Practical Buprenorphine

Michael F. Bierer MD MPH FASAM
mbierer@mgh.Harvard.edu
Physician, Massachusetts General Hospital
Assistant Professor of Medicine, Harvard Medical School
Former President Massachusetts Society of Addiction Medicine

No financial disclosures/ conflicts of interest

Outline

- Clinical management using buprenorphine
  - 1 Overall guidelines
  - 2 Phases of care
  - 3 Intake / initial evaluation
  - 4 Patient management, including induction and follow-up
  - 5 Prescription pointers
  - 6 Special considerations

Learning Objectives

- 1 Understand the flow of outpatient care for individuals presenting for treatment with buprenorphine
- 2 Be able to make and document the diagnosis of opioid use disorder
- 3 Manage follow-up visits
- 4 Name 2 resources for further learning

Take Home Points

- Prepare your practice by thinking through protocols and templates
- Respectful, non-judgmental attitude is essential part of care
- Starting buprenorphine can be tricky with patients using fentanyl; consider ‘microinduction’ using small doses of buprenorphine
- Patients get better, are grateful, have reduced mortality and better health
    - AND Grateful patients make happy doctors

Ongoing Advice and Expertise is There for You

Learning objective #4

- PCSS- Providers Clinical Support System
  - Mentors/live & recorded webinars/ slide sets
- ORN- Opioid Response Network
- Boston Medical Center "Officed Based Addiction Treatment" program
  - OBAT recorded trainings at
  - https://www.bmcobat.org/training/pre-recorded/
- Project ECHO (Extension of Community Healthcare Outcomes)
  - 30 states—hub and spoke model
  - Video conferences with consultation for de-identified pts
- Yale School of Medicine Emergency department protocols
  - https://medicine.yale.edu/edbup/

A Call To Action For The Medical Community On The Need To Address Opioid Epidemic

Hillary Kunins, PCSS clinical expert discusses the opioid epidemic and urgent need for primary care providers to begin treating OUD patients.

Watch Video | View Video Library

Calendar of Events

Featured Events

Opioid Response Network

About Us | Assistance | Lessons Learned | Education | SUBMIT A REQUEST

COVID-19 PUBLIC HEALTH UPDATE >

We HELP YOU HELP OTHERS

General guidelines

- You can get your x-waiver if you have a full prescribing license:
- https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner
- Assume patient has h/o trauma; adopt trauma informed care
- Acceptance/non-judgment/empathy
- Attention to patient's comfort
- View addiction and trauma through lens of racism irrespective of race of patient
  - Historical: Laws outlawing drug use
  - Incarceration disproportionately of minorities but also of others
  - Adverse Childhood Experiences also in part a result of sociocultural pressures
  - Healthcare structure/access
- Immerse yourself in 'harm reduction' theory and practice
  - NEJM S Messmer. May 26, 2022: "When Naloxone Isn't Enough"

Outpatient Buprenorphine management phases (Learning objective #1)

- Initial evaluation and engagement
- Starting bup: “Induction”
- Titration and Stabilization
- Maintenance
- Why NO TAPER PHASE?
  - *BMJ* 2020; 368 doi: https://doi.org/10.1136/bmj.m772 (31 March 2020)
    - Mortality is ½ during treatment and rises abruptly after
    - Fentanyl era: mortality is 1/3 during treatment compared to out of treatment.

Bierer MF Treating Opioid Use Disorder in the Primary Care Setting in Gorrol AH and Mulley AG (eds) Primary Care Medicine (8th ed) Wolters Kluwer 2021

Basic Buprenorphine Pharmacology

- Know basics of Pharmacology
  - Partial Mu Agonist; high affinity to mu receptor
  - Competitively inhibits most mu agonists
  - Can induce precipitated withdrawal unless patient in relative opioid withdrawal
  - t ½ around 24-32 hours; blood level peaks 90 min after SL dosage
  - Metabolism: CYP 34A; most eliminated in feces; 1/3 eliminated in urine
  - SL absorption better than oral

Patient Evaluation

- General introductory discussion: Explore patient's goals of care
  - Drug related: cessation? Risk reduction? Control?
  - Non-drug related
    - Work? Relationships? Health? Parenting? Saving money? Avoid criminal punishment?
  - Take note of patient's motivators AND barriers to change
- Drug use history
  - Prior buprenorphine experience?
  - Chronologic organization: what drug when
  - Medical risk—what consequences are imminent; chronic (h/o overdose or infection)
  - Severity-consequences
  - Comorbid psychiatric and medical issues and other drugs
  - What has accounted for periods of remission? What has precipitated relapse?

Evaluation-establish diagnosis of OUD (Learning objective #2)

- 11 CRITERIA per DSM-5
  - Withdrawal
  - Tolerance
  - Using more/more often than intended
  - Using despite known negative medical/psychiatric consequences
  - Recurrent use resulting in social/relation problems
  - Use resulting in failure to fulfill responsibilities
  - Loss of a major role
  - Spending much time using/recovering from use
  - Craving
  - Hazardous use
  - Persistent efforts or desire to cut down/stop

SEVERITY:
2-3 mild
4-5 moderate
>5 severe

Initial -- continued

- Deciding to use bup
  - Shared decision making
  - Alternatives (methadone at least as effective but limited/constrained access)
  - No contraindications to outpatient induction
    - Severe psychiatric instability; severe medical comorbidity: chiefly CAD

Initial-continued

- Expectations / rules
  - Medication refill protocols
  - Follow up visits in-person versus virtual
  - Frequency of visits/contacts
  - Written agreement ("contract") not evidence-based. May clarify mutual expectations
  - Toxicologies: No evidence: may enhance future disclosure: "What will the toxicology show?"
- Medication use
  - Dissolve without swallowing saliva; hold 10 minutes
  - Protect from loss
  - Avoid other sedating medications
  - Time of day
    - Take first thing "before the addiction has a chance to wake up"
    - Once daily versus divided doses? Pharmacology versus patient preference
- Rx Naloxone

Starting Buprenorphine ("Induction")

- Old or "Standard Induction" methods
  - Abstain from all opioids (Ops)-prescribed or non-prescribed (eg heroin)
  - Evaluate severity of withdrawal (W/D) with Clinical Opioid Withdrawal Scale or COWS
  - When W/D severity is moderate (COWS 8-12), use Bup SL 4mg initial dose although higher dosages in first day recommended (min 12mg)
    - https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781956
  - Inpatient OR In-office OR Home OR emergeny ward Induction.
    - www.pcssnow.org
  - Use 'comfort medications' to treat symptoms/signs of w/d

Assess w/d severity after 2-3 half-lives off op

- Clinical Opioid Withdrawal Scale (Google “COWS Opiate”)
- 11 signs/symptoms scored 1-4 (mostly). Moderate score 12-24
    - Tachycardia
    - Diaphoresis
    - Restlessness
    - Anxiety
    - Tremor
    - Piloerection
    - Pupillary dilatation
    - GI upset
    - Bone/joint aches
    - Yawning
    - Lacrimation/rhinorrhea

New Method: ”Bernese” or “micro-induction”

Gaining traction due to Fentanyl—effective 4-7 day half-life

- Generally, start with lower dose eg 1/4 of a 2mg strip is 0.5mg bup
- CO-ADMINISTER while patient continues w pure mu-agonist activity
  - Long-acting drug still auto-tapering or
  - Patient still self-administering opioids and induction overlaps continued use
  - Use ‘comfort medications’ to attenuate mild w/d patient may experience.
    - (clonidine, dicyclomine, ondansetron, NSAID, trazodone/benzodiazepine)
- Gradual up-titration of bup/nal over many days (3-8)
- When BUP dosage is 12mg per 24 hours, may d/c mu agonist

One buprenorphine micro-induction template

- All are at level of case series
  - Day 1--0.5mg sl qd
  - Day 2--0.5mg sl bid
  - Day 3-- 1mg sl bid
  - Day 4—2mg sl bid
  - Day 5—3mg sl bid
  - Day 6– 4mg sl bid
  - Day 7– 12 mg/sl—may discontinue other opioids

- Randhawa PA, Brar R, Nolan S. Buprenorphine-naloxone "microdosing": an alternative induction approach for the treatment of opioid use disorder in the wake of North America's increasingly potent illicit drug market. *CMAJ*. 2020;192(3):E73. doi:10.1503/cmaj.74018

Follow up visits and documentation (Learning objective #3)

- Medication-focused history
  - How medication is used—adequate duration of dissolution
  - S/E Constipation, libido, others
  - Effectiveness-is dose adequate?
    - Ablate preoccupation/craving/drug dreams
    - Ablate drug use
- Salient Goals-focused history
  - Moving toward them?
    - Drug related—cessation? Decrease? Avoid injection?
    - Life—eg: work/relationships/saving $
    - Health—managing chronic conditions

Follow-up

- Responding to struggle or distress
  - “Relapse prevention”-dealing with thoughts of using
  - Mental health care
  - Engaging in recovery activities
  - Mutual help groups
- More frequent check-ins; higher dose of bup; shorter prescriptions (for early consumption not related to inadequate dosage
- Anticipate periods of high-potential for relapse and overdose
  - Stressors
  - Exposure to opioids (eg sick housemate prescribed opioids)
  - Period immediately after Incarceration or hospitalization
    - King C, Cook R, Korthuis PTJ Addict Med. 2021 Sep Epub ahead of print. PMID: 34510087; PMCID: PMC8907339.

Follow-up

- Documentation:
  - Comment on unexpected or abnormal data or history and your clinical response
    - Tox results
    - Prescriptions use/ prescriptions missed. (may be mandated to check prescription database state-by-state)
    - Clinical response: dose /followup / other services
- Frequency of visits or virtual visits/phone calls
  - no standard; patient comfort/provider comfort

Prescriptions pointers/ Prescription Hygiene

- MUST Include your ‘X-dea’ on the prescription
- 30 d max; may have 3 refills
- If you do not have electronic record, keep track of the active prescriptions *Max 30 individuals w* concurrent active prescriptions
- Write ”Ok to dispense tablets or films depending on insurance”
  - Maddening shifting insurance / Prescription Benefit Manager coverage
- Have colleagues covering for refills and empower your coverage to fully re-fill
- Dosage maximum without prior authorization may apply (often 16mg with no good evidence)

Special considerations

- Pregnancy—preference for 'mono' product or bup/nal: both are safe
- REF:https://www.ajogmfm.org/article/S2589-9333(20)30123-3/fulltext
- Pain
  - Option to increase and/or divide dose of bup/nal tid
  - Option to add other analgesics and/or pain adjuvants
  - Option to combine bup/nal and pure mu agonists
    - Reduce dosage to 4mg bup or 4mg/1mg bup/nal
  - Option to stop buonp/nal and provide pure mu agonist with close follow-up
    - Patients stable bup often are uncomfortable with the feeling of craving that mu-agonists induce and convert back to bup/nal
    - Every case is different
    - REF: https://www.psychiatrist.com/jcp/psychiatry/perioperative-buprenorphine-administration-simultaneous-with-full-opioid-agonist/
- Comorbid drug / alcohol use
  - Bup can increase connection to care—refer for treatment
  - Note: may be risky to withdraw bup

Depo-Buprenorphine

- Increasing use of monthly sub-cutaneous depo bup last few years
- Patient should tolerate sublingual bup
  - Supposed to be stable on SL bup prior to injection
  - Several centers are using it not according to package insert
    - Beginning sooner after administering short-acting bup SL
    - Altering recommended dosages
    - Weekly or monthly
- Advantage for those without stability or safe storage
- Prevents opioid overdose (theoretically) more stably
- Advantages and disadvantages compared to daily dosing
- Expensive; challenges of storing, ordering, and reimbursement

Filter out the Pharma Hype and keep open mind

CALIFORNIA

Can a monthly injection be the key to curbing addiction? These experts say yes

LA Times May 4, 2022

Back to the beginning: Practice preparation—before first patient

- Intake and follow-up templates for note writing
- Patient agreement documents
- Prototols: Access to clinic/patient flow—phone? Walk-in? Appointment? Policy for lateness?
- Toxicologies; options
- Psychosocial supports-develop your network
- Referrals and expert support
  - Hep c; HIV
  - Psychiatric
  - Navigators/Peer support specialist/”recovery coach”

Summary and Case

- 34 year-old w Hep C using oxycodone a co-worker sells him
- h/o H and incarceration; works for company where he was placed during parole
- In psychotherapy weekly
- Evaluation: contracting/ shared expectation/ rx provided
- Induction uncomplicated—abstains for 18 hours and starts bup/nal and comes in later same day: “I forgot what it’s like to feel normal.”
- One period of use of oxycodone and one ‘lost prescription’ in 17 years
- Rising through ranks of the same company; personal goals tracking

Case summary

- Married, 2 children, owns home
- Has dropped his weekly psychotherapy
- Working on hypertension, hyperlipidemia and weight management
- Continues stable daily sublingual bup/nal
- Have offered monthly depo-bup but he’s not interested
- “I can’t believe when I first met you, I could not afford the medication co-pay; now I’m playing golf with your hospital president.”

Take Home Points

- Prepare your practice by thinking through protocols and templates
- Empathic, non-judgmental attitude is essential part of care
- Starting buprenorphine can be tricky with patients using fentanyl; consider ‘microinduction’ using small doses of buprenorphine
- Patients get better, are grateful, have reduced mortality and better health
  - Grateful patients make happy doctors