Dear Chair Murray and Honorable Committee Members,

My name is Lisa Rodrigues. I am a Nurse Practitioner working in addiction medicine with some of our state's most vulnerable populations. I am writing in support of passage of S2109 which would prohibit health insurers from conducting prior authorization for medications for opioid/alcohol use disorder.

One patient I saw today recently switched his commercial insurance to BCBS. He has been stable and long-term illicit drug free on 24-6 mg of buprenorphine/naloxone daily. He is employed full time and he and his wife are expecting a baby in early June. He was told by the pharmacy last month he has a cap of 16 mg of buprenorphine daily by his insurance company. A sudden reduction of 33.3% of his normal daily dose would likely result in opioid withdrawal symptoms. Furthermore, he is an insulin-dependent diabetic and GI symptoms such as vomiting or diarrhea or profuse sweating can cause electrolyte and glucose abnormalities that threaten his physical health to the point, it could result in hospitalization. In addition, this would take a very stable person who is doing well and destabilize them only for the sake of saving the insurance company money. This provider wrote a letter of medical necessity for him to submit to his insurance company but he has yet to hear back, leaving him still likely having an $80 copay for the difference. This also seems discriminatory, aimed at persons with SUD as I am not aware he has been capped on his lantus, ozempic, or rosuvastatin doses.

Also JAMA (Journal of the American Medical Association) published an article in October 2025 entitled "Rapid Initiation of Extended Release Buprenorphine-Evidence and Barriers." Thakrar found that approximately 40% of standard induction participants using fentanyl discontinued buprenorphine treatment in the first day compared with only approximately 20% of individuals using fentanyl in the rapid induction arm. Prior authorizations, however, impede same-day administration which negatively impacts treatment retention and patient outcomes. From a clinician perspective, as this trial underscores, the first 24 hours are critical for retention.

"In this study, Shiwach et al[6] found that same-day initiation of injectable buprenorphine is safe and improves early retention compared with low initial doses of sublingual buprenorphine, even among people using fentanyl. The clinical message is clear: patients benefit when they achieve and maintain adequate doses of buprenorphine early in treatment, and rapid induction of extended-release buprenorphine is one way to reach this goal. The policy message is equally clear: until the regulatory, supply chain, and reimbursement thicket is cleared, the advantages of starting long-acting injectable buprenorphine on the first day of treatment will remain inaccessible to many patients who need them most".

We are all painfully aware of the opioid epidemic, I implore you to help us help our patients and help heal our communities. Stand with us in putting people's lives first. Please support S2109.

Best regards,

Lisa Rodrigues, FNP-BC