

Treatment medications for fentanyl use disorder: Prescriber practices and support needs in WA State



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Key Findings

- Prescribers used multiple medications for opioid use disorder (MOUD), with different initiation and dosing approaches. While all reported success starting and stabilizing some patients on medications, all also expressed persistent challenges with MOUD starts for people physically dependent on fentanyl.
- Many felt that some MOUD forms and dosing approaches were less effective for fentanyl than for heroin or pharmaceutical opioids. Other challenges specific to fentanyl included: treating younger, more treatment naïve patients; high frequency of fentanyl use; social aspects of smoking fentanyl that may challenge recovery; and physiological/pharmacological issues such as high tolerance and needing higher doses of MOUD.
- Prescribers broadly relied on frequent patient communication during MOUD initiation. Transportation and communication/phone barriers were common among patients. Multiple providers tried to reduce barriers by offering drop-in access, more rapid MOUD starts, and enhancing engagement and retention services.
- Prescribers wanted to know more about which medications might work best for certain patients and optimal ways to start the medications. Many wanted to know about how to use higher doses of buprenorphine and methadone more quickly while ensuring patient safety.
- Needs that were commonly expressed included patient-centered decision-making tools, flexible approaches to utilizing medications, persistence in treatment efforts, and an improved evidence base for MOUD in the fentanyl era.
- Prescribers were very interested in multiple supports for themselves and their staff as well as MOUD shared decision-making tools for patients dependent on fentanyl.

BACKGROUND

Fentanyl use, overdose, and use disorder have increased dramatically in WA State since illicitly manufactured fentanyl entered the WA State market around 2016. We will use the term “fentanyl” in the rest of this document. In 2021 fentanyl-involved deaths surpassed those involving heroin in WA State¹. By 2022 providers indicated that fentanyl had clearly surpassed heroin as the opioid most commonly used among those initiating medications for opioid use disorder (MOUD).

¹ UW Addictions Drug & Alcohol Institute. Opioid trends across Washington State:
<https://adai.uw.edu/wadata/deaths.htm#byOpioidSubtype>

In 2022 the Center for Community-Engaged Drug Education, Epidemiology and Research at the University of Washington conducted qualitative interviews with people who use fentanyl, finding they had serious fears about overdose and many challenges accessing humane and effective care for their opioid use disorder, as well as other urgent health and social concerns².

To understand the perspective of healthcare providers who treat individuals who use fentanyl, we conducted an anonymous online survey with MOUD prescribers to learn about their emerging approaches to using MOUD for fentanyl use disorder, other supports they provided to patients, and the needs prescribers have for better information and support.

METHODS

The survey was emailed to 24 providers known to treat opioid use disorder with medications in WA State. They were also encouraged to share the email invitation with other MOUD prescribers they knew. The email text included the following introduction:

We would like to invite you to participate in a brief online survey about your approaches to using medications for opioid use disorder (MOUD) for people who use illicitly manufactured fentanyl. As you are aware, fentanyl use/dependence poses challenges to the way MOUD is used. We would like to capture current practices from prescribers in our region to help clarify for others what has worked well (and what has not). We are not creating clinical practice guidelines. We are creating a description for other prescribers to draw upon your experiences.

The survey (included in the Appendix) included a combination of multiple choice and free text questions on the following topics:

- length of experience treating patients dependent on fentanyl.
- types of geographies and care settings in which they work.
- type of populations served.
- frequency with which they use each type of MOUD.
- approaches to dosing.
- perceived effectiveness of different medication dosing approaches.
- types of non-medication support offered to patients.
- gaps that exist in clinical knowledge.
- types of support they and their care teams need to enhance their use of MOUD with patients using fentanyl.

The survey procedures were reviewed by the University of Washington Human Subjects Division and determined to be exempt from review.

² Winstead T, Newman A, Maroon E, Banta-Green C. (2023). Unmet Needs, Complex Motivations, and Ideal Care for People Using Fentanyl in Washington State: A Qualitative Study. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, School of Medicine, University of Washington. URL: <https://adai.uw.edu/download/8203/>

FINDINGS

1. Characteristics of the survey respondents

Overall, 18 survey responses were received in January 2023. The characteristics of respondents are provided in Table 1. The majority of respondents worked in Western Washington and in urban areas. Almost all had been treating patients for at least two years who were dependent on illicitly manufactured fentanyl. Many providers worked in multiple settings, most often in primary care, but also in opioid treatment programs (OTP), hospitals, and low barrier programs. Low barrier programs have increased in recent years in WA State since an early program started in Seattle in 2017³. Characteristics of low barrier programs are detailed online and generally include drop in access to MOUD⁴.

Table 1. Characteristics of survey respondents, n=18

	#	%
Region of WA		
Western	16	89%
Eastern	2	11%
Type of area		
Urban	16	89%
Rural	2	11%
Years treating fentanyl use disorder		
<1 year	0	0%
1-2 years	1	6%
2+ years	16	94%
Care settings (multiple responses possible)		
Primary care	11	61%
Opioid treatment program	8	44%
Low barrier program	5	28%
Hospital	5	28%
Free standing opioid use disorder clinic	3	17%
Emergency department	2	11%
Social/housing/community services	2	11%
Residential treatment	1	6%
Populations served		
Adult	18	100%
Youth	2	11%
Psychiatric conditions	12	67%
Infectious disease care	5	28%

2. Use patterns for each form of MOUD

Medication utilization, by type

Table 2 provides descriptive data on the use of different forms of MOUD. Oral buprenorphine was utilized by all respondents with a median number of 30 patients and a maximum of 500. Long-acting injectable buprenorphine, which is relatively new, had been utilized by 10 of 18 respondents with a median of 5 patients and a maximum of 20. Ten respondents utilized methadone with a median of 140 patients and maximum of 1,200. Note that most of those who prescribed/dispensed methadone worked in opioid treatment programs. Some who worked in OTPs (and other settings), and others who did not work in OTPs, prescribed methadone via a 72-hour rule in other care settings such as hospitals, emergency departments, and outpatient health clinics. Naltrexone-injectable, the long-acting formulation, had been used by 11 respondents, although the number of patients was not documented. However, data below show that only one respondent indicated they used it "a lot."

³ Hood JE, et al. Engaging an unstably housed population with low-barrier buprenorphine treatment at a syringe services program: Lessons learned from Seattle, Washington. *Subst Abuse* 2020;41(3):356-364. doi: [10.1080/08897077.2019.1635557](https://doi.org/10.1080/08897077.2019.1635557)

⁴ UW Addictions, Drug & Alcohol Institute. Learn About Treatment: Low-Barrier Buprenorphine: <https://www.learnabouttreatment.org/for-professionals/low-barrier-buprenorphine/>.

Table 2. Use of each medication type

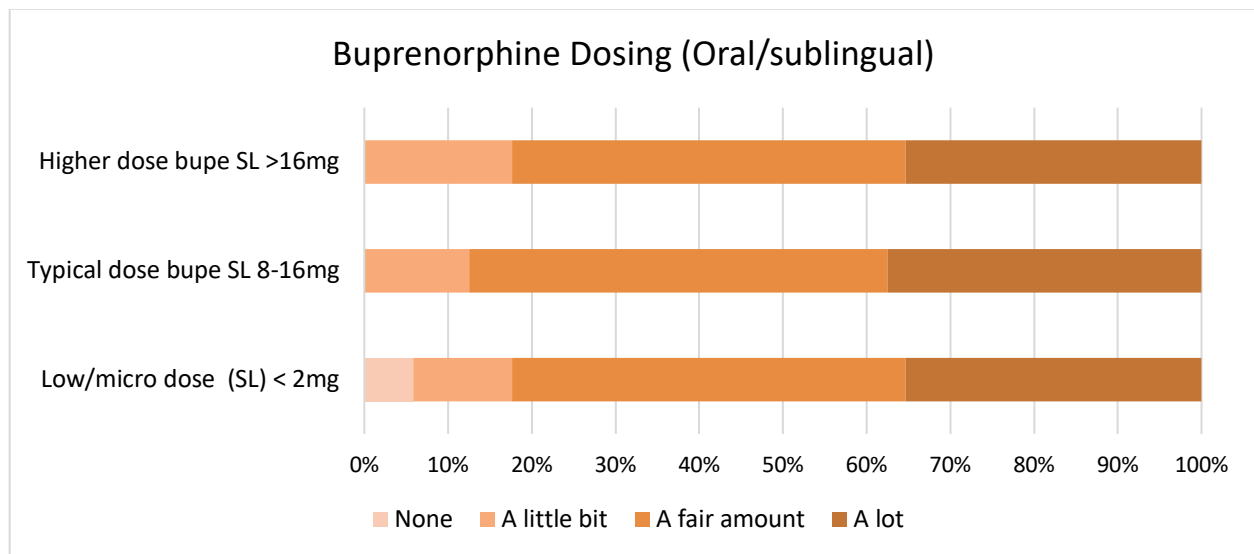
	Buprenorphine oral	Buprenorphine injectable	Methadone	Naltrexone injectable
Any use	18	10	10	11
# of patients started (among providers who utilized medication type)				
Minimum	1	1	20	...
Median	30	5	140	...
Maximum	500	20	1200	...
Average	87.6	7.9	248	...

Dosing approaches, by medication type

Providers were asked how often (i.e., *none, a little bit, a fair amount, a lot*) they used common dosing approaches with different types of MOUD.

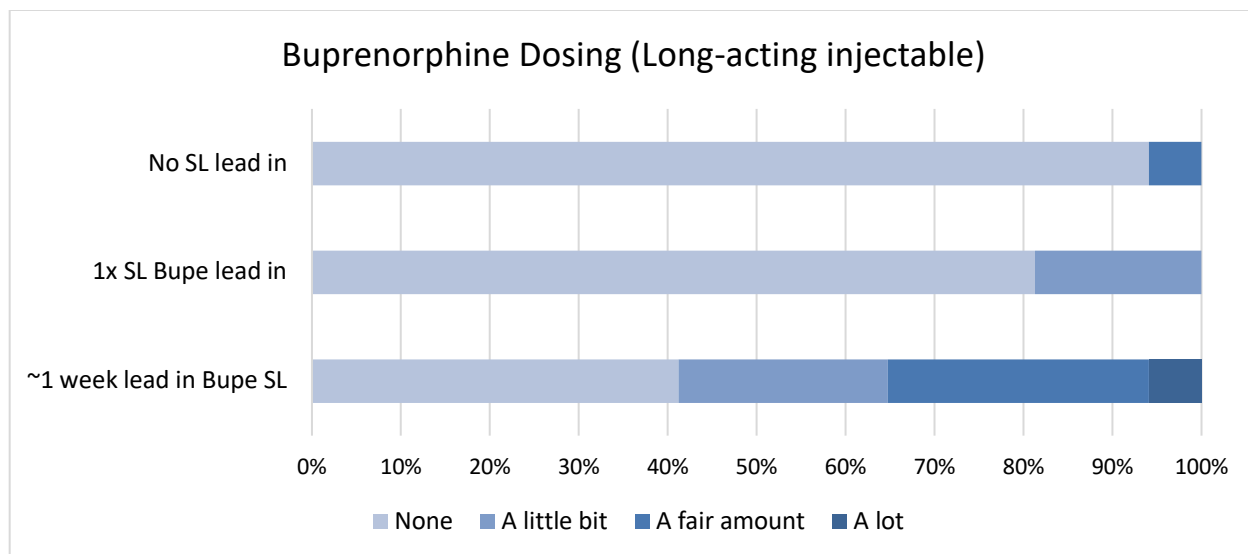
Buprenorphine, oral forms (sublingual/SL)

Oral buprenorphine induction dosing was documented as low/micro dose (<2mg), typical (8-16mg), and higher dose (>16mg). Most providers (>80%) reported using each of these approaches “a fair amount” or “a lot.” Most providers reported they used multiple dosing approaches.



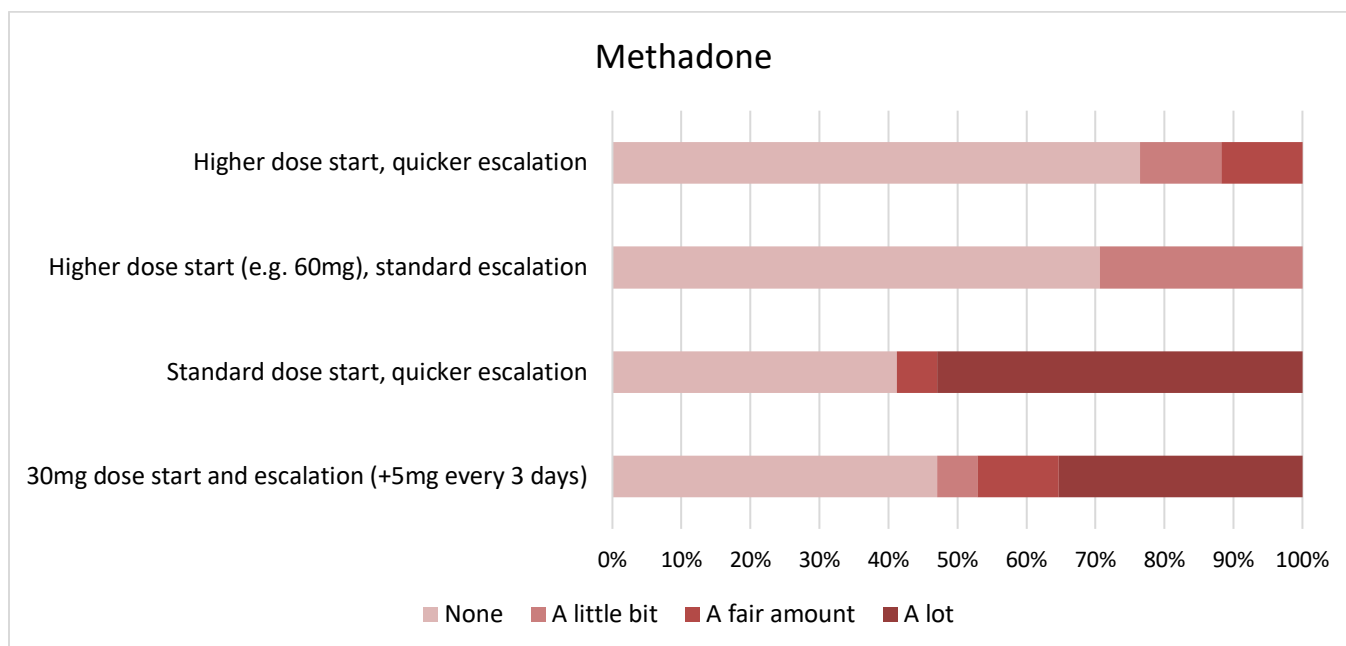
Buprenorphine, long-acting injectable/extended release (xr-bupe)

Among those who had utilized xr-bupe, the most common approach was to provide at least a one week lead in with oral/sublingual buprenorphine, which is what the package insert indicates. Three providers indicated that they provide a single oral dose of buprenorphine “a little bit” of the time and one provider indicated they provide xr-bupe with no oral buprenorphine lead in “a fair amount.”



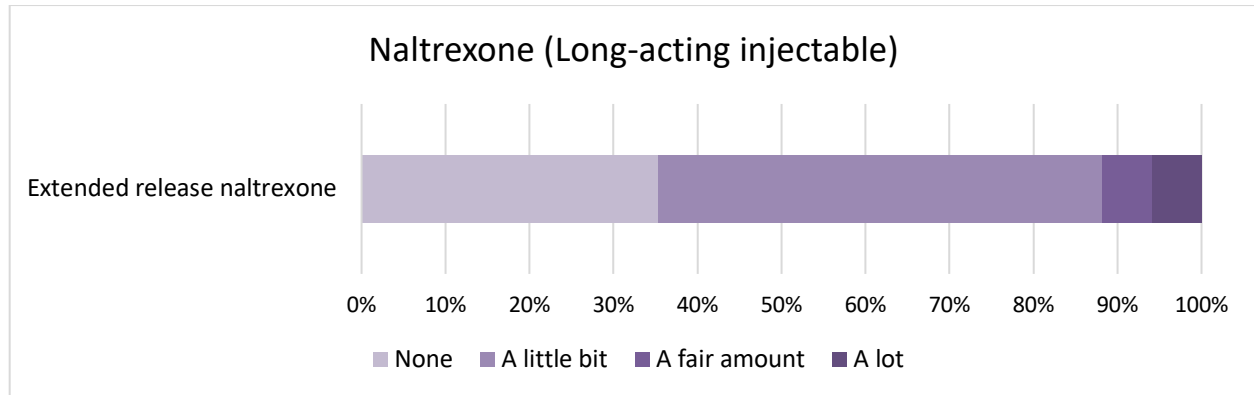
Methadone

Providers were asked about four different induction dosing approaches for methadone. Most of those who utilized methadone reported they used a standard starting dose with standard escalation and most also reported using a standard starting dose and quicker escalation. Half of those who utilized methadone indicated they use a higher starting dose "a little bit" of the time. Among the four people who said they used a higher dose and quicker escalation, two indicated they do they "a little bit" and two reported doing this "a fair amount."



Naltrexone, long-acting injectable

Among the 11 respondents who indicated they used the long-acting injectable form of naltrexone, the most common frequency reported was "a little bit" (n=9) with one respondent each indicating they used it "a fair amount" or "a lot."



3. Prescribers' perspectives on different medications, clinical supports, social supports, and clinic structures and policies

Representative responses to open text questions are provided below.

What approach(es) to starting MOUD have you found to work best from medication and support perspectives? Why?

Buprenorphine, oral

Using higher doses than we used previously, before we saw a lot of fentanyl. Most common dose is 24 mg, with ranges of 16-32 mg.

Low-dose buprenorphine starts in the hospital and "traditional starts" outside the hospital. But prescribing enough and instructing can take a higher amount like up to 32 mg during the first day.

Once induced, patients use either bupe/nal[oxone] preparations or bupe monotherapy (if former isn't tolerated) at dose that works for them to resolve cravings and withdrawal symptoms, up to 32 mg daily.

Timing can be what suits the patient best, but we try to make it easy (once or twice daily) whenever possible so patient won't forget to take it.

Buprenorphine, long-acting injectable (Brand names Sublocade and Brixadi)

Ideally transitioning someone to Sublocade injections [from oral] ASAP if they are willing since daily adherence is one of the biggest barriers.

My preference is to get them on Sublocade due to inconsistency with taking all of the films needed to get to a high enough dose.

Don't need to wait the full week of oral bupe before Sublocade.

Injectable buprenorphine has been working the best even if it precipitates some withdrawal at the start. For motivated patients, switching quickly [from oral] to injectable 300 mg dose and staying there for multiple months seems to have good outcomes.

Methadone (Note typical starting dose in an OTP is 30mg/day)

Accelerated induction with methadone, increasing 10mg daily until at 60mg, then every 3 days until at maintenance dose (with medical provider evaluation for each dose increase).

More rapid titration of methadone dose in the first week followed by larger dose changes. But then interval visits every 4-7 days to reach their effective dose. Frequent visits early on with the goal being retention.

More aggressive methadone initiations for hospitalized patients.

Naltrexone long-acting injectable

Bring up XR NTX (Vivitrol) with anyone opioid free for a few weeks (e.g., in jail), but VERY few want it. Very few patients can be abstinent for a week before IM [intramuscular] naltrexone.

Patient choice

Giving patients options and then agency to choose dosing to transition seems to work well and be motivating for patients.

Discuss risks/benefits of multiple approaches and let patient decide what they think will work best for them. If one approach doesn't work, try another one.

What support do you as the prescriber provide to patients during initial days of MOUD use and over time? When, how do you communicate with the patient/family?

We aim to contact patients daily or every few days, but often this is limited by patients' not having a working phone.

Encourage them to call, text, or walk-in to clinic with any questions or concerns. We do outreach calls and texts too, but many of our patients aren't easily reachable by phone.

Most often via staff- nurses, nurse care manager, medical assistant, care navigator. Try to make phone or text contact within 2-3 days of starting. I rarely have direct contact during initial days unless staff are uncomfortable with the situation.

Rarely with family, most patients do not want that or don't have contact with families. Support is seeing frequently, using motivational interviewing techniques.

I will call them within 2-3 days after starting buprenorphine. In the cases of people starting Sublocade without any lead-in buprenorphine, I will call them the next day.

Providers working in OTPs utilizing methadone:

Frequent face to face visits along with attempts to engage patient in the other services offered such as case managing, counseling, peer support and primary care.

I see the patient daily for dose evaluations, provider encouragement.

What other care team members support care over initial days and over time? Who, when, how communicate?

OBOT RN (nurse care managers).

We have peer support specialists, community health workers, nurses, and program coordinators contacting patients and providing different levels of support.

We have a community health worker to help with basic resources (food, clothing, shelter referrals, etc.), a social worker to help with behavioral health needs and referrals, and an RN who does a lot of outreach.

Care navigators to help schedule appointments, nurse care manager available as needed for clinical questions, generally calls every day or two. Communication via phone, text, in person depending on patient preference. Prescriber generally sees patient 1time per week but is available for phone calls any time. Also prescriber available to help ER/hospital MDs for dosing and discharge planning via personal cell or EHR messaging.

We have changed our security staff to be a "Hospitality and Engagement" team and the tone has truly improved. The effort now is much more collaborative and patients seem to have responded in kind.

Care coordinator- she helps patients by calling to get them a PCP if needed, or dental appointment or mental health appointment, gives them encouragement, does contingency management, assists with coordinating treatment programs.

We often give patients a number they can text, and text support with RNs is a means of supporting patients. A few patients use MyChart, but very few.

Providers working in OTPs utilizing methadone:

Dispensary nurses - ongoing evaluations and communication back to prescribing team. SUDP/SUDPt (Substance Use Disorder Professional trainee) services with assessments and coordination of other services. Services to identify opportunities to reduce barriers to treatment.

SUDP counselors, meet with patients.

How well would you say these approaches [to MOUD described above] work? For whom do they work best?

Success rate with fentanyl on first try seems much less than other opioids. Prolonged induction phase often occurs with patient alternating between bupe and fentanyl for sometimes several weeks which usually ends in either lost to follow up (prolonged relapse) or improvement and stabilization.

The people who are the most successful are those with a stable living situation and good social supports, which are a minority of our patients.

Really motivated people who are employed or have kids.

Just starting Sublocade has been working the best to get people on buprenorphine in an ambulatory setting.

It's really hard to say, hard to predict who is showing up for a brief reprieve or a desire to turn the intensity of their drug using life down - versus those who are showing up ready to do everything.

We now see a younger clientele and using for a shorter interval, so there's a shift to treatment-naive individuals... 19 year old kids having used fentanyl for 3 months, desperate to quit but simultaneously thinking they can address their issue with short term remedies or only fleeting participation in their treatment. [That] type of population has always existed - but the immediacy of fentanyl addiction I would say has caused the size of that group to grow and makes up a larger percentage of the new patients presenting every month.

OTP level care seems to be most effective in older patients who have had a number of past treatment attempts.

Are there different approaches that you think might work better? What are they? What would it take for you to implement them?

High dose initiation [of oral buprenorphine], rapid starts of long-acting buprenorphine.

More housing, primary care and MH [mental health] resources! A decent, progressive world and appropriate, predictable, consistent funding.

I would like to be able to prescribe Sublocade at more than [one site]. Sublocade to NOT be tied to my DEA license address but to have more flexibility.

Inpatient admission for induction might be more successful for some very difficult patients. Significant barriers include getting hospital buy in, reimbursement, more interested providers with hospital privileges, standardized protocols etc.

I would like to see more clinics and patients offer ketamine. This has enormous potential but the numbers I have had the opportunity to work with are too small, and patient response too sporadic, to really understand how best to use this promising tool. (Case study citation below⁵.)

Providers working in OTPs utilizing methadone:

I really wish we could have a medication-only track that can meet the patient desire and get the harm reduction benefit, keeping the patient alive long enough to grow into readiness for the whole recovery package.

⁵Hailozian C, et al. Synergistic effect of ketamine and buprenorphine observed in the treatment of buprenorphine precipitated opioid withdrawal in a patient with fentanyl use. J Addict Med 2022;16(4):483-487. doi: [10.1097/ADM.0000000000000929](https://doi.org/10.1097/ADM.0000000000000929)

More locations to provide clinic dosing vs a large clinic setting. We definitely need more research on this population which is very different than the OUD patient of 10-20 years ago.

What questions do you have about MOUD for people dependent on fentanyl?

What are the most effective ways and timing for initiating buprenorphine?

When is Sublocade not the best option?

What have they [patients] found useful when they have engaged OUD services?

We do all these fancy things - high dose, low dose, but the literature is mostly case reports. Lots of art of medicine going on.

Why is it so difficult for some people using fentanyl to start buprenorphine, but not others? What are the individual factors?

Smoking of fentanyl seems to be more social, people are congregating more for use...how does that impact recovery?

What scientific or practice knowledge gaps do you think exist regarding MOUD for fentanyl dependence?

High dose starts; the true difference between methadone and buprenorphine (feels really anecdotal right now); more than case series for first day initiation of Sublocade.

All of them. None of our data, guidelines, and practices were developed for this drug and we really are shooting in the dark to do the best possible care for our patients.

How has frequent smoking changed the effect of the medications that were originally studied on mostly heroin? How is the ritual of use affecting how well the medications can work? What other non-pharmacological interventions are effective?

Best way to induce [buprenorphine] is still a question. How soon to see a patient after induction? (2 days vs 7 days or other).

How fast can we start Sublocade?

How well does Naltrexone IM work for these patients? I don't have confidence that it would work very well and certainly it would be hard for patients to initiate if actively using fentanyl.

What is a safe upper level and truly should we raise doses faster? (OTP provider using methadone.)

Is there anything special/unique that you provide in your care that you think provides added value?

We do a lot of help with transportation, but that is also one thing we are always struggling to help with. It is a very high barrier for many patients. Also, patients still have a lot of trouble keeping phones or reliable ways we can contact them. Also, many patients are so disorganized; they need personal assistance.

Generous attendance policy, reduced [discharge for drug positive drug screens], increased support (peer, primary care on site), same day/walk-in admissions.

Basic primary care helps keep patients engaged if they have other health needs. Basic kindness, great RN care navigation staff who care. Non-punitive attitude, less focus on monitoring and more focus on patient autonomy.

Co-occurring mental health evaluation and treatment.

Harm reduction supports. Hepatitis C treatment keeps people motivated and returning even if they don't continue MOUD treatment. Wound care helps continue to engage individuals.

Option for very brief initial intake visit if necessary. A new patient can be registered and started on medication in <30 minutes if necessary.

What approaches have you tried that do not work well?

Outpatient low-dose buprenorphine starts are really tough.

Lower doses of MOUD do not work well!

Can't predict, so best to provide the patient flexible options right from the start (both 2-mg strips and 8-mg tablets [of buprenorphine], enough for a few days).

Being strict about following any one approach doesn't work well since different individuals have different needs and seem to respond differently to the exact same dosing strategy.

4. Types of support needed

The most common type of support that providers indicated they needed was ongoing support for other care team members (Table 3). Over half of respondents indicated they needed shared decision-making tools for OUD treatment medications specifically for those dependent on fentanyl. And, over half reported needing pharmacy regulatory help. Half reported needing ongoing clinical support for MOUD prescribers and half reported needing advocacy/education for agency administrator. One-third said they needed help with payment issues, and a quarter indicated general training needs.

Table 3. Types of support needed

	#	%
Ongoing support for other care team members	12	67%
MOUD shared decision-making tools for fentanyl dependent people	11	61%
Pharmacy regulatory help	11	61%
Ongoing clinical support for prescriber	9	50%
Advocacy/education for agency administrators	9	50%
Payment help	6	33%
Training	5	28%

DISCUSSION

The prescribers' responses to this survey were complex and thoughtful. Most used multiple types of medications, with different initiation and dosing approaches. Many worked in multiple clinical settings. While all indicated having success with some patients initiating and stabilizing on medications, all also expressed persistent challenges with MOUD starts for people dependent on fentanyl. The need for patient centered decision making, flexible approaches to utilizing medications, persistence in treatment efforts, and an improved evidence base for MOUD in the fentanyl era were commonly expressed.

Medication type and dosing issues

Overall, oral buprenorphine was used the most and most providers used multiple dosing strategies. Research published in 2023 increasingly supports the use of doses of buprenorphine higher than 16mg⁶ ⁷.

Long-acting injectable buprenorphine products have been brought to market relatively recently, initially in 2017 and in 2023. Providers have noted its potential to stabilize people using fentanyl due to its long-acting formulation and wanted to learn more about getting people started on it more quickly. These surveys were done when Sublocade was the only long-acting injectable buprenorphine available, in a 28-day formulation. Brixadi was introduced after surveying was completed and has 1-week and 4-week formulations.

The most common approach to using methadone was a standard dose start and a quicker escalation. Several providers indicated they are starting with higher doses with either a standard or more rapid increase in dose. Interestingly, several prescribers used methadone outside an OTP setting.

Naltrexone was utilized by a majority of providers, but most reported using it only "a little bit" of the time. Providers noted it was challenging for patients to not use fentanyl for a week prior to starting naltrexone.

Prescribers wanted to know more about which medications might work best for certain patients and optimal ways to start the medications. Many wanted to know about how to use higher doses of buprenorphine and methadone more quickly, while wanting to ensure patient safety.

Fentanyl specific issues

Several challenges specific to fentanyl were identified including:

- younger, more treatment naïve, patients.
- high frequency of use.
- social aspects of smoking fentanyl seemed more common than with heroin injection, causing possible additional recovery challenges.
- physiological/pharmacological issues including high tolerance and needing higher doses of MOUD. Some forms of MOUD were perhaps less effective with fentanyl than with other opioids.

⁶ Chambers LC, et al. Buprenorphine dose and time to discontinuation among patients with opioid use disorder in the era of fentanyl. JAMA Netw Open 2023;6(9):e2334540. doi: [10.1001/jamanetworkopen.2023.34540](https://doi.org/10.1001/jamanetworkopen.2023.34540)

⁷ Grande LA, et al. Evidence on buprenorphine dose limits: a review. J Addict Med 2023;17(5):509-516. doi: [10.1097/ADM.0000000000001189](https://doi.org/10.1097/ADM.0000000000001189)

Adapting service models to support engagement and retention

Prescribers and/or their staff generally checked in with patients very frequently during the MOUD induction process and encouraged patients to check in as needed. Transportation and communication/phone barriers were commonly expressed, and some sites indicated that they have some staff and other resources to try to address these common challenges. Multiple respondents indicated the need to reduce barriers by offering drop-in services, more rapid MOUD starts, and enhancing engagement and retention services. Finally, some respondents described the need for more clinical support to help people get on MOUD. These supports could include ongoing reassurance and emotional support from the clinical team during the induction process and some may benefit from a 12-72 hour admission to an MOUD brief observational unit.

Conclusions

These providers provided heartfelt and impassioned responses. Almost all providers wanted additional supports for themselves and their staff and most wanted multiple types of supports. They clearly care greatly for their patients' well-being and recovery. They are providing the best care with the tools they have and are continuing to try new clinical approaches to starting and maintaining MOUD, with enhanced social supports, and lowering barriers to accessing care.

The clinical approaches and practices described here generally aligned well with the needs expressed by people previously interviewed who have fentanyl use disorder. The prescribers who responded here are trailblazers working to rapidly improve their use of MOUD to care for people with fentanyl use disorder. The clinical practices and supports they describe here could be adopted much more widely by other prescribers, clinics, and health care systems, as well as providing a road map for future research directions.

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APPENDIX: MOUD Provider Survey

Please complete the survey below.

Thank you for participating in this provider survey.
The survey is intended to be completed by prescribers who use methadone or buprenorphine with people who use fentanyl.

- Yes
 No

Did you review the information sheet that was attached to the email that included the survey link? If not, please select "no" and the information sheet will display.

The survey will take 15-30 minutes to complete.

Information sheet:

- We are conducting a survey at the University of Washington Addictions, Drug & Alcohol Institute. We are asking you to complete a survey about providing medications for opioid use disorder (MOUD) treatment for people who use fentanyl.
- We are going to give you some information to help you decide whether or not to complete the survey.
- Feel free to contact us to ask questions about the purpose of the survey, what we will ask you to do, the possible risks and benefits, your rights as a participant, and anything else about participating.
- We are asking you to participate because you provide MOUD treatment in your care setting. We want to know about your experience with providing MOUD treatment for people who use fentanyl, how MOUD is administered in your setting, what works well, and what can be improved.
- We want to make information we collect available to other potential providers who want to know more about providing MOUD care for this population. We are not creating practice guidelines but are summarizing experiences at this point in time. We want to get about 40 surveys from providers around the state.
- The survey will take about 15 minutes. We will ask questions like, "What knowledge gaps do you think exist regarding MOUD for fentanyl dependence?" You may refuse to answer any questions.
- We may use quotes of things you say in the survey, but they will not include your name, that name of your employer, or other information that can tell others who you are.
- We will make every effort to keep your information confidential, but it is possible someone may find out you are participating. We will not use your name or the name of your employer.
- There are no physical risks for completing the survey. The survey will be provided online.
- There is no direct benefit to you for participating. We hope that information will help other providers provide informed MOUD treatment.
- University staff sometimes reviews projects like this one to make sure they are being done safely. If a review takes place, they may see what you said, but not your name.
- The information collected as part of this survey may be used as the basis for future research studies.
- Completing the survey is voluntary. You will not be compensated for completing the survey.
- Thank you and please contact us if you have any questions.

What part of the state do you typically serve?

- Western
 Central
 Eastern

Is your geographical area urban or rural?

- Urban
 Rural

How long have you been treating patients dependent on illicitly manufactured fentanyl?

- Less than 1 year
 1-2 years
 >= 2 years
 Not applicable

What clinical settings do you work in?

- Primary care
 Free-standing OUD clinic
 Mobile OUD clinic
 Opioid Treatment program
 Low-barrier program
 Syringe services program
 Hospital
 Emergency department
 Social/housing/community services
(Select all that apply.)

How would you describe the clinical populations that you serve?

- Youth
 Adult
 Infectious disease care
 Psychiatric conditions
(Select all that apply.)

Approximately how many patients with OUD who are fentanyl dependent have you started on buprenorphine sublingual (e.g. Suboxone)?

Approximately how many patients with OUD who are fentanyl dependent have you started on long-acting injectable buprenorphine (e.g. Sublocade)?

Approximately how many patients with OUD who are fentanyl dependent have you started on methadone?

These next questions are specific to your treatment approach for people dependent on illicitly manufactured fentanyl in comparison to those with OUD not using fentanyl.

What approach(es) to starting MOUD have you found to work best from medication and support perspectives? Why?

What is/are your approach(es) to using medications for OUD stabilization and maintenance (i.e., forms, dose, timing)?

What is your approach for using supplemental non-MOUD medications? (i.e. medications for opioid withdrawal or stabilization)

What support do you as the prescriber provide to patients during initial days of MOUD use and over time? When, how do you communicate with the patient/family?

What other care team members support care over initial days and over time? Who, when, how communicate? (Detailed responses are appreciated.)

How well would you say these approaches work? For whom do they work best?

Are there different approaches that you think might work better?

-What are they?

-What would it take for you to implement them?

What types of supports do you need to advance your care in this area?

- Training
 - Ongoing clinical support for prescriber
 - Ongoing support for other care team members
 - MOUD shared decision making tools for fentanyl dependent people
 - Advocacy/education for agency administrators.
 - Pharmacy regulatory help
 - Payment help
 - Other supports (please describe below)
- (Select all that apply.)
-

What other supports are needed?

Once people are stabilized on medications, around day 30, what supports do you continue to provide?

Approximately what % of people are continuing MOUD day 30 onward (including Sublocade second doses)?

What questions do you have about MOUD for fentanyl dependent people?

What scientific or practice knowledge gaps do you think exist regarding MOUD for fentanyl dependence?

Is there anything special/unique that you provide in your care that you think provides added value?

If you haven't found anything to work well for those who are fentanyl dependent, what approaches have you tried that do not work well?

For each of the following how much experience do you have for fentanyl dependent patients?

	None	A little bit	A fair amount	A lot	N/A
Low/micro dose bupe sublingual (SL) < 2mg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Typical dose bupe SL 8-16mg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Higher dose bupe SL >16mg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sublocade with ~1 week lead in with bupe SL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sublocade with 1x SL dose lead in	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sublocade with no SL lead in	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone 30mg dose start and escalation (+5mg every 3 days)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone standard dose start, quicker escalation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone higher dose start (e.g. 60mg), standard escalation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone higher dose start, quicker escalation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extended release naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is there anything more we should know about your prescribing practices?
