An Office Base Induction of Buprenorphine/Naloxone using PEER Guideline

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Learning Objectives

At the end of this session, participants will be able to:

- Initiate a patient on Buprenorphine/Naloxone
- Provide ongoing care and support

About Buprenorphine/Naloxone

- Buprenorphine + Naloxone
  - Naloxone present to deter IV misuse
  - Administration: Sublingual tablet
    - 2 generic dosing strengths - 2mg/0.5mg & 8mg/2mg
  - Mechanism of Action: Partial opioid agonist, high affinity for mu receptor
  - Most common adverse events: Nausea, Constipation
  - Onset of action: 30-60 mins
  - Peak effect: 1-4 hours
  - Duration of action: Up to 2-3 days at higher doses

Think of a car

Methadone = a fast car going 180 Km per hour

Buprenorphine = A car going 50 Km per hour

Naloxone = 0 Km per hour

https://www.youtube.com/watch?v=3DNJyddI0M
Precipitated Withdrawal

- Buprenorphine has a high affinity for the opioid receptors and will displace other opioids off the receptors.
- Because it has lower intrinsic activity, the person goes into precipitated withdrawal because the receptors are only partially stimulated.
- If this happens, it causes opioid withdrawal symptoms.

Office-Based Induction

- In order to avoid precipitated withdrawal:
  - Ensure there has been a minimum time period since last opioid use:
    - 12-24 hours since last use/dose
  - Evaluate the patient to see if they are in moderate-severe opioid withdrawal state:
    - Clinical Opioid Withdrawal Scale (COWS) > 12
  - Provide the patient with a low initial dose to minimize risk of precipitating withdrawal.

Office-Based Induction: Day 2

- The daily dose is established as equivalent to the total amount that was administered on Day 1 plus additional doses for day 2.
- Doses may be subsequently increased in 4 mg increments each day as needed for ongoing treatment of withdrawal symptoms and cravings.
- Dose may be increased to a maximum dose of 24 mg/day.
- If side effects occur, the dose should be maintained or lowered until side effects resolve.

Home Inductions

- Take-home inductions can be an effective alternative to office based inductions, for some individuals.
- Provide the patient with the Subjective Opiate Withdrawal Scale (SOWS) as a way to self-measure their level of withdrawal.
- Provide education to the patient about the need to be in withdrawal before starting the buprenorphine/naloxone.
- Ideally, the patient should be able to call a provider with questions.
Caring for a Patient on Buprenorphine/Naloxone

- The goal dose is 16 – 24mg. You can adjust up or down by 4 mg per day.
- See the patient weekly until they are stable, then extend the prescriptions to every 4 weeks, or longer, depending on patient stability.
- If ongoing cravings, withdrawal or substance use can consider increasing beyond 24mg.

Ongoing Care for a patient on OAT

- When seeing a patient for a follow up visit ask:
  - Adequate dose?
  - Side effects?
  - Substance Use?
  - Cravings?
  - Sleep?
  - Psychosocial functioning

OAT and concurrent Benzodiazepine use

- Opioids and benzodiazepines both decrease respiratory drive.
  - should not be co-prescribed.
- Observational data suggests: 1,2
  - 6x increased risk of opioid overdose death when sedative-hypnotics are combined with opioids.
  - In patients on OAT for OUD, this risk is lower at ~2x
- If a patient is on benzodiazepines, prescribed, or illicit, that is not a reason to withhold OAT.

Special Considerations

- Pregnancy
- Acute pain or injury
- Elective Surgery
- Hospitalization
- Incarceration
- Bottom Line: Do NOT stop OAT for any of these circumstances.

Tapering

- Involuntary
  - Risks > Benefits?
- Voluntary
  - Pt driven
  - Maximize chance of success
  - Poor prognosis if - using other substances, pregnant, unstable physical or mental health, poor psychosocial fnn
  - May take up to a year or longer to successfully complete cessation and few pts have a good prognosis

Questions?