Opioid Response Network

Easy Buprenorphine Prescribing for Everyone

Fairbanks Opioid Summit, September 2023

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Opioid Response Network

Learning Objectives

- Review epidemiology of OUD and MOUD as standard of care
- Explore regulatory and insurance issues
- Review diagnosis and assessment of OUD
- Develop appropriate medication initiation strategies
- Troubleshoot common problems in early treatment

Financial Disclosures

- I have no financial conflicts of interest to disclose

- I am currently employed by the Ninilchik Traditional Council

- I work as a treatment consultant for the Opioid Response Network in Alaska, ANTHC, as well as for other non-profit agencies.

Reframing the perception of buprenorphine prescribing

OLD

A high-risk medication requiring specialized training and integrated behavioral health to prescribe

NEW

A very safe, effective medication that is the gold standard treatment for a deadly disease, that all prescribers should be comfortable prescribing

The Waiver is Gone!!!

- All prescribers authorized to prescribe schedule 3 narcotics can prescribe buprenorphine for OUD or pain
- No limits on numbers of patients
- No requirement to refer for counseling
- No educational requirements (but 8 hour waiver course does meet the DEA MATE act requirements)

NO EXCUSE NOT TO PRESCRIBE THIS LIFESAVING MEDICATION!

Every day of BUP treatment is helpful

- All providers should be comfortable in the basics of MOUD
- Lack of follow-up arrangements are not a contraindication to prescribing BUP
  - Warm handoff always preferred when possible
- Aways provide SLBUP Rx on discharge (minimum 1 week)
- Every day that a patient takes BUP reduces their risk of overdose
- Not prescribing MOUD is NOT following standard of care guidelines and results in worse outcomes

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

ASAM 2019

DSM-5 Criteria for SUDs

Loss of control
- more than intended
  - amount used
  - time spent
- unable to cut down
- giving up activities
- craving

Physiology
- tolerance
- withdrawal

formerly "dependence"

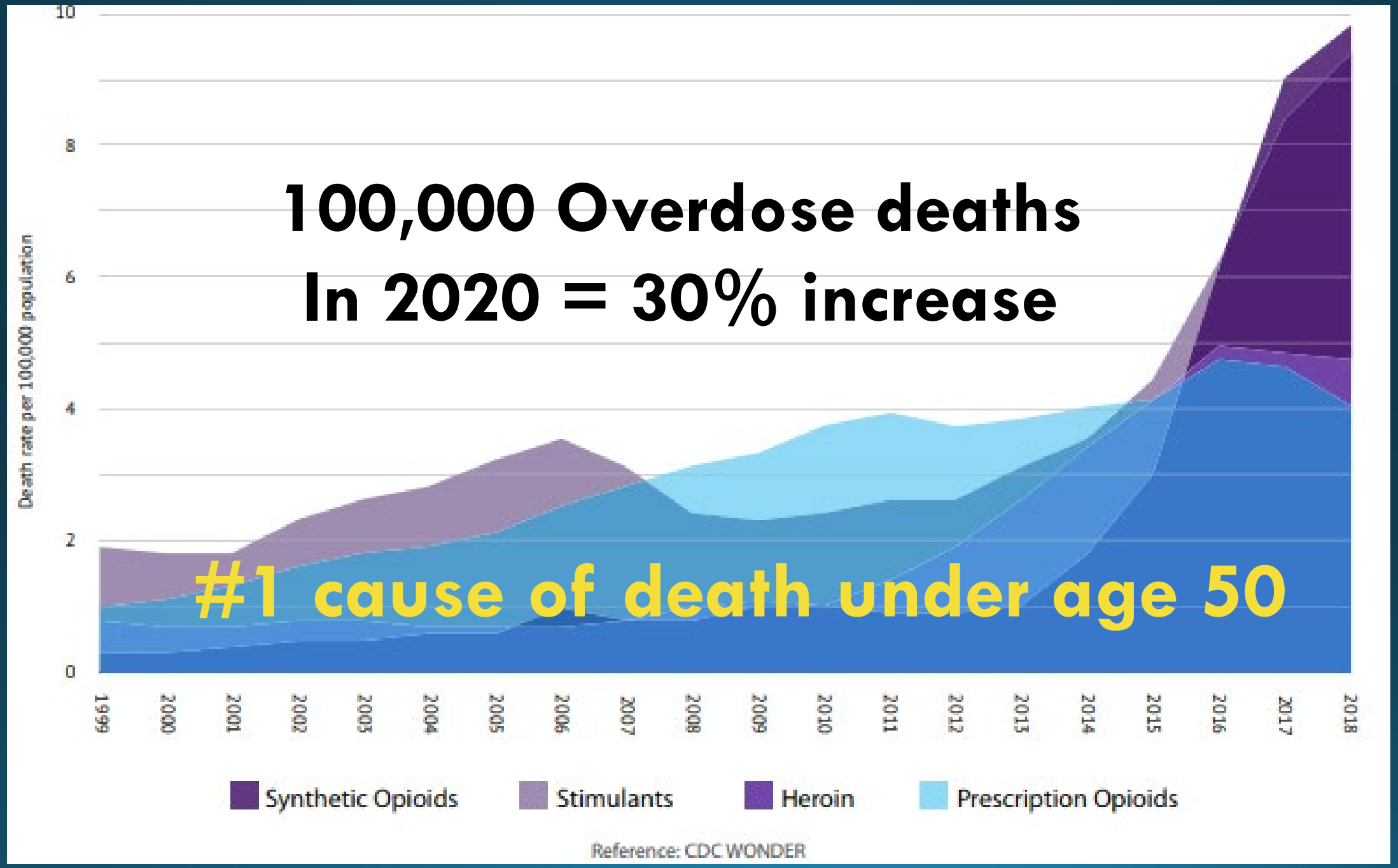
Consequences
- unfulfilled obligations
  - work
  - school
  - home
- interpersonal problems
- dangerous situations
- medical problems

formerly "abuse"

- A ***substance use disorder*** is defined by having 2 or more • in the past year resulting in distress or impairment.
- **Tolerance** and **withdrawal** alone don't necessarily imply a disorder.
- Severity is rated by the number of symptoms present:
  - 2-3 = mild
  - 4-5 = moderate
  - 6+ = severe

APA, 2013

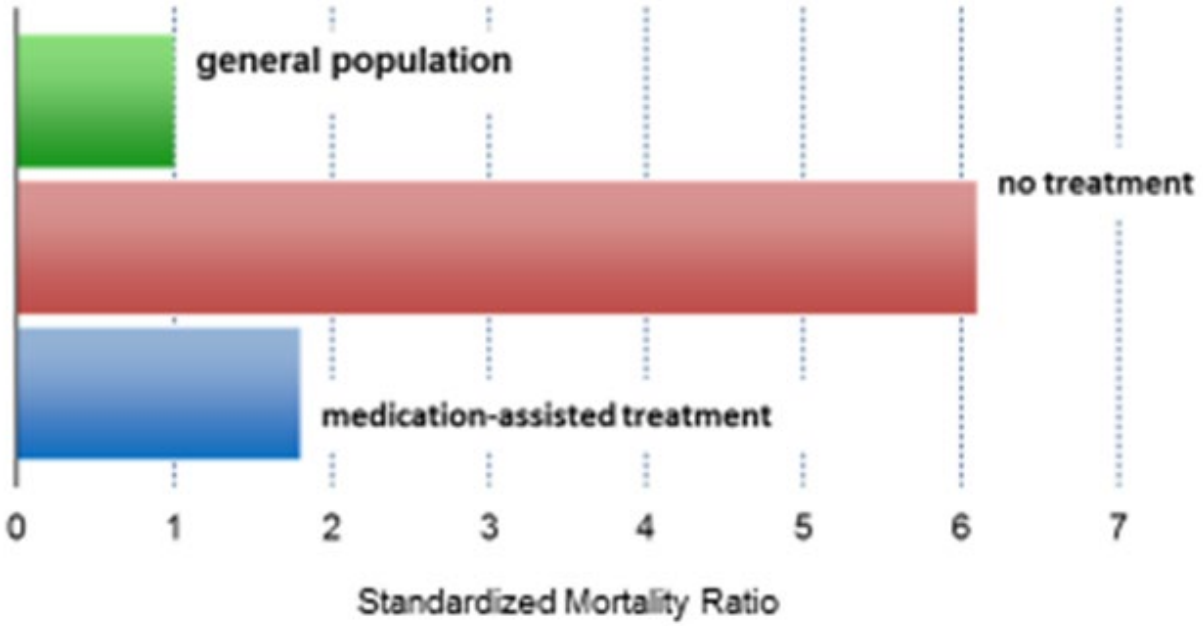
PCSS Providers Clinical Support System


100,000 Overdose deaths
In 2020 = 30% increase
#1 cause of death under age 50
Death rate per 100,000 population
10
8
6
4
2
0
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Synthetic Opioids
Stimulants
Heroin
Prescription Opioids
Reference: CDC WONDER

Benefits of MAT: Decreased Mortality

Overdose risk the first 2 weeks after leaving treatment is 10-30 times higher

Death rates:



MAT can reduce death rates by 80%

Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

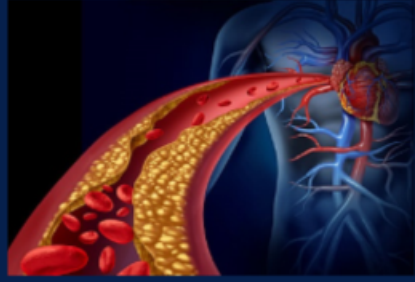
PCSS Providers Clinical Support System

The Gap in Treatment

10% of people who have a SUD are able to access treatment.

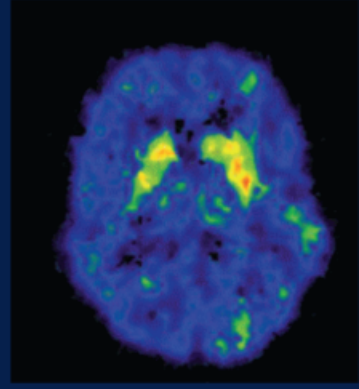
Results from the 2015 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: SAMHSA

Systems Failures, Not Patient Failures



- Patient admitted to the hospital with heart attack…
  - Told it's her fault because of diet, high stress job, and history of tobacco use
  - Advised to call a list of cardiologists/cath labs
  - Told she can't get aspirin or cholesterol medication until she sees a nutritionist first
  - Sent home with a stern reminder to not have another heart attack

Systems Failures, Not Patient Failures



- Patient admitted to the hospital with endocarditis…
  - Told it's her fault because of her substance use disorder
  - Advised to call a list of treatment programs
  - Told she can't get addiction medication until she sees a counselor first
  - Sent home with a stern reminder to not use drugs

Mortality rate after 1st Heart attack
is about 7% at one year

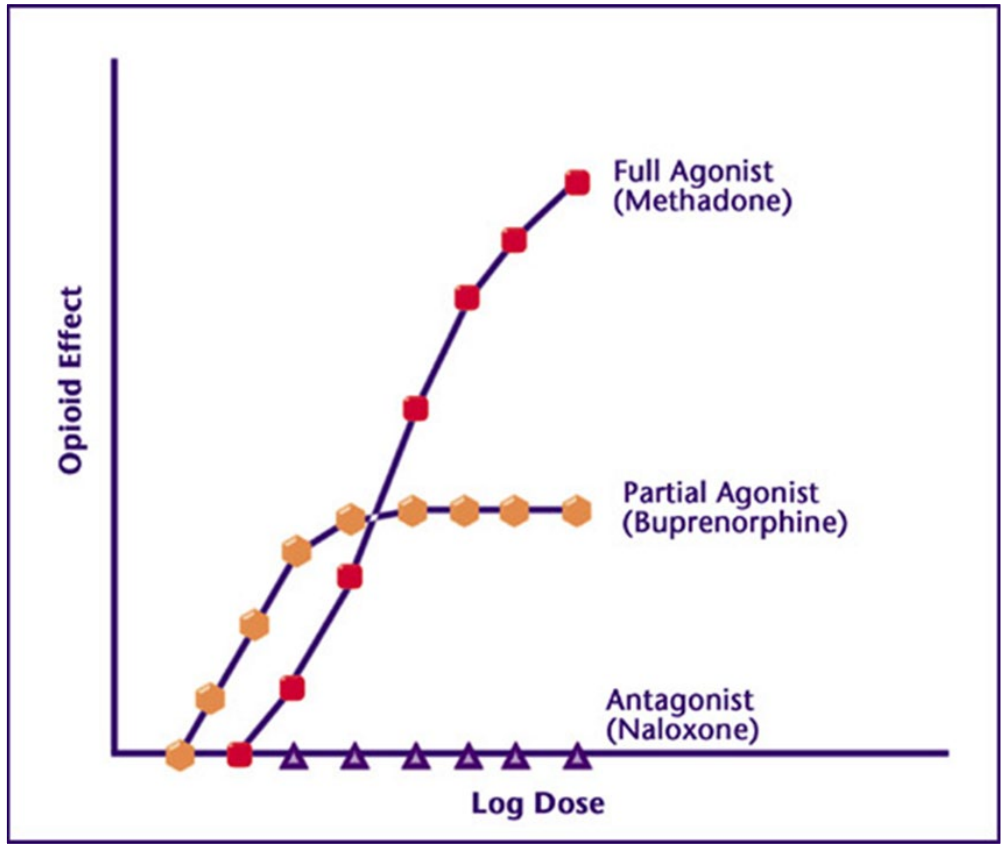
We would never send a patient home without Aspirin or statin, which reduce mortality by 22%

Mortality rate after 1st Heart attack
is about 7% at one year

We would never send a patient home without Aspirin or statin, which reduce mortality by 22%

Mortality rates after first overdose
are 7-15% at one year

However, patients are routinely sent home without MOUD, which reduces mortality by 80%

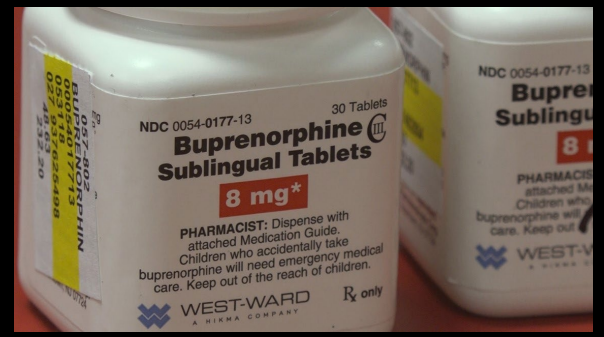


Properties of Buprenorphine, a *μ*-Opioid Partial Agonist

- Ceiling effect on respiratory depression
- High affinity for μ-opioid receptor
- Slowly dissociates from μ-opioid receptors
- Ameliorates withdrawal once underway
- Can precipitate withdrawal if given in temporal proximity to full agonist opioids

FORMULATIONS OF BUPRENORPHINE

Brixadi
Weekly/monthly SQ injection, various doses



Buprenorphine SL tab
(for pregnancy, 2 & 8mg)

Buprenorphine/naloxone
SL/buccal films (Generic/brand, many strengths)

Buprenorphine/naloxone
SI tabs (generic/brand)

Sublocade
Monthly Buprenorphine SQ depot injection

IV Buprenorphine

(Transdermal and Buccal Buprenorphine products used for chronic pain (Butrans/ Belbuca) are general considered too low dose to be used for OUD, not legal)

Naloxone is included in buprenorphine products as an

abuse deterrent

Is has minimal absorption and no clinical effect when used as directed sublingually (it does not alter the effectiveness of the medication or cause precipitated withdrawal or block opioids)

It only has action if the product is misused
(injected or smoked)

Prescribing this combination product reduces diversion risk 3-6 fold compared to plain buprenorphine products

Advantages of SL buprenorphine films

- Can be cut to easily adjust dosage (to make 0.5 mg from 2mg film)
- Abuse deterrent formulation
- Generic and widely available
- Easy to count and transport (individually wrapped)

Formulations of Buprenorphine NOT allowed for OUD/WD outpatient

- Butrans (transdermal, pain only)
- Belbucca (buccal, pain only)
- IV BUP
- It is illegal to use any other opioid agonist to treat opioid withdrawal in the outpatient setting
- ALL forms of BUP and all opioid agonists may be used in the **inpatient/ED** setting to treat withdrawal

Initial Assessment

https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

- A patient history: medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports.
- Access the patient's prescription drug use history through the state's Prescription Drug Monitoring Program (PDMP) to detect unreported use of other medications, such as sedative-hypnotics or alcohol, that may interact adversely with the treatment medications.
- A physical examination that focuses on physical findings related to addiction and its complications. (heart murmur, track marks, skin infections)
- Laboratory testing to assess recent opioid use and to screen for use of other drugs.
  - Urine drug screen (send out confirmation for fentanyl and alcohol metabolites)
  - Pregnancy test
  - CMP
  - Hepatitis B and C and HIV

Providers should not delay treatment initiation while awaiting lab results

Important Points to Review With the Patient

- Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.
- Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death (but is NOT a contraindication to BUP).
- Understand the importance of informing providers if they become pregnant.
- Tell providers if they are having a procedure that may require pain medication.

https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

Buprenorphine

What You Need to Know

September 2020

CA BRIDGE

What is buprenorphine?

- Buprenorphine - or bup - is medicine for people who have chronic pain or addiction to opioids (heroin or pain pills). Many people know it by brand names like Suboxone® and Subutex®.
- Buprenorphine helps get rid of cravings and withdrawal, without making you feel high.
- People have less overdoses when they take buprenorphine.
  It is a safe medicine that has been used for 30 years.
- It is not substituting one drug for another—it is a daily medicine that you may need to stay healthy.
- Often buprenorphine and naloxone are taken together in 1 pill. Naloxone is the same as Narcan®, but if you take the medicine under the tongue the naloxone doesn't go in your body and can't make you sick. Naloxone is only there to make sure that people don't crush the pill and inject it—if you do that, the naloxone does go into your body and does make you sick.

What is it like to take buprenorphine?

- Many people say that their cravings and withdrawal go away, they feel "clear in the head," and their chronic pain gets better.
- Every morning you put a pill or a film strip under your tongue and let it dissolve—don't swallow it.
- People need to take it every day in most cases, and do feel sick if they stop taking it suddenly.
- Usually there are no side effects, but some people have headaches, stomach upset, or trouble sleeping.
- Many people keep taking it for years, or forever. If you want to stop taking it that is ok, but talk to your medical team first.
- The chance of an overdose on buprenorphine is very low, but if mixed with other drugs or alcohol overdose is possible.
- Some people take buprenorphine as a once a month shot under the skin of the belly. This is a great option if taking a medicine every day is hard for you.

Is buprenorphine right for me?

- If you are currently taking methadone, talk to your medical team before switching.
- Before taking the first dose of buprenorphine, most people need to feel some withdrawal. That is important because if you take it while other opioids are in your system, you can get very sick.
- **Talk to your medical team to see if buprenorphine is a good medicine for you.** There are many good choices for treatment, only you and your team know what is best for you.

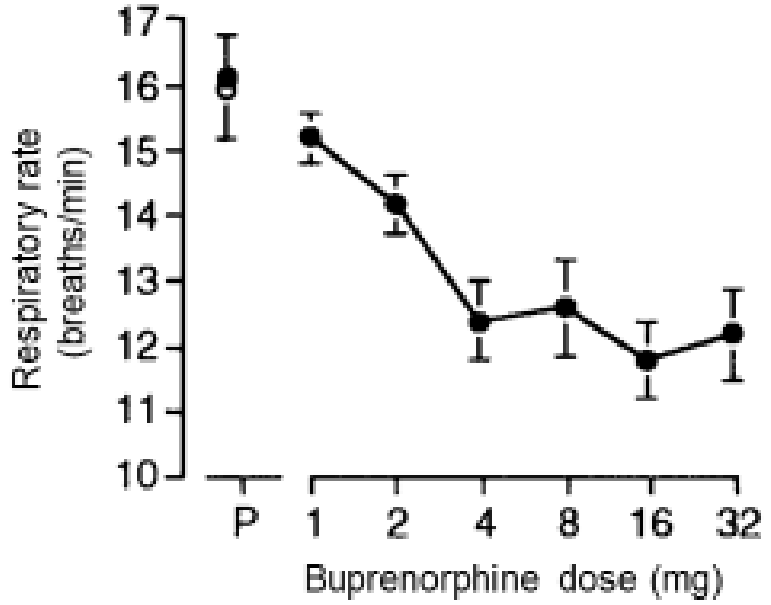
How do I get buprenorphine?

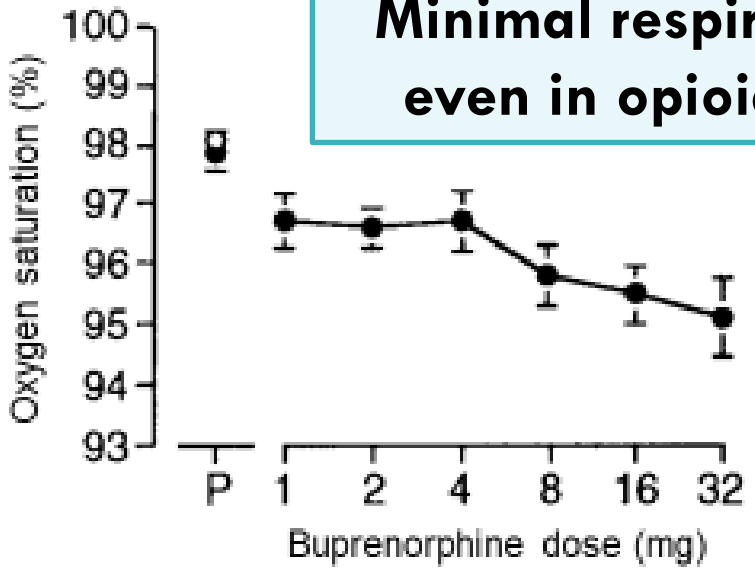
- **You can go to any of the places below to get started.** You may need to visit more than once before getting the first dose. In some clinics (like methadone clinics), you may come in every day to pick up your buprenorphine dose.
- Instead of going to a methadone clinic, you can get the medicine from a **primary care doctor**. At first you may need daily visits, but many people can soon switch to weekly or monthly visits.
- Some **telemedicine groups** offer prescriptions over the internet/phone instead of in a doctor's office, so you need a phone and internet to use those services.

https://bridgetotreatment.org/resource/buprenorphine-what-you-need-to-know/

Buprenorphine Dosing: Safety

- Cognitive and psychomotor effects appear to be negligible





Minimal respiratory depression even in opioid naïve patients

- Nearly all fatal poisonings involve multiple substances

Hakkinen et al., 2012
Walsh et al., 1994

PCSS Providers Clinical Support System

Lower dose BUP is NOT better

ASAM 2020 guidelines recommends minimum 16 mg/day for those in early recovery

Doses 16 mg+ have superior retention in treatment and abstinence

Fentanyl blockade requires minimum 16mg/day (higher is better)

Dosing Frequency

Buprenorphine has a slow dissociation rate from the mu opioid receptor, which gives rise to its prolonged suppression of opioid withdrawal and blockade of exogenous opioids (24-48 hours).

- Once daily dosing for control of drug cravings and withdrawal
- Most patient prefer BID-TID
- Relatively short analgesic duration(6 hours)
- QID dosing for pain control

Dosing instructions

- Wet mouth first, avoid smoking before dose
- Dissolve under tongue for 15-20 mins (tabs or films)
- No talking, eating, drinking, smoking
- Spit out excess saliva (swallowing can increase nausea)
- Rinse and spit after finished
- Peak effect in 1-2 hours

Common BUP Side Effects

- Nausea
- Headache
- Sweating
- Edema (XBRUP)
- Oversedation/dizziness
- Constipation (chronic)

Precipitated Withdrawal

- Precipitated withdrawal can occur due to replacement of full opioid receptor agonist (heroin, fentanyl, or morphine) with a partial agonist that binds with a higher affinity (Buprenorphine).
- Typically occurs 30-60 mins after SLBUP dosed
- Symptoms are similar to severe opiate withdrawal
- Avoid by ensuring adequate withdrawal before induction (COWS > 12; Fentanyl may require higher COWS score)

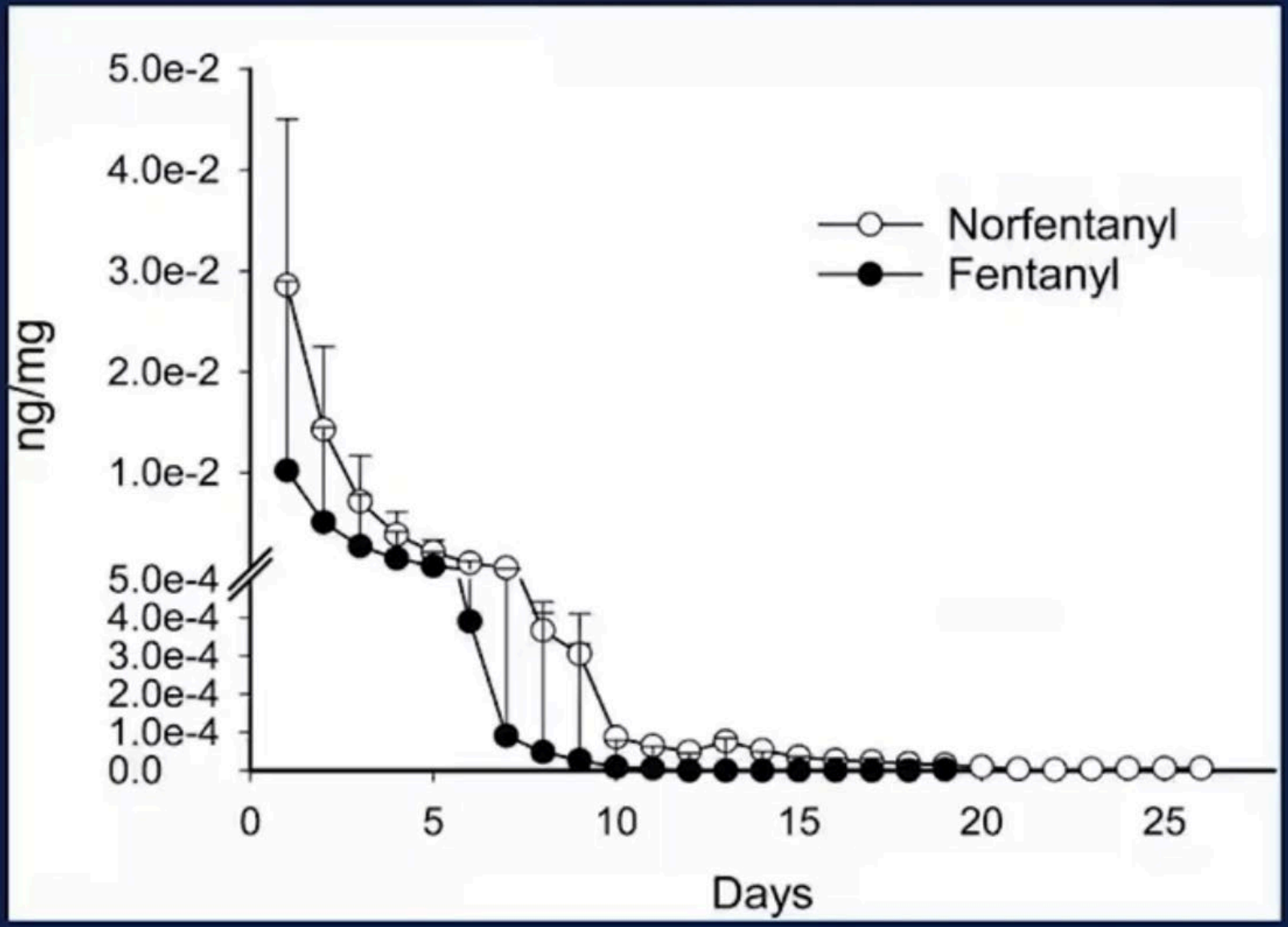
Illicit Fentanyl: DEA analysis has found counterfeit pills ranging from .02 to 5.1 milligrams (more than twice the lethal dose) of fentanyl per tablet (42% of seized pills contain at least 2mg)

https://www.dea.gov/resources/facts-about-fentanyl

Illicitly-manufactured fentanyl

- Though prior pharmacokinetic studies of fentanyl report half lives ranging from 1.5-7 hours, these studies generally relied on brief periods of drug administration.
- Fentanyl is highly lipophilic, allowing it to be sequestered in adipocytes in chronic users, similar to THC.

FENTANYL NORFENTANYL ELIMINATION IN URINE



Huhn SA et al. Protracted renal clearance of fentanyl in persons with opioid use disorder. Drug Alcohol Depen. 2021

Some evidence suggests fentanyl withdrawal…

- Starts sooner, lasts longer, is more severe (survey of 114 pts)[13]
- Is more likely to lead to precipitated withdrawal with bup
  - OR 5.2 for precipitated withdrawal with bup (v. methadone) within 24 hrs of fentanyl use (multi-center survey of 1679 pts)[14]
  - Precipitated withdrawal with bup despite extended (24-48 hrs) periods of abstinence and high COWS (4 pt case series)[15]
- Is harder to relieve with bup:
  - "24 mg not uncommonly necessary to manage withdrawal"[16]
  - Only 38% reported bup "completely alleviated" fentanyl withdrawal[14]

Gryczynski 2019, Varshneya 2021, Shearer 2021, Neimark 2020

Increasing reports of buprenorphine precipitated withdrawal merit caution

Most people in withdrawal can start bup without issue

In populations with 25-76% fentanyl use, 0-3% precipitated withdrawal (EMS, multi center NIDA, single site ED, multi site CA Bridge)

CA BRIDGE

Varshneya NB, Thakrar AP, Hobelmann JG, Dunn KE, Huhn AS. Evidence of Buprenorphine-precipitated Withdrawal in Persons Who Use Fentanyl. J Addict Med. 2021 Nov 23. doi: 10.1097/ADM.0000000000000922. Epub ahead of print. PMID: 34816821.

D'Onofrio et. al, unpublished abstract

Hern et al, unpublished data

ZSFG, upublished data

Lesaint, unpublished data

D'Onofrio G, Fiellin D. Emergency Department-INitiated bupreNOrphine and VAlidaTIOn Network Trial (ED-INNOVATION) (NIH HEAL Initiative). Presented at: Second Annual

Ask about previous experience with BUP

- Helpful for cravings? What dose worked best?
- Initiation well tolerated:
  - Proceed with standard initiation
- Experienced Precipitated withdrawal:
  - How long did they wait?
  - What dose did they take?
  - Did they succeed with initiation?
  - Consider high dose or low dose overlapping start
  - Consider pre-medication with ondansetron 4-8 mg and clonidine 0.2 mg

Determine Withdrawal

Objective withdrawal signs help establish physical dependence

The risk with initiating buprenorphine too soon is that buprenorphine has a very high affinity for the mu receptor and will displace any other opioid on the receptor, thereby causing precipitated opioid withdrawal.

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

COWS Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea *5* Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat *on* brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated *5* Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms *5* Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

At home withdrawal assessment

- Wait 12-24 hours after last opioid use

- Wait until you have at least 4 WD sxs
  - Rhinorrhea, sweating, tearing, N/V/D, abd cramping, myalgias, goosebumps, restlessness, yawning, anxiety

Wait until you can't wait anymore!

Common Rx at First Visit

- Buprenorphine/naloxone 8/2 mg tab or film, as directed, max 16-24 mg/day, dispense #14-24
- Ondansetron 8 mg ODT, ½ SL tid prn, disp #12
- Clonidine 0.1 mg, 1-2 tid prn restlessness and sweating, disp #30
- Naloxone nasal spray kit (refill X3)
- Consider Trazodone 100 mg qhs for insomnia, Tizanidine 4mg qid for spasms, ibuprofen 800 tid for pain, Imodium 2 qid for diarrhea, hydroxyzine 50 mg tid for anxiety
- Order XRBUP to be shipped to office (300 mg)

Standard BUP initiation

- Wait until in moderate WD
- Start with 8 mg SL (2-4 mg in patients with low levels of tolerance)
- Repeat 4 mg every 2 hours as needed up to 16 mg on day 1
- Consider increasing to 24 mg/day is needed to control symptoms

Low Dose Overlapping Buprenorphine Initiation (AKA Micro-dosing)

Micro-dosing (ultra-low dose overlapping BUP starts) allows patients to start taking their buprenorphine without first having to stop their full opioid agonist and without having to experience prolonged periods of withdrawal symptoms prior their first dose.

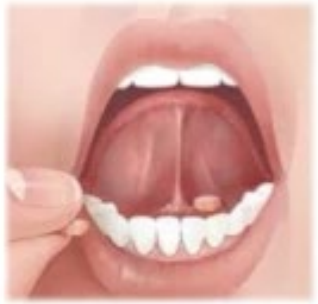
This is accomplished by starting with very low doses of buprenorphine (**0.5 mg or less**)

Basics of Micro-dosing Buprenorphine Induction

- Allow patients to continue the full opioid agonist as starting small doses of buprenorphine
- Start with small doses of buprenorphine to gradually displace full opioid agonist
- Gradually increase amount of buprenorphine patients receive
- Continue full opioid agonist during induction period
- Stop full agonist as tolerated after buprenorphine maintenance dose achieved (16+ mg)
- Limited evidence, mostly case series reports

When to consider Micro-dosing?

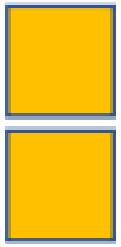
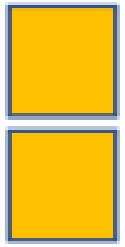
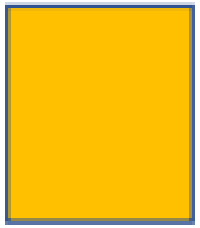
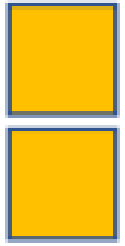
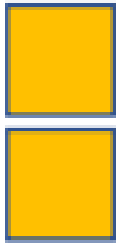
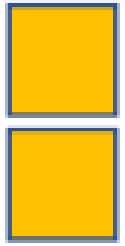
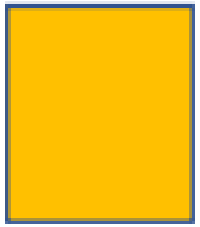
- Transitioning from methadone to buprenorphine
- Chronic fentanyl use
- Patient with severe acute pain and OUD
- Previous failed attempts at induction due to PW



Day	Total dose
1	0.25 mg
2	0.5 mg
3	1 mg
4	2 mg
5	4 mg
6	8 mg
7	12 mg

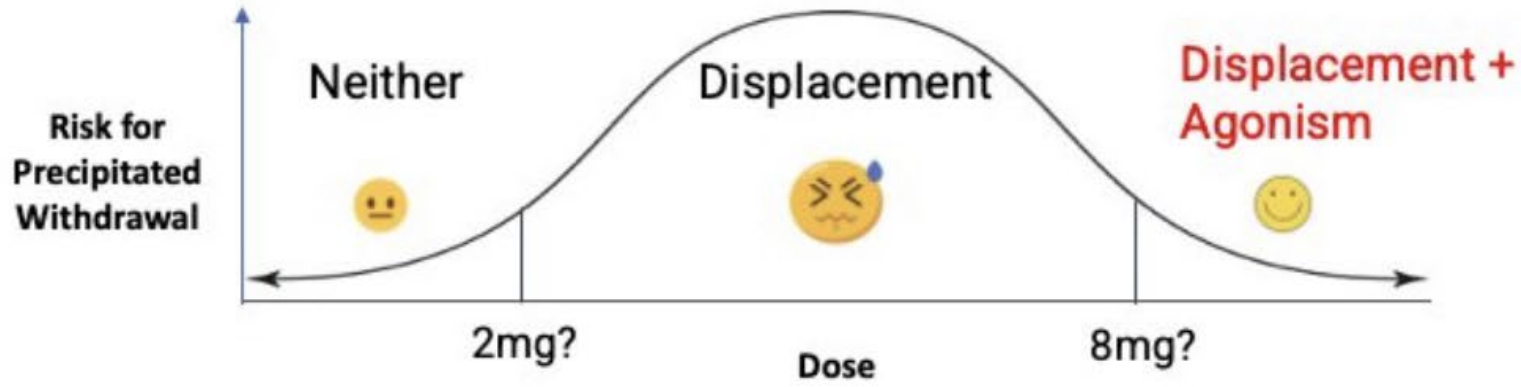
Stop other opioids once tolerating 12 mg of BUP

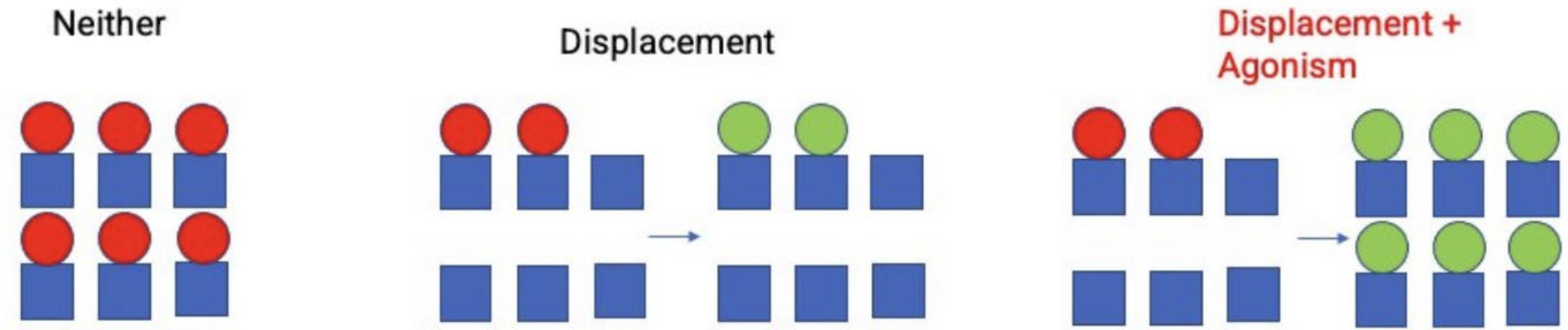
How to

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine dose	0.5mg daily	0.5mg BID	1mg BID	2mg BID	4mg BID	4mg TID	8mg BID
Film size	2mg	2mg	2mg	2mg	2mg	2mg	8mg
Morning dose							
Afternoon Dose							
Night dose							
Full agonist	Continue	Continue	Continue	Continue	Continue	Continue	STOP

High-Dose Buprenorphine Initiation (AKA: Macro-dosing)

Buprenorphine Micro- and Macrodosing Induction Using a Bell-Shaped Curve Framework





Herring AA, et al. *Am J Emerg Med*. 2019 Dec;37(12):2259-62.
Huhn AS, et al. *Drug Alcohol Depend*. 2020 Jul 2;214:108147.

MEDICATION-ASSISTED TREATMENT CENTERS OF EXCELLENCE

High-dose starts: principles

- Defined as day 1 TDD > 12 mg[26]
- Ceiling effect limits risk of AEs[27, 28]
- Bup Cmax ≈ 1 hr[27-29]
- TDDs >12 mg needed for blockade[29] and to fully address withdrawal and cravings, which improves retention in care[30-34]
- Why not get there in 2-3 ***hours*** instead of 2-3 ***days***?

	Standard	High-dose
COWS	Not specified	≥ 8
1st dose	2-4 mg	8 mg
Dosing freq.	~2 hrs	1 hr
Day 1 TDD	8-12 mg	16-32 mg

Herring 2021, Walsh 2003, Ahmadi 2018, Greenwald 2015
Danilewitz 2020, McNeil 2014, Simon 2020, Fareed 2012, Jacobs 2015

CA BRIDGE

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

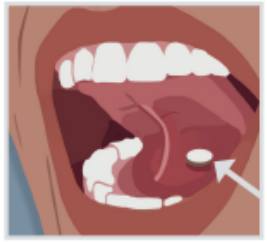
1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.



Place dose under your tongue (sublingual).

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Not going well? Have questions? Contact your Navigator for help!

https://bridgetotreatment.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

Additional buprenorphine doses are the treatment of choice for precipitated withdrawal

Evidence for Additional Buprenorphine Doses

Buprenorphine has been well established as an effective treatment for opioid withdrawal and thus it is an attractive option to Macrodosing give additional doses of buprenorphine to treat precipitated withdrawal if the first dose of buprenorphine made symptoms worse.[1] Extrapolating from the management of naltrexone induced POW, 3 case reports and one case series described the use of buprenorphine to treat precipitated withdrawal, with resolution of precipitated withdrawal within hours using doses of 4mg to 22mg.[20-23] Buprenorphine has also been described as a treatment for naloxone precipitated opioid withdrawal in a case report.[24] In case reports of buprenorphine to manage buprenorphine POW, doses of 8-16mg were given with improvement of symptoms within 1-2 hours of receiving the additional doses.[11,25]

http://www.emdocs.net/buprenorphine-precipitated-opioid-withdrawal-tips-for-prevention-and-management-for-the-emergency-clinician/

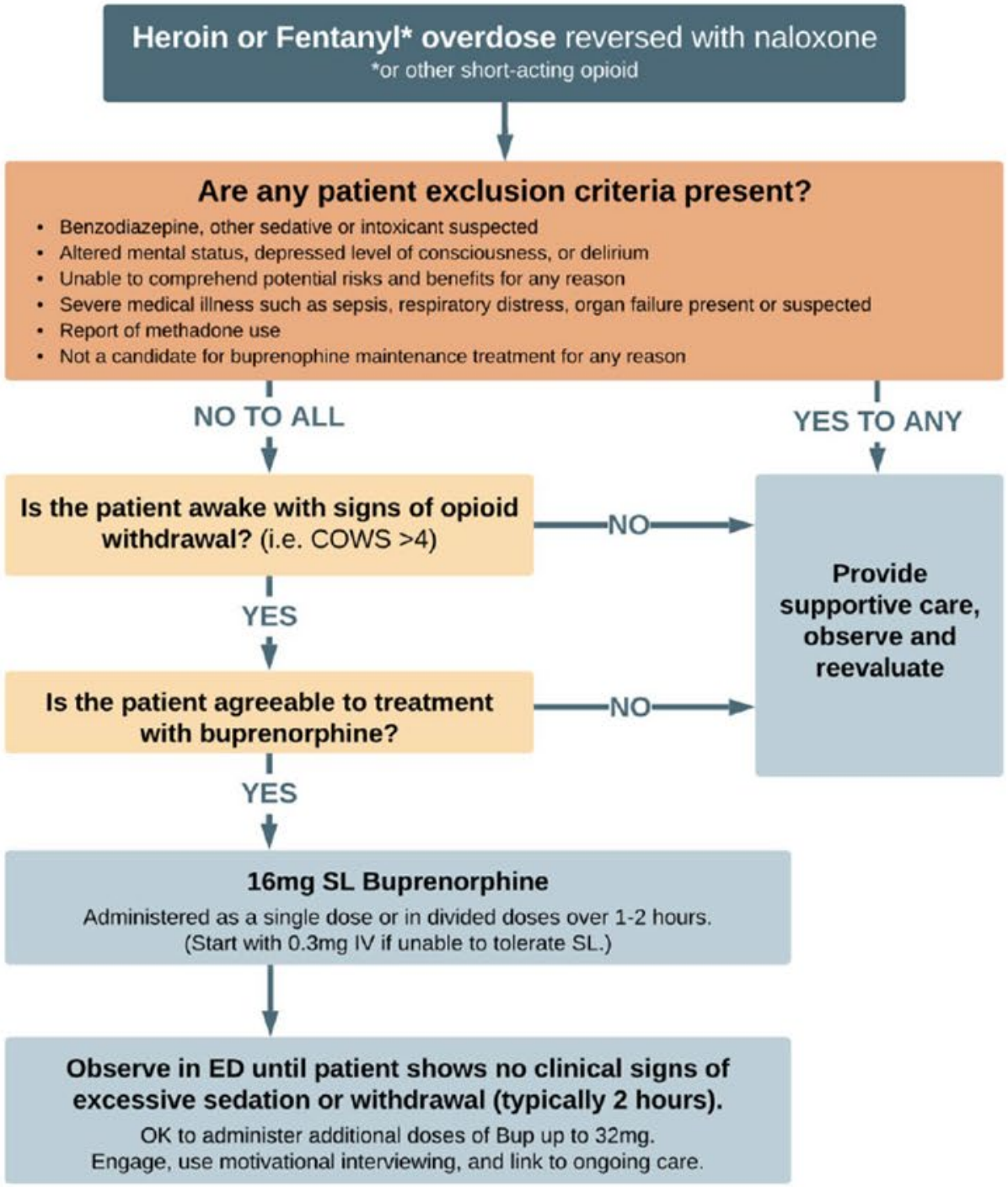
If you experience precipitated withdrawal:

- Immediately take 16 mg of Buprenorphine (2 strips or tablets) dissolve under tongue for 20 mins. You may repeat 8-16 mg of buprenorphine again in 1-2 hours if needed (max 40 mg)

- Take Ondansetron 4-8 mg dissolve under tongue for nausea

- Take Clonidine 0.1 mg 1-2 tabs every 4 hours for restlessness and sweating

Other comfort meds as needed: tizanidine, hydroxyzine, trazodone, gabapentin, ketamine/benzodiazepines/hydromorphone (inpatient)



Treating Naloxone Induced Precipitated Withdrawal

Bup Induction after Overdose

Telemedicine Intakes

- First visit via tele-med (same day when possible)
  - Reduces no-show rates
  - Over half via telephone only
- Review treatment options and discuss patient goals
- Provide medication initiation instructions and prescribe supportive meds and naloxone
  - Traditional, low-dose overlapping, high dose starts
- Counsel to come to in person visit even if failed to initiate SLBUP
- XRBUP takes 3-6 days to ship (tele-med 1 week prior to injection appt)

What should I do if a patient diverts or misuses the medication?

- Misuse or diversion doesn't mean automatic discharge from the practice.
- Document and describe the misuse and diversion incident. Also document the clinical thinking that supports the clinical response, which should be aimed at minimizing future risk of diversion while still supporting the use of MAT.
- Strongly consider smaller supplies of medication and supervised dosing.
- Treatment structure may need to be altered, including more frequent appointments, supervised administration, and increased psychosocial support.
- When directly observed doses in the office are not practical, short prescription time spans can be considered.
- In situations where diversion is detected, open communication with the patient is critical. Providers may consider injectable and implantable buprenorphine to reduce diversion, once verified.

Maintenance therapy

- Check PDMP regularly to ensure prescriptions are filled, and to check other prescriptions.
- Order urine drug testing (UDT) and consider confirmatory testing for unexpected results. UDT can facilitate open communication to change behavior.
- Ask about how patient is taking their meds
- Discuss cravings and what triggers them
- Discuss side effect management
- Adjust dose as needed to control cravings
- Address co-morbid disorders
- Initial weekly visits until use extinguished, then q2wk, monthly for long term stable patients

RECOVERY RESEARCH INSTITUTE

MGH 1811

Even 3 years into treatment, patients that stay on their medication have 2/3 less relapse
5 years in have ½ the relapse rate

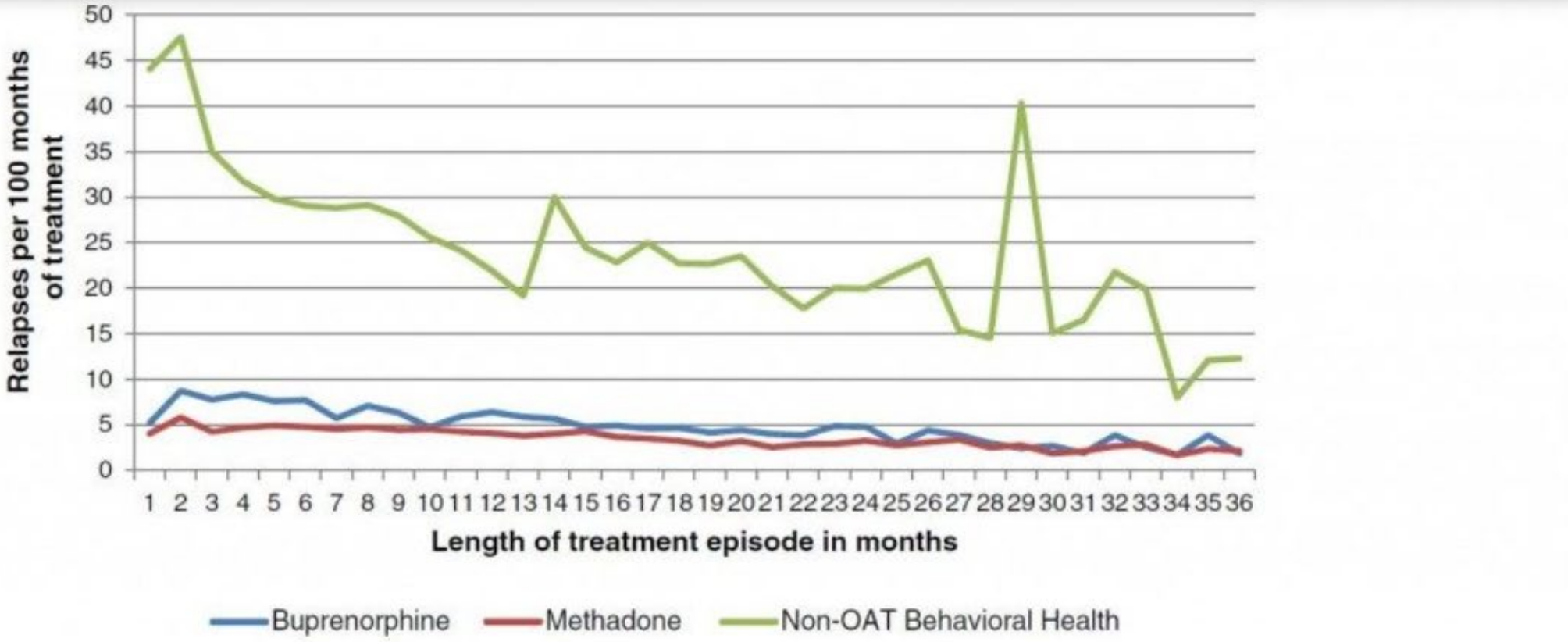


Fig. 1. Relapses during treatment among MassHealth members who received treatment for opioid addiction between 2003 and 2010[1]. [1] N = 18,866 episodes of buprenorphine treatment, 24,309 episodes of methadone treatment and 31,220 episodes of non-OAT behavioral health treatment in month 1. 33% of buprenorphine episodes, 52% of methadone episodes, and 12% of non-OAT treatment episodes lasted 12 months or more. 13% of buprenorphine treatment episodes, 27% of methadone episodes, and 1% of non-OAT treatment episodes lasted 24 months or longer.

Co-occurring Disorders

- Most patients with OUD will have co-occurring disorders
- Many patients report substance use to self medicate
- Uncontrolled symptoms trigger return to use
- Offer non-narcotic treatment of depression/anxiety, chronic pain, insomnia
- Offer referral to psychosocial support

Psychosocial Support comes in many forms

- Individual or group counseling
- Mutual support groups (AA/NA)
- Online support groups (SMART recovery)
- Peer support
- Motivational Interviewing during medical appointments
- Contingency management
- Mobile messaging/text support/apps

Refer the patient for more intensive or specialized services if office-based treatment with buprenorphine or naltrexone is not effective, or the clinician does not have the resources to meet a particular patient's needs. Providers can find programs in their areas or throughout the United States by using SAMHSA's Behavioral Health Treatment Services Locator at https://findtreatment.samhsa.gov/

https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

What is a Higher Level of Care?

- Closer interval follow up, shorter Rx, dose change
- Comprehensive care
- Small achievable goals
- Reduction of harmful consequences
- Recall other chronic conditions and their management if patient not responding

When to Consider Taper?

- Patient Insists (for the right reasons)
- Relapse free for a year
- Stable housing, job, family life
- No major stressors (legal, financial)
- Stable Mental Health
- Actively engaged in strong recovery network

TAPER SHOULD ALWAYS BE PATIENT INITIATED

We work to counsel patient AGAINST discontinuation:

- During Pregnancy/postpartum
- During high stress times
- During surgery/hospitalization
- Due pressure from family/friends
- Because they “don’t need it anymore”

Resources

- Bridge to treatment: practical tools, algorithms, patient education https://bridgetotreatment.org/tools/resources/
- SAMHSA Buprenorphine Quick Start Guide https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf
- ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids https://journals.lww.com/journaladdictionmedicine/Fulltext/9900/ASAM_Clinical_Considerations__Buprenorphine.212.aspx