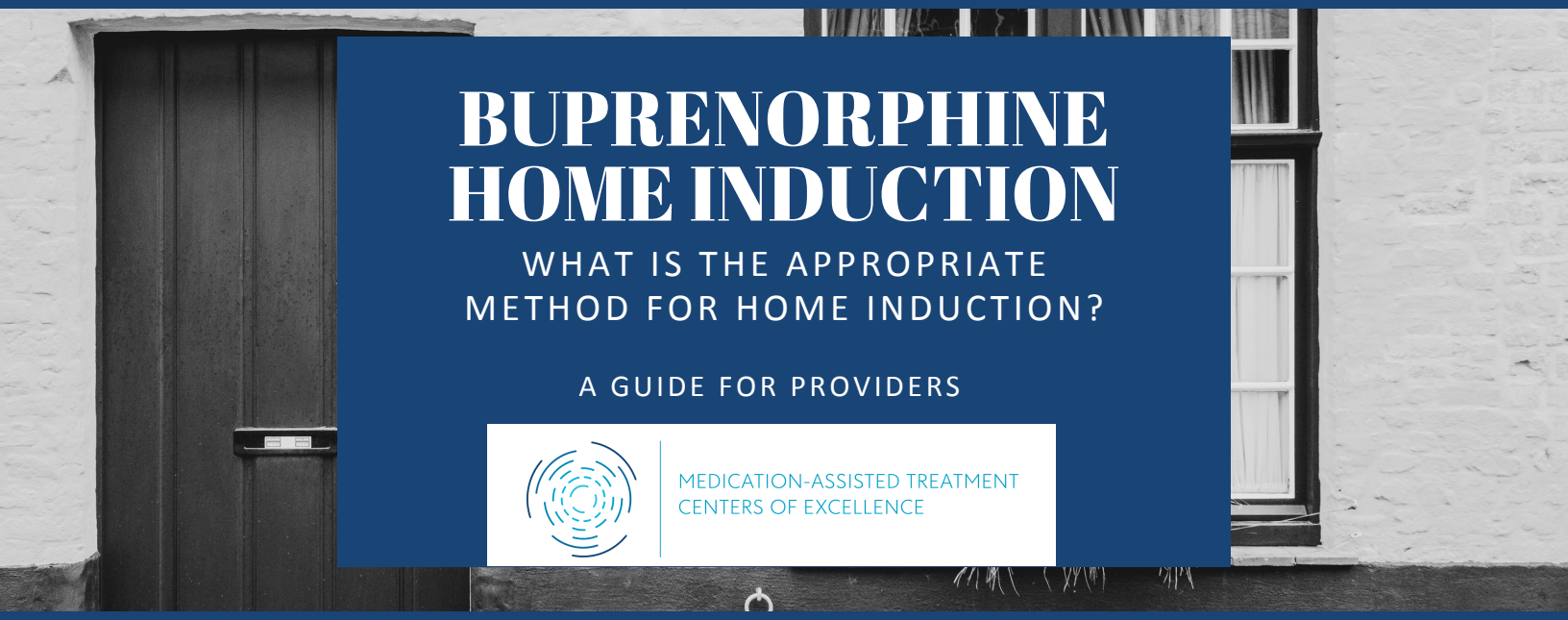
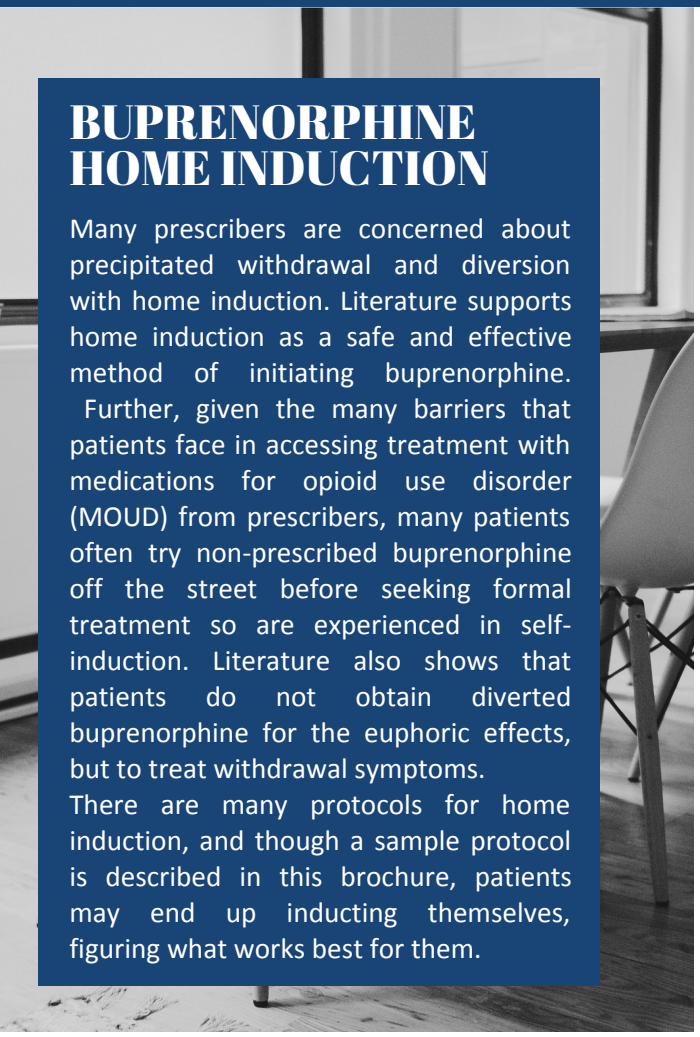


BUPRENORPHINE HOME INDUCTION

WHAT IS THE APPROPRIATE METHOD FOR HOME INDUCTION?

A GUIDE FOR PROVIDERS

MEDICATION-ASSISTED TREATMENT CENTERS OF EXCELLENCE



BUPRENORPHINE HOME INDUCTION

Many prescribers are concerned about precipitated withdrawal and diversion with home induction. Literature supports home induction as a safe and effective method of initiating buprenorphine. Further, given the many barriers that patients face in accessing treatment with medications for opioid use disorder (MOUD) from prescribers, many patients often try non-prescribed buprenorphine off the street before seeking formal treatment so are experienced in self-induction. Literature also shows that patients do not obtain diverted buprenorphine for the euphoric effects, but to treat withdrawal symptoms.

There are many protocols for home induction, and though a sample protocol is described in this brochure, patients may end up inducting themselves, figuring what works best for them.

For case-based support, call or text our 24/7 NJ MAT Provider Hotline 844-HELP-OUD (844-435-7683)

STEP 1: PREPARING FOR WITHDRAWAL

Patients should be told that they need to be in a period of moderate withdrawal prior to starting buprenorphine. Patients can assess this using the Subjective Opiate Withdrawal Scale (SOWS Scale). They need to be at a level of withdrawal that is nearly intolerable. The more intolerable their symptoms are, the likelihood of greater success. For many patients, this may occur when the SOWS score is at least 11. Clinicians can assess for appropriate withdrawal using the Clinical Opiate Withdrawal Scale (COWS Scale). A COWS score of at least 8 may be appropriate to start buprenorphine.

Patients should be provided with a prescription for buprenorphine 8mg BID (16mg/day) with a week's duration (possibly longer during the COVID-19 pandemic) to ensure close monitoring during induction.

CLINICAL PEARLS

In general, patients should start buprenorphine based on their level of withdrawal rather than on the number of hours since last use. Generally, it takes about 12-16 hours for short-acting opioids such as heroin, hydrocodone, oxycodone IR, and can be much longer for long-acting opioid pain medications, methadone, and highly potent synthetic opioids such as fentanyl. These wait times may vary significantly; this is why it is important to focus on the level of withdrawal.

NOTE: It is not sufficient to wait for withdrawal symptoms in patients on chronic methadone treatment. Induction in these patients will require longer waits, and you may consider consultation with an addiction specialist in these cases.

STEP 2: INITIATING BUPRENORPHINE

After experiencing nearly intolerable withdrawal symptoms, patients are then instructed to start with 4-8mg(higher doses may be appropriate for patients who are anxious, uncomfortable, have had previous failed inductions, or higher COWS/SOWS scale). Then, they are asked to monitor their symptoms and take an additional 4mg every 2 hours as needed for withdrawal up to a total daily dose of 24-32mg.

NOTE: Helping patients understand that the treatment of withdrawal is with more buprenorphine is crucial to reducing risk of patients going back to their illicit opioid of choice. Many patients are eventually maintained on 24mg/day. If patients are in precipitated withdrawal, they should be encouraged to take more buprenorphine but if they are severely agitated or in psychosis, they should go to the emergency room.

SOWS Score

0=not at all; 1= a little; 2=moderately; 3=quite a bit; 4=extremely

I feel anxious; I feel like yawning; I am perspiring; My eyes are tearing; My nose is running; I have goosebumps; I am shaking; I have hot flushes; I have cold flushes; My bones and muscles ache; I feel restless; I feel nauseous; I feel like vomiting; My muscles twitch; I have stomach cramps; I feel like using now.

Mild withdrawal = Score of 1-10
Moderate withdrawal = Score of 11-20
Severe withdrawal = Score of 21-30

Available from: https://www.asam.org/docs/default-source/education-docs/sows_8-28-2017.pdf

STEP 3: DOSING TOWARDS MAINTENANCE

On the next day, the patient may take the total daily dose of day 1, divided into BID or TID dosing. Some patients may require higher total daily doses of 24-32mg during the induction period, especially if they have been taking highly potent synthetic opioids. After a few days, they can be trialed on a taper down to 16-24mg daily as a maintenance dose.

If needed, patients may take the following over-the-counter products for additional withdrawal symptom management, assuming no contraindications for the patient:

- Loperamide 4mg at initial experience of diarrhea, then 2mg as needed for each episode of loose stool or diarrhea thereafter (not to exceed 16 mg/24h);
- Acetaminophen or ibuprofen for aches and pains
- Diphenhydramine for insomnia

NOTE: It's important that patients are not under-dosed with buprenorphine, which increases the risk of precipitated or protracted withdrawal.

RATIONALE FOR AN OPTIMAL BUPRENORPHINE MAINTENANCE DOSE

Greenwald and colleagues explored buprenorphine pharmacokinetics and optimal dosing for maintenance. 16mg/day is usually sufficient for most patients since most patients require most of the opioid receptors to be saturated (at least 80%) in order to get the benefits of buprenorphine and curb withdrawal/cravings. Given the highly potent synthetic opioids, however, a greater percentage may need to be saturated (upwards of 90%) to reduce the risk of withdrawal, cravings, and maintain opioid blockade. Therefore, the standard maintenance dose of buprenorphine is at least 16mg, but many may need 24mg/day, and some may need 32mg/day. There is little to no risk of overdose on these higher doses, as buprenorphine has a ceiling effect. This effect also explains why home induction is safe. Emphasize the importance of inducting as directed. The goal is to curb withdrawal, reduce cravings, and prevent one from trying to overcome the mu-receptor blockade with non-prescribed opioids, as well as to retain patients in treatment.

REFERENCES

1) Silverstein SM, Daniulaityte R, Miller SC, et al. On my own terms: Motivations for self-treating opioid-use disorder with non-prescribed buprenorphine. Drug Alcohol Depend. 2020 May 1;210:107958/

2) Greenwald MK, Comer SD, Fiellin DA, et al. Buprenorphine maintenance and mu-opioid receptor availability in the treatment of opioid use disorder: implications for clinical use and policy. Drug Alcohol Depend. 2014 Nov 1;144:1-11.

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