Initiating Buprenorphine for Patients Using Fentanyl

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Disclosures

- Brian Hurley, M.D., M.B.A., DFASAM, FAPA
- No financial conflicts of interests

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
Three Waves of Opioid Overdose Deaths

http://www.cdc.gov/opioids/basics/epidemic.html
Receipt of Any Substance Use Treatment among People with a Past Year SUD

- **Received Treatment**: 6%
- **Didn't Receive Treatment**: 94%

447,000 Felt They Needed Treatment and Made an Effort to Get Treatment (1.1%)

837,000 Felt They Needed Treatment and Did Not Make an Effort to Get Treatment (2.1%)

39.5 Million Did Not Feel They Needed Treatment (96.8%)

40.7 Million People with an Illicit Drug or Alcohol Use Disorder Who Did Not Receive Substance Use Treatment at a Specialty Facility
Receipt of Medication for Opioid Use Disorder among People with a Past Year OUD

- 78% Received MOUD
- 22% Didn't Receive MOUD

Buprenorphine & Methadone Pharmacokinetics

Log Dose

Opioid Effect

100%

Ceiling Effect

Agonist (methadone)

Partial Agonist (buprenorphine)

Antagonist (naltrexone)

Log Dose

Slide Credit: Curtis Geier and Ben Smith
# Buprenorphine Formulations for Opioid Use Disorder

<table>
<thead>
<tr>
<th>Content</th>
<th>Route</th>
<th>Product</th>
<th>Available Doses</th>
<th>Equivalent Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combo Product</td>
<td>Sublingual</td>
<td>Film - Generic, Suboxone</td>
<td>2 mg Bup/0.5mg Nx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 mg Bup/1mg Nx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 mg Bup/2mg Nx</td>
<td>8mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 mg Bup/3mg Nx</td>
<td></td>
</tr>
<tr>
<td>Mono Product</td>
<td>Sublingual</td>
<td>Tablet-Generic</td>
<td>2 mg Bup/0.5mg Nx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 mg Bup/2mg Nx</td>
<td>8mg</td>
</tr>
<tr>
<td>Pending Mono Product</td>
<td>Injectable</td>
<td>&quot;Brixadi&quot;</td>
<td>Weekly and Monthly</td>
<td></td>
</tr>
</tbody>
</table>

- **0.7mg Bup/0.18mg Nx**
Benefits of MAT: Decreased Mortality

**Death rates:**

- **General population**
- **Medication-assisted treatment**
- **No treatment**

Standardized Mortality Ratio

Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017
Treatment Retention and Decreased Illicit Opioid Use on MAT

• Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids

![Graph showing treatment retention and decreased illicit opioid use over time.]

Kakko et al, 2003
Soeffing et al., 2009
Major Features of Buprenorphine

**Partial agonist** at mu receptor
- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

**Long acting**
- Half-life ~ 24-36 Hours

**High affinity** for mu receptor
- *Blocks* other opioids
- *Displaces* other opioids
  - Can precipitate withdrawal

**Slow dissociation** from mu receptor
- *Stays on receptor for a long time*
Instruct the patient to abstain from any opioid use for a minimum of:

- 12-16 hours for short-acting opioids
- 24 hours for sustained-release opioid medications
- 36 hours for methadone

Observe and document Mild vs. Moderate withdrawal:

- **NOTE:** Be aware of Fentanyl; do not induce unless moderate withdrawal (COWS 13 to 15) is observed
Classic Buprenorphine Initiation

- First dose: 2-4 mg SL buprenorphine/naloxone
- Relief of opioid withdrawal symptoms should begin within 30-45 minutes after the first dose
- Re-dose every 2-4 hours, if opioid withdrawal subsides then reappears
- Stabilize at dose that eliminates craving; typical dose range from 8 mg to 16 mg
- Gradually increase dose after establishment of a steady state over as needed for continued craving.
  - Note: This can be increased more rapidly if the patient has a lot of craving.
Classic Buprenorphine Initiation

- Day #2: Continue dose established on Day #1
  - Encourage patient to preferably take Day #1 dose on the morning of Day #2
  - Encourage office staff to contact patient on Day #2 to assess dose response
  - After contact with patient there may be reason for additional dose adjustments:
    - If patient feels well, instruct patient to continue Day #1 dosing
    - If patient is experiencing cravings or discomfort consider increasing dose by 2-4 mg
    OR
    - discuss relapse prevention and assure patient that discomfort will stabilize over time
- Avoid rapid dose adjustments
Stabilization will occur for most patients between 8 to 16mg per day:

- Most individuals do not need more than 16mg per day but occasionally higher doses may be needed for persistent symptoms/ongoing opioid use
  - Most insurance companies limit daily doses to 24 mg
  - Though there is approval for a maximum dose of 32mg, doses above 24mg may increase risk of diversion

- Note – If there are concerns for diversion:
  - Consider more intensive monitoring [E.g. more frequent urine testing, shorter prescription durations, supervised dosing]
“Everything is not right anymore”: Buprenorphine experiences in an era of illicit fentanyl

Sydney M. Silverstein, Raminta Daniulaityte, Silvia S. Martins, Shannon C. Miller, Robert G. Carlson

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Self-treatment

ABSTRACT

Background: Conducted in the Dayton Metropolitan area of Southwestern Ohio, this qualitative study explores the self-treatment practices of people who use illicit opioids (PWUIO) amidst the new risk environment produced by illicit, non-pharmaceutical fentanyl (NPF). We explore local perceptions of the presence of NPF in the Dayton area, and how this has both positively and negatively impacted practices of non-prescribed buprenorphine use among PWUIO.

Methods: This study analyzes qualitative data from 63 interviews conducted between October 2018 and June 2019. Participants were selected from a larger longitudinal study on non-prescribed buprenorphine use among individuals with opioid use disorder. Qualitative interviews were transcribed in their entirety, and their transcriptions were analyzed using NVivo software, drawing on a mix of thematic and inductive coding.

Results: Interview respondents ranged from 19 to 70 years old, with a mean age of 38.9 years. 54% of them were male, and 85.7% identified as non-Hispanic White. 98.4% of the sample had used heroin, and 93.7% of the sample reported use of NPF. Participants agreed NPF dominated the illicit opioids market in the area, and was

Fentanyl Pharmacokinetics

- $t_{1/2}$ of 2–4 h
- Rapidly decline $\rightarrow$ redistribution to other tissues
- Rapid sequestration in adipose
- Case series of 12 patients:
  - Mean time for uutox clearance
    - Fentanyl – 7.3 days
    - Norfentanyl – 13.3 days


Buprenorphine Initiation Options

- High Dose Starts
- Low Dose Starts
- Controlled Environment Starts
- Pain Management / Analgesic Dosing
High Dose Starts
Buprenorphine (Bup) Emergency Department Quick Start

Objective uncomplicated opioid withdrawal

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

If no improvement or worse consider:
Undertreated withdrawal: Occurs with lower starting doses and heavy tolerance, improves with more bup (add 1 8-16 mg SL)
Other substance intoxication or withdrawal: Stimulant intoxication, alcohol/serax/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

We encourage shared decision making with patient for dosing.
* Opioid Withdrawal:
At least one clear objective sign (prefer ≥ 2):
Tachycardia, mydriasis yawning, micromere, vomiting, diarrhea 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 4q6h PRN cravings, usual dose 16-32 mg/day After first day, consolidate dosing to daily

Discharge
- Prescribe sufficient bup/rx until follow-up, e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Note to pharmacy: bill Medi-Cal FTFS, ICD 10 F11.20
- An X-waiver is no longer needed to prescribe bup.
- 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

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

Withdrawal improved?

Administer 8-16 mg bup SL

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 3-10 minutes or continuous infusion until calm). Once withdrawal is managed, continue daily bup dose.

http://cabridge.org/resource/buprenorphine-bup-hospital-quick-start
High Dose Buprenorphine Outcomes: Hospital Settings

- 492 patients administered buprenorphine, 44 (9.5%) used fentanyl
- 439 patients (89.3%) initiated high-dose buprenorphine (8-32 mg)
  - Follow-up at 30 days among patients administered buprenorphine was similar for those who did and did not report fentanyl use: 36 patients [41.4%] vs 301 patients [37.2%]
- Precipitated withdrawal was documented for 8 patients overall (1.6%).
  - For patients who reported fentanyl use, 2 cases (4.5%) of precipitated withdrawal.
  - No precipitated withdrawal required hospital admission
  - 4 patients (50.0%) had documentation of follow-up at 30 days.
- Adjusted odds ratios for patients who reported fentanyl use compared with patients who reported other opioid use:
  - 0.60 (95% CI, 0.32-1.07) for administered or prescribed buprenorphine in the ED encounter
  - 1.09 (95% CI, 0.62-1.92) for follow-up at 7 days
  - 1.33 (95% CI, 0.73-2.41) for follow-up at 30 days.
- No differences in follow-up engagement by patients with self-reported fentanyl use (adjusted odds ratio, 1.09), and precipitated withdrawal was rare (8 patients [1.6%]).

High Dose Buprenorphine: Ambulatory

You need at least 3 of the following feelings before taking your first buprenorphine dose*:

- Yawning
- Enlarged pupils
- Joint and bone aches
- Shaking or twitches
- Watery eyes/Runny Nose
- Nausea, vomiting or Diarrhea
- Sweating or chills
- Restless/Can’t sit still
- Anxiety, irritable, fast heart beat
- Bumpy skin (Gooseflesh)
- Lost Appetite, Stomach cramps

• Dosing: Take ½ to 1 strip or tab every 1 hour until withdrawal / cravings are gone
• Can go up to a recommended max dose of 32mg, but not every patient needs this dose
2. Put the tablet/film under your tongue and let it dissolve [don’t swallow, don’t chew]

![Image of tablet under tongue]

3. After 1 hour, how are you feeling?
   - IF GOOD: nothing more to do
   - IF still having the withdrawal symptoms or feeling worse:
     put another tablet under your tongue

**Day 2:**
- IF you feel good the next day, take the **same** number of pills you took the day before
- during the day: if you feel withdrawal symptoms or feel cravings you can take another tablet under your tongue

**Day 3:**
- IF you feel good, you can take the same number of pills you took the day before or split it however you want throughout the day.
- IF you are taking LESS than 4 tablets AND you have cravings later in the day, you can take yourself the 4th tablet whatsoever time of the day you want.
ER Buprenorphine Injection
ER Buprenorphine Injection

ER Bup 300mg/300mg, then 100mg qMonth

ER Bup 300mg qMonth
Single Day ER Bup Inj Protocol

- Five patients, open label protocol, 12 week study
- ER Bub Inj 300 mg after patient tolerated > 24 mg of SL buprenorphine in a single day
  - In clinic-setting
  - Hourly SL buprenorphine dosing schedule was 2 mg-6 mg-8 mg-8 mg
  - One hour after last buprenorphine dose → ER Bup Inj 300 mg
- Three total monthly injections of BXR (300 mg-300 mg-100 mg), patients monitored 4 weeks following third injection
- 5 (100%) retained all 12-weeks & received all three injections
- Acceptability of the single-day start on ER Bup inj was high
- Longest period of illicit opioid use during study period: 5 days

Low Dose Starts
**Table 2. Outpatient Microinduction Protocol Using Sublingual 2 mg Buprenorphine/Naloxone Tablets or Films**

<table>
<thead>
<tr>
<th>Day</th>
<th>Bup/Nlx Dose and Frequency</th>
<th>Full Agonist Opioid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.5 mg daily (1/4 tablet or film)</td>
<td>No change</td>
</tr>
<tr>
<td>2</td>
<td>0.5 mg BID</td>
<td>No change</td>
</tr>
<tr>
<td>3</td>
<td>1 mg BID (half-tablet or film)</td>
<td>No change</td>
</tr>
<tr>
<td>4</td>
<td>2 mg BID</td>
<td>No change</td>
</tr>
<tr>
<td>5</td>
<td>2 mg TID</td>
<td>No change</td>
</tr>
<tr>
<td>6</td>
<td>4 mg TID</td>
<td>No change</td>
</tr>
<tr>
<td>7 and beyond</td>
<td>Per provider discretion</td>
<td>Taper by 25% weekly</td>
</tr>
</tbody>
</table>


http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/31941547
<table>
<thead>
<tr>
<th>DAY</th>
<th>OPTION 1</th>
<th>OPTION 2</th>
<th>OPTION 3</th>
<th>ADJUNCTIVE THERAPIES FOR MANAGING WITHDRAWAL SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.5 mg and 0.125 mg SL daily</td>
<td>0.5 mg and 0.125 mg SL once daily</td>
<td>0.25 mg and 0.0625 mg SL once daily</td>
<td>• 0.1 mg of clonidine twice daily as needed for agitation</td>
</tr>
<tr>
<td>2</td>
<td>0.5 mg and 0.125 mg SL daily</td>
<td>0.5 mg and 0.125 mg SL twice daily</td>
<td>0.25 mg and 0.0625 mg SL twice daily</td>
<td>• 400-600 mg of ibuprofen 4 times daily as needed and 650-1000 mg acetaminophen every 6 h as needed for myalgia</td>
</tr>
<tr>
<td>3</td>
<td>1 mg and 0.25 mg SL daily</td>
<td>1 mg and 0.25 mg SL twice daily</td>
<td>0.5 mg and 0.125 mg SL twice daily</td>
<td>• 50 mg of dimenhydrinate every 6 h as needed for nausea or vomiting</td>
</tr>
<tr>
<td>4</td>
<td>1.5 mg and 0.375 mg SL daily</td>
<td>2 mg and 0.5 mg SL twice daily</td>
<td>1 mg and 0.25 mg SL twice daily</td>
<td>• 2 mg of loperamide after loose bowel movement as needed for diarrhea</td>
</tr>
<tr>
<td>5</td>
<td>2 mg and 0.5 mg SL daily</td>
<td>3 mg and 0.75 mg SL twice daily</td>
<td>2 mg and 0.5 mg SL twice daily</td>
<td>• Can consider providing 2 doses of 2 mg and 0.5 mg of SL buprenorphine-naloxone every h as needed for withdrawal</td>
</tr>
<tr>
<td>6</td>
<td>3 mg and 0.75 mg SL daily</td>
<td>4 mg and 1 mg SL twice daily</td>
<td>4 mg and 1 mg SL twice daily</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>4 mg and 1 mg SL daily (can stop short-acting or begin tapering long-acting opioids)</td>
<td>12 mg and 4 mg SL once daily (stop all opioids)</td>
<td>12 mg and 4 mg SL once daily (stop all opioids)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>5 mg and 1.25 mg SL daily</td>
<td>Adjust further dosing based on patient symptoms</td>
<td>Adjust further dosing based on patient symptoms</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>6 mg and 1.5 mg SL daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>7 mg and 1.75 mg SL daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>8 mg and 2 mg SL daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>10 mg and 3 mg SL daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>12 mg and 4 mg SL daily (stop all opioids)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Adjust further dosing based on patient symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SL—sublingual.
Data from Patel et al, Lee, Crawley et al, Sandhu et al, and Cho and Lu.

Slide Credit: Joshua Bloom, MD
Supportive medications

- Clonidine 0.1-0.2 every 4-6h
  - Sweating, goosebumps
- Ondansetron 8 mg every 8h
  - Nausea, vomiting
- Hydroxyzine 50 mg every 6h
  - Anxiety, insomnia
- Ibuprofen 600 mg every 6h
  - Myalgias, arthralgias
- Loperamide 1-2 at onset of diarrhea

Slide Credit: Joshua Bloom, MD
Pain Management / Analgesic Dosing
How to Switch to Buprenorphine from Opioids
like oxycodone, hydrocodone, morphine or methadone

**Goal:** Start buprenorphine without period of withdrawal

**Apply Butrans Patch.**
- Remove bedtime on 5th day
- Rarely covered by insurance.
- Cheap via 340B and only need a single patch

**Taper Opioid as tolerated**
- Use clonidine as needed
- Reduce by ~50% Day 2
- Stop on Day 3 or 4

**Start Sublingual Buprenorphine on Day 3 and gradually increase.**
Prescribe buprenorphine/naloxone 2/0.5mg film #30 and a single Butrans patch

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<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Butrans Patch</strong>*</td>
<td><strong>Oxycodone</strong> etc</td>
<td><strong>SL Buprenorphine</strong>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apply Patch</td>
<td>Continue</td>
<td>Continue</td>
<td>Continue</td>
<td>Remove at Bedtime</td>
<td>Continue</td>
<td>Continue</td>
</tr>
<tr>
<td>Continue</td>
<td>Continue</td>
<td>Stop at Bedtime</td>
<td>1mg TID (1/2 film)</td>
<td>2mg TID</td>
<td>2-4mg TID</td>
<td>2-4mg TID or more</td>
</tr>
</tbody>
</table>

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Buprenorphine Patch Dosing
MED=30 = 5mcg/hour
MED 30-90 = 10mcg/hour
MED>90 = 20 mcg/hr

---

Stop old Opioid on Day 3-4
Stop

---

Adjust dose Day 5+
based on withdrawal, pain and sedation

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Adapted from
1. Amer Raheemullah, MD; Anna Lembke, MD. JAMA internal medicine. January 2019. Initiating Opioid-Agonist Treatment for Opioid Use Disorder in the Inpatient Setting: A Teachable Moment

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Slide Credit: Joshua Bloom, MD
**How to Switch to Buprenorphine from Opioids (Microdosing)**

**Goal:** Start buprenorphine without period of withdrawal

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<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Opioid*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Start Sublingual Buprenorphine**

- **Day 1**: 0.5mg BID
- **Day 2**: 1mg BID
- **Day 3**: 1mg TID
- **Day 4**: 2mg TID
- **Day 5**: 2-4mg TID

**Adjust Bup Dose**
- Typical Pain Dose: 4-12mg divided 3-4 times daily

**Transdermal Buprenorphine Patch**

- **Remove Patch Day 5 Bedtime**

**Buprenorphine Patch Dosing**
- MED<30 = 5mcg/hour
- MED 30-90 = 10 or 15mcg/hour
- MED>90 = 20 mcg/hour

*Discontinue after 5 days or begin taper day 2-3

†Prescribe buprenorphine/naloxone 2/0.5mg film or tab. MEDD<40 may stabilize on 1mg TID-QID. MEDD = Morphine Equivalent Daily Dose

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Slide Credit: Joshua Bloom, MD

From Matt Perez 2020
Buprenorphine Pharmacokinetics

Fig. 4. The time course of plasma levels of buprenorphine, norbuprenorphine and naloxone for a subject receiving a sublingual dose of the combination tablet of buprenorphine (16 mg) and naloxone (4 mg) (data from Jones et al., 1997).

Slide Credit: Curtis Geier and Ben Smith
Controlled Environment Starts
Starting SL Buprenorphine in a Controlled Setting After Withdrawal

How to start buprenorphine/naloxone after the patient is no longer in withdrawal?

- Week 1: 1mg/0.25mg daily x7d
- Week 2: 2mg/0.5mg daily x7d
- Week 3: 3mg/0.75mg daily x7d
- Week 4: 4mg/1mg daily x7d
- Week 5: 6mg/1.5mg daily x7d
- Week 6: 8mg/2mg daily x14d
- Week 7: 16mg/4mg daily QOD

However… *participants started onto buprenorphine at a rate faster than the induction schedule.*

- In another trial:
  - Initial dose 4 mg which could be stepped up to a maximum of 8 mg on the first day. On subsequent days the subject could be stepped up to a maximum of 32 mgs, if clinically indicated and the patient agreed.

Medication FIRST Model

- People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatments planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
- Pharmacotherapy is discontinued only if it is worsening the person’s condition.

http://www.nomodeaths.org/medication-first-implementation
Medication FIRST Model

- Medication *first does not mean* Medication *only*
- Medication is contingent upon the pt’s benefit, not based upon a timeframe, patient’s participation in counseling, an unexpectedly positive test result, etc

http://www.nomodeaths.org/medication-first-implementation
References


PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.

- PCSS Mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD).

- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.

- No cost.

For more information visit:  
https://pcssNOW.org/mentoring/
PCSS Discussion Forum

Have a clinical question?

Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register
**PCSS** is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

<table>
<thead>
<tr>
<th>Addiction Technology Transfer Center</th>
<th>American Society of Addiction Medicine</th>
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<tbody>
<tr>
<td>American Academy of Family Physicians</td>
<td>American Society for Pain Management Nursing</td>
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<tr>
<td>American Academy of Pain Medicine</td>
<td>Association for Multidisciplinary Education and Research in Substance use and Addiction</td>
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<tr>
<td>American Academy of Pediatrics</td>
<td>Council on Social Work Education</td>
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<tr>
<td>American Pharmacists Association</td>
<td>International Nurses Society on Addictions</td>
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<tr>
<td>American College of Emergency Physicians</td>
<td>National Association for Community Health Centers</td>
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<tr>
<td>American Dental Association</td>
<td>National Association of Social Workers</td>
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<tr>
<td>American Medical Association</td>
<td>National Council for Mental Wellbeing</td>
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<tr>
<td>American Osteopathic Academy of Addiction Medicine</td>
<td>The National Judicial College</td>
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<tr>
<td>American Psychiatric Association</td>
<td>Physician Assistant Education Association</td>
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<tr>
<td>American Psychiatric Nurses Association</td>
<td>Society for Academic Emergency Medicine</td>
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</tbody>
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Educate. Train. Mentor

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