CLINICAL PROVIDER QUICK TIPS

ADDRESSING FENTANYL USE IN PRIMARY CARE SETTINGS

CME AVAILABLE AT NO COST

WHAT YOU NEED TO KNOW

UCLA David Geffen School of Medicine
Integrated Substance Abuse Programs

ASIS-TTA
Opioid and Stimulant Implementation Support Training and Technical Assistance

Session Title

Buprenorphine for Patients Using Fentanyl

Presenter

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Takeaway Tips

- Fentanyl is prevalent in illicit opioids and greatly increases overdose risk; engaging patients in MOUD increases retention and reduces risk.
- Using good practices when starting buprenorphine with fentanyl-using patients will increase treatment success.
- Assess and address patients needs during and after the induction of buprenorphine.

Clarification of terms/acronyms that will be used

- Regular drug use -> Desensitization -> Tolerance
  - Tolerance – requires higher dose for the same effect
  - Dependence – will experience withdrawal without the substance, substance required to feel “normal”
  - Addiction – complex diagnosis related to negative psychosocial behaviors and consequences resulting from substance use

- SUD – Substance Use Disorder
- OUD – Opioid Use Disorder
- MAT – Medications for Addiction Treatment
- MOUD – Medications for Opioid Use Disorder

- Please remember – SUD is a chronic treatable medical condition (like diabetes, asthma, hypertension) it needs to be viewed and treated as those conditions are.

Terms you will not hear

- Intentional use of non-stigmatizing language – person first language

Terms to Use

- Person with a substance use disorder
- Person with an alcohol use disorder
- Person with an opioid use disorder
- Person in recovery
- Negative/positive result(s)
- Substance use disorder
- Patient with schizophrenia
- Patient with diabetes

Terms NOT to Use

- Addict, abuser, user, junkie, druggie
- Alcoholic, drunk
- Oxy-addict, meth-head
- Ex-addict, former alcoholic
- Drug seeker
- Clean/dirty (drug test)
- Addictions, addictive disorders

Objectives:

- **Understand the current situation with illicit fentanyl and how you can use that information to determine which patients are candidates for MOUD with buprenorphine**
- Understand how to start buprenorphine treatment for patients with fentanyl use disorder
- Understand how to assess and address patient needs during and after the induction

Fentanyl

- Synthetic opioid – lab designed
  - Stronger, more effective (dosed in micrograms vs milligrams of other opiates)
  - High receptor affinity (more additive, higher risk of overdose)
  - Does NOT show up on routine urine toxicology screens
  - Lipophilic – builds up in fat stores over time
- Cheap and easy to add to ANY street product
  - Meth, cocaine, heroin, cannabis, “Xanax”, “Percocet”, “pinkie”, etc.
- Trafficking is by the kilogram
  - 1kg of fent can kill 500,000 people

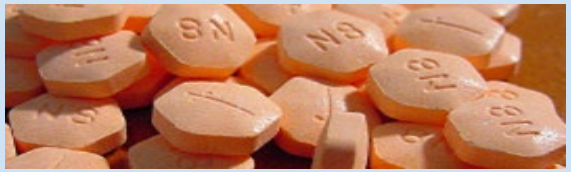
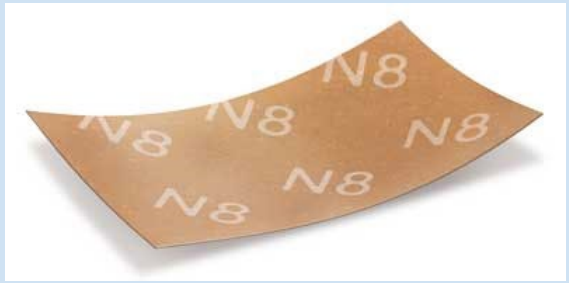
Fentanyl

- Even unintentional exposure can lead to dependence and very high tolerance
- Any patient dependent on opioids, including fentanyl, is a candidate for buprenorphine
- For every 2 patients that you start on MOUD you will retain one in treatment
- A patient in treatment has a reduced MORTALITY – treating opiate use disorder saves lives!

Objectives:

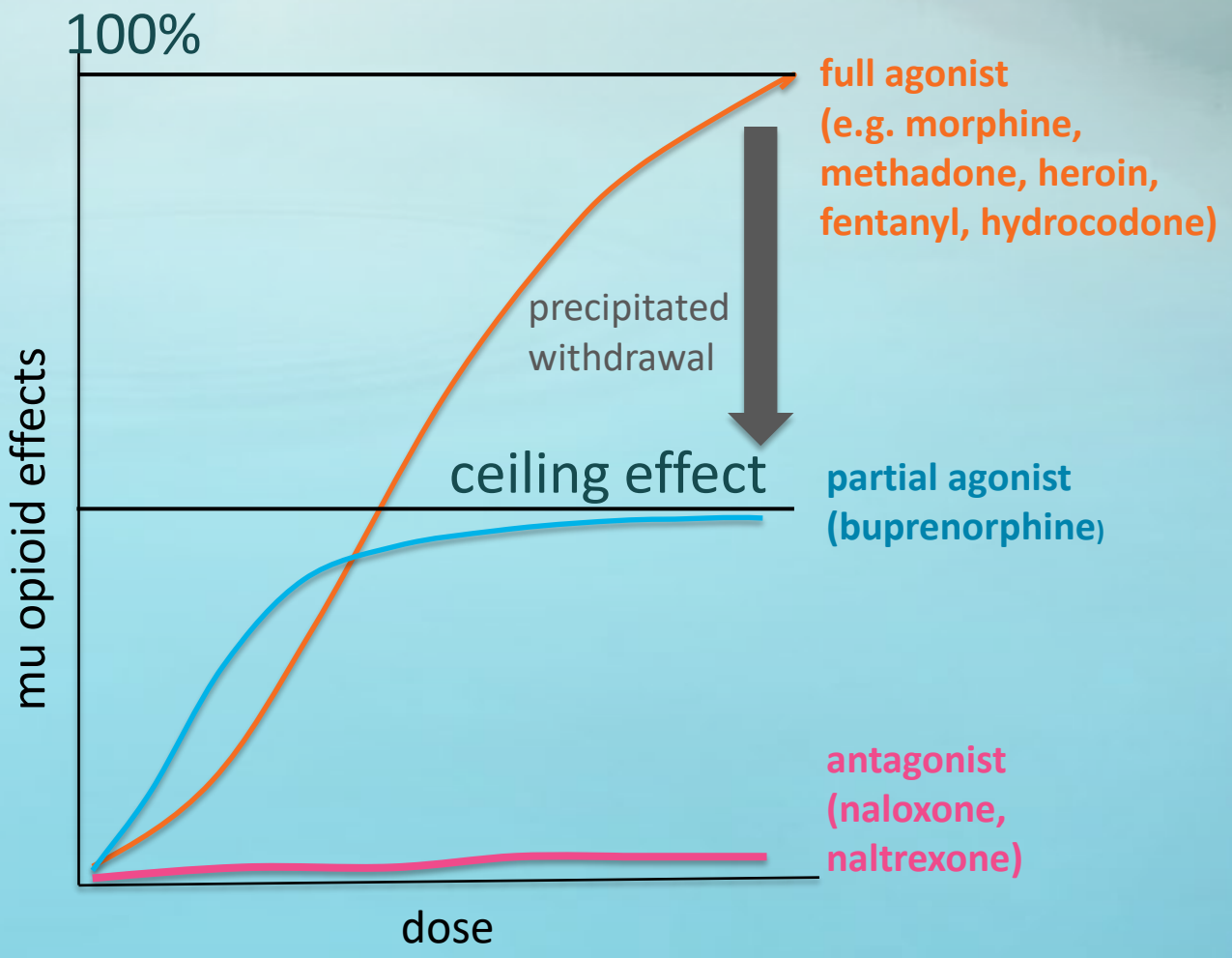
- Understand the current situation with illicit fentanyl and how you can use that information to determine which patients are candidates for MOUD with buprenorphine
- **Understand how to start buprenorphine treatment for patients with fentanyl use disorder**
- **Understand how to assess and address patient needs during and after the induction**

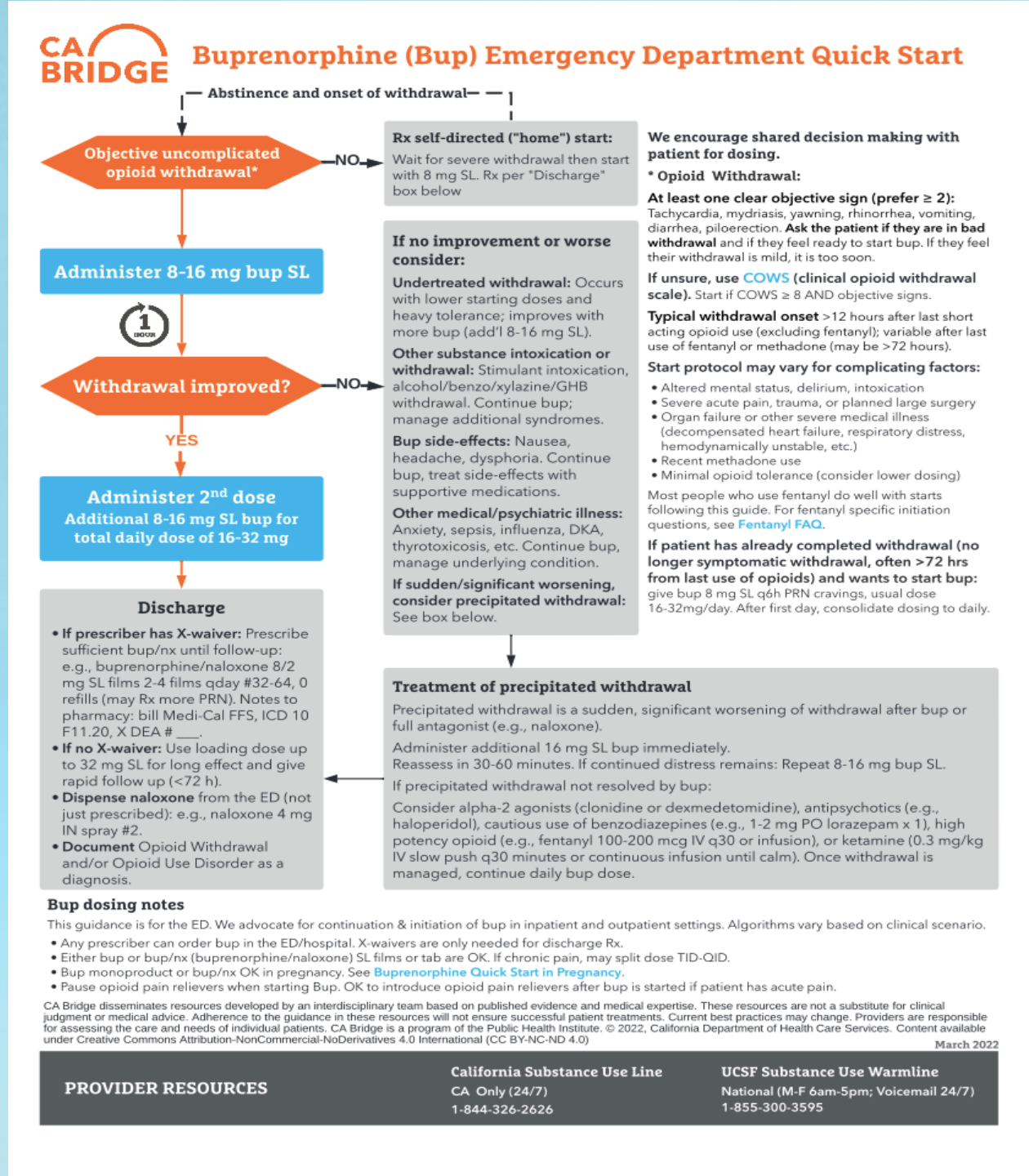
Medications for Opioid Use Disorder (MOUD)

Methadone	Buprenorphine ± Naloxone	Naltrexone
Full mu (opioid) receptor agonist	Partial mu receptor agonist	Mu receptor antagonist (blocker)
	 	
Oral (often solution)	Sublingual (tab, film), IV, IM, subcutaneous injection, transdermal patch	Intramuscular injection (extended release) or Oral Ex: “Vivitrol,” “ReVia”

Enter: Buprenorphine

- Treats withdrawal, cravings, & prevents overdose
- Partial agonist → less respiratory depression & sedation
- High affinity
  - Blocks & displaces other opioids
  - Can precipitate withdrawal
- Half-life ~ 24-36 hours (long acting)





CA BRIDGE

Buprenorphine (Bup) Emergency Department Quick Start

Abstinence and onset of withdrawal

Objective uncomplicated opioid withdrawal* — NO →

Rx self-directed ("home") start:
Wait for severe withdrawal then start with 8 mg SL. Rx per "Discharge" box below

Administer 8-16 mg bup SL

1 hour

Withdrawal improved? — NO →

If no improvement or worse consider:

Undertreated withdrawal: Occurs with lower starting doses and heavy tolerance; improves with more bup (add'l 8-16 mg SL).

Other substance intoxication or withdrawal: Stimulant intoxication, alcohol/benzo/xylazine/GHB withdrawal. Continue bup; manage additional syndromes.

Bup side-effects: Nausea, headache, dysphoria. Continue bup, treat side-effects with supportive medications.

Other medical/psychiatric illness: Anxiety, sepsis, influenza, DKA, thyrotoxicosis, etc. Continue bup, manage underlying condition.

If sudden/significant worsening, consider precipitated withdrawal: See box below.

YES

Administer 2nd dose
Additional 8-16 mg SL bup for total daily dose of 16-32 mg

We encourage shared decision making with patient for dosing.

*** Opioid Withdrawal:**

At least one clear objective sign (prefer ≥ 2): Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND objective signs.

Typical withdrawal onset >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours).

Start protocol may vary for complicating factors:

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma, or planned large surgery
- Organ failure or other severe medical illness (decompensated heart failure, respiratory distress, hemodynamically unstable, etc.)
- Recent methadone use
- Minimal opioid tolerance (consider lower dosing)

Most people who use fentanyl do well with starts following this guide. For fentanyl specific initiation questions, see Fentanyl FAQ.

If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup: give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

Discharge

- **If prescriber has X-waiver:** Prescribe sufficient bup/nx until follow-up: e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Notes to pharmacy: bill Medi-Cal FFS, ICD 10 F11.20, X DEA # ___.
- **If no X-waiver:** Use loading dose up to 32 mg SL for long effect and give rapid follow up (<72 h).
- **Dispense naloxone** from the ED (not just prescribed): e.g., naloxone 4 mg IN spray #2.
- **Document** Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

Treatment of precipitated withdrawal

Precipitated withdrawal is a sudden, significant worsening of withdrawal after bup or full antagonist (e.g., naloxone).

Administer additional 16 mg SL bup immediately.
Reassess in 30-60 minutes. If continued distress remains: Repeat 8-16 mg bup SL.

If precipitated withdrawal not resolved by bup:

Consider alpha-2 agonists (clonidine or dexmedetomidine), antipsychotics (e.g., haloperidol), cautious use of benzodiazepines (e.g., 1-2 mg PO lorazepam x 1), high potency opioid (e.g., fentanyl 100-200 mcg IV q30 or infusion), or ketamine (0.3 mg/kg IV slow push q30 minutes or continuous infusion until calm). Once withdrawal is managed, continue daily bup dose.

Bup dosing notes

This guidance is for the ED. We advocate for continuation & initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.

- Any prescriber can order bup in the ED/hospital. X-waivers are only needed for discharge Rx.
- Either bup or bup/nx (buprenorphine/naloxone) SL films or tab are OK. If chronic pain, may split dose TID-QID.
- Bup monoproduct or bup/nx OK in pregnancy. See Buprenorphine Quick Start in Pregnancy.
- Pause opioid pain relievers when starting Bup. OK to introduce opioid pain relievers after bup is started if patient has acute pain.

March 2022

PROVIDER RESOURCES

California Substance Use Line
CA Only (24/7)
1-844-326-2626

UCSF Substance Use Warmline
National (M-F 6am-5pm; Voicemail 24/7)
1-855-300-3595

Starting Buprenorphine in the hospital/ clinic/when someone is in withdrawal

KEY TAKEAWAY

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

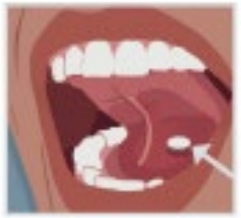
1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg)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

Call or text your Navigator for help at _____

3.28.22

Starting Buprenorphine in the outpatient setting/self start

First, identify the right patient & rule out contraindications

*** Opioid Withdrawal:**

At least one clear objective sign (prefer ≥ 2): Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND objective signs.

Typical withdrawal onset >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours)

Start protocol may vary for complicating factors:

- Altered mental status, delirium, intoxication
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If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup: give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

No methadone for at least 72 hours

CAUTION: benzodiazepines, alcohol, other respiratory suppressants

Fentanyl? Higher COWS + “hard signs”

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Include 1+ *objective* signs!

- Dilated pupils
- “Goose bumps”
- Vomiting
- Tachycardia
- Yawning
- Runny nose & eyes

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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 sifting 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

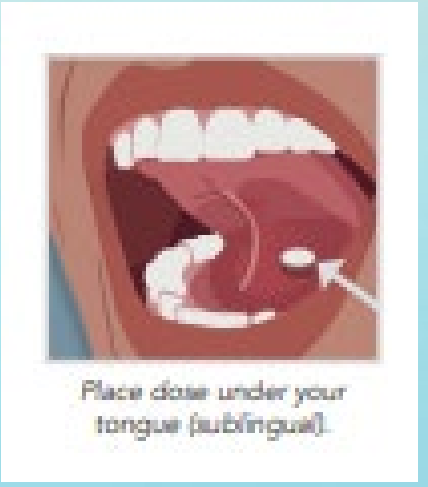
Patient in moderate to severe withdrawal?
Wants help quitting illicit opioids?
Give 8-16mg Buprenorphine sublingual.

Typically start 8 mg bupe sublingual

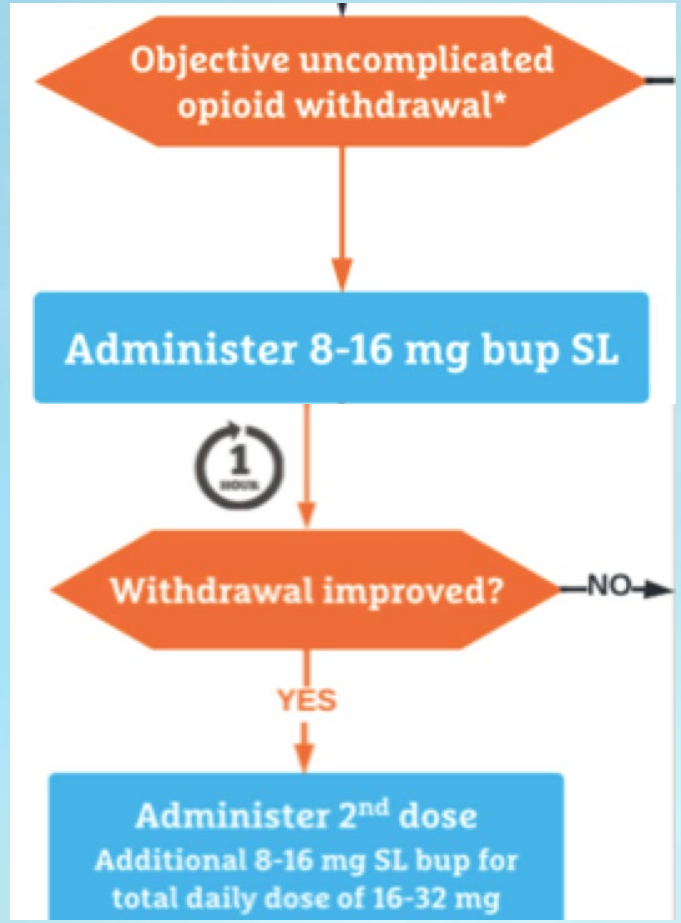
For fentanyl, may require higher dose, 16-32 mg

How to take buprenorphine

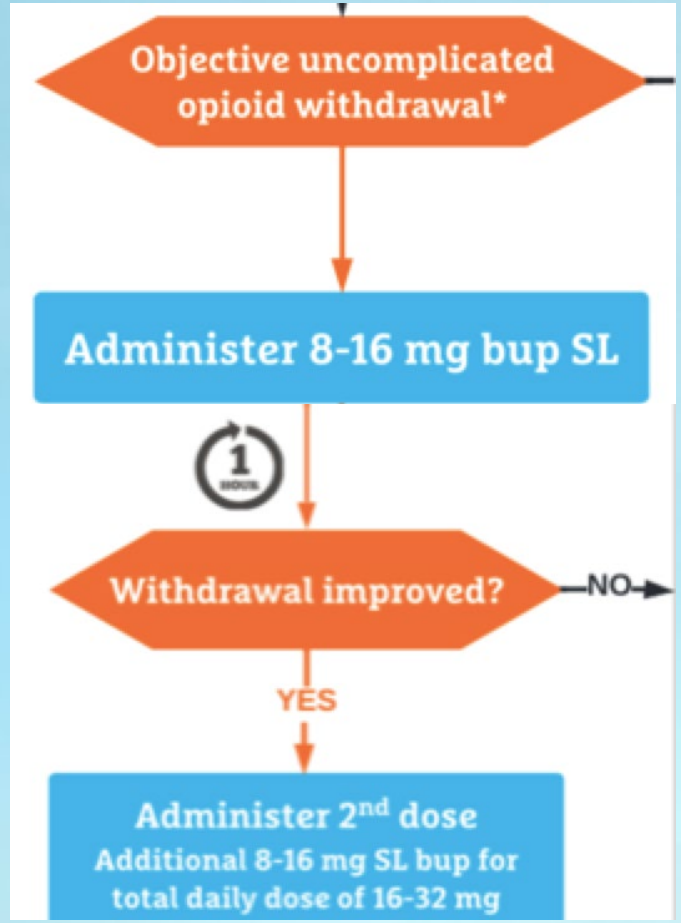
- The dose must be absorbed from under the tongue to be effective
- No food or water for 15 minutes after taking bup



Wait. Reassess.
Better? Give another dose.
No? Widen your ddx.



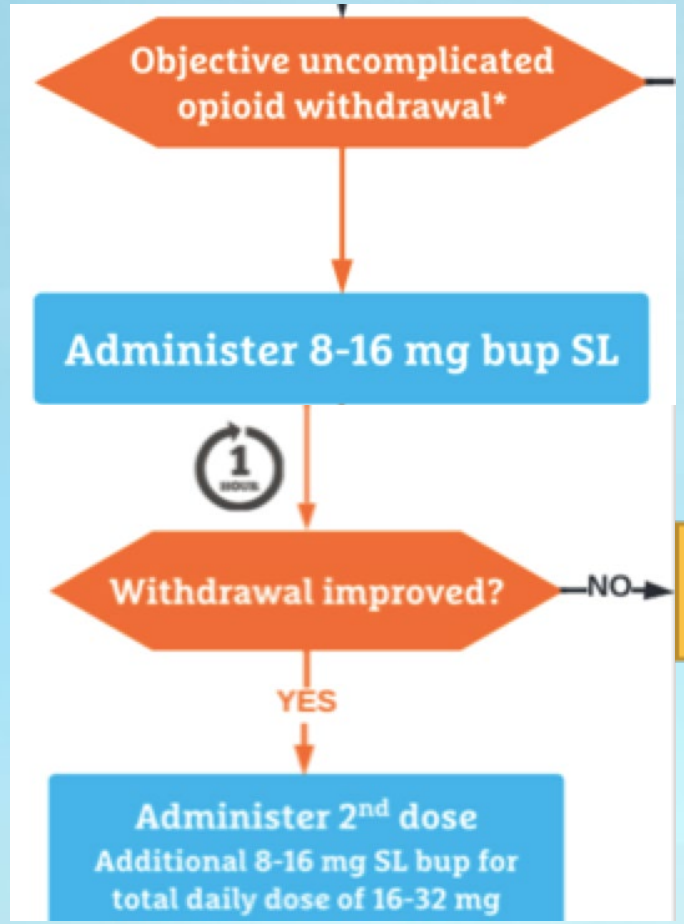
Wait. Reassess.
Better? Give another dose.
No? Widen your differential.



Don’t be afraid to repeat dose!
For fentanyl, may take more doses.

Note: *Most* patients will *still* do great with bup 16-32mg total.

Wait 1 hour. Reassess.
Better? Give another dose.
No? Widen your differential.



If no improvement or worse consider:

Undertreated withdrawal: Occurs with lower starting doses and heavy tolerance; improves with more bup (add'l 8-16 mg SL).

Other substance intoxication or withdrawal: Stimulant intoxication, alcohol/benzo/xylazine/GHB withdrawal. Continue bup; manage additional syndromes.

Bup side-effects: Nausea, headache, dysphoria. Continue bup, treat side-effects with supportive medications.

Other medical/psychiatric illness: Anxiety, sepsis, influenza, DKA, thyrotoxicosis, etc. Continue bup, manage underlying condition.

Undertreated Withdrawal

- Small bupe doses given to pt with high tolerance → ongoing symptoms
- Incomplete treatment of symptoms
- As time goes on between doses, symptoms get worse – from ***lack of enough*** bupe, not ***because*** of it
- Can be *normal* part of the buprenorphine induction experience

Precipitated Withdrawal

- Very rare! (<1% in NIDA data)
- **How? *"Too little bupe too soon"***
- What? Rapid, *significant* & *sudden* worsening withdrawal sxs
- Painful, unpleasant, agitation, "excited delirium"

- **Note: this is what happens** *on purpose* **when we give naloxone!**

It may take some time for the medication to work;
I'm here for you
and will help you
no matter what happens.

I know going through withdrawal is terrible.
I'm here to help make this the BEST WITHDRAWAL EXPERIENCE EVER!
With SUPPORT and MEDICATION, to ease your pain.

Have you ever tried buprenorphine before? Do you know anybody who has? What concerns do you have?

We need to *normalize* the withdrawal experience for patients

KEY TAKEAWAY

If you *do* precipitate withdrawal…

KEEP
CALM
AND
GIVE
BUP …and more bup!

What if you *do* precipitate withdrawal???

Treatment of precipitated withdrawal

Precipitated withdrawal is a sudden, significant worsening of withdrawal after bup or full antagonist (e.g., naloxone).

Administer additional 16 mg SL bup immediately.
Reassess in 30-60 minutes. If continued distress remains: Repeat 8-16 mg bup SL.

If precipitated withdrawal not resolved by bup:

Consider alpha-2 agonists (clonidine or dexmedetomidine), antipsychotics (e.g., haloperidol), cautious use of benzodiazepines (e.g., 1-2 mg PO lorazepam x 1), high potency opioid (e.g., fentanyl 100-200 mcg IV q30 or infusion), or ketamine (0.3 mg/kg IV slow push q30 minutes or continuous infusion until calm). Once withdrawal is managed, continue daily bup dose.

For discharge:

Maintenance Treatment
16 mg Bup SL/day

Titrate to suppress cravings;
Usual total dose 16-32mg/day

Discharge

- **If prescriber has X-waiver:** Prescribe sufficient bup/nx until follow-up: e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Notes to pharmacy: bill Medi-Cal FFS, ICD 10 F11.20, X DEA # ___.
- **If no X-waiver:** Use loading dose up to 32 mg SL for long effect and give rapid follow up (<72 h).
- **Dispense naloxone** from the ED (not just prescribed): e.g., naloxone 4 mg IN spray #2.
- **Document** Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

Need help?

California Only
CA POISON CONTROL (24/7)
1-800-222-1222

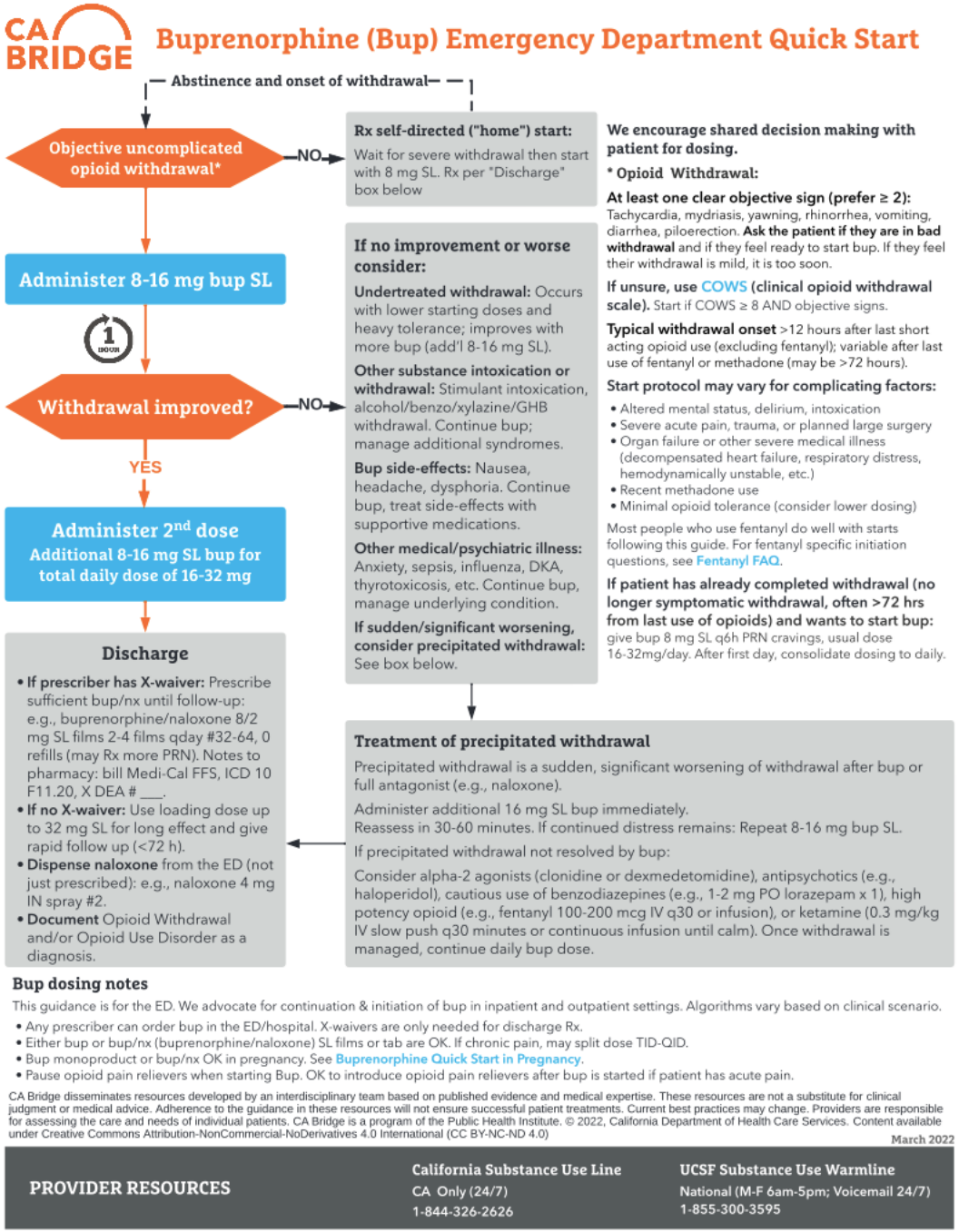
National Clinician Consultation Center
Substance Use Warmline
M-F 6am-5pm. Voicemail 24 hrs, 7 days/wk.
Specialty addiction medicine consultation
(855) 300 – 3595

CA BRIDGE GUIDE

Buprenorphine Waiver Notification

Recap!

www.cabridge.org



KEY TAKEAWAY

What if the pt is interested in treatment, but not in withdrawal now?

Patients can self-start on buprenorphine!

Studies show pt's self-rating for withdrawal ≥ COWS.

Instructions mimic hospital start.

Safe, effective option.

CA BRIDGE

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

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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).
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- 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!

Call or text your Navigator for help at _____

3.28.22

Culture of Radical Acceptance

Meet people where they're at – *get on the same page*.

- **Normalize:** *"Many of my patients use drugs like fentanyl…"*
- **Acknowledge:** *"...and I know it can be tough to talk about with a doctor/nurse/PA."*
- **Align:** *"I want to help you feel better. Can I ask you some questions?"*
- **Ask (instead of assume)...**

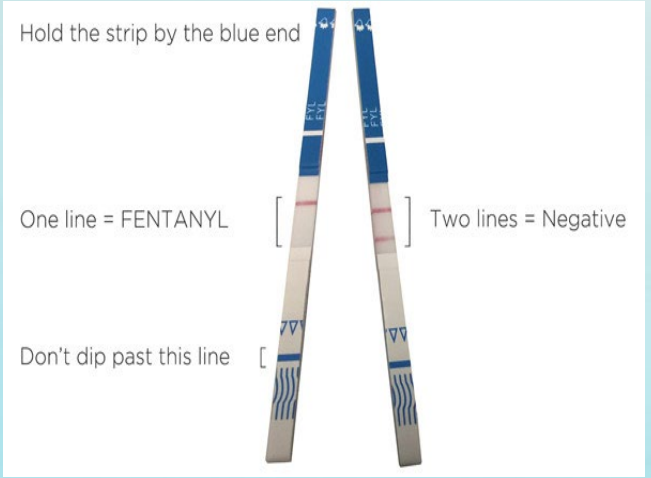
Culture of Radical Acceptance

Meet people where they're at – *understand their story*.

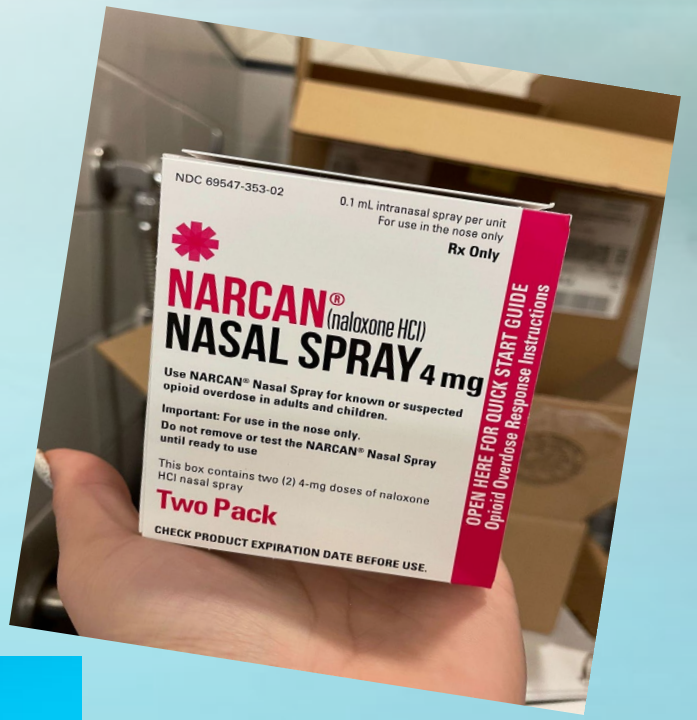
- ***Talk to me about your drug use. What kinds of drugs do you use? How do you use your drugs? How much?***
- ***Do you often use drugs by yourself? Or mostly with others?***
- ***Have you heard about fentanyl?***
- ***Do you know anybody that has tried or been on buprenorphine? Have you ever tried it?***
- ***Do you have any worries about your drug use? What are they?***
- ***Do you ever use other drugs – "uppers" or something to balance your fentanyl?***

What else can we offer patients? Harm Reduction

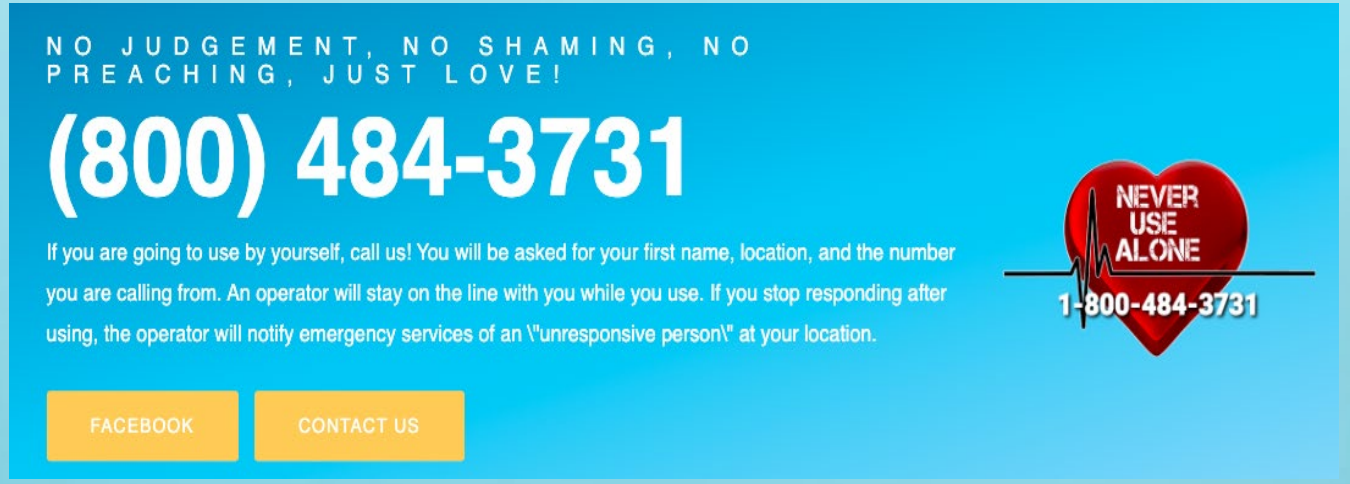
- **Fentanyl test strips**



- **Naloxone**



- **Never Use Alone**



NEVER GIVE UP

KEY TAKEAWAY

THANK YOU

Clinical Provider Quick Tips

-- Addressing Fentanyl Use in Primary Care

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