Medication Assisted Treatment (MAT) Community of Practice (CoP)

June 21, 2018

Meeting Topic: Inducting Patients onto Buprenorphine

Questions and Answers

Q1. Is it feasible to determine substance use among patients who use more than one substance prior to buprenorphine induction?

A1. The Clinical Opiate Withdrawal Scale (COWS) is a standardized tool that can be used to assess withdrawal. It is a subjective and objective tool. Onset of withdrawal varies depending on the substance used. Fentanyl is the shortest where people using this substance can experience withdrawal symptoms within a couple hours whereas methadone can take a 1.5-2 days. It is important to get a good history of the substance(s) used. The Subjective Opiate Withdrawal Scale (SOWS) may be instrumental in assessing symptoms including anxiety which remain difficult to assess.

Q2. If you have high risk high need individuals, do you still advise induction onto buprenorphine if patient has a positive urine drug test?

A2. It is advised to continue treatment for individuals with a positive urine drug test with close monitoring. For example, a patient in jail had been prescribed about 2 mg daily and the urine test was positive. The clinician continued to administer the prescription and monitor them regularly.

Q3. Do the majority of patients receive home or office buprenorphine induction?

A3. Typically, the first buprenorphine dose will be in the office but the majority of cases do transition to home induction. The clinician will prescribe 4mg of buprenorphine and will teach the patient to administer the COWs. For high risk high need populations, prescriptions are written for naloxone in an effort to prevent an overdose.

Q4. If a patient tests positive for benzodiazepine, what are the appropriate next steps in treatment?

A4. Inform and educate the patient that benzodiazepine and buprenorphine interactions are harmful. It is important to ensure that the patient is engaged in appropriate counseling. Address use of benzodiazepines in consent and treatment agreement to help ensure that there isn't ongoing use. The Food & Drug Administration (FDA) recently released a statement to advice clinicians to keep prescribing the appropriate dosage of buprenorphine even though benzodiazepine use is present. In some cases i.e. klonopin use, withdrawal management is strongly not advised due to medicinal interactions within the body.

Q5. How do you determine if an increase in dosage level is needed for patients who experience increased withdrawal symptoms?

A5. It is best to discuss the underlying cause of the increased withdrawal symptoms. The clinician can ask the patient to describe the symptoms associated with withdrawal and reinforce the way the medication works. The clinician may advise patient to come in the office to discuss treatment options rather than increasing the dose at home. The typical dose may range from 12-16 mg depending on the diagnosis. Some patients will inform the clinician of the extra doses they took due to experiencing withdrawal symptoms.

In addition, clinicians need to advise patients against splitting doses to address their withdrawal symptoms. The intent of the prescription is to best saturate them using the most appropriate medication. The medication may stay in the body for 24 hours, more or less. However, it is common to compare heroin use and buprenorphine, with the notion that they need to take it more often. It is great to engage with patients to understand the underlying stressors while offering emotional and behavioral support.

Q6. For pregnant women, does it matter whether she is given the mono (buprenorphine) or combination (buprenorphine/naloxone) product?

A6. Most advise the use of the combination (buprenorphine/naloxone) product during pregnancy. This product is favored during pregnancy to avoid diversion and prevent unnecessary complications once the baby is delivered. There have not been many difficulties associated with infants. The Moms in Recovery program provide the combination product.

Q7. In your clinic settings, how many patients are enrolled in the mono (buprenorphine) or combination (buprenorphine/naloxone) product?

A7. Dartmouth hospital has 275 patients, 15-16 of these patients are enrolled in mono-therapy. In one clinic, five patients are enrolled in mono-therapy. Cost remains the determining factor since mono-therapy costs 4 times as much as combination product.

Q8. Are there symptoms associated with mono (buprenorphine) compared to the combination (buprenorphine/naloxone) product?

A8. Some patients have noted switching from mono to combination product due to edema, nausea, GI and withdrawal symptoms. Anxiety has been noted to be a common symptom as well.