SHOUT TEXAS

Buprenorphine Standard Initiation 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 **standard buprenorphine initiation**. Clinical considerations for alternative buprenorphine initiation strategies can be found in this guidance document.

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 NO LONGER REQUIRED in order to administer or prescribe buprenorphine for patients.

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*)
- Medically unstable (*consult with specialist*)
- Acute pain or surgery requiring opioid agonist therapy - use full agonist opioids as appropriate *(review "cross-over" administration protocol)*

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

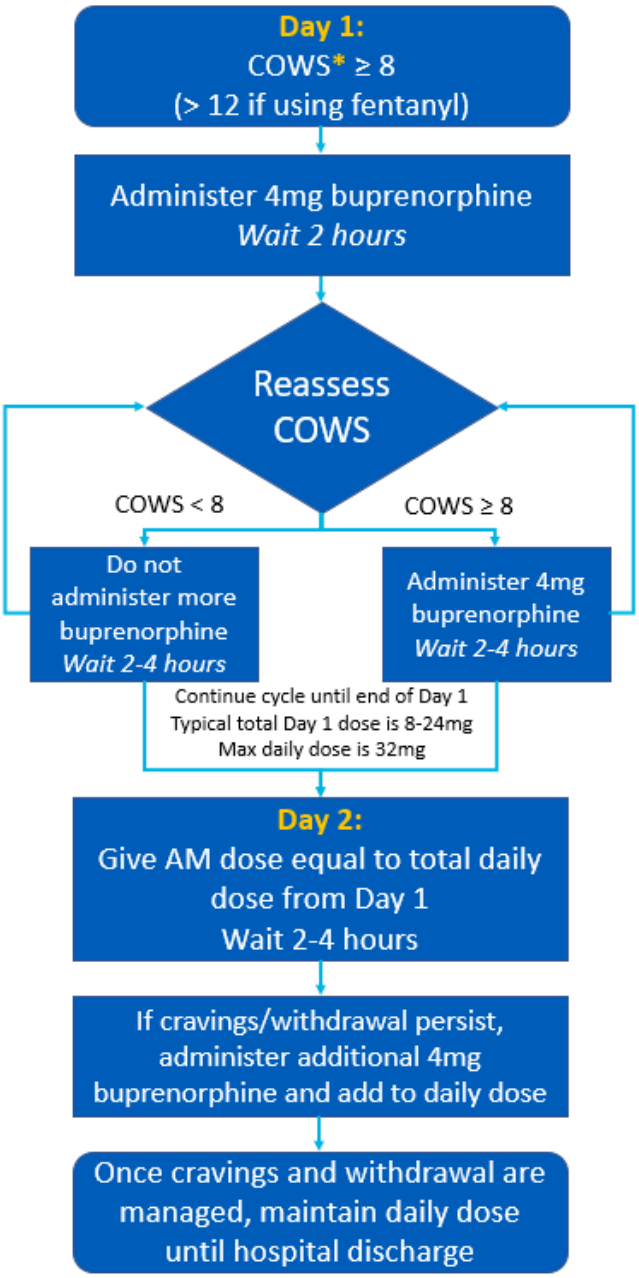
- Outline process for monitoring withdrawal
- Describe adjunctive medications to be used to treat withdrawal symptoms before, during, and after buprenorphine administration
  - Ondansetron for nausea
  - NSAIDs for muscle and joint pain
  - Loperamide for diarrhea
  - Hydroxyzine or Lorazepam for anxiety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

3. Assess

Assess patient readiness

- Discontinue all opioids
  - 12 hours for short-acting
  - 24 hours for long-acting
  - 24 hours or longer for fentanyl
  - 96 hours or longer for methadone

4. Administer Buprenorphine



Verifying Home Dosage: If a patient is stable on a home dose of buprenorphine or methadone, without a lapse in dosing that has resulted in moderate to 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 8-32mg).
- 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 or other opioids 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 (7-20 days is reasonable/common).

- Anticipate upcoming discharge date. A DEA X-waiver **is no longer required** to write a buprenorphine bridge prescription upon hospital discharge (Learn more about the removal of the DEA x-waiver and new educational requirements).
- Counsel patient on safe administration and storage, risks of concurrent alcohol or benzodiazepine use.
- Always prescribe naloxone for overdose reversal.

If a prescription cannot be placed 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