern.

- What is the most appropriate pharmacist action?
 - A. Dispense naltrexone and advise the patient to stop oxycodone abruptly
 - B. Recommend avoiding naltrexone due to risk of precipitated opioid withdrawal and coordinate with the care team**
 - C. Increase the oxycodone dose to overcome receptor blockade
 - D. Switch naltrexone to methadone for alcohol cravings



Pharmacist Billing Opportunities

- Provider status
- Incident-to
- E/M codes
 - Medical decision-making
 - Time-based
- Administration of long-acting injectables



Family Health Services of Darke County (FHS)

Feb 2024

- Meeting with Medical Director and Treatment Coordinator

April 2024

- Completion of required 8 hrs CE for DEA licensure

July 2024

- OUD CPA approval
- Submitted BOP RPh Controlled Substance Prescriber endorsement



FHS

Oct 2024

- BOP approved endorsement
- Submission of DEA application

Nov 2024

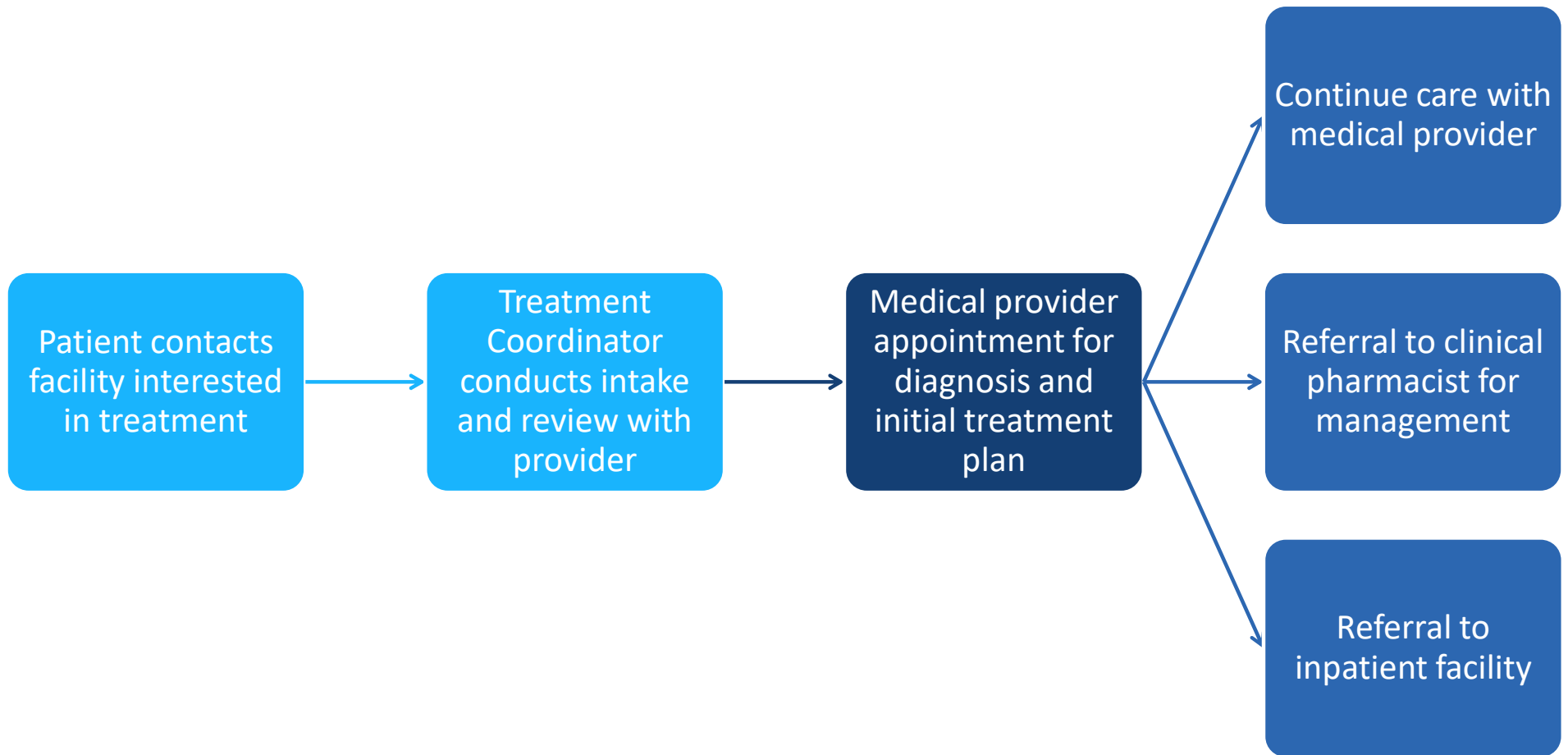
- DEA license approved
- AUD CPA approved

Dec 2024

- Completion of first patient visit for OUD



FHS Workflow



FHS Clinical Pharmacist Role

- Ensure completion of visit requirements (vitals, medication review, screening forms, etc.)
- Update pertinent sections of HPI
- Review OARRS
- Review urine drug screen and other recent labs
- Complete physical exam and review of systems
- Discussion with patient
- Order medications and labs
- Billing/tracking



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Need More Information?

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