Buprenorphine Prescriber Information for Jails and Prisons

For additional information, please see TIP 63: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf
Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63 Publication No. PEP21-02-01-002. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

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

Prescribing Buprenorphine

Effective January 2023, an X-waiver is no longer required to prescribe buprenorphine. Section 1262 of the Consolidated Appropriations Act, 2023 (i.e., Omnibus bill), removed the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of OUD.

Before Starting Buprenorphine

1. Document OUD or opioid withdrawal
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)
      i. Buprenorphine has not been studied in Child Pugh Class C liver disease or
      ii. Long QT syndrome
   b. Staff should document risk, benefit, alternatives discussion with patient
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 other SUD treatment or mutual support

Buprenorphine is almost always given as buprenorphine/naloxone and comes in films or sublingual (SL) tablet or a long-acting injection. 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
- Patient understands the risk associated with discontinuing medication (chance of relapse and accidental death from use)
- 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. Check and document Physician Drug Monitoring Program (PDMP)
3. Prescribe adequate amount of medication to cover until next visit
4. Discontinue other opioids
5. Provide *Patient Guide to Starting Buprenorphine in Carceral Settings*
   a. For patients who are, or will soon, undergo withdrawal review the Patient Guide to Starting Buprenorphine in Jails/Prisons
      i. Prescribe 8mg tabs or films to start when objective withdrawal symptoms present
      ii. Average dose 16mg/ day (≥16mg/ day is more effective than 8mg)
   b. **For those who have already completed withdrawal**, yet remain at risk of return to opioid use review Patient Guide to Starting Buprenorphine in Jails/Prisons
      i. Start 2-4mg every day (lower dose due to loss of tolerance) & adjust dose to target dose of 16mg/day
      ii. Reassess at least 1 week after reaching 16mg/day to allow steady state blood level to be reached
      iii. Arrange follow up (see follow-up section below)

Monitoring Patients on Buprenorphine

1. How is the patient doing?
   a. Side effects? Drug or alcohol use? Cravings?
   b. 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 and annually

If patient is doing well:

1. Continue current treatment plan and see patient back regularly
2. Arrange follow up 1-2 days after starting medication, weekly for 4-6 weeks, then monthly for first 6-12 months of abstinence; can extend beyond monthly with extended abstinence. At time of release, follow up within 1 week is highly recommended

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**[1]
   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 to address?
3. Does the patient need a higher level of addiction treatment?
   a. What level of SUD treatment are they getting?
   b. What mutual support are they attending?
   c. Do they need a higher dose of buprenorphine, injectable buprenorphine or a change to another medication?
4. Do NOT stop buprenorphine for inconsistent toxicology test or lack of psychosocial treatment/ mutual support; adjust the treatment plan
5. Adjust treatment plan AND continue to follow up with the patient frequently (more than monthly where possible) until stabilization occurs

[1] Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014 Feb 6;(2):CD002207. doi:10.1002/14651858.CD002207.pub4. PMID: 24500948.