Ohio Administrative Code

Rule 4730-4-02 Standards and procedures for withdrawal management for substance use disorder.

Effective: October 31, 2024

(A) In order to provide ambulatory withdrawal management, as that term is defined in rule 4730-4-01 of the Administrative Code, a physician assistant shall comply with the following requirements:

(1) The physician assistant shall hold a valid prescriber number;

(2) The physician assistant shall provide withdrawal management under the supervision of a physician who provides withdrawal management as part of the physician's normal course of practice and with whom the physician assistant has a supervision agreement;

(3) The physician assistant shall comply with all state and federal laws and rules applicable to prescribing; and

(4) The physician assistant who practices in a healthcare facility shall comply with all policies of the healthcare facility concerning the provision of withdrawal management.

(B) Prior to providing ambulatory withdrawal management for any substance use disorder the physician assistant shall inform the patient that ambulatory withdrawal management alone is not complete treatment for a substance use disorder. If the patient prefers continuing treatment for a substance use disorder, the physician assistant shall comply with the requirements of section 3719.064 of the Revised Code.

(C) The physician assistant shall provide accurate, objective and complete documentation of all patient encounters, including referrals, test results, and significant changes to the treatment plan.

(D) When providing withdrawal management for opioid use disorder a physician assistant may be authorized to use a medical device that is approved by the United States food and drug administration as an aid in the reduction of opioid withdrawal symptoms.

(E) Ambulatory withdrawal management for opioid use disorder.

(1) The physician assistant shall provide ambulatory withdrawal management only when the following conditions are met:

(a) The patient has adequate social, medical, and psychiatric stability to engage in and safely complete ambulatory withdrawal management; and

(b) There is little risk of medication diversion.

(2) The physician assistant shall provide ambulatory withdrawal management under a defined set of policies and procedures or medical protocols, with patient placement in outpatient or residential settings consistent with American society of addiction medicine's level of care criteria. Such services are designed to treat the patient's level of clinical severity, to achieve safe and comfortable withdrawal from a drug, and to effectively facilitate the patient's transition into treatment and recovery. In the event that ambulatory withdrawal management is unsafe or inappropriate for a patient, referral to a higher level of care, such as inpatient hospitalization shall be completed. The ASAM criteria can be obtained from the website of the American society of addiction medicine at https://www.asam.org/. A copy of the ASAM criteria may be reviewed at the medical board office, 30 East Broad street, third floor, Columbus, Ohio, during normal business hours.

(3) Prior to providing ambulatory withdrawal management, the physician assistant shall perform an assessment of the patient to gather sufficient information and data to justify the use of this treatment intervention. The assessment shall include a thorough medical history and physical examination sufficient to assure safety in commencing ambulatory withdrawal management and shall include a review of the patient's prescription history in OARRS. The assessment must focus on signs and symptoms associated with opioid use disorder and include assessment with a nationally recognized scale, such as one of the following:

(a) "Objective Opioid Withdrawal Scale" (OOWS);

(b) "Clinical Opioid Withdrawal Scale" (COWS); or

(c) "Subjective Opioid Withdrawal Scale" (SOWS).

(4) If any part of the assessment cannot be completed prior to the initiation of treatment, the physician assistant shall complete as soon as possible following initiation of treatment.

(5) The physician assistant shall inform the patient about the following before treatment for opioid withdrawal is initiated:

(a) The withdrawal management process and importance of subsequent treatment for substance use disorder, including information about all medications approved by the United States food and drug administration for use in MOUD treatment;

(b) The risk of relapse and lethal overdose following completion of withdrawal without entry into continuation of MOUD treatment;

(c) The safe storage and disposal of prescribed medications.

(6) The physician assistant shall not establish standardized regimens of medications for management of substance withdrawal symptomatology but shall formulate an individualized treatment plan based on the needs of the specific patient.

(7) For persons projected to be involved in withdrawal management for six months or less, the physician assistant shall offer the patient counseling as described in paragraph (D) of rule 4730-4-03 of the Administrative Code.

(8) The physician assistant shall require the patient to undergo urine and/or other toxicological screenings during withdrawal management in order to assess for use of licit and/or illicit drugs. The physician assistant shall consider revising the treatment plan or referring a patient who has a positive toxicological screening result to a higher level of care, and shall confer with the supervising physician prior to prescribing the buprenorphine/naloxone combination product to the patient.

(9) The physician assistant shall comply with the following requirements for the use of medication:

(a) The physician assistant may treat the patient's withdrawal symptoms with any of the following medications as determined to be most appropriate for the patient.

(i) A medication that is specifically FDA approved for the alleviation of withdrawal symptoms. Methadone may only be utilized with strict adherence to the stipulations of 21 C.F.R. 1306.07(b).

(ii) An alpha-2 adrenergic agent along with other non-narcotic medications as recommended in the American society of addiction medicine's "National Practice Guideline" (https://www.asam.org/), which is available from the medical board's website at https://med.ohio.gov;

(iii) A combination of buprenorphine and low dose naloxone (buprenorphine/naloxone combination product), unless contraindicated, in which case buprenorphine mono-product may be utilized.

(b) The physician assistant shall not use anesthetic agents to treat the patient's withdrawal symptoms.

(c) The physician assistant shall comply with the following:

(i) Treatment with a buprenorphine product must be in compliance with the United States food and drug administration approved "Risk Evaluation and Mitigation Strategy" for buprenorphine products, which can be found on the United States food and drug administration website at the following address: https://www.accessdata.fda.gov/scripts/cder/rems/index.cfm.

(ii) The physician assistant shall determine on an individualized basis the appropriate dosage of medication to ensure stabilization during withdrawal management.

(A) The dosage level shall be that which is effective in suppressing withdrawal symptoms and is well tolerated by the patient.

(B) The dosage level shall be consistent with the currently accepted standards of care.

(iii) In withdrawal management programs of thirty days or less duration, the physician assistant shall not prescribe nor dispense more than one week of unsupervised or take-home medications for the patient.

(10) The physician assistant shall offer the patient a prescription for an overdose reversal drug, directly provide them with the overdose reversal drug, or direct the patient to an easily accessible source to obtain the overdose reversal drug, such as http://www.naloxone.ohio.gov, a local health department, or other agency or facility that provides overdose reversal drugs.

(a) The physician assistant shall ensure that the patient and, if possible, those residing with the patient receive instruction on the drug's use including, but not limited to, recognizing the signs and symptoms of overdose and calling 911 in an overdose situation.

(b) The physician assistant shall offer the patient a new prescription for an overdose reversal drug upon expiration or use.

(c) The physician assistant shall be exempt from this requirement if the patient refuses the prescription. If the patient refuses the prescription the physician assistant shall provide the patient with information on where to obtain the overdose reversal drug without a prescription.

(11) The physician assistant shall take steps to reduce the risk of medication diversion by doing one or more of the following: frequent office visits, pill counts, urine drug screening, and frequent checks of OARRS.

(F) The physician assistant who provides ambulatory withdrawal management for benzodiazepines or other sedatives shall comply with paragraphs (A), (B), and (C) of this rule and "TIP 45, A Treatment Improvement Protocol for Detoxification and Substance Abuse Treatment" by the substance abuse and mental health services administration available from the substance abuse and mental health services administration website at the following link: https://store.samhsa.gov/. (Search for "TIP 45") and available on the medical board's website at: https://med.ohio.gov.

(1) The physician assistant shall provide ambulatory withdrawal management for benzodiazepines with medication only when a patient has sufficient social, medical, and psychiatric stability when their use of benzodiazepines was primarily in therapeutic dose ranges and when they do not have polysubstance dependence. The patient should exhibit no more than mild to moderate withdrawal symptoms, have no comorbid medical condition or severe psychiatric disorder, and no history of

withdrawal seizures or withdrawal delirium.

(2) Prior to providing ambulatory withdrawal management, the physician assistant shall perform an assessment of the patient that focuses on signs and symptoms associated with benzodiazepine or other sedative use disorder and include assessment with a nationally recognized scale, such as the "Clinical Institute Withdrawal Assessment for Benzodiazepines" ("CIWA-B").

(3) Prior to providing ambulatory withdrawal management, the physician assistant shall conduct and document a biomedical and psychosocial evaluation of the patient to gather sufficient information and data to justify the use of this treatment intervention.

(4) The physician assistant shall instruct the patient about the following before treatment for benzodiazepine withdrawal management is initiated:

(a) Not to drive or operate dangerous machinery during treatment;.

(b) The withdrawal management process and importance of subsequent treatment for substance use disorder, including information about all medications approved by the United States food and drug administration for use in substance use disorder treatment;

(c) The risk of relapse and lethal overdose following completion of withdrawal without entry into continuation of treatment for substance use disorder; and

(d) The safe storage and disposal of prescribed medications.

(5) During the ambulatory withdrawal management, the physician assistant shall regularly assess the patient so that medication dosage can be adjusted if needed.

(a) The physician assistant shall require the patient to undergo urine and/or other toxicological screenings during withdrawal management in order to assess for the use of licit and/or illicit drugs.

(b) The physician assistant shall consider revising the treatment plan or referring the patient who has a positive toxicology screening to a higher level of care.

(c) The physician assistant shall take steps to reduce the chances of diversion by doing one or more of the following: frequent office visits, pill counts, urine drug screening, and frequent checks of OARRS.

(G) The physician assistant who provides ambulatory withdrawal management for withdrawal from alcohol addiction shall comply with paragraphs (A), (B), and (C) of this rule and "Clinical Practice Guideline on Alcohol Withdrawal Management" by the American society of addiction medicine available from the American society of addiction medicine website at the following link:http://www.asam.org/quality-care/clinical-guidelines/alcohol-withdrawal- management-guideline.

(1) The physician assistant shall provide ambulatory withdrawal from alcohol only when:

(a) The patient has sufficient social, medical, and psychiatric stability to adhere to prescribed treatments and successfully complete withdrawal with minimal risk of complications;

(b) The patient is not at risk for serious withdrawal from substances other than alcohol; and

(c) The patient has no history of withdrawal seizures or withdrawal delirium.

(2) Prior to providing ambulatory withdrawal management, the physician assistant shall perform an assessment of the patient. The assessment must focus on signs and symptoms associated with alcohol use disorder and include assessment with a nationally recognized scale, such as the "Clinical Institute Withdrawal Assessment for Alcohol-revised" ("CIWA-AR").

(3) Prior to providing ambulatory withdrawal management, the physician assistant shall perform a biomedical and psychosocial evaluation to gather sufficient information and data to justify the use of this treatment intervention.

(4) During the ambulatory withdrawal management, the physician assistant shall regularly assess the patient so that the dosage can be adjusted if needed.

(a) The physician assistant shall require the patient to undergo toxicological screenings in order to assess for the presence of alcohol metabolites, licit or illicit drugs;

(b) The physician assistant shall consider revising the treatment plan or referring a patient who has a positive toxicological screening test to a higher level of care; and

(c) The physician assistant shall take steps to reduce the risk of diversion by doing one or more of the following: frequent office visits, pill counts, urine drug screening, and frequent checks of OARRS.