BUPRENORPHINE TAPERING:
APPROACHING DISCUSSIONS WITH A PATIENT

A GUIDE FOR PROVIDERS

A REALISTIC SCENARIO

"I have an individual on prescribed buprenorphine who has been tapering off and is now down to 2mg (from 16mg). I told him to just stop taking the 2mg to finish the taper, but he has been waking up sick and ends up taking the 2mg because he can't go without it. He wants to know if there is a medication to help him get off buprenorphine."

PROVIDERS SHOULD UNDERSTAND THEIR PATIENTS' RATIONALE FOR STOPPING BUPRENORPHINE

Understanding their overall clinical presentation and risk for relapse (environment, triggers, history of relapse)

Does the patient prefer not to take buprenorphine daily?

Does the patient want to avoid pill burden?

Consider the use of extended-release injectable buprenorphine or naltrexone as possible options after tapering to reduce the risk of overdose due to a lower opioid tolerance.

KEY POINTS:

BENEFITS OF LONG-TERM THERAPY

Before providing options to taper off buprenorphine, it is important to know that:

- Patients understand benefits vs. risks and receive appropriate education, especially in the current landscape of highly potent synthetic opioids. Risks may include relapse, post-acute withdrawal syndrome that puts someone at risk of relapse, and more.
- Evidence strongly suggests MOUD be continued indefinitely unless the patient adamantly wants to stop taking MOUD and/or continued treatment is harming the patient.
- Providers NEVER advise or dictate when patients should stop or taper; it should be dictated by the patient.

In the scenario mentioned, imagine if this patient were so sick and didn't have access to buprenorphine. Due to opioid withdrawal, the patient could potentially "relapse," then use a full-opioid to self-treat, and have a subsequent fatal overdose.

Williams and colleagues conducted a database review and found that the longer a patient is on treatment, the less likely they are to use the emergency room, be admitted, or even use a prescription opioid. Interestingly, when comparing those who have been on buprenorphine 6-9, 9-12, 12-15, or 15-18 months and then stopped, ALL of these groups had similar risks of overdose (>5%), which emphasizes the importance of long-term therapy.

EXPLAINING SUD AS A CHRONIC ILLNESS

Often times, patients think that MOUD are only meant for temporary use, and not for primary treatment. Providers should explain that medications are FOR opioid use disorder, rather than for "assisting" in one's road to recovery.

Help patients understand that OUD is chronic disease like diabetes, HIV, etc. and that managing chronic diseases often requires a chronic medication.

Example: If a patient with co-morbid OUD and HIV is on HIV medications, ask them what their rationale is for being on HIV medications long-term. They may respond and say that they want to live a long life and keep their HIV controlled. Develop discrepancy and help them think in the same way with MOUD in that the medication will help them stay alive and keep their OUD under control.

CONTROLLING WITHDRAWAL

Buprenorphine is a partial agonist (40%), different from other opioids, with a ceiling effect that greatly reduces risk for overdose.

> *A 2mg dose may not all be that protective in cases of relapse, but if the patient feels well enough on 2mg, it may help control other opioid withdrawal symptoms and prevent a patient from resorting to other opioids.*

Patients may have difficulty achieving abstinence because their opioid receptors have been continuously stimulated for a long period of time, leading to a change in the homeostatic set point. Consider how buprenorphine may assist with neurobiological recovery.

> *If patients continue to experience withdrawal, and are therefore not controlling the symptoms, then the neurobiological recovery process is slowed or even halted.*

RISK OF TAPERING

Kakko and colleagues conducted a randomized clinical trial of 40 patients admitted in the hospital, started on buprenorphine, and then discharged. 50% were tapered off with placebo. Approximately 75% retained in treatment in the buprenorphine group while 100% relapsed in the tapering group (none retained in treatment). In addition, 4 of the patients died in the tapering group, whereas none died in the patients maintained on buprenorphine. This is additional evidence to support that for most patients, tapering leads to worse and, possibly, fatal outcomes.

A TAPERING APPROACH FOR PATIENTS ADAMANT ABOUT TAPERING

Evidence is limited in the best approach for buprenorphine tapering. In fact, Fiellin and colleagues conducted a randomized clinical trial of a primary care-based buprenorphine taper vs. maintenance therapy for prescription "opioid dependence", measuring illicit opioid use via urinalysis and patient report, treatment retention, and re-induction of buprenorphine. It found that the mean percentage of urine samples that were negative for opioids was significantly lower in the taper group compared to the maintenance group, as well as more days per week of illicit opioid use in the taper group. Those in the taper group also had fewer maximum consecutive weeks of opioid abstinence compared to those in the maintenance group. **These results provide more evidence that tapering is not as efficacious as ongoing maintenance with buprenorphine.**

It is also important to note, however, that Fiellin and colleagues, along with other studies, studied shorter durations of tapering, along with higher last doses of buprenorphine. Given the lack of successful, evidence-based strategies for tapering, providers are often unsure of how to best approach this idea, leading patients to seek social media for solutions.

A thematic analysis of Reddit content by Graves and colleagues found the following:

- Tapering schedules to be longer than those in the medical literature. In Fiellin and colleagues, the duration of taper was 3 weeks and amongst those who reported in Reddit that they successfully tapered, the median type to cessation was 93 days to taper from 2mg down to 0. This suggests that the challenge of completely tapering most often occurs at 2mg, and also means that tapering from the maintenance doses of 16mg or higher are likely to take even longer
- Some patients cut the 2mg buprenorphine films into "16 or 32" pieces to facilitate further tapering and the most frequent termination doses also occurred at 0.063mg (1/32 of a film) and 0.125mg (1/16 of a film)
- Only an estimated 15% were able to successfully taper
- Patients experienced fatigue, GI effects, and mood disturbances and used loperamide and vitamins/supplements to ameliorate symptoms

SUMMARY

There is no available evidence-based approach for tapering buprenorphine. As a provider, understanding and supporting the patient in their decision to taper, and evaluating the evidence for tapering is important. Be open with your patient and emphasize expectations so that any interventions, whether initiated by you or the patient, are done through a shared-decision making approach. Be sure to emphasize the risks of the taper, and educate the patient on the appropriate use of adjunctive medications, to minimize harms while tapering. **The limited evidence available indicates that a very slow taper using "micro" doses of buprenorphine (<2mg) is the best approach.**

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REFERENCES:

1. Williams AR, Samples H, Crystal S, et al. Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder. Am J Psychiatry. 2020 Februrary 01;177(2):117-24.

2. Kakko J, Svanborg KD, Kreek MJ, et al. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. Lancet. 2003 Feb 22;361(9358).662-68.

3. Fiellin DA, Schottenfeld RS, Cutter CJ, Moore BA, Barry DT, O'Connor PG. JAMA Intern Med. 2014 Dec;174(12):1947-54.

4. Graves RL, Perrone J, Al-Garadi MA, et al. J Addict Med. 2021 Dec 3. doi: 10.1097/ADM.0000000000000940.