Buprenorphine Induction 101 Q&A

Taken from 1/14/20 and 1/28/20 WPSI Webinar Sessions with Dr. Candy Stockton-Joreteg

Note: Boldface indicates material extracted from Dr. Stockton-Joreteg's slides and narration of those slides. Interjected questions and answers are presented in regular font.

Question: I have a question related to abuse of Suboxone itself. I have several patients who melt down the Suboxone and separate it from the naloxone. Is there a lab screen that can test for naloxone being in their system?

Answer: I'm curious, are they using it to inject, or are they still taking it sublingually? When it is taken appropriately, there should be a minimal amount of naloxone absorbed in to the patient's system. To the best of my knowledge (and a quick internet search), there is currently no test for naloxone. If you believe these patients are genuinely taking their bup, these might be good candidates for a trial of the monthly injectable version to work around this issue.

Answer: I don't go above 16mg on day 1 with home starts. I don't think I've ever had a patient report back that it wasn't enough. I am checking with a couple of programs I share resources with to see if they are ok with sharing copies of their induction protocols with outside groups.

Question: What about switching pt that have chronic opioid use to buprenorphine and when and how to switch? wait for withdrawal as well?

Answer: If you decide it's appropriate to make the transition, you would still need to have the patient stop medications and wait for withdrawal symptoms to develop before starting, otherwise you could precipitate severe withdrawal symptoms. No all patients who take opioids for pain and are physically dependent on these medications have addiction or are appropriate for transition, but I've had really good response in many patients, with improved pain control and fewer side effects associated with the transition.

Question: Thoughts on starting contraception before or on treatment?

Answer: I start contraception on any women who want it as soon as possible. It can be difficult for women to be stable enough to get on to contraception while they are actively using, so it often doesn't happen until they get in to treatment, but I do it as soon as possible and will do even before we start treatment if it's possible. With a preference for LARC's, whenever possible.

Question: since beyond 16 mg doesn't improve saturation, why or when is more than 16 mg useful?

Answer: I find that some patients continue to have strong, persistent cravings on 16mg daily. In those patients, I will often try increasing to 20-24mg daily to see if there is an improvement in cravings and decrease in illicit drug use. If there is not, I don't continue the higher dose. The link below is to a journal article that discusses dosing and mu-receptor bioavailability.
Greenwald, Mark K et al. "Buprenorphine maintenance and mu-opioid receptor availability in the treatment of opioid use disorder: implications for clinical use and policy." Drug and alcohol dependence vol. 144 (2014): 1-11. doi:10.1016/j.drugalcdep.2014.07.035

Question: we as well are needing inpatient start order set protocols. also reference articles to submit to our pharmacy as we request an addition to our inpatient formulary
The California Bridge Program has inpatient protocols and guidelines for developing site specific order sets. Link here: https://www.bridgetotreatment.org/resources
I'm passing the question regarding pharmacy resources to Gloria, I believe she has a pharmacist contact who might be able to assist you.

Answer: I missed what you said about legal issues with changing methadone to buprenorphine in regards to pain vs. addiction. Can you please re-state that. Thanks!
Candy - In an outpatient office, methadone can be prescribed for pain. You can only prescribe methadone for addiction through a certified narcotic treatment program. It is illegal for you to prescribe methadone for addiction/opioid dependence from an regular medical office/clinic. It is illegal to prescribe any schedule II opioid for addiction. If a patient is being prescribed methadone for pain, and you are planning to start buprenorphine, I usually transition on to another opioid for 10-14 days to wash out the methadone before I start bup, but you can only do that if the patient is being written opioids for a legitimate pain diagnosis, not for management of addiction or withdrawal symptoms. If you are in doubt about the decision, don't risk it. I use it only in patients with clear cut pain diagnosis who are being transitioned due to side effects and lack of efficacy on their current treatment.

Question: of these areas that are rural areas are indian country included? reservations?

Answer: Many Indian reservations are located in rural areas. I work with a few programs that are based out of UIHS programs and one based on a reservation clinic. Are you trying to connect with similar programs?

Question: How do you approach or discuss concurrent methamphetamine and marijuana use?

Answer: This one is a little more involved than a quick answer, but I'll try to give a brief summary. While I talk to patient's about their marijuana use, I don't specifically have an expectation about stopping or not during treatment. I try to take more of a harm reduction approach.
We have an expectation of stopping methamphetamine use, but recognize that this is a separate disease. As a general rule, patient's cannot progress beyond weekly visits while they continue to use methamphetamines. This is not intended as punishment, but intended to be additional support. Given the absence of any other viable treatment for methamphetamine abuse, frequent contact and support is the best treatment we can currently offer.

Question: Would there happen to be a Spanish form? Of the Start at home

Answer: Here is a link to a Spanish translation of home induction instructions: https://drive.google.com/file/d/184apEFfBZwGcd-xgv0rwR6U2-ew87NJH/view?usp=sharing. SAMHSA has some patient information in Spanish, and the CA BRIDGE site also has some patient materials in Spanish, but I couldn't find that one anywhere.

Question: I thought naloxone in suboxone had only 3-5% oral bioavailability?
Follow-up: Might this be enough to cause those symptoms of opioid antagonism (mostly GI) that you spoke of if the patient swallows saliva after 3-5 minutes?
Follow-up : Didn't those 16mg studies come from the pre-fentanyl era? Now, with widespread fentanyl, it seems like many people need 24mg to curb cravings... and that the pharmacologic studies looking at saturation don't necessarily translate into what we're seeing clinically...?

Answer: See answer above.

Question: Would you touch on the micro dosing concept again and who that may be appropriate for? 99% of my patients do not need this, but may be useful for a few. Thank you!

Answer: It is intended to be used for patients who need to be transitioned from long acting opioids or those who may not be able to tolerate withdrawal symptoms to get to induction using normal procedures.

Question: I have pt who been on 24mg for years, and she refuse to have taper down to 15mg, do I keep her on 24mg daily?

Answer: I might need more details to give a more informed opinion, but I'd start with the following. Why doesn't she want to decrease her dose? If she is worried about withdrawal, I sometimes try a self-directed taper. ("I'm going to write your regular prescription this month, but I want you to try decreasing your dose by ¼ strip per day this week, if you develop withdrawal symptoms during the day, you can take your other ¼ strip, but I'm pretty sure you won't need it most of the days. Bring any remaining strips to your next appt, and we'll see how it goes.") You need to consider the possibility of diversion in a patient on a higher dose who refuses to consider decreasing dose and doesn't have a plausible explanation as to why. You might try random strip counts and urine testing for norbup to confirm she is actually taking it.

Question: Hi! I work in a large, urban county jail where I hope we'll one day be able to offer Bup treatment (either to start or continue…), but we're not there yet for a variety of reasons. A few questions: 1) in the jail, pretty much all of our patients present in some degree of withdrawal due to approx 48-72 hr delay in the booking process prior to medical assessment. Also, length of incarceration is very difficult to predict — some patients stay < 24 hrs and others for weeks to months. How would you anticipate these basic facts of jail care affecting MAT treatment? 2) the vast majority of our pts actually use methamphetamine as their primary drug, with some of these also using opioids along with the meth. How would you expect this to affect treatment success? How do you manage pts using multiple substances, particularly when the opioid use may not be the primary drug driving the pt in the addiction cycle?

Answer: I am actually part of our county "Jail MAT" project. We face the same issues and they have all been manageable, although it is a longer discussion than a paragraph on this sheet. I'd be happy to talk about this more offline. Here's a link to the website for the learning collaborative that is coaching teams

from jails across California to help sites implement MAT. In regards to polysubstance use, bup will not treat other substance use disorders, but you should still treat opioid use disorder when it exists. https://addictionfreeca.org/California-MAT-Expansion-Project/Expanding-Access-to-MAT-in-County-Criminal-Justice-Settings

Question: Data looks like buprenorphine is far superior in safety, ease of use and success rates. When would you change from Methadone to Buprenorphine
Follow-up: Is there any new treatment on the horizon? e.g. 18 MC?

Answer: There are differences between the two treatments and, like any other condition, people have different preferences and needs for treatment. I wouldn't change a patient who was stable and doing well on methadone over unless the patient wanted to change. Some people will do better with the highly structured nature of methadone programs.
In regards to new treatments on the horizon, I'm not aware of anything new expected in the near future. I believe that they are just getting ready to start phase 2 trials on 18-MC, so even if it does pan out we are likely still several years away from an approved drug.

Bryan is 32 years old when he first starts interacting with me. He's been abusing opioids for more than ten years. His problem started with an opioid prescription, but he also had problematic drug use prior to that. He used pain pills when he could get them, eventually transitioning to IVed heroin when he couldn't get any more pills. He attempted to go cold turkey, and that worked for 8 months, but he then relapsed with heroin, hiding that fact from his wife. When she found out, she gave him an ultimatum that amounted to: "Quit or get out."

Question: Has he had any previous treatment?

Answer: He did one previous 30-day program. He had been sober for several months following the program. He had a history of recreational drug use going back to his teens. He was a non-smoker who drank 3-7 beers a week and had med screenings suggestive of anxiety, but no formal diagnoses. He had chronic back pain from an old injury. He lives with his wife, who interestingly is employed in a chronic pain management clinic, and his 16- year-old daughter. He's privately insured thru Blue Cross. Does odd jobs in construction. All these issues are pertinent to treatment choices and can influence an outcome.

Question: Does he want to quit?

Answer: Great question. The answer is that I don't know. In my experience, patients who show up after having been given an ultimatum *partially* want to quit. But they're not my most successful patients. I counsel them about this, stating that when a spouse gives an ultimatum and drags you into the office, even when you do well and manage to achieve sobriety, the relationship oftentimes still ends. This is frustrating for patients and myself alike, because you've worked so hard to achieve sobriety, and then 2-3 months later, you find yourself filing for divorce. We assess whether the patient is truly there for themselves and if they truly want to quit, or if they're only doing it for the sake of the relationship.

Bryan last took 2 Hydrocodone/APAP (10/325) this morning (about 6 hours ago). He typically takes 6-10 per day when he can get them. He last used heroin last week.

He reports he is starting to feel like he's in withdrawal, but it's tolerable. It's Thursday afternoon, about 4 PM.

Question: Is the marriage thing anecdotal?

Answer: Yes, I don't have any research on it and I'm not aware of any, but in my experience, more often than not, either the treatment fails *and* the marriage ends, or the patient succeeds at treatment but the marriage still ends.

Next Steps:

Labs drawn today (Normal, CBC, CMP, Hep Panel, HIV, RPR)

Naloxone NS given; educated patient and wife on use
Explained that insurance auth would take 48-72 hours, and that I understood he would probably continue using during that time.

Rx for bup/nal 8/2mg 1-2 strips given daily x 1 month

Scheduled for in-office bup start on Monday morning

Scheduled for apt with counselor on Wednesday morning

Advised not to use anything after 10pm Sunday night

***If he'd been using a longer-acting drug like methadone, he'd have needed a longer washout period. I also gave him naloxone. At the time I was part of a pilot program that allowed us to administer it on-site. I was explicit about my observation that patients who are dragged in on an ultimatum are sometimes not successful, and I counseled him about this, as I do all patients in this situation.**

Day One: Starting Bup

Bryan arrived on Monday morning at 9 AM. His COWS score was 16, which is at the higher moderate end of withdrawal. He reported that he last used at 9:55 PM the previous night, taking 3 tabs of hydrocodone 10/325. He was anxious about the upcoming treatment and thus took more than his usual 2 tabs.

He reviewed the instructions for use and I gave him ½ strip (4/1mg). We waited about 45 minutes and reassessed, but he didn't seem to feel much better. His COWS score was now 15, and we administered another ½ strip. It's OK if symptoms don't noticeably improve in 20-40 minutes, but that's also a reasonable timeframe in which to make sure symptoms of withdrawal don't rear their head.

We assessed again at 10:30 AM, and the COWS score was now down to 6, and Bryan felt much better. I gave Bryan and his wife a copy of the COWS scale, which she easily understood because of her medical background. I told Bryan that if his symptoms got back up to 10 that afternoon, he could take another ½ strip. I also instructed him to check in by phone the following morning.

Day Two on Bup

Bryan had 2 significant episodes of withdrawal symptoms in the early afternoon and night, so by the end of Day One he'd taken 16mg. On Day Two, he took 2 strips in the morning and was reminded of his counseling appointment the next day. I poked my head in to check on him at his appointment.

Follow-Up

Bryan did surprisingly well. He was treated daily with 16mg for about 2 months, then decreased to 12mg with good symptom control.

*Question***:** When it comes to the use of transdermal buprenorphine to switch patients from methadone to suboxone in an outpatient setting, what protocols are in place?

*Answer***:** I don't do this. If you have a MAT 2000 waiver for buprenorphine, you are allowed to prescribe Schedule III, IV and V medications that are FDA-approved for the treatment of addiction. So if you have a patient on methadone for addiction and you want to transition them to buprenorphine, technically, using transdermal bup is illegal. Which is idiotic because it's the same thing, just in a different form. But that's the way the law was written. If you have a patient on methadone for pain who also has misuse or addiction complication problems and you want to transfer them to buprenorphine and you're writing the bup patch for the pain diagnoses, technically that is legal, but there's risks associated with it and you want to be cautious. It's potentially risky for you as a prescriber, so you want to understand the liability surrounding this method.

About 3 months later, Bryan called the office crying and asking for a new naloxone Rx. He found out that his now 17-year-old daughter was using, and he discovered her OD'd in her room. He managed to save her life with his initial naloxone Rx. It was a very important reminder that this medicine saves lives and that you never know when that will happen.

I followed Bryan for 2 years after treatment, at which point he was taking 4mg daily. He was off disability and back at work full time. He remains in recovery, still working full-time, and he's now stable on 2mg/daily but struggles to go lower than that. We reassess every six months or so. He's meeting his own landmarks for treatment success, and contrary to expectations, his marriage is still intact.

I'm much more likely now to do home starts on bup than when I first saw Bryan. I'm a little less adamant that patients complete all labs and evals prior to initiating treatment. It's a little easier now with insurance too – authorizations don't take as long. Price is about $2-3 per day. We can start with generic instead of brand if cost or accessibility are issues.

Question: When did you start tapering the dose down from 16mg?

Answer: I don't remember the exact time frame, but in my experience, people often require a higher dose at first, whereas 4-6 months in, they don't need quite as much. I actually talk to patients early on and as we move forward, suggest an intermittent decrease of ½ strip. Most people who have had several months of steady dosing don't need as much for their maintenance dose. I'll write them the same 16mg Rx, but tell them to take the second half of the strip on an as-needed basis. We then reassess and, depending on results, lower dosage or keep the same.

Comment: We've been doing home starts for 2 years with only one precipitated withdrawal. That particular patient was on much more methadone than we thought.

Answer: I had that experience too but it was in the office, unfortunately. I have not had a home start precipitated withdrawal in the four years I've been doing them. Patients are less likely to precipitate withdrawal at home. They're good at judging when they're in withdrawal, but when forced to be at the right stage of withdrawal when they come in, we increase the jeopardy of the situation. They tend to exaggerate the symptoms of their withdrawal out of fear we'll send them home without treatment. Home starts are much less likely to precipitate withdrawal than office settings. Home starts are a benefit to doctor and patient.

Comment: I have a patient who's been on 24mg for over 5 years, and I decided to cut back to 16mg, but then agreed to go back up to 24mg because the patient says that dosage helps with her ADHD and anxiety.

Answer: This is complicated. I have seen patients who do better on 24mg, but 5 years is a long time to be on that dose. There's a couple issues: first, there's a lot of medications in play here, so is there a possibility she's diverting some? Second, addiction is more than just a chemical response; there's a mindset to it as well. She may be emotionally and psychologically dependent on that dosage and having a hard time converting. If I'm maintaining a patient on that high of a dose for an extended period of time, I put a few safeguards in place to monitor for diversion. I send urine tox out for confirmatory testing for buprenorphine and norbuprenorphine. This confirms she's taking at least some of the medicine and not diverting it all. I give the test periodically, but not too often because it's expensive. If she's having ADHD and anxiety issues at this point, it may be time to call in a psychiatrist or behavioral health specialist for a formal ADHD assessment. Using opioids to treat ADHD or anxiety is not medically valid.

Comment: Tramadol is a useful bridge when used in a single dose of up to 200mg. Eliminates risk of precipitation.

Answer: I think in that case you're talking about the time at which you're starting treatment. All I can say is that tramadol is not FDA-approved for the treatment of addiction or management of withdrawal, so if you're prescribing that as part of the induction of treatment, you need to be very cautious. While it makes perfect sense from a scientific, biochemical standpoint, we have archaic and unreasonable laws that govern prescribing those substances. There's some danger you could have run-ins with the med board and DEA for doing that. Use non-FDA approved opioids for pain, and not for management of addiction.

Comment: I have trouble getting patients tapered off the last 2mg of bup and naloxone.

Answer: So do I. I generally ask the question, "Why do I want to?" If it's because philosophically I think they should come off it at some point, that's not a very good reason. If I had a patient with diabetes who made a lot of lifestyle changes with exercise and diet, but still needed a slight dose of insulin to complement the regimen, I'd of course continue the insulin. With patients who are stabilized long term on a low dose, there's no risk that we're aware of in staying on that low dose. We should treat this condition the same as you would other conditions. It's about disease control and assessing the risks and benefits of treatment vs. no treatment. If you have a patient who is well-controlled but needs a low dose, I'd document the reasons for doing that. There's a big push to get people off these medicines, but

in reality, we expect diabetic patients to take insulin forever and other patients with chronic diseases to keep taking their medicines forever. It should be the same in this case, accepting the scientific model that this is a chronic disease.

Comment: We have a patient who seems very confused about home start. We provided a home start handout and went over the instructions a few times.

Answer: I give most of my patients home starts because most do better that way. An exception is made for patients who seem cognitively unable to follow the directions or to understand the concept of home start. I imagine you've presented the graphics to the patient and outlined things for them, and if not, we can provide them. Some people don't follow directions well in general, though, and I will call these patients into the office to start treatment.

Question: I have a patient on suboxone 16mg who states he needs to take clonazepam 1mg or an ADHD med simultaneously. Is this ok?

Answer: Short answer, yes. Long answer, it's tricky and you'd better have documentation. Your patient's request is contradictory – does the patient need medicine for anxiety or a stimulant for ADHD? These medicines are at the opposite ends of the spectrum. It's possible that the patient is doing well on suboxone treatment, but still wants to get a bit of a drug effect – something to make her feel better. I do have patients on buprenorphine and clonazepam. I typically don't start them on clonazepam, but sometimes they're already taking it. I try to focus on the buprenorphine treatment first, stabilizing them before tackling the benzodiazepine taper. I do have some patients being prescribed benzos by a psychiatrist, which I don't love, but in those cases I make sure I communicate with the psychiatrist. While there's an increased risk of death with concomitant use of opioids and benzos, including buprenorphine, *untreated* substance abuse along with med use carries a *higher* risk of death. I recognize that the treatment is risky, but *not* treating it is more risky. I do document carefully. ADHD is another matter, and I'm still trying to figure it out. People with ADHD are at a higher risk for developing substance use disorders with a variety of drugs. I tell providers to do a thorough ADHD eval. Having a behavioral health specialist is a bonus, but document thoroughly if you don't have that luxury. Set specific goals to monitor treatment efficacy (getting to work on time, completing schoolwork). Justify continuing treatment. Sometimes, it's appropriate.

Question: Do you screen carefully for alcohol use with benzos and bup?

Answer: There's two ways this question could be read. Does it refer to patients using alcohol who are also using a *combination* of bup and benzos, or to when I'm dealing with either of those substances alone in combination with alcohol? Yes, I screen carefully for it and monitor it too. I find that just because you stabilize someone's opioid use, it doesn't mean you ameliorate their tendency to chase chemical escape. Patients turn to alcohol sometimes when they're struggling with recovery.

Comment: If ADHD is mild or patient is high-risk for addiction, there are non-stimulants that can be prescribed. That's what I do.

Answer: There are a couple that are non-stimulants. If patients are in fact seeking stimulants, they'll tell you that nothing else works. You can use Strattera or Wellbutrin (although Wellbutrin is off-label). Those are the common ones I use.

If I have a patient I believe in enough to prescribe a riskier treatment, I have a frank conversation with them and inform them about the risks; that it's frowned upon in general. I tell them about some of the things they'll have to do, such as getting drug tested more often, periodically coming in to my office to count pills, etc. I try to be clear that it's not just for the patient's good, it's for my good too so that I can retain my license and keep providing great care. If you have a treatment method that is questionable, you really should put some protective measures in place. You want to be able to show that you're a responsible prescriber. Having higher-risk patients follow a tighter monitoring regimen can be very beneficial to both parties. You can also reach out to me.

Comment: Maintenance on a 2mg dose of bup has another advantage, in that you can increase the dose for 24-48 hours if and when the patient experiences cravings.

Answer: Yes. We do have that conversation. The most common time I've seen people lapse after having been previously stable for a long time is when a close family member or friend overdoses. This seems paradoxical, but it happens. Having the ability to go up in dose temporarily as a safety measure is important.

Question: I have several patients who melt down the Suboxone and separate it from the naloxone. Is there a lab screen that can test for naloxone in their system?

Answer: As far as I can tell, there currently is no test to spot naloxone in the system, but if you're taking your medicine properly, you should have little to no absorption of the naloxone. I was curious as to whether they're using it to inject, or are they still taking it sublingually. If you have a patient who is trying to misuse bup but they're still showing up to treatment, they're probably a good candidate for the injectable version.

Question: We are working on standardized guidelines for starts in various settings – ED, inpatient, outpatient and home. We find the SHOUT guidelines too conservative for inpatient, and the ED Bridge too aggressive for outpatient/home. Are there other already-vetted easy-to-read algorithms that you can recommend so we don't need to re-invent the wheel?

Answer: There are a number of hospitals and outpatient programs throughout California. I'd Google "Addiction Treatment Starts Here" thru the CCI. They have several cohorts working on this now and most of them have posted their policies and procedures online.

Question: Thoughts on starting contraception before or on treatment?

Answer: As soon as is absolutely possible. If you're a female in treatment and you're not on a LARC, we check every 3-6 months for pregnancy. If a woman is pregnant, we want to make sure she gets the additional support and treatment she needs. If contraception can be started before bup treatment, all the better.

Question: Since increasing beyond 16mg doesn't necessarily improve saturation of the medicine, why do you often go up to 24mg?

Answer: I find that some patients continue to have strong, persistent cravings on 16mg daily. In those cases, I will often try increasing to 20-24 mg daily to see if there's an improvement in cravings and decrease in illicit drug use. If not, I don't continue the higher dose.

Addendum to this question from Bup Trimmed video

I don't go up to 24mg in the first day or week – 16 is the norm. Some studies show a higher retention rate than normal. I don't normally go above 16mg, but if I have a faithful patient who continues taking buprenorphine, yet still has lapses and their urine tox has norbut too, I'll often try going up to 20 or 24 to see if uncontrolled cravings are the problem. About 1 in 20/30 patients go up to this level, and if I don't see an appropriate clinical improvement (i.e. a decrease in toxicology and a difference in behavior), I'll go back down to 16. About half the patients who go up to this level show a clinical improvement and the other half go back down to 16mg.

Question regarding legal issues with changing methadone to buprenorphine when it comes to pain vs. addiction.

Answer: If you're not part of an NTP clinic or a certified methadone program, you can't prescribe methadone for addiction. Only for pain. You have to be cautious when switching meds in order to follow the law.

Question: Are any sites conducting these programs located on Indian reservations?

Answer: I work with a few different clinics located on reservations. Some are based out of UIHS programs and one is based on a reservation clinic. If you're trying to connect with similar programs, we can try to help you connect.

Question: How do we approach or discuss concurrent methamphetamine and marijuana use?

Answer: The published evidence on this is conflicting. Some data suggest there's a decreased risk of overdose; some suggest it's a gateway drug to more drug use. I try to be pragmatic here. I don't have an expectation they'll stop, but I do have a discussion with the patient and explain that marijuana is still a mind-altering drug, and that taking it is not the best way to escape their problems. If they're going to lapse and use SOMETHING, though, I'd rather it be marijuana than heroin. We don't really know scientifically what the right answer is. Regarding meth, it's clearly harmful in long-term use. It's a separate disease and addiction, though, and we don't have specific medication treatment for it in my program. The best interventions we have are contingency management and frequent monitoring and support. In strictly opioid use disorder patients, they'll gradually develop longer spans between their visits as we transition to chronic disease management. But if you use meth while on opioid treatment, we'll still require you to come in weekly. That's the best method we have.