

Medications for Opioid Use Disorder

(MOUD) Provider Education



Facts about Buprenorphine



FDA approved for Opioid Use Disorder (OUD) treatment in an office-based setting.



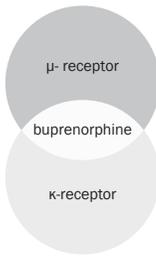
Available in sublingual tablet, sublingual film, or subcutaneous injectable formulations.



For those with tolerance to opioids as a result of OUD, buprenorphine is often a safe choice.



Many formulations contain naloxone to prevent injection diversion. This formulation is the preferred treatment medication. The buprenorphine only version is often used with pregnant women to decrease potential fetal exposure to naloxone.



Buprenorphine acts as a partial mixed opioid agonist at the μ -receptor and as an antagonist at the κ -receptor. It has a higher affinity for the μ -receptor than other opioids, and it can precipitate withdrawal symptoms in those actively using other opioids.



There is a “ceiling effect” in which further increases above 24 mg in dosage does not increase the effects on respiratory or cardiovascular function.



It is dosed daily, has a long half-life, and prevents withdrawal in opioid dependent patients.



Overdose with buprenorphine in adults is less common, and most likely occurs in individuals without tolerance, or who are combining buprenorphine with other medications that increase risk (i.e., benzodiazepines, opioids, etc.).



Buprenorphine should be a part of a comprehensive management program that includes psychosocial support. While initial treatment should not be withheld in the absence of psychosocial support, it should be arranged as part of the ongoing treatment plan.

Important points to review with the patient



Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.



Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.



Understand the importance of informing providers if they become pregnant.



Tell providers if they are having a procedure that may require pain medication.

Checklist for prescribing Medication for the Treatment of Opioid Use Disorder

✓ **Assess the need for treatment**

- ✓ For people with diagnosis, first determine the severity of the substance use disorder (SUD), then identify any underlying or co-occurring disease or condition.



✓ Assessments should include:

- ✓ A comprehensive patient history; both medical and psychiatric
- ✓ A brief mental status examination
- ✓ Substance use history
- ✓ Evaluation of family and psychosocial supports
- ✓ Prescription drug history using a PDMP system – OARRS
- ✓ A physical examination focusing on findings related to addiction
- ✓ Laboratory testing to assess opioid use including a urine drug screening to establish a baseline prior to prescribing
- ✓ For women of childbearing age, a pregnancy test
- ✓ Testing for HIV, and hepatitis B and C with consideration of testing for tuberculosis and sexually transmitted infections in patients with known risk-factors

✓ **Provider education about available treatment options and information about how the medication works including risks and benefits along with overdose prevention information.**

✓ **Obtain a signed treatment agreement and plan that includes**

- ✓ Rationale for the specific medication to be used
- ✓ Patient education
- ✓ Informed consent
- ✓ Random urine drug screens
- ✓ A plan for psychosocial needs as addressed below

✓ **Evaluate the need for medically managed withdrawal**

- ✓ Those starting buprenorphine must be in withdrawal

✓ **Address co-occurring disorders**

- ✓ Use an integrated team approach to address identified needs

✓ **Integrate both pharmacological and nonpharmacological therapies**

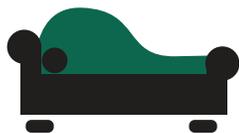
✓ **Refer patients to higher levels of care when appropriate**

- ✓ Treatment services can be found using:
 - ✓ www.findtreatment.samhsa.gov
 - ✓ www.relink.org

Addressing Psychosocial Needs



If the prescribing provider is not either a board-certified Addictionologist or Psychiatrist, the patient should be referred to, and work jointly with a qualified behavioral healthcare provider, community mental health services provider, or community addiction services provider.



At a minimum the treatment should include a psychosocial assessment, supportive counseling, links to existing family supports, and referrals to community services.



Treatment by a qualified behavioral healthcare provider should include at least one of the following unless exceptions are documented in the patient record:



Should the patient refuse treatment from behavioral healthcare provider, they will be required to participate in a 12-step program or other self-help recovery program.



Cognitive behavioral therapy



Motivational interviewing



Behavioral couples therapy



Contingency management/motivational incentives



Community reinforcement approach

Induction Considerations



The dose of buprenorphine depends on the severity of withdrawal and when the last opioid use occurred.



Longer acting opioids, such as methadone or fentanyl require 48-72 hours since last use before starting buprenorphine.



Short acting opioids, such as heroin, require approximately 12 hours since last use before starting buprenorphine.



Clinical presentation should guide this decision on an individual patient basis.

Determine Withdrawal

The risk with initiating buprenorphine too soon is that it may displace other opioids on the mu receptor, causing precipitated withdrawal.

Using the Clinical Opiate Withdrawal Scale (COWS), determine the level of withdrawal.

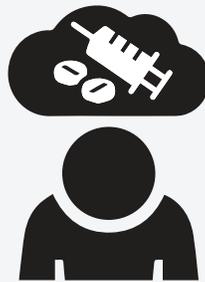
Use the COWS tool in your EMR system or scan below for a mobile friendly calculator.



Precipitated Withdrawal



Precipitated withdrawal can occur when buprenorphine displaces lower affinity opioids from the mu opioid receptor.



Symptoms are similar to opioid withdrawal.



Precipitated withdrawal can be avoided by ensuring withdrawal is at the appropriate level. A COWS score should be greater than 8.



It is recommended to start buprenorphine at a lower dose (i.e., 4 mg) and reassess frequently for additional dosing based on symptoms of withdrawal. Do not exceed 12 mg of buprenorphine on the first day.



Precipitated withdrawal is managed by treating acute symptoms and providing support.

Avoid the use of benzodiazepines

Maintenance Therapy



Unless contraindicated, combination medications with naloxone should be used



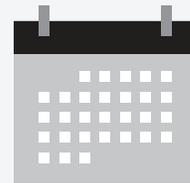
The goal is once-daily dosing



If patient requires more than 16 mg per day of buprenorphine provider must discuss case with a physician board certified in addiction sciences and document consultation in patients chart.



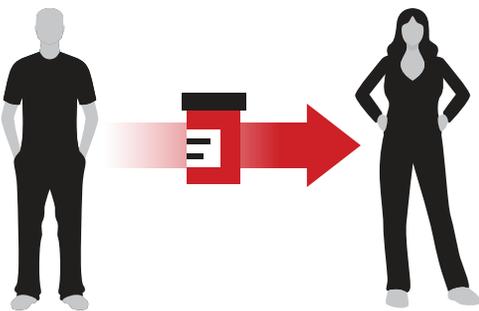
Check PDMPs and order urine drug screenings at follow-up visits



Assess for readiness for extended follow up. The patient should be seen at least weekly for the first month, at least every other week for month 2-3, then at least monthly for the first year.

Follow-up visits should include documentation of the following:

Diversion of Medications



Diversion is defined as the unauthorized rerouting or misappropriation of prescription medication to someone other than for whom it was intended (including sharing or selling a prescribed medication); misuse includes taking medication in a manner, by route or by dose, other than prescribed.

Diversion of buprenorphine does not necessarily mean the medication is not still being used for withdrawal management or treatment. If diversion is suspected, providers should work with patients on a plan to address concerns rather than discharging the patient from care.

How to minimize Diversion Risk



Early in treatment patients should be seen often, and less frequently only when the provider determines they are doing well.



Providers should inquire about safe and locked storage of medications to avoid theft or inadvertent use, especially by children. Patients must agree to safe storage of their medication. Counsel patients about acquiring locked devices and avoiding storage in parts of the home frequented by visitors.



Limit medication supply. Prescribe an appropriate amount of medications until the next visit. Do not routinely provide an additional supply "just in case."



Use buprenorphine/naloxone combination products when medically indicated



Providers should order random urine drug testing to check for other drugs and for metabolites of buprenorphine. Urine drug screens should be performed at follow-up visits.



Ensure that the patient understands the practice's treatment agreement and prescription policies. A treatment agreement and other documentation are clear about policies regarding number of doses in each prescription, refills, and rules on lost prescriptions.

**PDMP
OARRS**

Providers should make inquiries with PDMP systems, like OARRS, to ensure that prescriptions are filled appropriately and to detect prescriptions from other providers.



Early in treatment, providers can ask the patient to sign a release of information for a trusted community support individual, such as a family member or spouse, for the purpose of communicating treatment concerns including diversion.

If you suspect diversion is taking place

- ▶ Directly observe ingestion randomly when diversion is suspected.
- ▶ Doctors should schedule unannounced pill/film counts. Periodically ask patients to bring in their medication containers for a pill/film count.

What to do if a patient diverts or misuses buprenorphine



Diversion is not an automatic discharge from the practice



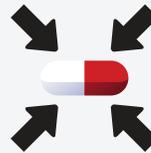
Document plan to reduced risk for future diversion or misuse



Document and describe the concerns and diversion incident. Also document the clinical response and rationale behind it.



When in-person doses are not practical, use shorter prescription time spans



Consider smaller doses and supervised dosing



Open communication is critical with the patient to make a plan



Consider injectable or implantable options to reduce future incidents where appropriate

Buprenorphine Side Effects

Side effects may be less than those of full agonists

Possible side effects may include



Oral numbness



Vomiting



Opioid withdrawal syndrome



Constipation



Intoxication



Sweating



Tongue pain



Palpitations



Blurred vision



Oral mucosal erythema



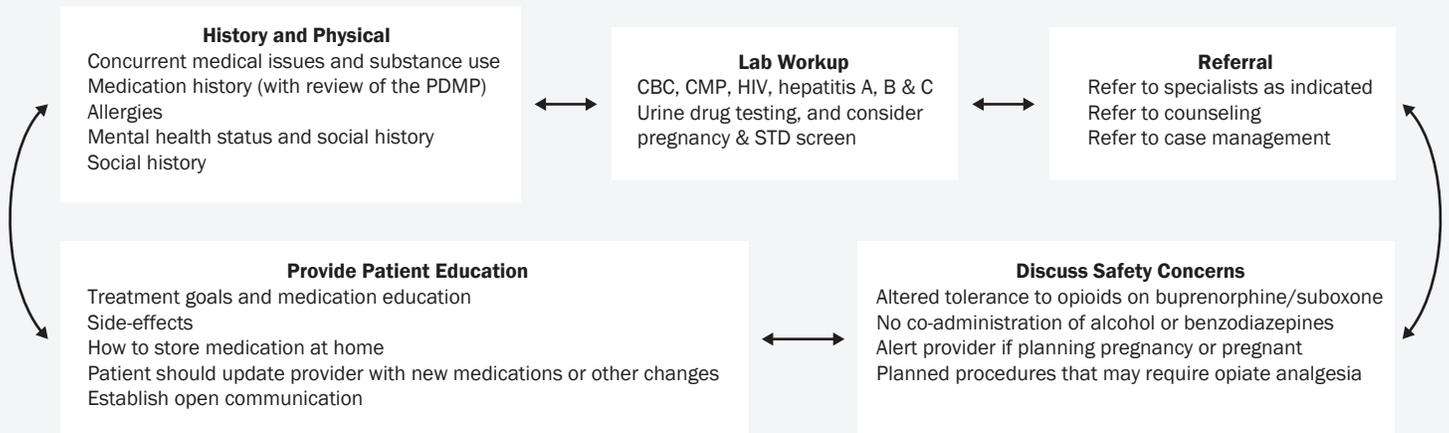
Insomnia

[View the FDA label for all potential side effects](#)



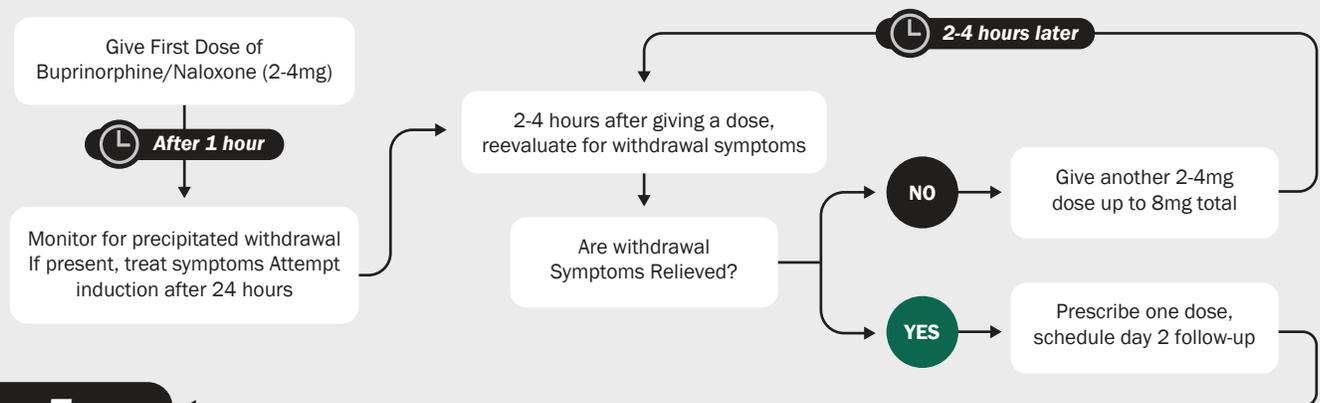
Algorithm for in-office induction

Initial Assessment

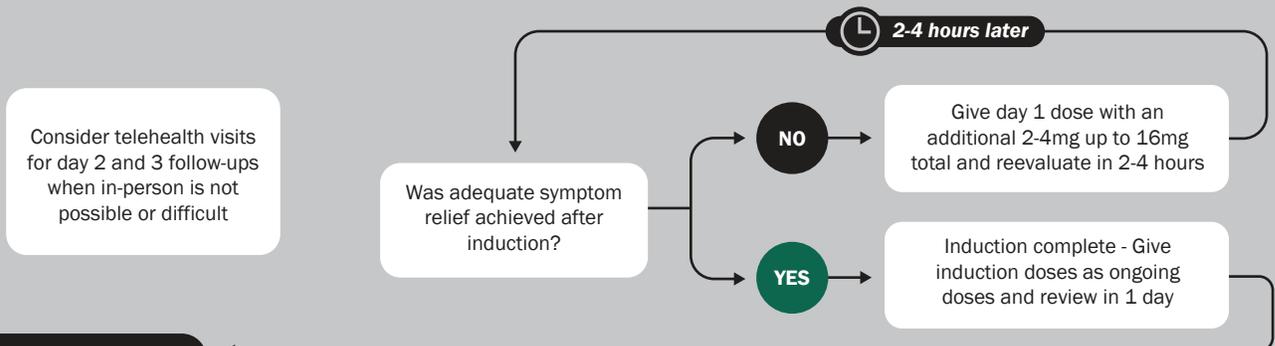


Ensure that last opioid use was at least 12 hours ago and moderate withdrawal is present - COWS>8

Day One (Induction)



Day Two



Maintenance

