Massachusetts Consultation Service

MCSTAP

for Treatment of Addiction and Pain

June 20, 2024

Bup 101 for the new prescriber: discussion

Jessica Gray, MD, Physician Consultant, MCSTAP [(1)]
James Ledwith, MD, Physician Consultant, MCSTAP[(2)]

Affiliations/conflicts: 1. MGH / 2. UMASS

UMass Chan MEDICAL SCHOOL | UMass Memorial Health

BOSTON MEDICAL CENTER
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BU Boston University School of Medicine

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Massachusetts Consultation Service

MCSTAP

for Treatment of Addiction and Pain

Call **1-833-PAIN-SUD** (1-833-724-6783)

Monday through Friday - 9 am to 5 pm

WWW.MCSTAP.COM

mcstap@beaconhealthoptions.com Christopher.Shanahan@bmc.org;
Amy.Rosenstein@beaconhealthoptions.com; John.Straus@beaconhealthoptions.com

What is MCSTAP?

To support clinicians increase their capacity and comfort using evidence-based practices to screen, diagnose, treat, & and manage the care of patients with chronic pain &/or SUD

- Real-time, "*Curbside*" phone consultation for ALL clinicians on safe prescribing and managing care for patients with ***Chronic Pain*** or ***SUD***
- Info on community resources to address patient needs
- Free consultations for **ALL** patients statewide, insurance amnestic
- **1-833-PAIN-SUD** (1-833-724-6783) / Monday - Friday, 9 am- 5 pm
- Funding: Mass. Executive Office of Health & Human Services

MCSTAP Provides Expert Consultation for Clinicians Caring for Patients with Chronic Pain or SUD (CP/SUD) using Evidence-Based Practices

We provide:

- Personalized, real-time coaching
- Initial & FU consultation & longitudinal coaching for all your patients with SUD or CP as needed, free of charge
- Resources in your community to address your patient's needs
- Technical support when you decide to enhance your practice infrastructure & capacity to improve your care of patients

Receive Live Support by Telephone Consult on important clinical issues, including:

- Treatment of patients with MOUD (Prescribing ***buprenorphine***,
-
-
-
- Clinical outcomes, etc. (before, during, & after office visits)
- Misc. Issues: Pregnant women, Special populations, Ethical, Stigma (Patients, Clinicians, etc.)

Additional Expanded Services

1. Individual **Mentorship** Sessions
   - Free, 3 months, Prescriber request only
2. Primary Care **Residency Training Program** Outreach & training
3. **Training** using free CME: Monthly Case Webinar, etc.

The MCSTAP team

- Ten Physician Consultants from different health systems across Massachusetts
- All have:
  - Expertise in treating CP/SUD
  - Experience teaching & mentoring providers
  - **Deep commitment** to helping others work for better outcomes for patients with CP/SUD

Training Requirements & Credits:
AMA CME (Type I), MA Risk Management, DEA Licensure

Each Monthly MCSTAP Case Webinar can be used to:

- Earn 1.0 AMA CME credits for participating in each Webinar
- Earn 1 hour toward your total 8-hour DEA License New/Renewal Certificate training requirement (every 2 years). (3/27/2023 memo)
- Earn 1 hour of Risk Management credits toward your total Massachusetts State Controlled Substances License renewal training requirement (every 2 years). (3/27/2023 memo)

MCSTAP Webinar Content aligns with these regulatory agencies' guidelines:

- SAMHSA's content recommendations required by the 2022 Medication Access & Training Expansion (MATE) Act
- Massachusetts Commonwealth of Massachusetts, Board of Registration in Medicine (BORIM), Quality and Patient Safety Division

House rules for group discussion

- **Our goal is to foster a Safe & Interactive Learning Environment**

TREAT EACH OTHER WITH RESPECT

- **When listening:**
  - **Turn on your video** to enhance our group's interaction
  - Please **mute your audio** until you wish to speak
  - Place your **questions in the Chat** addressed to "Everyone"
- **To Speak**
  - Please **raise your hand**
  - Please don't use the **names** of patients, colleagues, or others

All questions welcome!!

Agenda

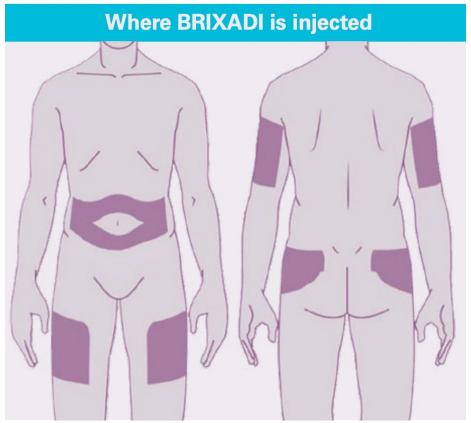
- This time is meant to be less formal, chance to bring questions or cases and utilize the wisdom of the group
- Panel includes MCSTAP consultants

Questions from last session

Long-acting injectable buprenorphine

- Is Brixadi less painful with injection than Sublocade?
- patients often complain of the burning with Sublocade. How should we manage?
- How do you deal with itching at Sublocade site?

Brixadi:



(1/2in) thin (23-g)
fluid <1cc

Sublocade:

Massachusetts General Hospital Substance Use Disorder Bridge Clinic

Optional Lidocaine injection / local anesthetic for XR buprenorphine injections

Purpose:
Some patients find topical ice is insufficient to manage the procedural pain from XR buprenorphine injections, which has led some patients to fear initiating XR buprenorphine or to discontinue injections despite preference for this formulation

Procedure:

1) Identify site for XR buprenorphine in abdominal quadrant
2) Apply ice to site while preparing lidocaine for injection into subcutaneous tissue
3) Prepare 1% Lidocaine, without epinephrine:
    - Wipe top of lidocaine bottle with alcohol pad
    - Draw up 2cc Lidocaine with large bore needle in a 3 or 5 cc syringe
    - Change needle to 1 inch, 25 or 27 gauge
4) Clean abdominal site with alcohol swab
5) Tent skin and Inject 2 cc Lidocaine at ~75 degree angle, releasing lidocaine into tissue while pulling back
6) Apply 2x2 gauze to area and massage gently in circular motion to allow lidocaine to diffuse the area
7) Keep 2x2 resting on skin and reapply ice pack

*Wait at least 3 minutes before injecting XR buprenorphine

XR Buprenorphine injection:

1) Clean abdominal site with alcohol wipe where lidocaine was injected, identifying the lidocaine puncture site
2) Tent skin and inject XR Buprenorphine into the same puncture site and track of lidocaine
3) Apply band-aid
4) Have patient lay for recommended time per manufacturer

Created: 3.15.2021
Jessica Gray, MD and Laura Kehoe, MD, MPH

Questions from last session

- Switching from methadone to buprenorphine
  - Can you address how you would coordinate w/ methadone provider if patient wants to switch to suboxone? would you do low dose transition with help of methadone provider?

Questions from last session

Acute /perioperative pain management

For most elective surgeries is the goal to continue suboxone pre and post op, do you just increase frequency of dosing for better analgesia post op?

Perioperative management: continue buprenorphine maintenance

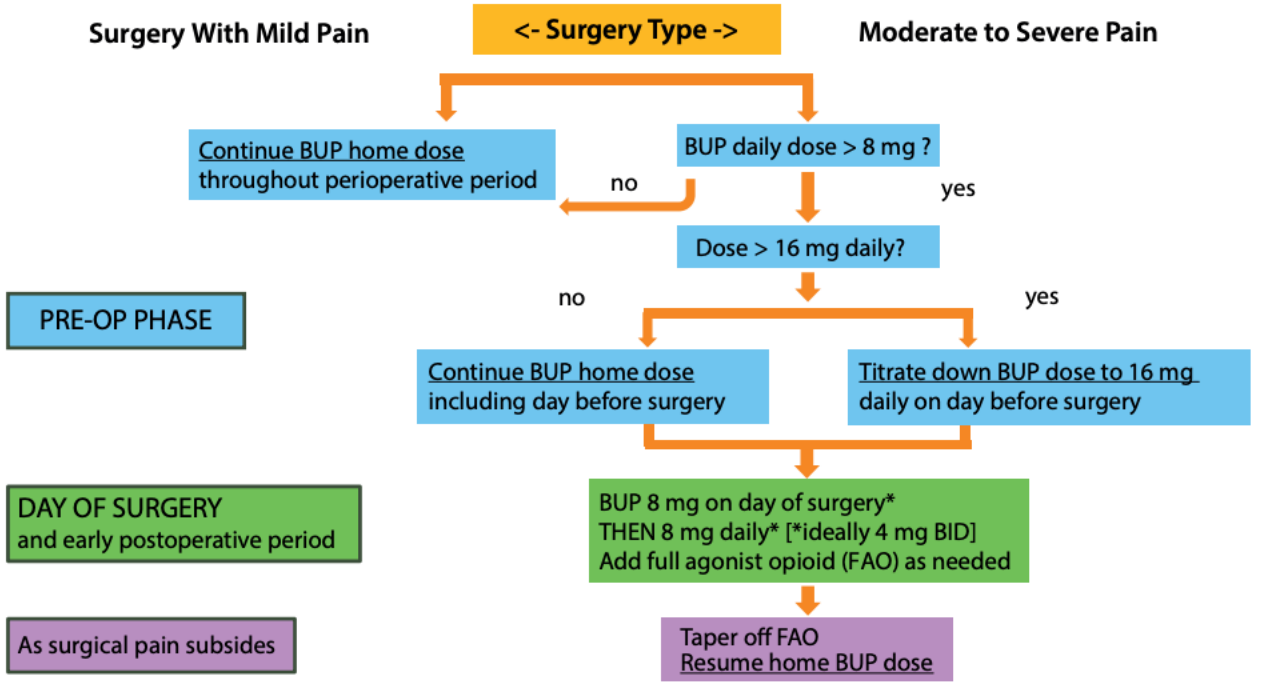
- Avoids complexity of delaying surgery for taper
- Minimizes pre-operative withdrawal
- Avoids re-induction with risk of increase in chronic pain and potential OUD destabilization
- Achieves equivalent pain control
- Full agonist requirements lower than when buprenorphine stopped

- Buprenorphine dose adjustment: growing consensus
  - varies by institution and severity of expected pain

Lembke Pain Medicine 2018
Vilkins, Bagly, Alford. J Addict Med 2017
Macintyre PE et al. Anaesth Intensive Care 2013
Acampora et al, J Clin Psych: 2020
Hickey Med Clin N America 2022

Perioperative Buprenorphine Management

Figure 2. MGH Department of Anesthesia Critical Care and Pain Medicine Guideline for Perioperative Buprenorphine Management[a]



[a]Protocol implemented at Massachusetts General Hospital (MGH) in March 2018 (revised by G.A.A. February 2019).
Abbreviations: BUP = buprenorphine, PRE-OP = preoperative.

We also recommended increased pre- and postoperative communication between the various clinical disciplines caring for the patient, including the following:

- Identify the name and contact information of the physician who provides the patient's BUP-MAT and contact that physician whenever possible to reach consensus on management plan.
- Ensure addiction consultation service is engaged whenever appropriate to help identify resources and support available for patient postoperatively.
- Upon discharge, pain service consultation teams and/or addiction consultation team will contact patient's buprenorphine prescriber and provide a handoff of the buprenorphine management course and postdischarge plan.
- All nonopioid adjuvant (multimodal) pain medications (gabapentin, pregabalin, tricyclic antidepressants, muscle relaxers, acetaminophen, etc) should be considered postoperatively and postdischarge.

Acampora GA, Nisavic M, Zhang Y. Perioperative Buprenorphine Continuous Maintenance and Administration Simultaneous With Full Opioid Agonist: Patient Priority at the Interface Between Medical Disciplines. J Clin Psychiatry. 2020 Jan 7;81

Quaye, Zhang. Perioperative Management of Buprenorphine: Solving the Conundrum. *Pain Medicine 2019*

Case: buprenorphine inductions

Patient-centered approach

50F with HTN using pressed fentanyl pills (insufflation) 3-5x/day comes to you asking for help to come off. Has never used bup/nal previously

Q: how do we get her started on buprenorphine?

Buprenorphine induction options

	Standard	Low-dose	High-dose	Low dose bup with full agonist continuation
Post-agonist washout duration	16h (short acting) 48→72h (long acting)	24 - 36h	16→24h	NO washout Usual dose of full agonist continued
First dose of buprenorphine	2 mg	0.5 - 1 mg	2→16 mg	0.25 or 0.5mg
First day total dose of buprenorphine	8→12 mg	8 mg	16→32 mg	7 day: 0.5-1mg 3 day rapid: 4mg
Adjuntive medications	As needed	Standing doses up to maximum tolerability	As needed	None initially May be needed as progress

PCSS Practice-Based Guidelines: Buprenorphine in the Age of Fentanyl. May 2023

A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin you want to feel very sick from your withdrawal symptoms

It should be at least . . .

- 12 hours since you used heroin/fentanyl
- 12 hours since snorted pain pills (Oxycontin)
- 16 hours since you swallowed pain pills
- 48-72 hours since you used methadone

You should feel at least three of these symptoms . . .

- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose
- Body aches
- Tremors/twitching
- Chills or sweating
- Anxious or irritable
- Goose pimples
- Stomach cramps, nausea, vomiting or diarrhea

Once you are ready, follow these instructions to start the medication

DAY 1:

8-12mg of buprenorphine

Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

Step 1.

Take the first dose

Wait 45 minutes

- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

Step 2.

Still feel sick? Take next dose

Wait 6 hours

Most people feel better after two doses = 8mg

Step 3.

Still uncomfortable? Take last dose

Stop

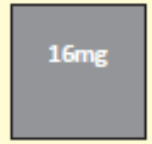
- Stop after this dose
- Do not exceed 12mg on Day 1

DAY 2:

up to 16mg of buprenorphine

Take up to a 16mg dose

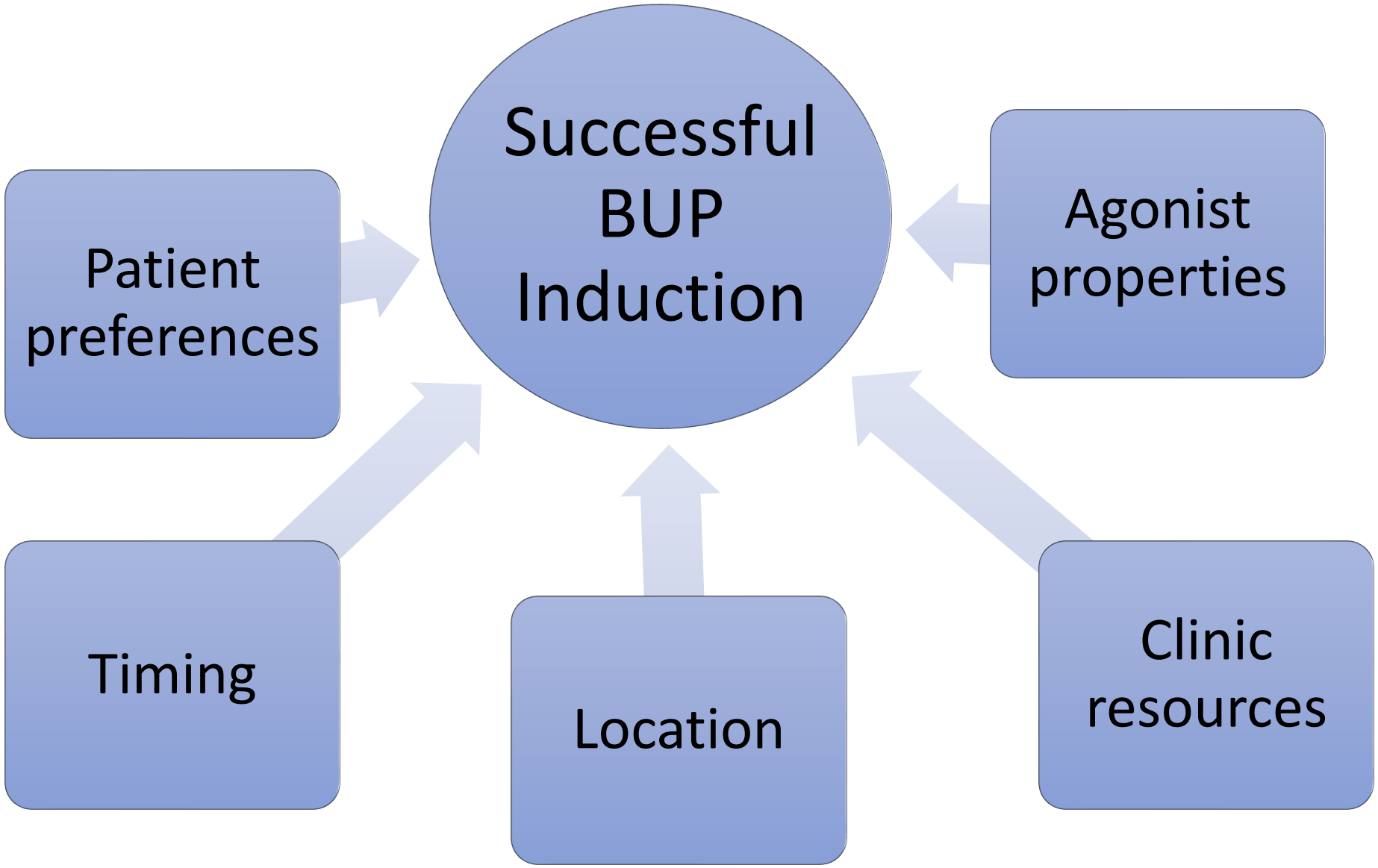
Most people feel better with up to a 16mg dose



Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

Note: This is a modified version of a NIDA guidance document


Successful BUP Induction
Patient preferences
Agonist properties
Timing
Location
Clinic resources

Case 2: buprenorphine inductions

Evaluating withdrawal

47M new patient wants to get on buprenorphine to manage OUD. Prior on methadone, didn't like it. Hx of 6 lifetime overdoses, none in few years. Smoking cocaine daily. Goal is abstinence due to justice involvement.

- 48h since fentanyl use
- Exam: vs 102/72, hr 70. cooperative with good eye contact, anxious, fidgety, mild diaphoresis. Pupils 4mm. Appears mildly uncomfortable

Q: How severe is their withdrawal?

COWS
Clinical Opiate Withdrawal Scale

Exam: vs 102/72, hr 70. cooperative with good eye contact, anxious, fidgety, mild diaphoresis. Pupils 4mm. Appears mildly uncomfortable.

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/_____:_____

Reason for this assessment:_____

Restina Pulse Rate:_____beats/minute

Measured after patient is sitting or lying for one minute

0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI Upset: *over last ½ hour*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*

0 No tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness *Observation during assessment*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds

Yawning *Observation during assessment*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil size

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/ muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin

0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection

Runny nose or tearing *Not accounted for by cold symptoms or allergies*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____

The total score is the sum of all 11 items

Initials of person completing Assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
Source: Wesson and Ling 2003[326]

https://www.ncbi.nlm.nih.gov/books/NBK143183/

Subjective Opiate Withdrawal Scale (SOWS)

Instructions: Answer the following statements as accurately as you can. Circle the answer that best fits the way you feel now.

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

		Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious.	0	1	2	3	4
2	I feel like yawning.	0	1	2	3	4
3	I'm perspiring.	0	1	2	3	4
4	My eyes are tearing.	0	1	2	3	4
5	My nose is running.	0	1	2	3	4
6	I have goose flesh.	0	1	2	3	4
7	I am shaking.	0	1	2	3	4
8	I have hot flashes.	0	1	2	3	4
9	I have cold flashes.	0	1	2	3	4
10	My bones and muscles ache.	0	1	2	3	4
11	I feel restless.	0	1	2	3	4
12	I feel nauseous.	0	1	2	3	4
13	I feel like vomiting.	0	1	2	3	4
14	My muscles twitch.	0	1	2	3	4
15	I have cramps in my stomach.	0	1	2	3	4
16	I feel like shooting up now.	0	1	2	3	4

The Subjective Opiate Withdrawal Scale (SOWS) consist of 16 symptoms rated in intensity by patients on a 5-point scale of intensity as follows: 0=not at all, 1=a little, 2=moderately, 3=quite a bit, 4=extremely. The total score is a sum of item ratings, and ranges from 0 to 64.

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc.

Other Sources: Gossop 1990; Bradley 1987.

- Patient self-rating of 16 symptoms
- Can guide virtual symptom assessment
- Not recommended to start traditional induction until SOWS >17

https://portal.ct.gov/-/media/dmhas/forms/mat/sowsscalepdf.pdf
https://www.asam.org/docs/default-source/education-docs/unobserved-home-induction-patient-guide.pdf

- 47M new patient wants to get on buprenorphine to manage OUD. Prior on methadone, didn't like it. Hx of 6 lifetime overdoses, none in few years. Smoking cocaine daily. Goal is abstinence due to justice involvement.
- He notes has been 48h since fentanyl use
- Exam: vs 102/72, hr 70. cooperative with good eye contact, anxious, fidgety, mild diaphoresis. Appears mildly uncomfortable.

- Patient requests home induction

Q: Next steps for prescribing?

Q: When do you want to see him back?

Comfort medications

TABLE 3
Symptomatic management of opioid withdrawal

Symptom	Drug	Dose
Anxiety	Hydroxyzine	25–100 mg orally every 6–8 hours as needed (maximum 400 mg/day)
	Lorazepam	1 mg every 4–6 hours as needed (maximum 6 mg/day)
Hypertension, tachycardia	Clonidine	0.1–0.2 mg every 6–8 hours, taper if given for > 7 days
Diarrhea	Loperamide	4 mg initial dose followed by 2 mg after each loose stool (maximum 16 mg/day)
Myalgias, arthralgias	Acetaminophen	1,000 mg every 6–8 hours
	Ibuprofen	600 mg every 6 hours for up to 7 days (maximum 2,400 mg/day)
Nausea, vomiting	Ondansetron	4 mg every 6 hours as needed (maximum 16 mg/day)
Insomnia	Trazodone	25–100 mg nightly (maximum 300 mg)
Muscle cramps	Cyclobenzaprine	5–10 mg every 8 hours as needed (maximum 30 mg/day)
Gastrointestinal cramps	Dicyclomine	10–20 mg every 6–8 hours as needed (maximum 160 mg/day)

Based on information in references 36, 39, and 40.

https://www.ccjm.org/content/ccjom/90/9/557.full.pdf

Follow up

Seen next day when patient shares his experience:

- Gives additional history:
  - Before last visit he got thru withdrawal by staying ‘curled in a ball’ for 48hrs with a lot of weed, no meds
- Since Yesterday:
  - Took 16mg as soon as left the office
  - Symptoms went from “a 10 to a 6” (anxiety, sweats, stomach upset, restless legs)
  - 4 hours later he took 2nd 16mg. He notes didn’t seem to make a difference in symptoms
  - Tried clonidine x1, made his mouth too dry

Q’s: What kind of induction was this?

Next steps in prescribing?

Sample protocol

CA BRIDGE

Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

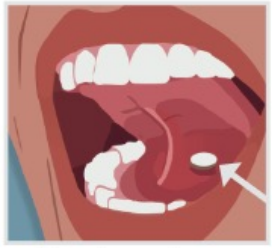
1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.



Place dose under your tongue (sublingual).

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin a day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Not going well? Have questions? Contact your Navigator for help!

https://bridgetotreatment.org/resource/rapid-guidance-for-patients-starting-buprenorphine-outside-of-hospitals-or-clinics/

Case: buprenorphine for pain

Opioid rotation

56M factory worker, severe OA and LBP, dependent on oxycodone for years who has started calling for early refills

- Meds: Oxycontin + IR. MME 180 and still with uncontrolled pain
- Functionally: not getting good response

Q's:

Differential diagnosis?

Next steps in management?

How do you do an opioid rotation to buprenorphine?

What if he were also using non-prescribed full agonists?

A practical guide for buprenorphine initiation in the primary care setting

CLEVELAND CLINIC JOURNAL OF MEDICINE VOLUME 90 • NUMBER 9 SEPTEMBER 2023

https://www.ccjm.org/content/ccjom/90/9/557.full.pdf

TABLE 1
Buprenorphine formulations and indications

Generic name and administration route	Brand name	Dose formulations	US Food and Drug Administration indication
Buprenorphine hydrochloride for intravenous or intramuscular administration	Buprenex injection	0.3 mg/mL	Acute moderate-to-severe pain
Buprenorphine transdermal system	Butrans	5 µg/hour 7.5 µg/hour 10 µg/hour 15 µg/hour 20 µg/hour	Chronic pain
Buprenorphine buccal film	Belbuca	75 µg 150 µg 300 µg 450 µg 600 µg 750 µg 900 µg	Chronic pain
Buprenorphine extended-release injection for subcutaneous use	Sublocade	300 mg/1.5 mL monthly after induction for first 2 months 100 mg/0.5 mL maintenance dose monthly (can increase to 300 mg)	Opioid use disorder
Buprenorphine sublingual tablets	Subutex	2 mg 8 mg	Opioid use disorder
Buprenorphine/naloxone sublingual film	Suboxone	2 mg/0.5 mg 4 mg/1 mg 8 mg/2 mg 12 mg/3 mg	Opioid use disorder
Buprenorphine/naloxone sublingual tablets	Suboxone	2 mg/0.5 mg 8 mg/2 mg	Opioid use disorder
Buprenorphine/naloxone sublingual rapid-dissolve tablets	Zubsolv	0.7 mg/0.18 mg 1.4 mg/0.36 mg 2.9 mg/0.71 mg 5.7 mg/1.4 mg 8.6 mg/2.1 mg 11.4 mg/2.9 mg	Opioid use disorder

Based on information in references 22 and 23.

2 Cases: chronic pain turned OUD

- 54 yo on full agonist for years (90mg oxycodone/day)
- First drug test performed in 4 years was positive for 2 benzodiazepines, cocaine, oxycodone and dilaudid

Q’s: what is diagnosis(es)?

How do you manage this patient?

- 70 yo F prescribed 50mg/day methadone in divided doses for pain x 10 years, no tox in several years. Seen quarterly, no early refills
  - Called PCP to let them know she started using IN fentanyl for withdrawal symptoms

Q: Diagnosis? Next steps in management?

Case: Low dose Bup induction

Courtesy of MCSTAP consultant Laura Kehoe

Emerging Strategies

Low Dose Buprenorphine- Opioid Continuation

- SIMULTANEOUSLY continue full agonist while giving small and gradually-increasing doses of buprenorphine over 2-7 days
- Initial doses: typically <1mg buprenorphine
- Many cases & case series (n ~ 250)
- Various buprenorphine formulations used
  - Intravenous
  - Buccal film
  - Transdermal patches
  - SL film or tabs

1 pager

Cohen, et al. Low Dose Initiation of Buprenorphine: A narrative Review and Practical Approach. Journal of Addiction Medicine, 2021.

Slide adapted with permission from Dr Laura Kehoe

Case 1

- 27 yo female with 10yr hx severe OUD, uses fentanyl IV, hx of necrotizing fasciitis, numerous OD, GAD.
- Goals: abstinence and transition to ER Buprenorphine
- “I’m desperate. Please help me.”
- She is terrified of POW, having experienced it numerous times
- Adamantly opposed to methadone
- Asks to try LDB-OC initiation after a friend successfully transitioned onto bupe
- She works part time and is living with her parents

Poll

- How long after her last fentanyl use can she start low dose buprenorphine, 0.5 mg?

- A) immediately – no need to wait
- B) once COWS 8-12
- C) once COWS 13-15
- D) 24 hours after last fentanyl use

Case 1 continued

- Day 1:
  - You explain LDB-OC initiation process, steps, document shared decision making
  - You review and provider her with patient handout, and send Rx buprenorphine with instructions
  - You administer 0.5 mg buprenorphine/naloxone in clinic which she tolerates well
  - You arrange daily phone check in
  - You reinforce harm reduction strategies and provide safer equipment

Case 1 continued

- Day 2:
  - she was fine the first night, but experienced POW sx after her dose this am
  - she was confused between the 2 and 8 mg films prescribed and inadvertently took a ¼ of the 8 mg film (2 mg)
  - she misunderstood the directions about what to do with fentanyl and decreased her dose

Question: Thoughts on next steps?

Outpatient LDB initiation pearls for practice

Shared decision making with patient, clear information

Ensure ongoing access to full agonist opioid and continue as long as needed

- Do not taper down, or withdrawal will ensue, irrespective of buprenorphine
- This includes any full agonist opioid
- If they do not have ongoing opioid, do not employ LDP

Provide a bubble pack if possible

***Clear and frequent communication with patient**

- Provide them with handout for reference, daily call
- Reminder: do not taper down the full agonist
- Help with cutting buprenorphine strips/bubble packs if possible
- Problem solve with them
- Provide comfort meds prn
- Harm reduction
- Cheerlead!

***Pause or slow if withdrawal symptoms, or challenges**

Case 1 continued

- Day 3-5:
  - Restart process, pre-medicate with lorazepam
  - Tolerates well, experiences a little flushing, restlessness day 5, anxious about advancing
  - You slow process and repeat current dose for a couple days, encourage comfort meds

- Day 7-10:
  - Process slowed, continue 8 mg daily x 2 days, increase to 12 mg day 9.
  - Stops fentanyl and advances bupe to 16 mg by day 10
  - Day 10 returns to clinic, and receives Buprenorphine ER and tolerates well without any withdrawal
  - Supplemental buprenorphine films given
  - Tolerating well, continues with monthly Buprenorphine ER, engaging, with markedly decreased fentanyl use

LDB Wrap Up

- Terminology and language are important
- Low dose buprenorphine initiation leading the way given current drug supply, limited ability to traditionally induce
- Shared decision making with patients is critical
- Can be utilized with any full agonist including illicit opioids, but prescribed, safe supply ideal
- LDB initiation should be used as a guide and adjusted prn
- Anticipatory anxiety about POW is real: liberalize comfort meds
- Harm reduction education and support key
- Don’t forget methadone as a treatment option

Questions?

Massachusetts Consultation Service

MCSTAP

for Treatment of Addiction and Pain

Call **1-833-PAIN-SUD** (1-833-724-6783)

Monday through Friday - 9 am to 5 pm

WWW.MCSTAP.COM

mcstap@beaconhealthoptions.com Christopher.Shanahan@bmc.org;
Amy.Rosenstein@beaconhealthoptions.com; John.Straus@beaconhealthoptions.com