Induction 101: Starting Buprenorphine Treatment

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Disclosures

There are no relevant financial relationships with ACCME-defined commercial interests for anyone who was in control of the content of this activity.
Buprenorphine Starts 101

The basics
How to assess withdrawal
Different Settings: Emergency Department, Hospital, Clinic, and Home
Special Cases: Pregnant patients & Patients already on methadone
Who is a candidate for OBOT?
Case Presentation
Questions
Induction vs. “Starts”

Language is important

Sounds scary and overly technical (to patients and providers)

Confusing when working with pregnant women
Staying well

- Chronic use
- Acute use
- Withdrawal
- Normal
- Tolerance & Physical Dependence

Euphoria
No longer in the cycle
Buprenorphine vs. Placebo for Heroin Dependence
Kakko, Lancet 2003

4 Subjects in Control Group Died
Initiating Buprenorphine

There is no single right approach.

Choices may be affected by options in your area:
- Inpatient/Hospital
- ED
- Clinic/Medical Office
- Patient’s Home
Withdrawal Scoring: COWS

<table>
<thead>
<tr>
<th>Subjective v. Objective symptoms</th>
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</thead>
<tbody>
<tr>
<td>Polysubstance use may effect this (effect of meth on pupils)</td>
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</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resting Pulse Rate: 0 pulse rate 80 or below</td>
<td>0</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>1</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>2</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>4</td>
</tr>
<tr>
<td>GI Upset: over last 1/2 hour</td>
<td>0</td>
</tr>
<tr>
<td>0 no GI symptoms</td>
<td>0</td>
</tr>
<tr>
<td>1 stomach cramps</td>
<td>1</td>
</tr>
<tr>
<td>2 nausea or loose stool</td>
<td>2</td>
</tr>
<tr>
<td>3 vomiting or diarrhea</td>
<td>3</td>
</tr>
<tr>
<td>5 multiple episodes of diarrhea or vomiting</td>
<td>5</td>
</tr>
<tr>
<td>Sweating: over past 1/2 hour was not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushing or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face</td>
<td></td>
</tr>
<tr>
<td>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</td>
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<tr>
<td>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</td>
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<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
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<tr>
<td>Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult</td>
<td></td>
</tr>
<tr>
<td>Bone or Joint aches: If patient was having pain previously, only the additional component attributed to opiate 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</td>
<td></td>
</tr>
<tr>
<td>Gooseflesh skin 0 skin is smooth 3 piloeruption of skin can be felt or hairs standing up on arms 5 prominent piloeruption</td>
<td></td>
</tr>
<tr>
<td>Ruddy 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 checks</td>
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</table>

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
Buprenorphine Induction Protocol
(Heroin/Short Acting Opioids)

Prior to induction
- Psychiatric Assessment including a detailed Addiction History including ROS
- Clinical Opiate Withdrawal Scale (COWS)
- Review Vital Signs and Urine Drug Testing
- Consider CBC, CMP, HIV & Hepatitis, & RPR
- **Check Pregnancy Test in all Women**

- When patient in mild opioid WD, start with Buprenorphine 4/1mg now, repeat another 4/1mg 1-2 hours later
- **Day 2-6: 8-12/1-1.5mg daily**
- **Day 7:** See them back in clinic and consider increase to 10-12mg daily
- **Dose range 8-24mg**
Initiating Bup in Non-Pregnant Patients

CA BRIDGE PROJECT

https://static1.squarespace.com/static/5c412ab755b02cec3b4ed998/t/5dc255df2d46c2731a7b366c/1573017059129/CA+Bridge+-+Protocol+-+Bup+Hospital+Quick+Start+-+NOV+2019.pdf
Initiating Bup in Pregnancy: CA BRIDGE Project

Buprenorphine (Bup) Quick Start in Pregnancy

- Bup is a high efficacy partial agonist that is SAFE in pregnancy and highly effective for treating opioid use disorder.
- If patient is stable on methadone or preferably naltrexone, recommend continuation of methadone as finishe treatment.
- Fetal Monitoring is not required to start Bup in a normal pregnancy regardless of gestational age.
- Admission for observation is NOT required at Bup start.
- Suppositories or Bup reconstituted in OK in Pregnancy.
- Split dosing and an increase in total Bup dose is often necessary esp in later trimesters.

Uncomplicated opioid withdrawal?**

YES (stop other opioids)

Administer 8mg Bup StL

Withdrawal symptoms improved?

YES

Administer 2nd dose

ED: 8mg (consider higher loading dose if high risk factors: substance use, prior treatment failures) intravenous: 8mg. On subsequent doses, decrease from 8mg Bup with withdrawal, AOG per pro coverage.

Maintenance Treatment

16 mg Bup SIDay

Continuous (same dose) for 14 to 21 days

Discharge

- Document Opioid Withdrawal and/or Opioid Use
- Provide information and education
- Provide a 3-day dose of 12 mg Bup for long acting and give exact follow up
- If known, address other issues (urgent care, Emergency Department if not dayouse patient, prescription opioid/diagnosis with follow up)

Overdose Education Naloxone Kit

Naloxone 0.4mg (14mg intranasal spray)

Buprenorphine Dosing

- Any provider can order Bup in the ED or inpatients
- If available, use local Bup for Bup 8mg Bup StL
- Administer 12 mg Bup BID or TID, may increase based on patient response and progress
- DO not start with lower than dose 2-2mg StL

Complicating Factors

- Recent trauma to head
- Significant respiratory compromise, medically unable to take Bup
- Recent methadone

** Disposing Opioid Withdrawal

Subjective symptoms (see one objective sign: Delirium, opnosia: Patient reports feeling "bad" due to withdrawal
Pt. wants high Bup dose, needs higher Bup dose)

Signs of acute opioid withdrawal (no oral intake)
- Restlessness, sweating, rhinorrhea, dilated pupils, Sympotiga, yawning, goose bumps, sweating, diarrhea, incontinence.

Typical withdrawal onset:
- 2-4 hrs after last opioid use
- 8-12 hrs after last opioid use
- 48-72 hrs after last opioid use (can be 72 hrs)

Fentanyl, use COMS (unlabeled opioid withdrawal script): Start if COMS < 4/day use opioid agonist

If Compliant Withdrawal
- Typically <72 hrs onset last class acting agent; may be longer for methadone.
- Start Bup using Bup StL or suppository
- Bup should be increased 2-4 times daily, may need to increase to 8 mg daily, may need to increase to 8 mg daily.

Symptoms / Supportive Meds

Can be used to help manage opioid withdrawal symptoms post-delivery: pethidine, promethazine, metoclopramide, promethazine, diazepam, lorazepam, etc.

The Bridge Program discontinues resources developed by an interdisciplinary team based on published evidence and expert opinion. These resources are not a substitute for clinical judgment or medical advice. Reference to the guide or in these materials will not ensure successful patient treatment. Current healthcare practices may change. Providers are responsible for assessing the care and needs of individual patients.

provider Resources

UCSF Substance Use Warmline
National Help Line: 1-800-327-3999
California Substance Use Line
CA (877) 330-6600
334-500-2026
Buprenorphine Induction Protocol (Methadone/Long acting opioids)

This can be a challenge

Taper patient down to 30mg or less of methadone

Wash out period for 48-72 hours

During this time manage symptomatically with Gabapentin 300-600mg TID + Clonidine 0.1-0.2mg TID (outpatient) or Lorazepam 2mg TID + Clonidine 0.1-0.2mg TID (inpatient) plus a hypnotic agent

Induce with Buprenorphine/Naloxone 2/0.5mg, if patient tolerates it well then administer Buprenorphine/Naloxone 6/1.5mg 30-40 minutes after the initial dose

Day 2-6: 8/1mg daily

Day 7: Consider increase to 10-12mg daily

Dose range 8-24mg
Micro-Dosing: transition from full agonists to buprenorphine

1. Initiation of very small doses of buprenorphine (0.2 - 2 mg SL) while continuing opioid dosing
2. Tapering opioid over 5-10 days or abruptly discontinuing around Day 8.
3. Has been successfully used when taking 40-100mg methadone daily.


Treatment Starts Here/CA BRIDGE Program

Starting treatment in acute care settings
Hospital systems and policies support MAT
Hospital culture is welcoming and nonstigmatizing
Referral connections support continued treatment after starts

From CA Bridge – BridgetoTreatment.org
Emergency Department Starts

An exception to the registration ("Waiver") requirement, known as the "three-day rule" (Title 21, Code of Federal Regulations, Part 1306.07(b)), allows a practitioner who is not separately registered as a narcotic treatment program or certified as a waivered DATA 2000 physician, to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient’s referral for treatment, under the following conditions:

- Not more than one day’s medication may be administered or given to a patient at one time
- Treatment may not be carried out for more than 72 hours
- The 72-hour period cannot be renewed or extended
Hospital Starts

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.
ALGORITHM
Available resources at www.BridgeToTreatment.org

Uncomplicated* opioid withdrawal?**
YES (stop other opioids)

Administer 8mg Bup SL

Withdrawal symptoms improved?
YES

Administer 2nd dose
Inpatient: 8mg. Subsequent days, titrate from 1.6mg with additional 4.8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment
16 mg Bup SL/day
Titrated to suppress cravings; usual total dose 36-32mg/day

No Improvement
Differential Diagnosis:
• Withdrawal mimic: Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlying illness.
• Incompletely treated withdrawal: Occurs with lower starting doses, improves with more Bup.
• Bup side-effect: Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
• Precipitated withdrawal: Too large a dose started too soon after opioid agonist.
  Usually time limited, self resolving with supportive medications.

In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short-acting full agonists.

Discharge
• Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
• If no X-waiver: Use loading dose up to 32mg for long effect and give rapid follow up.
• If X-waiver: Check CURIES (not required in Emergency Department if 57 day prescription), prescribe sufficient Bup/Nal until follow-up.

Overdose Education Naloxone Kit
Naloxone 4mg/0.1ml intranasal spray

Start Bup after withdrawal
Supportive meds prn, stop other opioids
Office Based Opioid Treatment Starts
<table>
<thead>
<tr>
<th>Criteria*</th>
<th>Office-based Opioid Treatment (OBOT)</th>
<th>Opioid Agonist Treatment Program (OATP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can an office-based setting provide needed resources for the patient</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patient’s psychosocial supports</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>Co-occurring psychiatric disorders</td>
<td>Stable</td>
<td>Unstable (e.g., chronically suicidal)</td>
</tr>
<tr>
<td>Dependence on CNS depressants (e.g., alcohol, benzodiazepines)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Previous failed treatment attempts, especially with opioid agonists</td>
<td>None / Few</td>
<td>Many</td>
</tr>
<tr>
<td>Response to sublingual buprenorphine in the past</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>Expected to be reasonably compliant in treatment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Co-occurring serious pain syndromes (especially those requiring opioids)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medication First and Low Barrier Care

Medical stabilization is a priority

Patient-centered care

If patients agrees to buprenorphine treatment, psychosocial treatment should be encouraged and available, but not mandatory

To extent possible, coordinate primary care, behavioral health, and wraparound services needed and desired by patient
Best Practices

Ensure patient understands in-office or home induction procedure
Give written instructions
Nurse calls daily to check on progress
Patient returns in 2-7 days
Buprenorphine: Beginning Treatment

Day 1
Before taking a buprenorphine dose, you want to feel lousy from your withdrawal symptoms. It should be at least 12 hours since you used heroin or pain pills (Oxycontin, Vicodin, etc.) and at least 24-48 hours or longer for long-acting opioids such as methadone. The worse you feel when you begin the medication, the better it will make you feel and the more satisfied you will be with the experience.

You should have at least 3 of the following feelings before taking the medication:
- twitching/tremors/shaking
- muscle, joint, and bone aches
- bad chills or sweating
- anxious or irritable
- goose bumps
- restlessness
- heavy yawning
- enlarged pupils
- stomach cramps, nausea

First Dose: 4 mg of buprenorphine

4 mg of buprenorphine is one half of an 8 mg sublingual film strip (One half tablet of 8 mg tabs, or two tablets of 2 mg tabs)

1. Start with full film
2. Cut full film in half
3. This is your first dose
Administration: Hour 1
1. Place under tongue
   Put the 4 mg strip (or tablet) under your tongue and do not swallow it.
2. Keep it there for 15 minutes
   The medicine is absorbed through the skin on the bottom of your tongue and will work over the course of 15 minutes.
3. Check in at one hour
   If you better, don’t take any more. If you still have feelings of withdrawal, put the remaining 4 mg under your tongue.

Administration: Hours 6 - 12
1. Check in at hour 6
   Later in the day (6-12 hours after the first dose), see how you feel again. If you feel fine, don’t take any more. If you have withdrawal feelings, take another 4 mg dose under your tongue.
2. 16 mg limit and withdrawal
   Do not take more than 16 mg on the first day. Most people feel better after 4 - 12 mg on their first day, but if you still feel really bad, like you are having a bad withdrawal, return to the Emergency Department.
3. Create a plan
   It is crucial that you follow up with a medical provider to start your follow-up care.

Symptoms
Clinical Opioid Withdrawal Scale (COWS)
- 11 item scale - objective and subjective items:
  - Pulse
  - Diaphoresis
  - Tremor
  - Pupils dilated
  - Yawning
  - Runny nose/tearing
  - GI upset
  - Restlessness
  - Bone/joint ache
  - Anxiety
  - Gooseflesh

Induction Visit Procedures
Models of Buprenorphine - Induction Erik Gunderson, MD
- General target score 6-10 prior to starting BUP
- After the first 3 months of experience, began to require >1 objective sign and raised the pre-dose COWS target to >7
- Discharge after the COWS decreased to < 4 Dosing
  - 2-4 mg q1-2 hr (BUP/NX or BUP) started at program
- Take home meds + instructions/phone #
- Max 16 mg Day 1
- Initial Rx/stored on site > dispensed (Requires locked storage and documentation)
Ancillary withdrawal meds taken as needed before or after initiation
Administration: Day 2  The right dose depends on how you felt on day one

- If you took 4 mg on Day 1 and felt fine this morning, take 4 mg as your Day 2 dose.
- If you took 8 mg on Day 1 and felt fine this morning, take 8 mg as your Day 2 dose. OR
- If you took 4 mg on Day 1 and woke up feeling withdrawal symptoms, take 8 mg as your Day 2 dose.
- If you took 8 mg on Day 1 and woke up feeling withdrawal symptoms, take 12 mg as your Day 2 dose. OR
- If you took 8 mg on Day 1 and woke up feeling withdrawal symptoms, take 12 mg as you Day 2 dose.
Starting Buprenorphine  
Outside of Hospitals/Clinics

Wait, Withdraw, Dose
For people with major medical issues or with lower opioid tolerance
(for example using pain pills like Norco or Percocet)

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 find ways to make it better.

If this is your first time on Bup:
- Gather your support team and if possible take a “day off.”
- Don’t drive.
- Using cocaine, meth, alcohol or pills makes starting Bup harder. Be safe.
- Too little Bup can make you still feel withdrawal.
- Too much Bup can make you feel sick or sleepy.

DAY 1
- Plan to take a day off and have a place to rest.
- Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best).
- Dose 1/2 of an 8mg tablet or strip (4mg) under your tongue & let it dissolve.
- If you feel suddenly worse after the first dose, call the Substance Use Navigator or go to the ER.
- Repeat dose (another 4mg) in an hour to feel well.
- If you still feel sick, take another 4mg every 6 hours, up to 24 mg.

DAY 2 AND BEYOND
- Take the total amount you needed on day 1 as a single dose in the morning—for example, if you took a total of 16 mg, take 2 tablets/films at the same time.
- Later in the day, if you still feel like you’re in withdrawal or craving, take 4 mg (half-tablet or half-film) more.
- If you’re too sleepy, take 4 mg less the next day.

Call or text your Substance Use Navigator for help at _______________________

Your next appointment is _______________________

11/18/19
Tips & Tricks: Set Expectations Before You Start

“It may take a little higher dose to get you stable in the beginning, but once you are stable, that dose may be too high and make you sleepy; let me know if that happens.

“Cravings can be both physical and mental. Pay attention when you are having cravings to see if you can tell if it is situational, locational, or purely withdrawal related.”

Most people will have lapses when they enter treatment, the most important thing is to keep taking your medication every day.

Some people, especially in the beginning, feel like the need to take their medication 2-3 times a day instead of once a day. Medically, it works the same, but if you feel like you need to split your dose in the beginning, you can try that. Make sure you don’t go above your daily dose and always let us know how you are taking your medication. Over time, you will want to take your medicine only once a day, because it is more convenient, but it’s ok if you need the extra reassurance right now.
Case presentation

“Bryan” is a 32 y/o male with a >10-year history of opioid abuse. He has used heroin (IV) but prefers pain pills when he can get them. He had been sober for approximately 8 months, and his wife just found out he has started using heroin again. He is here today because his wife gave him an ultimatum, “Quit, or get out.”

What else would you like to know?
Case Presentation

Addiction Hx: recreation use of other drugs in late teens/early 20’s. Non-smoker. Drinks 3-7 beers per week. One previous 30 day program, sober x 6 months following this. Most recently, quit cold turkey, sober x 8 months.

Screening suggestive of depression and anxiety, but no previous Dx or Tx.

Medical: He has chronic back pain from an old injury.

Social Hx: Lives with his wife and 16 y/o daughter. Disabled due to chronic pain from a back injury. Does odd jobs (construction) when available. He has Blue Cross Insurance.
Case Presentation

He last took 2 Hydrocodone/APAP (10/325) this morning (about 6 hours ago). He typically takes 6-10 per day when he can get them. He last used heroin last week.

He reports like he is starting to feel in withdrawal, but it is tolerable. It’s Thursday afternoon, about 4pm.
Next Steps

Labs drawn today [Normal CBC, CMP, Hep Panel, HIV, and RPR]

Naloxone NS given; educated patient and wife on use

Explained that insurance authorization would take 48-72 hours, and that I understood he would probably continue to use during that time.

Rx for bup/nal 8/2mg 1-2 strips daily given x 1 month

Scheduled for in office bup start on Monday morning

Scheduled for appt with counselor on Wednesday morning

Advised not to use anything after 10pm Sunday night
Day 1: Starting Bup

“Bryan” arrives at 9am. His COWS score is 16. He reports he last used at 9:55pm last night (3 tablets hydrocodone 10/325)

Reviewed instructions for use and administered ½ strip (4/1mg).

At 9:45 am, COWS score is 15, and “Bryan” feels no better. Another ½ strip given.

At 10:30 am, Bryan’s COWS score is 6 and he feels much better. I gave Bryan and his wife (an MA) a copy of the COWS scale and told him he could take another ½ strip if/when his symptoms got to a “10”.

Check in by phone tomorrow morning for dose.
Day 2:

Bryan had taken a total of 16/2mg on day 1. On Day 2, I had him take 2 strips in the morning and reminded him of his counseling appt the next day.
Follow up

Bryan was treated with 16mg daily for about 2 months, then decreased to 12 mg with good symptom control.

3 months later, he called the office crying and asking for a new Rx for naloxone. He and his wife found their 17 y/o daughter OD’d in her room and saved her with his initial naloxone Rx.

2 years later, Bryan was on 4 mg daily and was off disability and back at work full time.

Bryan remains in recovery, working full time, and stable on 2mg daily after 6 years of treatment. He has not been able to taper off the last 2mg, although he continues to try every 6 months or so.
Questions?

Email: cstockton@humboldtipa.com

24 Hour CA Substance Use Line for clinicians (UCSF): (844) 326-2626
Continuing the Conversation

Join Dr. Stockton-Joreteg on Tuesday, January 28th from 12 - 1pm PST when she will answer additional questions you may have about Buprenorphine Induction

Join information: https://uclahs.zoom.us/j/275471313

Dial by your location
+1 669 900 6833
Meeting ID: 275 471 313
MAT
WAIVERED PRESCRIBER SUPPORT INITIATIVE

Could you benefit from physician consultation to provide Medications for Addiction Treatment (MAT)?

Are you seeking additional resources to help patients struggling with opioid use?

Do you have questions about best practices to provide MAT for patients with complex needs?

Request Free Technical Assistance TODAY

Make a request at www.uclaisap.org/MATPrescriberSupport/
Additional Learning Opportunities

http://uclaisap.org/MATPrescriberSupport/
Up Next

- Tuesday, February 11th, 2020
  - Cheryl Ho, MD, presenting Shared Medical Appointments