ED Buprenorphine (BUP) for Opioid Use Disorder (OUD)

For *Any* Practitioner…… *ED INITIATED Buprenorphine (BUP)Practitioner Guide*

- If INITIATING buprenorphine, first make sure your patient is actively withdrawing, with a COWS score ≥ 8, and usually at least 6 hours (sometimes more) since the patient's last opioid use. Alternatively, the patient have recently endured days of opioid withdrawal and still craving.
- Make sure the patient is not currently taking methadone – otherwise the patient may develop a severe and prolonged buprenorphine precipitated opioid withdrawal.
- Give **8 mg** sublingual buprenorphine (consider starting with 16 mg if the patient is having severe symptoms or is a high dose user).
    - Consider a lower starting dose (e.g. 2-4mg) usually only in patients who are low dose heroin users, low dose prescription opioids, or who have significant comorbidities (e.g. elderly, oxygen dependent, CHF, COPD, etc.)
- After 30 minutes, **re-evaluate** -- if withdrawal symptoms have not improved much, consider another dose – can give 8 mg, 16 mg, or 24 mg as appropriate (high dose users may need more, light users need less). Unlikely to see further benefit after 32 mg (and caution if co-occurring alcohol use disorder).
- If you have an X-waiver, or if you can find an X-waivered provider, be sure to write a bridge prescription. Use the prescription order in the ED EMR buprenorphine order set.
- If you cannot find an X-waivered provider in the ED:
    - Option 1) Consider "buprenorphine loading" the patient with a total of 16mg-32mg of buprenorphine in the ED – to extend the time before the patient will withdraw again. [Caution with patients with an alcohol or benzodiazepine use disorder].
    - Option 2) The patient can return to the ED to dose again (up to 3 days in a row), to help the patient bridge to a clinic visit. The patient must register as a patient for each visit.

For X-Waivered Practitioners…. *Home Induction Buprenorphine*

- For patients who have OUD, but who are not actively withdrawing in the ED a home induction strategy may be used.
- From the ED buprenorphine order set, write a prescription for buprenorphine/naloxone "Suboxone"
    - If the patient will have difficulty filling the prescription promptly (no transportation, no ID, etc.) then ALSO order a take home pack (from ED EMR "take home bup")

For all patients…… *Access, Navigation and Referral to Community MAT Prescribers*

- An automatic referral from ____ EMR will be generated and sent to the ED Mental Health Provider.
- The patient will receive follow-up calls and monthly contact post discharge.

DURING DAYS: _____HOURS: 9-5

- The ED Mental Health Liaison/Social worker will meet with the patient and:
    - Complete assessments and enter data for tracking and follow up.
    - Provide contact information for the Certified Peer Support Worker (CPSW) and facilitate an introduction if the CPSW is on site.
    - Provide referral and schedule an appointment to a community MAT practitioner prior to discharge.

AFTER HOURS

- Nursing staff will have the patient complete the locator form and place in the referral folder.
- The patient will then be called as soon as possible to complete all of the items in the "during hours" process.

Please Remember to:

- Document a **COWS** score (can be done by a provider or nurse).

- Include the diagnosis *"Opioid Use Disorder"* on the chart (helps with referral to treatment). If patient is using heroin, or injecting an opioid, then the patient clearly has *"Severe Opioid Use Disorder."*

Frequently Asked Questions:

What if…my patient is being admitted?

- Start patients on buprenorphine while still in the ED, whenever possible. Hospitalists will be grateful.
- Remember that buprenorphine is a far more potent and safe analgesic than morphine.

What if…my patient is pregnant? Or breastfeeding?

- Preferred to prescribe the buprenorphine mono product ("Subutex"), instead of bup/nx ("Suboxone").
- Opioid withdrawal increases fetal distress and increases risk of pre-term labor (and pre-term delivery).
- During first trimester, may induce like normal and discharge (with navigation).
- Later in pregnancy, recommend consultation with OB and/or call NM Bup Helpline (see below).
    - Don't delay therapy for a pregnant woman in moderate to severe withdrawal (COWS $\geq$ 13).
- Buprenorphine is safe in lactation. Moms treated with buprenorphine are encouraged to breast feed.

What if…my patient is in treatment with methadone?

- Don't give buprenorphine unless the patient is in moderate to severe withdrawal (COWS of at least 13).
- Wait **<u>at least</u>** 2 days since the last dose of methadone (for patients in methadone treatment)
- Methadone patients, who are in withdrawal, can receive up to 30mg of methadone in the ED.
- If the patient is getting admitted, call the patient's methadone clinic to confirm the patient's last dose, then may administer patient's daily methadone dose (if patient hasn't already received for the day). DON'T give that patient buprenorphine – can precipitate a prolonged and severe withdrawal.

What if… my patient is in withdrawal after treatment with naloxone?

- Patients can get buprenorphine, and may be an excellent candidate. Same instructions as above.
- May need a higher intial dose of buprenorphine (to overcome the naloxone).
- Observe patient (if possible) for 2 hours after the last dose of naloxone, and 1 hour after the last dose of buprenorphine (peak effect in 45-60 minutes).

What if…my patient goes into withdrawal after treatment with buprenorphine?

- Seems counterintuitive, but more buprenorphine often will help.
    - Often the best treatment for buprenorphine precipitated withdrawal often is buprenorphine.
    - Confirm the diagnosis, recheck the history (e.g. ask again about recent methadone use).

What if…the buprenorphine doesn't seem to be working?

- The patient may have a very high tolerance, and may need more (particularly common with high dose fentanyl users). The patient may need 16-24mg to fully control withdrawal symptoms.
- The patient may have swallowed, drooled, vomited, or cheeked (and removed – because of fear) the first dose. May need to repeat the dose with **direct observation**/assistance/coaching/encouragement.
- Always re-evaluate the patient. COWS may have been over-estimated, due to confounders such as sepsis, viral syndrome, DKA, alcohol or benzodiazepine withdrawal, or stimulant toxicity. Treat as appropriate.

Administration Tips:

- Ensure the mouth is moist before placing the medication sublingually. DO NOT CHEW OR SWALLOW.
- Some patients need to be observed/assisted at the bedside through the entire dose (~ 3-5 minutes)
    - Confused patients (e.g. also withdrawing from alcohol) may forget and swallow the tablet.
    - Some patients are afraid of buprenorphine (afraid of precipitated withdrawal) and will remove the tablet when not observed (but will be afraid to admit this to the nurse or provider).
- When administering an order for 16mg or 24mg, best to administer 8mg sequentially (every 5 min).

Initiation Questions Bup Help Line 24/7: 800-222-1222 (NM Poison Center)

NM Poison Center Back number: 505-272-0064

Local BUP assistance: DR._____

ED Mental Health Liaison: