IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

CHRISTINE M. FINNIGAN,	)	
Plaintiff,	)	Civil Action No. 1:21-cv-00341
v.	)	Hon. Steven C. Seeger Mag. Sheila M. Finnegan
JAMES MENDRICK, *et al.*,	)	
Defendants.	)	

PLAINTIFF'S SUPPLEMENTAL STATEMENT

Plaintiff Christine Finnigan, by her attorneys, provides this supplemental statement in response to the Court's February 19, 2021 order, Dkt. 50, and states as follows:

I. PLAINTIFF'S RESPONSES TO QUESTIONS POSED BY THE COURT

Question 1: What are BOP and IDOC policies regarding methadone?

A. BOP Provides Methadone to People Entering Custody with a Prescription.

Federal Bureau of Prisons ("BOP") guidance ensures that someone receiving methadone upon incarceration will continue it. *See* Attachment A, Medication Assisted Treatment for Opioid Use Disorder Interim Technical Guidance ("BOP MAT Guidance"), UNITED STATES BUREAU OF PRISONS (Nov. 5, 2019). "All BOP institutions are expected to have established arrangements to provide all of the various MAT medications," meaning methadone, buprenorphine, and naltrexone. *Crews v. Sawyer*, No. 19-cv-2541, Dkt. 37-3 at ¶ 6 (D. Kan. Jan. 17, 2020). The BOP MAT Guidance is unequivocal that people arriving at a BOP facility on methadone "**will be continued** on established treatment plans, if clinically appropriate." BOP MAT Guidance at 3-4 (emphasis in original). The BOP intake screening notes "any/all MAT medications and histories of OUD," "[o]btain[s] medical records associated with MAT treatment programs," and notifies personnel of the person's arrival and prescription. Due in part to a "greater understanding of OUD," the BOP no longer recommends detoxification. *Id.* at 4. Facilities are not to "taper the patient's medication dose without consulting the MAT clinic" in the community. *Id.* at 6. Facilities not certified as an opioid treatment program ("OTP") would consult a MAT clinic in the community, using "orders" from the community clinic. *Id.* at 2, 6, 7.

B. IDOC's Health Care System Is Under a Consent Decree Related to Inadequate Medical Care and Currently Has No Methadone Policy.

To the best of our information, the Illinois Department of Corrections (IDOC) has no policy about methadone provision. But IDOC policy and practice is not instructive here for at

least two reasons. First, all IDOC medical care is currently subject to a consent decree. *See Lippert v. Pritzker*, No. 10-cv-4603, Dkt. 1238 (N.D. Ill. May 9, 2019) (the "Decree"). The Decree settled a long-running suit claiming that IDOC systematically exposed those in its custody to substantial risks of serious harm through a healthcare system that was underfunded, understaffed, and caused needless and preventable pain and suffering, claims substantiated by court-appointed experts in 2014 and 2018. *See Lippert*, No. 10-cv-4603, Dkt. 339, 767, *passim* (N.D. Ill.). The Decree mandates a comprehensive overhaul of virtually every aspect of IDOC medical care; among its specific requirements is the creation of "a comprehensive set of health care policies." Decree at 7, § II.B.8. A 2018 *Lippert* court-appointed expert report found IDOC's existing policies "inadequate" and not in conformance with national standards. *Lippert*, No. 10-cv-4603, Dkt. 767 at 10 (N.D. Ill. Nov. 14, 2018). Unfortunately, the crafting of this "comprehensive set" of policies was behind schedule at the onset of the pandemic and remains far from complete; no new policies have been finalized. *Lippert*, No. 10-cv-4603, Dkt. 1335 at 27–28 (N.D. Ill. Sept. 17, 2020) (Health Care Monitor 2d Report).

Second, unlike BOP, which is both a jail and prison system, IDOC is a prison system only. People enter after detention in county jails and processing through IDOC intake centers. The issue with medication continuity upon IDOC admission concerns continuity of medication from county jail to prison—not from the community to prison.

By contrast, the policies and practices at Cook County Jail (where Ms. Finnigan lives) and at other jails such as the Franklin County, Massachusetts facility that Plaintiff's expert Edmond Hayes supervises and the Rikers Island, New York jail where Plaintiff's expert Dr. Ross MacDonald administers an OTP, are highly probative as to the feasibility of continuing Ms. Finnigan's methadone. Complaint, Dkt. 1 at ¶ 58. These jails house individuals who, like Ms.

Finnigan, serve short sentences and can transition between their community OTP and one in the jail. Or if the jail does not operate an OTP, they can continue receiving their prescribed methadone from their current OTP or through "guest dosing" at a program selected by the jail.

To prevail upon claims that Defendants' conduct violates the Americans with Disabilities Act ("ADA") and the Constitution, Plaintiff does not need to demonstrate that a majority of jails and prisons continue methadone treatment for people receiving it pre-incarceration. Under the ADA, Ms. Finnigan need only establish that Defendants are denying her medical services (continued methadone treatment) because of her disability (OUD), in that there is no legitimate medical or other justification to interrupt or terminate her medication. *See Tate v. Wexford Health Source Inc.*, No. 3:16-cv-00092, 2016 WL 687618, at *1 and *5 (S.D. Ill. Feb. 19, 2016) (finding denial of medical services without a legitimate medical basis cognizable under ADA); *see also Estate of Crandall v. Godinez*, No. 14-cv-1401, 2015 WL 1539017, at *6 (C.D. Ill. Mar. 31, 2015) (same). Similarly, the Eighth Amendment entitles incarcerated people to adequate medical care, regardless of other jails' practices. *Cf. Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011) (finding effective treatment of gender identity disorder could require hormone therapy or gender affirmation surgery).[1]

[1] Evidence that continuing MAT in jails is a core component of the standard of care for OUD is, however, evidence of its feasibility in the DuPage County Jail and that as corrections professionals, Defendants are aware of the need to provide it in such cases. *See Holt v. Hobbs*, 574 U.S. 352, 368 (2015) ("While not necessarily controlling, the policies followed at other well-run institutions would be relevant to a determination of the need for a particular type of restriction.") (internal citation omitted); National Sheriffs' Association and National Commission for Correctional Health Care (NCCHC), *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* (Oct. 2018), https://www.ncchc.org/filebin/ Resources/Jail-Based-MAT-PPG-web.pdf ("Medication-assisted treatment (MAT), utilizing the [FDA]-approved medications methadone, buprenorphine, or naltrexone, is considered a central component of the contemporary standard of care for . . . opioid use disorders (OUDs)."); NCCHC, *Position Statement: Substance Use Disorder Treatment for Adults and Adolescents*, https://www.ncchc.org/substance-use-disorder-treatment-for-adults-and-adolescents (recommending continuation of prescribed MAT for jail sentences similar to Ms. Finnigan's).

Plaintiff is not asking the Court to write Jail policies. Plaintiff asks only for a straightforward application of settled law: Denying Ms. Finnigan uninterrupted access to methadone, which the undisputed evidence shows is the *only* medication that will work for her and that is the standard of care for her disability, violates the law. *See* Pl's PI Br. in Support of Prelim. Inj., Dkt. 27 at 10-16 (8th Am.); *id*. at 16-22 (ADA).

Question 2: Does Seventh Circuit caselaw support ordering treatment pre-incarceration?

Yes. In-Circuit case law supports the proposition that Ms. Finnigan need not await the forced withdrawal from her methadone treatment when that harm is sufficiently imminent, and that in these circumstances injunctive relief to require Defendants to provide adequate, non-discriminatory medical services on day one of her incarceration is proper.

The Seventh Circuit allows challenges to threatened conduct before it occurs to avoid irreparable harm. *See, e.g., Center for Indiv. Freedom v. Madigan*, 697 F.3d 464, 473-74 (7th Cir. 2012) (recognizing pre-enforcement challenge to limitation on speech and requiring only that plaintiff "faces 'a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement'") (quotations and citations omitted); *Ezell v. City of Chicago*, 651 F.3d 684, 695-96 (7th Cir. 2011) (plaintiffs had standing to challenge firearms restriction before its enforcement). Seventh Circuit law is clear that "a plaintiff 'does not have to await the consummation of threatened injury to obtain preventive relief.'" *Madigan*, 697 F.3d at 473 (citing *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979)); *ACLU of Illinois v. Alvarez*, 679 F.3d 583, 591 (7th Cir. 2012) ("probability of future injury counts as 'injury' for the purposes of standing"); *see also Franklin v. City of Chicago*, 102 F.R.D. 944, 947-48 (N.D. Ill. 1984) (plaintiff had standing to challenge Chicago Police Department's arrest

transportation procedure based on likelihood that he and other class members would be arrested in future).

An injunction requiring the Jail to continue Ms. Finnigan's methadone would be a straightforward application of well-established Supreme Court and Seventh Circuit precedents regarding prison medical care in the Eighth Amendment context. Civil rights litigants need not wait for a "tragic event" to obtain injunctive relief, *Farmer v. Brennan*, 511 U.S. 825, 845 (1994) (internal citations and quotations omitted), as "the Eighth Amendment protects against future harm to inmates." *Helling v. McKinney*, 509 U.S. 25, 33 (1993); *Byrd v. Hobart*, 761 F. App'x 621, 623 (7th Cir. 2019) (quoting same, and reversing dismissal of prisoner's claim for injunctive relief to address vermin infestation). Injunctive relief is proper to "prevent a substantial risk of serious injury from ripening into actual harm." *Farmer*, 511 U.S. at 845; *Henderson v. Sheahan*, 196 F.3d 839, 846-47 (7th Cir. 1999) (Eighth Amendment protects prisoners from "an official's deliberate indifference to conditions posing an unreasonable risk of serious damage to the prisoner's future health"). This is the very purpose of a preliminary injunction. *See, e.g.*, *Rasho v. Walker*, No. 07-cv-1298, 2018 WL 2392847, at *1 (C.D. Ill. May 25, 2018) (issuing preliminary injunction to address systemic issues with provision of mental health care in IDOC on behalf of class of "persons now *or in the future* in the custody of the [IDOC]") (emphasis added). Moreover, at least one court has found that a policy of refusing to pre-verify and arrange for life-saving, prescription medication *before incarceration* could be deliberate indifference. *Calhoun v. Ramsey*, No. 00-cv-3307, 2003 WL 1733564, at *11 (N.D. Ill. Mar. 31, 2003) ("a policy or practice which denies an inmate the opportunity to make sure

that his medication is available on a timely basis when he is initially taken into custody may reasonably be found to constitute deliberate indifference.").[2]

The harm to Ms. Finnigan is sufficiently imminent to warrant preliminary injunctive relief pursuant to these precedents. The Jail's de facto Mandatory Withdrawal Policy and its own actions toward Ms. Finnigan indicate that she will not receive methadone treatment absent action from this Court. Defendants have had all of the information that they need to make an appropriate medical determination since January 25th, yet have refused to do so. [redacted] ¶¶ [redacted], 42; Declaration of Joseph Longley ("Longley Decl.") Dkt 30 ¶ 11 and Exhibit 4 thereto. Additionally, as discussed in response to Question 4, the Seventh Circuit holds that cold turkey methadone withdrawal—including when caused by delayed provision of methadone—can amount to deliberate indifference. *See, e.g.*, *Davis v. Carter*, 452 F.3d 686, 696 (7th Cir. 2006). There is no reason that this Court must wait until that harm comes to pass in order to act. Indeed, it would be a substantial departure from established case law if this Court were to treat Ms. Finnigan differently from other individuals who seek judicial intervention to avoid serious and irreparable harm, merely because she will not enter the Jail for three more days.

In nearly identical cases, two courts in the First Circuit ordered a jail to provide MAT to a soon-to-be incarcerated person before a medical evaluation. *Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 162 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019); *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 49 (D. Mass. 2018). In one case, the jail pursued a nearly identical litigation strategy—

[2] The Plaintiff in *Calhoun* lost after a jury trial, and the Seventh Circuit upheld the verdict, finding that the court properly gave a *Monell* instruction over the Plaintiff's objection. *Calhoun v. Ramsey*, 408 F.3d 375 (7th Cir. 2005). The Court observed that the defendants had acted in accordance with the Illinois Jail Standards in timely verifying Plaintiff's prescription medications. *Id.* at 381. Here, in contrast, Plaintiff's evidence demonstrates that the Jail has not implemented measures to ensure Ms. Finnigan does not miss at least one dose of medication, or that it will provide her medication to her at all. *See* Section II.B *infra*.

arguing that they needed a medical evaluation before deciding to allow the plaintiff to stay on buprenorphine. *Smith*, 376 F. Supp. 3d at 157. The court rightly rejected this argument, finding it nothing more than a "theoretical possibility" that the jail would continue her life-saving MAT. *Id.* In the other case, the court found jurisdiction and issued the preliminary injunction prior to the plaintiff's sentencing. 355 F. Supp. 3d at 43; *see also* Pl's Reply Br. Dkt. 45 at 8 n. 4 (citing *Jasperson v. Fed. Bureau of Prisons*, 460 F. Supp. 2d 76 (D.D.C. 2006) and *Berke v. Fed. Bureau of Prisons*, No. 12-cv-1347, Dkt. 25 at 159:15–167:20 (D.D.C. Nov. 6, 2012)).

Question 3: **Does Seventh Circuit caselaw support ordering specific medications?**

Yes. The Seventh Circuit affirmed the grant of an injunction on a claim of deliberate indifference to plaintiffs' gender identity disorder where, as here, defendants did not produce evidence that another treatment could meet the standard of care. *Fields*, 653 F.3d at 556. The Seventh Circuit recognized that "for certain patients with [gender identity disorder], hormone therapy is the only treatment that reduces dysphoria and can prevent the severe emotional and physical harms associated with it. Although DOC could provide psychotherapy, antipsychotics and antidepressants, defendants failed to present evidence rebutting the testimony that these treatments do nothing to treat the underlying disorder." *Id.*; *see also Gonzalez v. Feinerman*, 663 F.3d 311, 314 (7th Cir. 2011) (holding that treating a hernia with pain medication rather than surgery could amount to deliberate indifference); *Gil v. Reed*, 381 F.3d 649, 664 (7th Cir. 2004) (finding that prescribing the very medication a specialist warned against, rather than the one they recommended, raised an issue of material fact in Eighth Amendment case); *Farnam v. Walker*, 593 F. Supp. 2d 1000, 1006-10, 1014 (C.D. Ill. 2009) (granting a preliminary injunction that ordered the jail to provide brand name, rather than generic, pancreatic enzymes, fat soluble vitamins, and other specific medical orders due to unrebutted recommendation by specialist).

Similarly here, Defendants have offered *no evidence* that any alternate treatment they offer meets the standard of care. [redacted]

The methadone treatment Ms. Finnigan seeks is objectively medically necessary, the only medically appropriate treatment, and administratively feasible. [redacted]; Section II.A *infra*. Defendants' suggestion of counseling and medications for withdrawal are not adequate alternatives; they will not "treat the underlying disorder." *Fields*, 653 F.3d at 556; MacDonald Decl. ¶ 29 (counseling or therapy without by MAT is not a treatment supported by evidence); Reeves Second Supp. Decl. ¶ 6 (medications for withdrawal symptoms do not treat OUD).

[redacted]; *see Petties v. Carter*, 836 F.3d 722, 730 (7th Cir. 2016), as amended (Aug. 25, 2016) ("Medical personnel cannot simply resort to an easier treatment they know is ineffective.")

Ignoring a specialist's recommendation can also amount to deliberate indifference. *See Jones v. Simek*, 193 F.3d 485, 490 (7th Cir. 1999) (refusing to follow recommendations of a treating specialist can constitute deliberate indifference). Defendants have not shown evidence that an addiction specialist will evaluate Ms. Finnigan.[3] It is proper for the Court to require that Defendants follow the recommendation of Ms. Finnigan's treating physician and continue her methadone treatment without interruption.

[3] Counsel asserted at the status hearing only that her examination will be by someone legally authorized to prescribe methadone. Tr. 16:14-16. However, this person likely would not be legally authorized to prescribe methadone for OUD, as opposed to for pain. Declaration of Mark A. Parrino ("Parrino Decl.") Dkt. 37 at ¶¶ 4-5; 21 C.F.R. § 1306.07. Moreover, this person would not have the experience necessary to change the treatment protocol of her treating physician. *See* MacDonald Supp. Decl. ¶ 4.

Question 4: Does Seventh Circuit caselaw hold that "cold turkey" withdrawal violates the Eighth Amendment?

Yes, two Seventh Circuit cases directly hold that cold turkey withdrawal from methadone can amount to deliberate indifference. In *Davis v. Carter*, the Seventh Circuit held that jail officials' failure to provide *timely* methadone and to treat withdrawal could constitute Eighth Amendment deliberate indifference. 452 F.3d 686, 695-97 (7th Cir. 2006). In *Foelker v. Outagamie Cty.*, the Seventh Circuit held that a jury could conclude that jail officials' failure to treat methadone withdrawal was deliberate indifference. 394 F.3d 510, 513 (7th Cir. 2005). Several district courts in the Seventh Circuit have also held that jails' failure to provide methadone can be deliberate indifference. Notably, *Chencinski v. Zaruba*, No. 17 C 5777, 2018 WL 10705083 (N.D. Ill. June 21, 2018), involved the jail in this case. The court found that allegations that the DuPage County Jail failed to respond to the *pro se* plaintiff's request for continued methadone treatment stated a claim of deliberate indifference. *Id.* at *3. In *Parish v. Sheriff of Cook Cty.*, No. 07-cv-4369, 2019 WL 2297464, at *19 (N.D. Ill. May 30, 2019), the district court denied summary judgment for defendants on claims involving forced methadone withdrawal. The court held that delays in providing methadone to persons taking methadone before admission, total denial of methadone due to improper screening, and a policy requiring tapering off methadone over 21 days could all constitute deliberate indifference. *Id.* at *15, *17, *18. In *Estate of Unborn Child of Jawson v. Milwaukee Cty.*, the court held that, as applied to a pregnant plaintiff, a de facto policy of failing to provide methadone treatment may constitute deliberate indifference. No. 19-C-1008, 2020 WL 4815809 at *6 (E.D. Wis. Aug. 19, 2020).

II. RESPONSES TO QUESTIONS POSED TO DEFENDANTS

A. The Medical Standard of Care to Treat OUD Is Methadone

During the hearing, when asked what treatment Defendants provide for OUD, Defendants

listed four medications and counseling, but not methadone. Not until the Court asked "what about methadone?" did counsel say the Jail "allowed methadone . . . *in the past*." Transcript of February 19 Status Conference ("Tr.") at 19:16-17, 23-24 (emphasis added).

The medical consensus is clear that the standard of care for OUD is opioid-agonist medication such as methadone. MacDonald Decl. ¶ 5; Reeves Decl. ¶ 6. This is undisputed in the record. However, Defendants assert, without evidence, that they have treated OUD through a combination of therapy and medications like Ativan, Librium, Clonidine, or "anything to treat withdrawals that has been listed by the FDA. . . ." Tr. 18:16-17; 19:6-7, 12-14. None of these medications is FDA-approved to treat OUD. Reeves Second Supp. Decl. ¶ 6; *see* MacDonald Decl. ¶ 16. By admitting to using these medications to "treat" OUD, the Jail admits it has violated the medical standard of care. *Cf. Finley v. Huss*, 723 Fed. App'x 294, 298-99 (6th Cir. 2018) (if "[a particular corrections practice] will exacerbate a mental-health disorder, claiming that medication makes it permissible is a little like bandaging a person's broken leg but then taking away his crutches").

Defendants also represented for the first time that they have prescribed Suboxone at the Jail. Tr. 18:10-12. While Suboxone is one of three FDA-approved medications to treat OUD, it is not appropriate for Ms. Finnigan. [redacted]; Supplemental Declaration of Christine Finnigan ("Finnigan Supp. Decl.") ¶ 9. Suboxone has a maximum dosage of 32 mg. Reeves Second Supp. Decl. ¶ 3. [redacted]. Such a transition would take months of a slow taper off of methadone, [redacted]; *see* Supplemental Declaration of Ross MacDonald, MD ("MacDonald Supp.

Decl.") Dkt. 43 ¶¶ 2, 4, with devastating consequences for Ms. Finnigan's health. [redacted]; MacDonald Supp. Decl. ¶ 7.

B. Unrebutted Evidence of a De Facto Mandatory Withdrawal Policy.

Defendants have not provided one iota of evidence to rebut Ms. Finnigan's evidence of the Jail's de facto Mandatory Withdrawal policy. Pl's Reply Br. at 1-6. Instead, they have denied such a policy through legal counsel, with vague utterances that Ms. Finnigan will receive methadone if they find it "necessary" (while admitting that *no one* currently incarcerated at the Jail receives methadone). Tr. 20:4-17; *Barcamerica Int'l USA Tr. v. Tyfield Importers, Inc.*, 289 F.3d 589, 593 n. 4 (9th Cir. 2002) (arguments and statements of counsel are not evidence). Defendants did not submit a declaration from the Jail's doctor explaining the process or criteria for determining when methadone is "necessary"—information repeatedly requested and crucial to assessing the likelihood of Ms. Finnigan's uninterrupted methadone. This failure supports Defendants' lack of a policy to ensure methadone access.

Defense counsel represented that "[t]he [Bobby Buonauro] Clinic will be called right away if that decision is made to continue methadone." Tr. 16:24-17:1. But even then Ms. Finnigan could miss at least one day's dose. Her sentencing papers require her to report at 6:00 p.m. on Thursday, February 25, Declaration of Christine Finnigan ("Finnigan Decl.") Dkt 22 and Exhibit 1 thereto, so that decision could very well occur after 12 p.m. her second day, which would be after the Bobby Buonauro Clinic ("BBC") closed for the day. Third Supplemental Declaration of Joseph Longley ("Longley Third Supp. Decl.") ¶ 6 and Exhibit 3 thereto. Therefore, under their own timeline, the Jail may not be able to *begin* arrangements with BBC until day three, requiring a missed dose on at least day two. Because methadone is highly regulated, arrangements should be made in advance, *id.* at ¶ 12; Parrino Decl. ¶ 9; MacDonald

Decl. at ¶ 40. Defendants' delay will likely cause Ms. Finnigan to experience withdrawal. Parrino Decl. ¶¶ 13-16; MacDonald Supp. Decl. ¶ 7. *See Davis,* 452 F.3d at 696 (delaying medical treatment may constitute deliberate indifference).

The Court asked Defendants directly "how likely it is that she is going to get methadone?" Tr. at 23:12-13. Defendants did not answer. Counsel conceded that they need no additional medical records, and repeated vague statements about needing to determine Ms. Finnigan's "current condition." *Id.* at 24:1-4, 15-18. Defendants fail to provide their clinical criteria for when methadone is "necessary," and admit it is "equally likely" whether she will be forced to go off methadone or will be prescribed it. Def's Resp. Br. Dkt. 34 at 6. Thus according to Defendants, it is a toss-up as to whether Ms. Finnigan will receive her medically necessary medication, despite being unable to provide any legitimate medical reason for not continuing methadone. Though evidence of the de facto Mandatory Withdrawal Policy suggests the likelihood is higher, Defendants' admitted 50% likelihood that they will deny Ms. Finnigan access to methadone presents a substantial risk of serious harm warranting relief. *Id.*

III. FURTHER GROUNDS WARRANTING A PRELIMINARY INJUNCTION

A. Ms. Finnigan Is Entitled to Relief Under the ADA.

Although the Court's questions for Plaintiff are targeted to the Eighth Amendment, the ADA is an independent basis for Ms. Finnigan to prevail. The injunctions in both *Pesce*, 355 F. Supp. 3d 35, and *Smith*, 376 F. Supp. 3d 146, relied on the ADA: *Pesce* on a disparate treatment theory, and *Smith* on a theory of disparate treatment and failure to provide reasonable accommodations.

In *Pesce*, the plaintiff alleged that a jail's refusal to administer methadone to treat his OUD denied him the benefits of the jail's health care program in violation of Title II of the

ADA. 355 F. Supp. 3d at 35. The court found the jail's alleged general security concerns were not specific to the plaintiff or to liquid methadone, "especially given that this is a common practice in institutions across the [country]." *Id.* at 46. The court also found the jail's proposed treatment had been documented as ineffective in treating the plaintiff and could place him at higher risk of overdose and death upon release. The court rejected the jail's argument that, because it provided a different medication and counseling, this was simply a dispute over the "adequacy of the treatment." *Id.* at 46–47. Accordingly, the court granted a preliminary injunction requiring the jail to provide the plaintiff with methadone during his upcoming incarceration. The court explained that the plaintiff was likely to succeed because "[a]bsent medical or individualized security considerations . . . , Defendants' policy as applied to Pesce is either 'arbitrary and capricious-as to imply that it was pretext for some discriminatory motive' or 'discriminatory on its face.'" *Id.* at 47 (citations omitted). In so ruling, the court looked to general practices elsewhere only to show the inadequacy of the defendant's generalized "security" concerns. Otherwise, the court focused on the defendants' own actions and the objective medical evidence about plaintiff's own treatment. *Id.* at 45–47.

The court in *Smith* reached the same conclusion on facts even more analogous to Ms. Finnigan's. It held that the jail likely violated the ADA by denying the plaintiff buprenorphine even though the jail *said* it would do an individualized evaluation of the plaintiff, because the jail's conduct was "consistent with . . . stigma against MAT. . . ." 376 F. Supp. 3d at 146, 160. The ADA argument is equally compelling in Ms. Finnigan's case, where there is no legitimate medical justification to deny her methadone, and the Jail has offered none. When considered alongside the Jail's insistence upon deviating from the prescription verification procedure in the

Illinois Jail Standards,[4] comments from Jail staff that methadone is "another form of addiction," Declaration of Rebekah Joab ("Joab Decl.") Dkt. 20 ¶ 8 and Exhibit 3 thereto at 7, Defense counsel's dismissal of expert opinions and evidence-based research as "biased assertions," Tr. 13:20-21, and the lack of any medical justification to deny Ms. Finnigan methadone, Ms. Finnigan has presented ample evidence of discrimination and is highly likely to prove an ADA violation.

The *Smith* court also found that the plaintiff was likely to succeed in showing the jail violated the ADA by failing to make the reasonable accommodation of exempting her from its buprenorphine prohibition and forced withdrawal. 376 F. Supp. 3d at 160-61. As in *Smith*, Ms. Finnigan can prevail by showing Defendants failed to reasonably accommodate her OUD, here by: (1) declining to conduct a medical evaluation and decide about her continued methadone prior to her incarceration to avoid interrupted treatment; or (2) modifying their de facto Mandatory Withdrawal Policy to allow her to continue her medication. Defendants have never explained why Ms. Finnigan's request to be evaluated prior to her report date is unreasonable. *See Bowers v. Dart*, No. 16-cv-2483, 2017 WL 4339799, at *7 (N.D. Ill. Sept. 29, 2017) (defendants' unsupported assertions do not mean an accommodation is unreasonable). To prevail, Ms. Finnigan need not demonstrate that the accommodation she seeks is standard practice at other correctional facilities in Illinois—only that it is reasonable. *Cf. Woodley v. Baldwin*, No. 18-cv-50050, 2018 WL 3354915, at *8 (N.D. Ill. June 14, 2018), report and recommendation adopted, No. 18-cv-50050, 2018 WL 3344593 (N.D. Ill. July 9, 2018) (finding prisoner was likely to succeed on claim that failure to grant requested accommodation of

[4] The Illinois Jail Standards require continuation of physician-prescribed medications after confirmation of the dosage and prescription status from the prescribing physician. Ill. Admin. Code tit. 20, §701.40(j)(1)–(2); *see* Pl's Reply Br. at 4 and 11-12.

prescribed vision aids, rather than alternate vision aids that had previously failed, violated Title II); *McKinnie v. Dart*, No. 14-cv-9588, 2015 WL 5675425, at *8 (N.D. Ill. Sept. 24, 2015) (denying motion for summary judgment because denied accommodation of a shower chair because "somebody might get hurt" was inadequate reason under the ADA). However, the fact that some jails and prisons do provide methadone, and the Jail's assertion on the record that it has done so before, suggests that the requested accommodation is reasonable. Tr. 18:7-12.

B. Denying Methadone Can Be Deadly Both During and After Incarceration.

Denial of methadone is deadly, even during incarceration. Between 2000 and 2013, over 900 deaths in jail were attributed to alcohol or opioid overdose. MacDonald Decl. ¶¶ 14, 33. Opiates are available in jails, and with the rise of deadly fentanyl, the danger of overdose death is greater than ever. *Id.* While Ms. Finnigan has no intention of using illicit opioids in the Jail, she is terrified of what might happen if she encounters illicit opioids, given the overwhelming urge she will feel to use absent methadone treatment. Finnigan Decl. ¶¶ 19, 24-25; Finnigan Supp. Decl. ¶¶ 2, 5-6. These statistics around deaths do not account for suicide—the leading cause of death in jail. Longley Third Supp. Decl. ¶ 7 and Exhibit 4 thereto. While Ms. Finnigan likewise is not presently suicidal, she does not "know if [she] can survive withdrawal." Finnigan Supp. Decl. ¶ 10. Even a day or two of missed doses endangers Ms. Finnigan's life and health and constitutes irreparable harm warranting injunctive relief. MacDonald Supp. Decl. ¶ 7.

IV. CONCLUSION

For the reasons stated above and in Plaintiff's Memorandum of Law and Reply in Support of the Emergency Motion for Preliminary Injunctive Relief, the Preliminary Injunction should be granted.

Dated: February 22, 2021

Respectfully submitted,

CHRISTINE FINNIGAN

By her attorneys,

/s/ Sally Friedman

Sally Friedman*
Rebekah Joab*
LEGAL ACTION CENTER
225 Varick St., 4th Fl.
New York, NY 10014
(212) 243-1313
sfriedman@lac.org
rjoab@lac.org
*Pro hac vice

/s/ Nusrat J. Choudhury

Nusrat J. Choudhury
Camille Bennett
ROGER BALDWIN FOUNDATION
OF ACLU, INC.
150 N. Michigan Avenue, Suite 600
Chicago, IL 60601
(312) 207-9740
nchoudhury@aclu-il.org
cbennett@aclu-il.org

/s/ Maggie E. Filler

Maggie E. Filler*
RODERICK AND SOLANGE MACARTHUR
JUSTICE CENTER NORTHWESTERN
LAW SCHOOL BLUHM LEGAL CLINIC
160 E. Grand Avenue, 6th Floor
Chicago, Illinois 60611
(312) 503-0899
Maggie.filler@macarthurjustice.org
*Pro hac vice

/s/ Joseph Longley

Maria Morris*
Joseph Longley**
AMERICAN CIVIL LIBERTIES UNION
NATIONAL PRISON PROJECT
915 15th Street NW Seventh Floor
Washington, DC 20005
(202) 548-6602
mmorris@aclu.org
jlongley@aclu.org
*Pro hac vice
**Pro hac vice; Not admitted in DC; practice limited to federal courts

Attachment A

U.S. Department of Justice

Federal Bureau of Prisons

Washington, D.C. 20534

NOV 0 5 2019

MEMORANDUM FOR ALL CLINICAL DIRECTORS
HEALTH SERVICES ADMINISTRATORS

FROM: RADM Chris A. Bina, Sr Deputy Assistant Director
Health Services Division

SUBJECT: Medication Assisted Treatment (MAT) Interim Technical Guidance

In February 2019, the Health Services Division in conjunction with Reentry Services Division and Correctional Programs Division implemented the MAT Program. This initial program offers naltrexone injections on a voluntary basis to inmates transitioning to community custody with an Opioid Use Disorder (OUD).

As HSD continues to move ahead with a plan to expand MAT to include buprenorphine and methadone, this interim technical guidance is being issued. This is an effort to ensure all institutions are prepared to receive and manage inmates who may be MAT program participants while ensuring coordination of care activities within our institutions.

Should you have any questions, please contact the Transitional Care Team at BOP-HSD/Transitional Care@bop.gov or Jeffrey A. Burkett, National Health Systems Administrator at 202-307-3077.

cc: N.C. English, Assistant Director, HSD
Jeffery D. Allen, Medical Director, HSD
Regional Medical Directors
Regional Health Services Administrators
HSD Branch Chiefs and Chief Professional Officers
MAST
CDR Irene Ahlstrom, Transitional Care Pharmacist
LCDR Jennifer Lee-Ramos, Transitional Care Social Worker

Medication Assisted Treatment for Opioid Use Disorder
Interim Technical Guidance

As the BOP expands the Medication Assisted Treatment (MAT) Program, this interim guidance will assist institutions with preparing for the implementation of the MAT programs.

MAT is the term used to describe the use of medication in combination with counseling and behavioral therapies for the treatment of Substance Use Disorders. The BOP is no longer requiring immediate rapid detoxification of inmates who arrive at our facilities currently receiving MAT for opioid use disorder. This would include methadone, buprenorphine, buprenorphine/naloxone and naltrexone.

History of the BOP's MAT Program

The BOP established the MAT Program in November 2018, focusing on offenders returning to the community. The Transitional Care Team was established as a cornerstone of the MAT Program to monitor and connect offenders with treatment services while transitioning back into our communities, utilizing naltrexone (brand name Vivitrol) as the initial medication for treatment. The BOP initially began rolling out the naltrexone program in the Northeast Region and in May 2019, to all BOP institutions nationwide.

Opioid Use Disorder (OUD) is now recognized as a chronic disease for which medication is an effective treatment in appropriately selected patients. The BOP estimates approximately 10% of the BOP population will be eligible to participate in MAT during their incarceration through continuation of treatment for new intakes and initiation or re-starting treatment for established inmates and for those preparing to release from custody. To meet this need and fulfill the requirements of the First Step Act (FSA), the BOP is expanding its MAT Program to include all FDA approved MAT medications currently available in the United States: (buprenorphine, methadone, naltrexone) and to consider continuation of treatment for new intakes or initiation / re-starting of treatment for established inmates.

Both buprenorphine and methadone have rigorous requirements, some of which are addressed later in this document while others remain under review at this time. Due to various laws and regulations pertaining to MAT medications, use of each medication is handled differently. As the BOP continues to research and develop program requirements to ensure compliance with applicable regulations and certifications for establishing Opioid Treatment Programs (OTPs) within the confines of a correctional institution, this guidance will address several current aspects of the program as well as the preparations needed for additional program implementation by institutions.

Medical Management and MAT

As BOP expands MAT programming, it is important to ensure BOP clinicians administering MAT have the required training and regulatory approval. The Office of General Counsel (OGC) has been and continues to be thoroughly engaged with all divisions while assisting in MAT expansion preparations. OGC has provided guidance on several aspects of the MAT program to date and will continue to advise Executive leadership as all divisions work through the rigorous regulations and requirements associated with implementing OTPs nationwide.

Medication Assisted Treatment for Opioid Use Disorder
Interim Technical Guidance

OGC has addressed two commonly asked questions related to the current MAT program.

1. BOP medical providers are working within their scope when utilizing orders from community providers as it relates to MAT medications. (i.e. buprenorphine, methadone, and naltrexone). As physicians and advanced practice providers (APP) obtain legal prescriptions from local OTP clinics for continuation of MAT medications for BOP offenders, the providers are covered legally as they are not "prescribing" these medications.
2. Health Services Units that meet the accreditation and registration requirements for an OTP and/or BOP medical providers who obtain the required waiver to prescribe buprenorphine are covered to perform all actions associated with clinical management as the MAT program expands to include buprenorphine and methadone medications.

Considerations for MAT Program Implementation

Staff considerations for managing MAT offenders

Training for all BOP staff is ongoing to ensure staff are aware of the MAT Program and the basis for moving toward full implementation of OTP programs within BOP institutions. Staff from all disciplines are encouraged to engage in MAT training as the MAT program is a cultural shift for the agency at large and requires full support from Executive Staff to align staff for implementation.

MAT Symposiums were conducted in September 2019 at FMC Lexington with additional symposiums scheduled at the MSTC in Aurora, CO, in the future.

Institution Considerations for Managing Offenders Participating in a MAT program

Managing offenders on MAT medications will be challenging initially, but with proper preparation, institutions will be able to manage these offenders in conjunction with established procedures. Sentry SMD codes have been established to clearly identify offenders and their status within the MAT program:

- **MAT SCREEN** – inmate meets the initial screening criteria as identified by the MAT dashboard. Requires further screening at the institution
- **MAT PENDING** – inmate has expressed interest, signed the consent form and is pending both psychological and medical clearance
- **MAT DECLINE** – inmate has declined to participate in MAT and has signed a MAT refusal
- **MAT WAIT** – inmate has been cleared by both psychology and medical and is waiting to initiate/continue MAT treatment
- **MAT ACTIVE** – inmate is receiving MAT medications currently
- **MAT INELIGIBLE** – MAT is contraindicated for the identified inmate

- **MAT DISCHARGE** – inmate has been discharged from the program for one of the following reasons:
  - Clinically determined to no longer need or no longer appropriate
  - Inmate refuses continued treatment (medication and counseling)
  - Failed RRC (case by case determination by clinical provider)
  - Death

Diversion of MAT medication is a concern in the correctional setting. Institutions should consider several strategies to reduce the risk of diversion when working with offenders undergoing MAT treatment.

Institutions are encouraged to convene an advisory group of Executive Staff, Health Services, Psychology, and Correctional Services (at a minimum) to discuss daily operations and logistics for managing these offenders, in a format similar to Health Services Governing Body or C-CARE meetings. A multi-disciplinary approach is best to ensure all program areas are addressed. The advisory group should address the following aspects:

- Identify and establish a working relationship with a local OTP clinic and/or buprenorphine prescriber in close proximity to the institution as most BOP providers are not yet credentialed to prescribe these medications. The mapping tool at this location can be utilized to identify local clinics: http://sallyport.bop.gov/co/hsd/health_services/MAT/OTP.jsp
- Pill lines for MAT medications should be separate from all other pill lines run at the institution. No other medications other than MAT medications should be administered during these pill lines. Buprenorphine will take approximately 15-30 minutes for the medication to dissolve orally and will be consumed orally in liquid form.
- Identify the staff assigned to supervise the MAT recipients throughout medication administration. As buprenorphine and methadone are both controlled substances, direct supervision throughout the duration of medication administration / consumption is required. Any staff member may directly observe the medication administration period. For example, those Health Services staff running pill line can continue with medication administration while Correctional Services staff directly observe the offenders.
- Thorough mouth checks of the recipients will need to be completed before and after medication administration to avoid diversion. As a best practice, after sufficient time has elapsed for oral absorption, institutions should consider requiring an inmate to consume a full glass of water, or a cracker, or similar item as a component of the mouth check after the tablet or film has had time to dissolve.

Offenders arriving on MAT treatment plans

This section will address inmates who arrive to institutions on currently established MAT treatment plans referred to as MAT Continuation Program.

Offenders arriving institutions with currently prescribed MAT treatment plans, consisting of buprenorphine, methadone, or naltrexone, **will be continued** on established treatment plans, if

clinically appropriate. All inmates diagnosed with opioid use disorder (OUD) arriving on MAT will be evaluated on a case-by-case basis for continuation of treatment with FDA approved medications for OUD. Every effort should be taken to confirm current or prior treatment of OUD by obtaining treatment records from the offender's previous provider. Established treatment plans include current valid prescriptions with the dose, frequency of medication to be administered, and expiration of the prescription. The Pharmacy Services Program Statement historically provided instruction to initiate a medically supervised withdrawal, a.k.a. detoxify, offenders from these types of medications; however, with the signing of the FSA and the greater understanding of OUD, detoxification is no longer the primary recommendation. As a result, the Pharmacy Services Program Statement is under revision to ensure compliance with the FSA requirements.

Institutions should follow these steps upon arrival of offenders on prescribed MAT treatment plans:

1. Conduct an intake screening noting any/all MAT medications and histories of OUD, or other substance use disorders
2. Obtain medical records associated with MAT treatment programs from community providers
3. Provide e-mail and/or telephonic notifications to the Regional Health Services Administrator, Regional Medical Director, Regional Chief Pharmacist, Regional Social Worker, and Transitional Care Team detailing the offender's arrival along with offender name, register number, and MAT medication currently prescribed
4. Specific questions relating to MAT Sentry codes, changes in MAT Sentry code status, or general MAT programming should be referred to the Transitional Care Team at BOP-HSD/TransitionalCare@bop.gov.

Offenders currently incarcerated within the BOP requesting MAT treatment

Offenders within the BOP requesting treatment under the MAT program will be evaluated on a case-by-case basis to determine the clinical indication for treatment. Several factors are involved in determining the appropriateness of MAT treatment for an individual offender. Health Services and Psychology Staff at the local level will need to collaborate in determining whether a clinical basis to initiate treatment exists. As noted above for continuation of treatment on newly-arriving inmates, it is recommended that similar steps be followed when initiating treatment for those who are currently incarcerated.

Medication Assisted Treatment for Opioid Use Disorder
Interim Technical Guidance

Resources

MAT Sallyport Page

MAT Program updates and information are located at the link below to include forms, instructions, and resource guide information. Updates will be posted as the program continues to expand.

http://sallyport.bop.gov/co/hsd/health_services/MAT/index.jsp

Transitional Care Team

The Transitional Care Team is the focal point for coordination of all MAT Services. Their contact information is located on the MAT Sallyport page above.

Staff Training

HSD will continue to offer MAT Symposiums at various times throughout the fiscal year and will advertise these opportunities and solicit participants via Training Opportunity Announcements (TOA). All staff are encouraged to apply for training.

For Health Services physicians and APPs, the Monday preceding the MAT Symposiums will offer the DATA Waiver (also known as X waiver) training at the MSTC. Staff willing to obtain their personal DEA numbers and apply for the DATA Wavier can do so at the following links:

DEA Registration (fee is waived for federal employees)

For individually assigned DEA registration, follow the link and click on Form 224 (Practitioner)

https://apps.deadiversion.usdoj.gov/webforms/jsp/regapps/common/newAppLogin.jspapply

Apply as "fee exempt" and for Certifying Official, use:

- CAPT A. Martin Johnston, Director of Pharmacy Programs BOP
- Phone: 202-353-4753

DATA Waiver Online Training and Registration

- For free online training: https://pcssnow.org/medication-assisted-treatment/
- For waiver application: http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

MAT Clinical Consultants

MAT Clinical Consultants were established from a variety of disciplines to assist institutions in preparing for and managing inmates participating in MAT treatment. As BOP medical providers are trained to manage offenders participating in MAT, the clinical consultants can be utilized to discuss complex case management concerns in addition to the Regional assets currently in place.

Medication Assisted Treatment for Opioid Use Disorder
Interim Technical Guidance

MAT Clinical Consultants will undergo training in the next several weeks and a list of clinical consultants assigned per Region will be published in the near future.

Given the complexity involved with managing MAT therapy, optimal management may necessitate the use of several MAT Consultant disciplines at the same time.

Medication Management

This section describes the process for BOP providers to prescribe to offenders requiring MAT Continuation Treatment upon entry to BOP institutions:

- BOP prescribers with their DATA waiver may prescribe buprenorphine if other requirements of their state license and board are met.
- BOP physicians with appropriate expertise based at a certified and registered OTP may prescribe methadone or buprenorphine, if other requirements of their state license and board are met.

This section describes the process for utilizing a community based prescription for those offenders requiring MAT Continuation Treatment upon entry to BOP institutions:

- Until training is completed and licensing/certification requirements are met by BOP providers and health services units so that they may prescribe medications for MAT, all other providers will be utilizing the prescription for either buprenorphine or methadone from a community MAT Clinic.
- When an inmate returns from a visit to a community MAT prescriber, a BOP clinician will generate an Administrative Note in BEMR that includes pertinent information relative to the MAT prescription as described in the example below.
    - A BOP physician or advanced practice provider will need to complete an encounter detailing the inmate's treatment plan from the community OTP or DATA Waived provider. Include all information regarding the OTP clinic and provider clearly documenting the inmate's OUD and MAT is being managed at the community OTP.
- Make sure the encounter has the full name and address of the clinic, the full name of the prescriber along with the DEA number and DATA Waiver information (for buprenorphine).
- Notify Pharmacy staff of this prescription
- Do not taper the patient's medication dose without consulting the MAT clinic.
- Verify any/all information presented by the offender with the community based MAT clinic whenever possible.

Sample language to utilize in documenting a BEMR note:

Medication Assisted Treatment for Opioid Use Disorder
Interim Technical Guidance

MAT Consultation follow-up [insert date of clinic visit]

Patient Engle, Zelda X, Reg # 12345-678 was seen today in [Insert Name of Community Clinic] MAT Clinic by Dr. [insert providers name] with DEA license # [insert number to include letters if appropriate] waiver and he prescribed [insert medication name: i.e. buprenorphine/naloxone].

The prescription states:
[Insert drug name, strength, directions]. Prescription is from [insert dates of beginning and ending of prescription]. Prescriber is Dr [insert provider name] with address of [insert address] and phone number [insert phone number].

The documentation (prescription and consultation) from Dr [insert name] has been scanned into BEMR document manager. The original prescription has been forwarded to the pharmacy for processing.

Will need a follow up consultation in 1 week.

Bureau of Prisons
Health Services
Clinical Encounter - Administrative Note

Inmate Name:	ENGLE, ZELDA X			Reg #:	00080-201
Date of Birth:	05/29/1990	Sex:	F Race:	Facility:	DAN
Note Date:	10/31/2019 10:08	Provider:	DOCTOR	Unit:	A01

Admin Note - General Administrative Note encounter performed at Health Services.
Administrative Notes:

ADMINISTRATIVE NOTE 1 Provider: DOCTOR

MAT Consultation follow-up [insert date of clinic visit]

Patient ZE, Reg # 12345-678 was seen today in [Insert Name of Community Clinic] MAT Clinic by Dr. [insert providers name] with DEA license # [insert number to include letters if appropriate] waiver and he prescribed [insert medication name: i.e. buprenorphine/naloxone].

The prescription states:
[Insert drug name, strength, directions]. Prescription is from [insert dates of beginning and ending of prescription]. Prescriber is Dr [insert provider name] with address of [insert address] and phone number [insert phone number].

The documentation (prescription and consultation) from Dr [insert name] has been scanned into BEMR document manager. The original prescription has been forwarded to the pharmacy for processing.

Will need a follow up consultation in 1 week.

Medication Assisted Treatment for Opioid Use Disorder
Interim Technical Guidance

Methadone:
Methadone may only be prescribed and dispensed by a provider working in a DEA registered and SAMSHA accredited Opioid Treatment Program (OTP). Unless the BOP facility meets these requirements, the inmate will need to be referred to a community OTP for treatment.

1. BOP pharmacy MAY NOT purchase methadone for OUD from the prime vendor unless the institution is a licensed OTP. If the institution is not a licensed OTP, the institution pharmacy may not dispense methadone used in MAT need to obtain. Instead
2. , methadone for MAT must be obtained as a filled prescription from the community OTP. The medication should be sent back with the inmate as "take home doses" from the community OTP.
3. Methadone "take home doses" brought back to the institution need to be logged into BEMRx inventory and accounted for as any other controlled substance.
    a. Create a new substock location using the name of the OTP as the name of the substock location.
    b. Document the medication as received from the substock location to the institution main stock inventory.
4. In addition to the documentation mentioned above by a BOP provider acknowledging the treatment plan, the medication order needs to be entered into BEMR by pharmacy via the "New Rx" function on the patient profile using the hard copy prescription from the OTP.
    a. The community provider will need to be added to the BEMR provider database. Please contact the BEMR workgroup at BOP-HSD/HealthInformatics@bop.gov to add the provider. Please specify the provider's name, address, phone number, DEA number and name of OTP.
    b. Pharmacy need to verify the provider's DEA number at this DEA website: https://apps.deadiversion.usdoj.gov/webforms/validateLogin.jsp. No other credentialing is necessary.
    c. Include all information regarding community provider and OTP in the directions of prescription label to indicate where the order came from.
    d. Label instructions should clearly denote which doses are expected to be administered in OTP clinic or during institution pill line.
    e. Any supporting documentation from the OTP should be scanned into BEMR and attached to the methadone order.
5. Document methadone administered at OTP on eMAR as "other" and add "admin at OTP" in free text field. Document methadone administered during pill line on eMAR the same as any other pill line medication. If medication is administered in the community clinic request copies, preferably weekly, of the administration record to scan in to BEMR
6. Current policy, PS 6360.01 Pharmacy Services, 17. METHADONE, prohibits the use of methadone for maintenance therapy of OUD, except for use in pregnant inmates. Until policy is updated, a policy waiver request for exception to this section should be submitted via appropriate channels when methadone is used for OUD Maintenance.

Buprenorphine and Buprenorphine/Naloxone.
Buprenorphine may only be prescribed by a provider working in an OTP or by a provider who possesses a Drug Addiction Treatment Act of 2000 (DATA) waiver, also called an "X" waiver,

to prescribe buprenorphine outside of an OTP. If the institution has no provider with a DATA waiver, the inmate will need to be sent to a community provider with a DATA waiver or an OTP for treatment. A written prescription for buprenorphine for OUD brought back to the institution may be filled by the institution pharmacy.

1. BOP pharmacy MAY purchase buprenorphine from the prime vendor regardless if the institution is a licensed OTP or not. Contact your Regional Chief Pharmacist regarding the process to obtain this medication via an emergency procurement. As a very last resort, buprenorphine may be obtained as a filled prescription from the community OTP or community pharmacy.
2. Buprenorphine brought back to the institution needs to be logged into the BEMRx inventory and accounted for as any other controlled substance.
    a. Create a new substock location using the name of the OTP or community pharmacy as the substock location name.
    b. Document the medication as received from the substock location to the institution main stock inventory.
3. Pharmacy may fill a prescription for buprenorphine or buprenorphine/naloxone from a non-BOP prescriber with a valid DEA DATA waiver.
    a. If the prescription order does not come from an OTP, the pharmacy will need to verify the prescriber's DEA DATA waiver at this SAMHSA website: https://www.samhsa.gov/bupe/lookup-form No other credentialing is necessary.
    b. If the prescription comes from an OTP, the pharmacy will need to verify the prescriber's DEA number at this DEA website: https://apps.deadiversion.usdoj.gov/webforms/validateLogin.jsp No other credentialing is necessary.
    c. If the prescription is written by a non-BOP provider, in addition to the documentation mentioned above by a BOP provider, the medication order will be entered into BEMR by pharmacy via the "New Rx" function on the patient profile using the hard copy prescription from the non-BOP provider.
    d. The community provider will need to be added to the BEMR provider database. Please contact the BEMR workgroup at BOP-HSD/HealthInformatics@bop.gov to have the provider added. Please specify the provider's name, address, phone number, DEA number and DATA waiver number (X number).
    e. Include all information regarding community provider and/or OTP in the directions of prescription label to indicate where the order came from.
    f. Label instructions should clearly denote which doses are expected to be administered in OTP clinic (if any) or during institution pill line.
    g. Scan the prescription into BEMR and attach to the RX order
4. SPECIAL DIRECTLY OBSERVED THERAPY NOTE: buprenorphine filmstrips and SL tablets require a 15 to 30 minute observation after administration and a second mouth check to ensure no diversion occurs. Local procedures need to be implemented to ensure this observation occurs. Non-health services staff may be used for this observation period.
5. Document buprenorphine administered at OTP on eMAR as "other" and add "admin at OTP" in free text field. Document buprenorphine administered during pill line on eMAR

as any other pill line medication. If medication is administered in the community clinic, request copies, preferably weekly, of the administration record to scan in to BEMR.

6. A BOP physician or advanced practice provider will need to complete an encounter detailing the inmate's treatment plan from the community DATA waived provider or OTP. Include all information regarding the OTP clinic and provider clearly documenting the inmate's OUD and MAT is being managed by the community DATA waived provider and/or OTP.
7. BOP policy does not prohibit the use of buprenorphine for maintenance of OUD treatment. Therefore, no policy waiver is required.

Naltrexone:
There are no special licensing or registration requirements to prescribe, purchase, dispense or administer naltrexone. The only exception is the REMS requirement for the long-acting injection formulation. Additional documentation of training to prevent injection site reactions is required before administering the long-acting injection.

Final Notes: Interim Technical Guidance

These instructions are being provided as interim technical guidance only. It would be expected that as the BOP's MAT program develops procedures and processes will be quite fluid during the coming months. Institutions who choose to develop an OTP program and/or have providers who obtain a DATA waiver will likely have a less onerous process than described above. Additional guidance, including Clinical Guidance is forthcoming.

Any additional questions may be directed to one of the MAT Clinical Consultants, Regional Chief Pharmacists, Regional Medical Directors or BOP Chief Pharmacist.