

Buprenorphine Administration Quick Start Guide

This guide is intended as a quick reference for clinicians treating patients with opioid use disorder (OUD) in a hospitalized setting who are interested in and appropriate for buprenorphine initiation. More information on hospital-based treatment of OUD can be found in the [SHOUT Texas Toolkit](#) and at [SHOUTx.org](#).

A DEA X-Waiver is NOT required in order to administer buprenorphine for hospitalized patients admitted for a primary medical condition other than opioid dependency.

1. Identify

Appropriate patients

- In opioid withdrawal, and
- Diagnosed OUD: Loss of **control** with ongoing **compulsive** use despite **consequences**.

Inappropriate patients

- Pregnancy (consult with specialist)
- Acute pain requiring opioid agonist therapy
- Anticipated surgery or medically unstable (use full agonist opioids as appropriate – may require higher doses if physically tolerant)

2. Counsel

Educate on the patient experience

- Withdrawal symptoms that will be managed
- Potential for precipitated withdrawal if any other opioids are present in system

Build rapport and trust

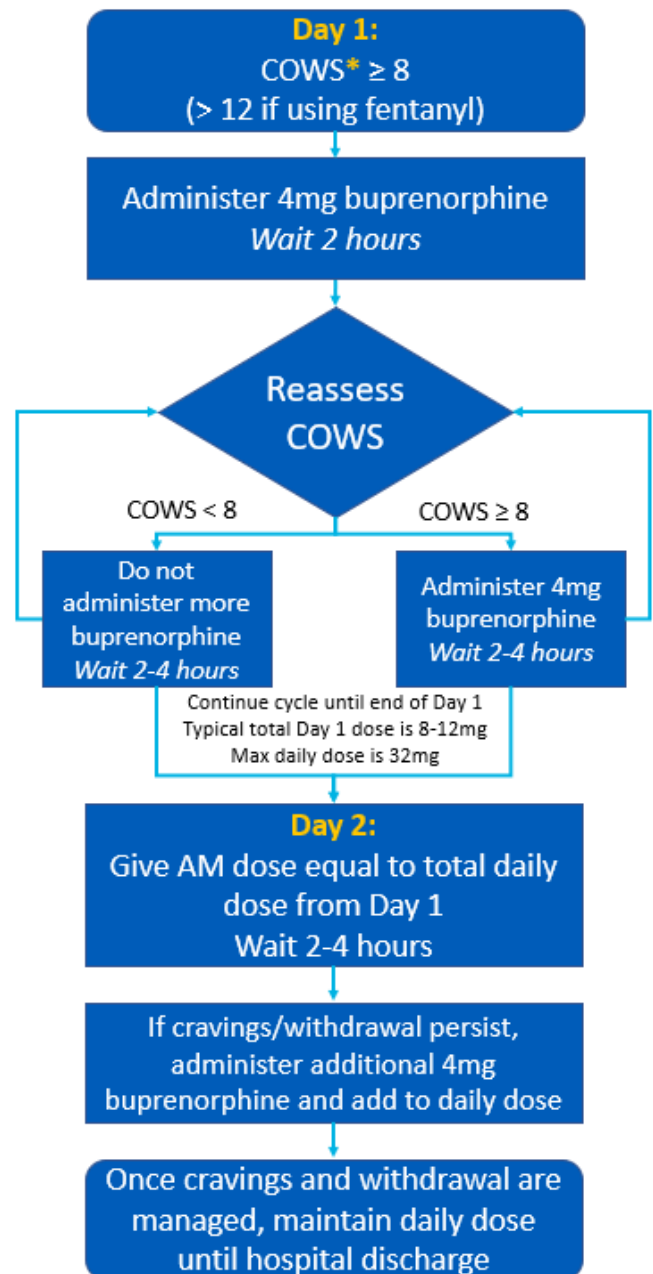
- Outline process for monitoring withdrawal
- Describe adjunctive medications to be used to treat withdrawal symptoms before, during, and after buprenorphine administration
 - [Ondansetron](#) for nausea
 - [NSAIDs](#) for muscle and joint pain
 - [Loperamide](#) for diarrhea
 - [Hydroxyzine](#) or [Lorazepam](#) for anxiety
 - [Clonidine](#) for sweating, goosebumps, anxiety

3. Assess

Assess patient readiness

- Discontinue all opioids
 - 8-12 hours for short-acting
 - 12-24 hours for long-acting
 - 16-24 hours for fentanyl
 - 36-96 hours for methadone

4. Administer Buprenorphine



If a patient is stable on a home dose of buprenorphine or methadone, **without a lapse in dosing that has resulted in moderate-severe withdrawal symptoms**, verify home dose with the outpatient provider or in the PDMP and continue home medications without following the protocol above. Methadone does *not* appear in the PDMP, the patients' Opioid Treatment Program must be contacted.

Don't delay initial dosing

- A urine drug screen and lab testing are **NOT** necessary prior to initial buprenorphine administration, especially if the patient is already experiencing withdrawal symptoms.
- Patients do **NOT** need to commit to ongoing outpatient care prior to starting buprenorphine treatment in the hospital setting.

Buprenorphine 101

Considerations

- Medications for OUD are the **cornerstone of treatment**. Information on other medications to treat OUD can be found in the [SHOUT Texas Toolkit](#).
- Typically administered sublingually and has very low oral bioavailability.
- Onset is within 15 minutes, peaks at ~1 hour, and reaches steady state in ~7 days.
- Can be dosed, daily, BID, or TID.
- Possesses a "ceiling effect" - doses higher than 24mg do not further suppress respiratory or cardiovascular function.

Side Effects

- Headache, nausea, constipation, and sweating.

Benefits

- **Safe, cost-effective, and evidence-based.**
- Reduces mortality by 50%.
- Relieves withdrawal (when started correctly).
- Suppresses opioid cravings (at 8-24mg).
- Can be prescribed from the outpatient setting.

Risks

- **Overdose with buprenorphine in adults is rare** but most often occurs in individuals without opioid tolerance or who are using substances like alcohol or benzodiazepines.
- Buprenorphine is a partial mixed opioid agonist at the μ -receptor and **can precipitate withdrawal symptoms in patients actively taking other opioids.**

Considerations for Hospital Discharge

Medically-supported withdrawal by **tapering buprenorphine during hospitalization or stopping on discharge increases risk of fatal overdose**. Make every effort to link patients to ongoing outpatient treatment and discharge with adequate bridge prescription to ensure dosing until initial outpatient appointment (7-14 days).

- A DEA X-waiver **is required** to prescribe a buprenorphine bridge prescription upon hospital discharge.
- Anticipate upcoming discharge date and seek discharge prescribing support from a DEA X-waivered provider (or [sign up for your own X-waiver](#) in less than two minutes).
- Counsel patient on safe administration and storage, risks of concurrent alcohol or benzodiazepine use.
- **Always prescribe naloxone for overdose reversal.**

If an X-waivered provider is unavailable prior to hospital discharge:

- Contact the post-discharge clinic for an immediate follow up appointment.
- A loading dose (24-32mg) can be administered to prevent withdrawal for ~48 hours.
- If available in the ED, patient can return daily for up to 3 days to receive buprenorphine administration.

* Sample COWS scale is available in the SHOUT Texas [Toolkit for Hospital Opioid Use Disorder Treatment](#)

MORE INFORMATION, RESOURCES, AND EDUCATIONAL OPPORTUNITIES AT: [SHOUTx.org](https://shoutx.org)

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