Buprenorphine for Patients Using Fentanyl

Key "Take-Aways":

1. Fentanyl is prevalent in illicit opioids and greatly increases overdose risk; engaging patients in MOUD treatment increase retention and reduces risk.
2. Using good practices when starting buprenorphine with fentanyl-using patients will increase treatment success.
3. Assess and address patients' needs during and after the induction of buprenorphine.

Presentation Transcript:

I would like to welcome you to Clinical Provider Quick Tips. This topic is **Addressing Fentanyl Use in Primary Care Settings**. My name is Reb Close. I'm an emergency physician, and I'm going to be taking my boards in addiction medicine later this month. I'm our lead clinical physician for the Monterey County Prescribed Safe Initiative and Regional Director for California Bridge to Treatment. I'm going to talk to you today about **buprenorphine for patients using fentanyl**.

There's more on the slides than I'm going to be able to say in these 15 minutes. But here are the big takeaways:

- Basic information about fentanyl, why it increases the overdose risk.
- How Medications Opioid Use Disorder (MOUD) can change that risk.
- Good practices when starting buprenorphine for your patients using fentanyl and how to increase your treatment success.
- How to address patient needs both during, before and after the induction.

Acronyms and Terms:

(01:09) I'm going to quickly talk about some of the acronyms that are going to be used. I preferentially use MOUD, Medications for Opioid Use Disorder. And the rest of the acronyms you can see here:

- SUD – Substance Use Disorder
- OUD – Opioid Use Disorder
- MAT – Medications for Addiction Treatment
- MOUD Medications for Opioid Use Disorder

Here are terms you will not hear (on the right). And I hope that if you do hear these, you call your colleagues or yourself out as we change our language to destigmatize this disease.

- Person with a substance use disorder
- Person with an alcohol use disorder
- Person with an opioid use disorder
- Person in recovery
- Negative/positive result(s)
- Substance use disorder
- Patient with schizophrenia
- Patient with diabetes
- Addict, abuser, user, junkie, druggie
- Alcoholic, drunk
- Oxy-addict, meth-head
- Ex-addict, former alcoholic
- Clean/dirty (drug test)
- Addictions, addictive disorders
- Drug seeker

Person first language is critical and that's going to be part of this presentation.

Objectives:

(01:35) My first objective is to help us:

1. Understand the current situation with illicit fentanyl, and how you can use that information to determine which patients are candidates for treatment with MOUD with buprenorphine.

The other objectives are things we mentioned earlier in the key points:

2. Understand how to start buprenorphine and how to address the patient needs.
3. Understand how to assess and address patient needs during and after the induction.

Current Fentanyl Situation:

(02:00) First, we're going to start with our current fentanyl situation. Fentanyl - I think people are aware at this point - is a synthetic opioid. It is lab-designed. You don't have to worry about crops, sun, and high-level trafficking. It's easy and cheap, and it is mixed in every street drug that is in my community.

And one thing that's specific to fentanyl that makes it important is the **lipophilicity**. It builds up in the fat scores over time. How I describe this to my patient is it is a buildup of fentanyl in their system that kind of leaks out over time. We're going to talk about why that's important.

Intentional exposure can lead to dependence and high tolerance. This is what a lot of my patients who are intending to use methamphetamine experience: they have fentanyl dependence and tolerance **with no intent of using fentanyl**.

Any patient who is dependent on opioids, including fentanyl, is a candidate for buprenorphine. For every two patients you start a Medications for Opiate Use Disorder, you'll retain one in treatment, and a patient in treatment has a **reduced mortality**. Treating opioid use disorder saves lives. That's why we're talking about it today. This is the rapid-fire overview on fentanyl. The rest of the information is in the slides.

Buprenorphine:

(03:14) Now, we are going to talk about buprenorphine. This is where we're going to really focus our time today: our patient needs and how we can meet them. As you can see on this slide, there are three medications listed. Methadone and naltrexone are not going to be covered in today's topic. Buprenorphine plus or minus naloxone is what we're going to discuss today.

This medication can be taken in a multitude of ways. IM, IV, subcutaneous injections, sublingual and tablet form, or film. You can also use a transdermal patch which is a **very versatile medication**.

(03:51) This side specifies why I love this medication so much. **Buprenorphine has a ceiling effect**. Buprenorphine can treat withdrawal and cravings and prevent overdose, but it does not have the capacity that a full agonist does to cause respiratory depression, excess sedation, and ultimately overdose and death. What it does - and this is kind of how I show to my patients my receptors - you have got the opioid receptors and you have fentanyl on that receptor, it fully activates the receptor, treating withdrawal, and cravings,

and causing respiratory depression, and sedation, and potentially, ultimately, death. Buprenorphine, when it binds, binds receptor but only partly activates it. It does some of the similar effect but not all of them. And that's why I love it so much because it's super safe.

They did studies with patients that had gotten 96 milligrams, so essentially 10 times the dose we were using at the time this was studied, with no ill effects. We'll talk more about mixing it with other drugs, but this is why I love this medication, is that it has a ceiling effect.

In monotherapy, it is exceedingly challenging to have significant sedation, or even overdose, with buprenorphine. And because it has such a long half-life, it really stays in the system and the **coming down off buprenorphine is less severe.** Say, if someone were to run out of a dose, it is less severe than coming down from fentanyl, or some of the more rapidly metabolized medications. It is just built in safety.

Determining Candidates for Buprenorphine:

(05:30) This is the quick guide that we use with the California Bridge program. I reference it, I'm going to go through many parts of it. This is available to you on the California Bridge website in the middle of your shift. That's literally when I've pulled it up. Just pull it up right there in the shift and make sure I'm doing what I need to do. Resources are at the bottom and the overall algorithm is right there.

(05:52) Here is a second resource that is available on the bridge website, and that's a patient facing flyer that we have. And it just helps people understand how to use this medication and some of the "why" behind us. This is all stored at your fingertips and we're going to reference some of this as we go on.

(06:13) First and foremost, you need to identify the right patient. For me, the first thing I want to do is to **rule out any contraindications**. I practice street medicine. Every patient that I take care of right now, essentially, is unhoused, and we have a street clinic that pops up out of a van by the side near a duck pond. That's where my patients are being induced and where they are going through the counseling for buprenorphine. I don't have the capacity to do labs or to monitor patients much more closely than that situation allows. Methadone, for me, is really an "I-can't-go-there" contraindication. I can refer those patients to a methadone provider to work it out with them. But, **for me, methadone is a hard stop**. I'm very clear with my patients about that.

This is a caution, the second one: **benzodiazepines, alcohols, other respiratory depressants**. Essentially, every one of my patients uses additional substances, essentially, 100%. Being aware that that can be a challenge for my patients, I just try to ask them to when they're inducing on buprenorphine to make it as least complicated as possible with the other substances. Talk about the other medications and other potential respiratory depressants. It's not a hard stop though like methadone.

(07:34) If you are looking when you're getting ready to start a patient on buprenorphine, you're looking for **evidence of withdrawal**. Because if those receptors are open and you add buprenorphine, the patient is going to feel better. If you don't have open receptors and the buprenorphine binds, the patient may feel worse. We used to, when we were dealing with heroin and norco and things like that, we would want

patients to have a COWS score of about eight. And it was pretty good; you could start them. Now with fentanyl, that's not the case. We're asking for **a little higher COWS score, more severe withdrawal, and one objective sign**. I tell my patients: you want to have goosebumps; you want to potentially even be vomiting. I tell people that might be with them: you're going to look for yawning or runny nose; something objective to tell you're ready for this dose. Fortunately, most of my patients have already used it on the street and so they're very aware of what they're watching for.

(08:45) Here is that COWS score that I mentioned. Heart rate, vomiting, the goosebumps that I mentioned. And then a few subjective things such as anxiety or agitation. Keeping in mind that, as I said, most of my patients use multiple substances. **Methamphetamine clouds some of that subjective and objective information** that you're looking for. Keep that in mind and discuss that with your patients because they are your biggest ally in making this an effective transition. **Hard signs plus a high COWS**: they should be ready to go. I ask my patients to wait as long as they possibly can to really maximize how much better they're going to feel when we start the buprenorphine.

Starting Buprenorphine:

(09:18) Going back to that algorithm I showed you; patient wants to quit illicit opioids. I ask my patients to take **two buprenorphine strips**, that's usually what my patients are using, **under the tongue** when they are in bad enough withdrawal; they're so sick from withdrawal they know it's going to make them feel better. We do that, and I kind of give them the demonstration of having to absorb under the tongue so it's fully effective in their body. **16 milligrams** is my start for my patient. And I literally show them this kind of absorber, under-the-tongue motion and tell them that any buprenorphine they swallow, that gets in the stomach, is essentially wasted. You want all that buprenorphine to get in to bind those receptors so they can feel better. This is why that other sheet is helpful.

I tell my patients, after you get the buprenorphine, and to get all absorbed, please **don't drink water**. Take about 15 minutes, get it all absorbed. You got to **wait a little bit**. My recommendation is an hour. Most of my patients can't do that, it's about 30 minutes or so.

If they're feeling somewhat better, **they need another dose**, they need more. “Did you repeat the dose?” I tell my patients to take another eight, maybe even take another 16. Usually, when I get patients to 32, they're good, that is where they feel better. I tell all my patients: you may need four doses in that very beginning start to get you induced. That's okay, we're here to help you through it. I don't have any patients currently on more than 32, and I have a significant fentanyl using population. So, I feel confident in this dosing.

Addressing Patient Needs After Induction:

(10:57) What if they don't feel better? Let us widen our differential.

First thing is that withdrawal is hard, and it feels awful. We might be undertreating; maybe that is 16; maybe the patient didn't get it under the tongue, and they swallowed some of it. But we need to **talk to them** about that and make sure **all of that buprenorphine was absorbed**. So, we **may consider adding more**.

But also think about the **co-ingested substances**. I had a patient here that when you're trying to induce some buprenorphine, meth makes it better. It didn't work out. The meth really was a challenge for his induction. Consider co-ingestments.

Also, please consider there are **other things that can look like withdrawal**: sepsis, DKA, thyroid disease. Go back to other things and consider there may be something else. If the patient is not feeling markedly better, we might be missing something. Consider that, please.

(11:47) Here what everybody is so scared of: **precipitated withdrawal**. When they legitimately studied it, it was less than 1%. Now, what do we do if we precipitate withdrawal? We precipitate withdrawal all the time. You give Narcan to somebody who is overdosing - that's precipitated withdrawal. We know how to deal with that. It's very rare and we know how to handle it.

Most likely, what we see is what's called **undertreated withdrawal**. Meaning the withdrawal syndrome is really challenging, and we need more medication to get through it. When we were starting patients on four and eight in the era of fentanyl, we were seeing very undertreated withdrawal, and we needed to increase our doses. It is not from the buprenorphine; it is the **lack of adequate dosing in buprenorphine**.

This is my favorite part in talking to my patients is that you normalize this. Just like I'm talking to you very candidly about what's going on, **talk to your patients** in the same way: We are going to make this the best withdrawal experience you have ever had; we are here to support you. Talk to them about their experiences with buprenorphine or what they've heard of from friends and address it. That is what make patients feel comfortable with what's about to happen.

Precipitate Withdrawal:

(12:58) If you precipitate withdrawal, keep calm, and give more buprenorphine. You can give the other 16, 16 more. Like I said, some studies have gone up to 96 milligrams in dosing with no ill effects, so you can give higher doses.

If you have gotten six doses of eight milligrams of buprenorphine, and the patient is at 48 milligrams, and they're not markedly better, we're going to probably need to add in something else. That may be due to the methamphetamines; it may be due to alcohol withdrawal; it may be something totally different. Consider that and go to **second line agents**. Clonidine is an option, our antipsychotics are an option. One of my colleagues, when he gives that dose of buprenorphine to treat the potential precipitated withdrawal, he gives lorazepam essentially immediately. Another colleague gives ketamine. These are other options, but in the clinic setting this may be when you need to ask for help, and that is totally fine. This is less than 1%.

Additional Resources:

(13:54) Start **maintenance dose**. I start every one of my patients on three a day. That is my standard dose. Patients will go up and down as needed. Like I said, I have all my patients on four day or less.

Need help? You've got two critical resources there. I personally have called one of these resources during a shift. If you have your **x-waiver**, you write the medication, you connect the patient to the treatment. If you don't have your x-waiver, here's how you get it. It's literally about five minutes, I did it for a number of my colleagues recently. Super-fast and easy, and makes it so you can take care of these patients and get them connected to care.

(14:35) Here's your recap. You see right down there on the bottom there's the **California substance use line and the UCSF substance use form line** as your resource. All that stuff was referenced in my slides earlier.

If the patient is not in withdrawal when you see them, you do exactly what I do on the street. Talk to them about how to start and go through all the same stuff we were just talking about. And that little star at the bottom is to remind me how important it is to **connect them with the next care provider**, and as well your navigator, the person that's going to be a warm handoff and make sure they're safe.

We talked **about normalizing, acknowledging what the patient is going to go through**, ask them, align with them, and realize they need to tell you their story. And if you approach them in a nonjudgmental way, they will. We have other things to offer our patients such as fentanyl test strips; we have Narcan, of course, everybody needs Narcan, friends, family, all the clients. And then as well, there are some additional resources such as this shown, and never use alone.

Most importantly, **there's no reason to give up**. You always have something to offer these patients. If they're ready for buprenorphine, that's it. If they need harm reduction supplies, yes. If they just need a non-stigmatizing and nonjudgmental environment, yes. You always have something you can do to help these patients. So please feel empowered to make a difference in their lives.

Here is where you get some more information. I hope this was helpful. All these slides will be available for some of that detail I ran through fast. Wishing you an awesome day and thank you for listening.