An Office-Based 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=3ORiydd1QM

Faculty/Presenter Disclosures

- Faculty: Jessica Kirkwood: Clinical Lecturer UofA, Boyle McCauley Health Centre
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Suboxone Training Program Handbook

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.
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 fxn
  ▪ May take up to a year or longer to successfully complete cessation and few pts have a good prognosis

Questions?