Buprenorphine Outpatient Prescriber Information

1. **Has Notice of Intent been completed with SAMHSA?**
2. **Do you need to notify SAMHSA that you need to increase your limit from 30 to 100 or 100 to 275?**

For both questions, if needed, take two minutes to complete the form at the following link: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php.

This is a clinical guide and not meant to replace appropriate clinical judgment. This information was distilled from SAMHSA & ASAM.

Buprenorphine is a high-affinity, opioid agonist with a ceiling effect. It is safe & highly effective for treating opioid use disorder (OUD).

❖ Before you start Buprenorphine

1. Take history and conduct exam
   a. This can be a problem focused exam
2. The only absolute contraindication to buprenorphine is allergy
   a. Do not withhold medication because of other medical/psychiatric diagnoses or substance use (other than allergy to buprenorphine)
   b. Have a risk, benefit, alternatives discussion with patient
      i. Buprenorphine has not been studied in Child Pugh Class C liver disease or
      ii. Long QT syndrome
3. Order LFTs, hepatitis panel, HIV, urine toxicology, urine HCG in females and consider EKG
   a. These results do NOT have to be available to start medication
4. Refer to substance use treatment and/or mutual support groups
   a. Do not withhold treatment from someone who refuses SUD treatment or mutual support

Buprenorphine is almost always given as buprenorphine/naloxone and comes in films or sublingual (SL) tablet

Reasons to use buprenorphine without naloxone:

- Recent fentanyl use
- Allergy to naloxone (rare)

❖ Duration of Treatment

- As long as benefits outweigh the risks, treatment can be continued
- Current recommendations are to discontinue treatment, only in those who want to discontinue treatment and have reached treatment goals
- Taper over months and stop taper (and increase to prior dose) if cravings or use occur

❖ Don't forget to:

1. Ensure diagnosis of OUD is documented in electronic medical records
2. Physician Drug Monitoring Program (PDMP) is checked and documented
3. Adequate amount of medication is prescribed until next visit
4. Naloxone rescue kit is prescribed or provided
5. Discontinue other opioids
6. Provide Patient Guide to Starting Buprenorphine at Home
   a. For patients who are, or will soon, undergo withdrawal review the Patient Guide to Starting Buprenorphine at Home
      1. Prescribe 8mg tabs or films, enough to take 16mg/ day until next appointment
   b. **For those who have already completed withdrawal**, yet remain at risk of return to opioid use review Patient Guide to Starting Buprenorphine at Home
      ii. Start 2-4mg every day (lower dose due to loss of tolerance) & adjust dose as stated in Patient Guide
      iii. Prescribe 8mg tabs or films, enough to take 16mg/ day until next appointment
7. Arrange follow up (see follow up section below)

❖ Monitoring patients on buprenorphine

1. How is the patient doing?
   a. Side effects?
   b. Drug or alcohol use?
   c. Cravings?
   d. Attendance at SUD treatment and/or mutual support?
2. Check urine toxicology
   a. More frequently at the beginning of treatment
   b. Monthly thereafter- SUD is a chronic (often relapsing) disease
   c. After a year of sobriety, minimally every two months
3. Check liver functions if signs or symptoms of liver disease present & annually

➔ If patient is doing well, then continue current treatment plan and see patient back regularly

1. Arrange **follow up** 1-2 days after induction, weekly for 4-6 weeks, then monthly for first 6-12 mo. of abstinence; can extend beyond monthly with extended abstinence

➔ If patient is not doing well:

1. Is their dose of buprenorphine therapeutic?
   a. **Treatment works better at 16-24mg every day than lower doses**
   b. Are they taking medication correctly (SL not PO)?
   c. Are they pregnant and need higher or more frequent dosing?
2. Does the patient have co-occurring disorders that need addressed?
3. Are they better served by a higher level of addiction treatment?
   a. What level of SUD treatment are they getting?
   b. What mutual support are they attending?
   c. Would they be better served by getting daily observed buprenorphine dosing from a narcotic treatment program?
4. Do NOT stop buprenorphine for inconsistent toxicology test or lack of psychosocial treatment/ mutual support; adjust the treatment plan