HUMAN SERVICES DEPARTMENT

Nuts and Bolts:

Basic Guidelines for Providers New to Buprenorphine Prescribing

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DSM-V Criteria for Opioid Use Disorder

While it is not necessary to have these memorized, it is helpful to be familiar with them.

1) Opioids are often taken in larger amounts or over a longer period than was intended.
2) There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3) A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4) Craving, or a strong desire or urge to use opioids.
5) Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6) Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7) Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8) Recurrent opioid use in situations in which it is physically hazardous.
9) Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10) Exhibits tolerance (see below).
11) Exhibits withdrawal (see below).

- Tolerance and Withdrawal Diagnostic Criteria:
  - The last two diagnostic criteria, related to tolerance and withdrawal, are not considered to be met for individuals taking opioids solely under appropriate medical supervision.

Initial Visit

Before Starting Buprenorphine:

- Check if insurance requires prior authorization
- Urine drug screen
- Check PMP

General Tips

- Be compassionate
- Discuss confidentiality, including limits of confidentiality. (Referrals to Child Protective Services, need to notify emergency services if homicidal or suicidal, insurance, court order)
- Give patient permission to not answer any question they feel uncomfortable with
- Start with the more basic medical history. Next ask drug history. Save the questions about consequences of drug use for the end, once you have developed some rapport.
- If you do not have adequate time to take the complete history below, it is reasonable to establish that the patient:
    - has an opioid use disorder,
    - wants to quit using illicit opioids (or other prescription opioids),
    - wants to begin treatment with buprenorphine,
    - and has a safe place to store the medication
    - and have the patient return for a more thorough history.

History

- Drug use history:
  - Age of first use, current use, how using (injecting, snorting, smoking, chewing, swallowing, etc.), how much using, how often, use of other drugs and alcohol
- Reason for wanting to quit now
- Rehab history:
  - Current counseling and meetings
  - History of counseling and meetings
  - Longest period drug-free – how did they do it?
  - Have they tried buprenorphine? Off the street or prescribed? How about methadone? How did methadone or buprenorphine work for the patient?
- Medical history, including chronic illnesses, psychiatric illnesses, surgeries, medications, allergies, vaccines.
  - Always ask about HIV and HCV.
- Contraception/pregnancy
- Living situation/partner/sources of support
  - Check if partner/people they live with use drugs and if they are supportive of patient quitting. If appropriate, consider offering therapy to those they live with. It is really hard to quit when people are using around you.
- Employment history
- Naloxone at home/history of overdose
- Children
  - Living with patient or not
  - THIS CAN BE A VERY EMOTIONAL TOPIC FOR MANY PATIENTS IF THEY HAVE LOST CUSTODY. ALWAYS BE KIND AND NEVER SCOLD.
  - Consequences of drug use: medical, social, work
  - It can be helpful to establish that they meet DSM-V criteria for opioid use disorder. (See first section)

Home-Based Initiation

- Most patients will already have tried buprenorphine on their own and will feel comfortable with how to do it. If so, it is usually fine to give them a prescription and let them start how they feel comfortable.
- There are two different ways to initiate buprenorphine.
    - The traditional way involves putting the patient into withdrawal and having them start buprenorphine 12-24 hours later.
    - Microdosing, while off label, involves starting very small doses of buprenorphine while the patient is still using and gradually increasing. The patient usually stops using on their own when they reach a certain dose of buprenorphine.
        - This is generally better tolerated by patients.
        - Seems to be particularly helpful for patients transitioning from fentanyl.
        - There is a lot less research on this, although the research that has been done is favorable.
        - It can be somewhat complicated, and some patients may not be able to do it.

Traditional Way to Initiate Buprenorphine

- Have the patient stop using opioids.
- Wait 12-24 hours until they are in withdrawal.
    - Withdrawal symptoms can be measured using the COWS score.
        - You want to aim for a COWS score of 7-9.
        - If they have been using fentanyl, you want to use a higher COWS score (e.g. 13).
- Can give acetaminophen/NSAID's, hydroxyzine, loperamide, clonidine, ondansetron to help with symptoms.
- Have them start at 2 -4 mg buprenorphine under the tongue. It is recommended to create the dosing schedule in collaboration with the patient.
- If symptoms improve or stay the same, have them take any additional 2 -4 mg in 30-60 minutes.
    - Continue to take 2mg every 30-60 minutes until symptoms are resolved.
- If symptoms worsen mildly, have them take medications for symptoms, and take another 2mg in 60-120 minutes. Continue to take 2mg every 60-120 minutes until symptoms resolve.
- If symptoms worsen significantly, have them take medications for symptoms and wait another 2-4 hours to take next dose. Alternatively, they can take buprenorphine every 30 minutes, which will eventually improve symptoms.
    - Feel free to call the poison center for help with this, as this can be quite tricky.
- Aim for a dose of 16mg on the first day. Patients using fentanyl may need higher amounts to control withdrawal symptoms. Note that insurance typically only covers up to a total of 24 mg daily.

Microdosing

- Patient does not stop using opioids right away.
- Instead, they start the buprenorphine at low dose and increase buprenorphine gradually.
    - Outpatient microdosing induction schedule for buprenorphine–naloxone. Take the buprenorphine right before using opioids for the first time in the day.
        - Day 1: 0.5 mg once a day (1/4 of a 2mg tablet or film)
        - Day 2: 0.5 mg twice a day
        - Day 3: 1 mg twice a day (1/2 of a 2mg tablet or film)
        - Day 4: 2 mg twice a day
        - Day 5: 3 mg twice a day (1 ½ of a 2 mg tablet or film)
        - Day 6: 4 mg twice a day
        - Day 7: 12 mg (stop other opioids)
    - May increase to 16 mg daily if needed
- The following are complicated situations for induction that should be deferred to experienced prescribers:
    - Pregnancy
    - Transition from methadone
    - Possibly induction if using fentanyl

Maintenance

- New Mexico law requires a PMP check when writing more than 5 days of a controlled substance.

Urine Drug Screens

- Until COVID, urine drug screen was often checked with every visit. Now, we are often checking every 6 months or more. It is not clear what the ideal interval will be once we are back in the office more.
- If possible, it is very helpful to have in-office tests.
    - These are cheap and easy, and results are available in five minutes, and while they lack sensitivity and specificity, they are useful as a tool in monitoring general progress, as long as one understands the limitations of the point-of-care test in use. The gold standard is chromatography with a mass spectrometer (LCMS or GCMS). These tests available as a send out. (This is also called a confirmatory test by many labs.)
- However, confirmatory tests are not routinely needed in the care of most patients.
    - All unexpected results should be confirmed. The easiest way to confirm is to ask the patient. If the patient acknowledges use, it has been confirmed. If the patient states they haven't used, the results need to be confirmed by LCMS or GCMS.
- Alternatively, sometimes prior to sending out a confirmatory test, a repeat, witnessed, urine sample can be obtained, tested, and discussed with the patient.
- If you do witnessed urine drug screens, they need to be with the patient consent. They need to be done in a non-stigmatizing way that protects the patient's dignity.
- Limitations of Urine Drug Screens:
    - The tests do not tell you when the patient used.
    - The tests do not tell you how often or how much they are using.
    - The tests do not tell you how they used.
    - The tests do not tell you the patient's level of commitment to getting drug-free.
    - Most "opiate" tests will not detect oxycodone use (a specific assay for oxycodone may be necessary).
    - Just buprenorphine requires a specific test, fully synthetic opioids such as fentanyl and methadone require specific assays.

How to Interpret the Presence of Buprenorphine Metabolites in Urine Drugs Screens:

- (Also, see how to address this in Bumps in the Road)

- Sometimes, patients will put a tablet of buprenorphine in the urine because the urine otherwise will not have buprenorphine.
  - This may be because they are not using buprenorphine and have weaned off.
  - This may be because they are not using buprenorphine and are using other opioids.
  - This may be because they are using someone else's urine.
- The in-office test will show positive for buprenorphine if either the patient puts a tablet in the urine or if the patient is taking buprenorphine properly.
- The ideal test would detect norbuprenorphine, but point-of-care tests, which detect norbuprenorphine are not commonly available.
  - The conformation test will show levels of buprenorphine and its metabolites.
    - The parent drug is buprenorphine.
    - The metabolites are buprenorphine glucuronide, norbuprenorphine glucuronide, and norbuprenorphine.
    - Some labs show all four separately. Some labs lump buprenorphine glucuronide and buprenorphine together and norbuprenorphine and norbuprenorphine glucuronide together.
    - The quantity of drug or metabolite dose in the urine does not correlate with blood levels.
  - If the patient is taking buprenorphine, there should be high levels of buprenorphine metabolites and low levels of the parent drug.
    - If the lab lists all four separately, the buprenorphine level will be low, and the other three will be high.
    - If the lab groups them together, both buprenorphine and norbuprenorphine will be high.
  - If the patient put a tablet in their urine, there will be high levels of the parent drug buprenorphine, and with no or minimal metabolites.
    - If the lab lists all four separately, the buprenorphine level will be high, and the other three will be low.
    - If the lab groups them together, buprenorphine will be high and norbuprenorphine will be low.

Basic History

- Is patient taking buprenorphine?
  - Is it effective?
  - Side effects?
    - Common side effects include constipation, nausea, and swelling in the hands or feet.
- Cravings? Patients with SUD have strong cravings they are trying to satisfy.
- Withdrawal symptoms
- Drug use
  - If patient answers yes on drug use, the following can be helpful:
    - What was the trigger? Was it internal (i.e., anxiety)? Was it external (i.e., a friend showed up with drugs)? A combination (a fight with family led to stress which led to relapse)?
    - Which drug did they use?
    - Did they get a response? (If they are on an adequate dose of buprenorphine, they should not get a high from an opioid.)
    - Do they have a plan to avoid using in the future?
- Alcohol use
- Storage
  - Medications should be locked and hidden.
  - If there are small children in the house, it should be stored so that children cannot get into it. Tiny amounts of buprenorphine can kill a toddler.
- Naloxone
- Contraception
  - It is vitally important to ask about contraception. 88% of pregnancies in women with OUD are unplanned.

Additional Questions That May Be Useful

- General functioning
- Meetings/counseling
- Use of seat belts
    - One study showed a 10x higher rate of death from car accidents in women with OUD.
- Employment
- Living situation
    - Are there other people in the household using drugs?
    - Is the living situation a supportive one for patient?
- Sources of support
- Psychiatric history
- Sleep

Dealing With Bumps in the Road

Positive Drug Screens

- Do not shame the patient. Most of the time, the patient is already quite ashamed of using, and many are very worried about disappointing us. Encourage the patient to be truthful. Relapses happen in addiction just like relapses happen in other chronic diseases like heart failure or cancer.
- Focus on problems with the treatment plan and how we can make it better.
- Ask questions about what happened to the patient using. Determine if it was a one-time use or ongoing.
- Find out the circumstances of use.
- Ask if they need more support, such as counseling or other support.
- Because of shame, many patients will not acknowledge use. Many patients are also worried that their buprenorphine will be discontinued.
    - It can be frustrating to us as clinicians when patients lie.
    - Continued use is often a sign that withdrawal symptoms or cravings are not controlled.
        - Every clinician is allowed to determine their own level of comfort with this.
    - In general, it is recommended to try to cultivate a relationship where the patient feels comfortable talking about use.
        - Helpful to understand that most patients with substance use disorders have been lying about their use (to others and themselves) for a long time, as an ongoing coping mechanism.
- It can take a while for patients to become comfortable disclosing their substance use.
    - An occasional lie is not uncommon, both in our substance use disorder populations and in our general population. It can be helpful to remind ourselves of this.

Drug Screens with Abnormal Buprenorphine Metabolites

- This is obviously concerning for diversion.
- Many providers will discontinue buprenorphine automatically at this time because they assume that they patient is not taking it. However, there are often other explanations. It is recommended that the clinician discuss this with the patient first and find out what it going on.
- There are some patients for whom it is a one-time mistake, and it may be reasonable to continue the buprenorphine with the understanding that it can't happen again.
- Discuss what the results showed.
    - If the patient acknowledges that they put a pill in the urine, discuss the circumstances, and why it happened.
    - If the patient doesn't acknowledge it, make it clear what the results showed and that it can't happen again.
- Recurrent urine drug screens that are negative for buprenorphine should be a cause for discontinuation.
    - Prior to discontinuation, alternative care should be done. This includes helping the patient find a higher level of care such as an inpatient treatment program or addiction clinic.
- However, prior to discontinuation of treatment, the clinician can make changes in care. These can include injectable buprenorphine, witnessed urine samples (by same gender staff), more frequent visits, shorter prescriptions, etc.

Pain

- Maximize non-opioid treatments:
  - NSAID's
  - Acetaminophen
  - Gabapentin/pregabalin
  - Duloxetine/venlafaxine/milnacipran
  - Physical therapy
  - Acupuncture
  - Therapeutic injections
  - Mindfulness
- If the pain is not relieved by the above measures, try increasing the dose of buprenorphine to 24 mg daily and splitting the dose to have the patient take it every 4 hours.
- If the pain is ACUTE and not relieved by the above measures, may prescribe opioids on top of the buprenorphine. Make it clear it is a short-term measure only.
- If the pain is chronic and not improved by the above measures, consider referring the patient to a methadone clinic. However, be aware that methadone in a methadone clinic is not dosed to provide good pain relief, as it is almost always dosed once daily. There may also be a delay in being started on methadone and in getting to a therapeutic dose.
- Under no circumstances should a clinician put a patient they have been treating with buprenorphine on methadone, as this may be viewed as a violation of federal law.

Need for Procedures/Operations

- Maximize non-opioid treatments:
  - NSAID's
  - Acetaminophen
  - Gabapentin/pregabalin
  - Duloxetine/venlafaxine/milnacipran
  - Physical therapy
  - Acupuncture
  - Therapeutic injections
- If the pain is not relieved by the above measures, try increasing the dose of buprenorphine to 24 mg daily and splitting the dose to have the patient take it every 4 hours.
- If the pain is not relieved by the above measures, the prescriber may prescribe opioids on top of the buprenorphine. Make it clear it is a short-term measure only.
- If the patient has a condition that will likely require opioids for an extended period, the provider can discuss with the patient whether to continue buprenorphine and prescribe opioids on top of the buprenorphine or stopping the buprenorphine for a period of time. If the buprenorphine is stopped, there should be a plan to resume buprenorphine in the future.

Pregnancy

- DO NOT STOP BUPRENORPHINE.
- If you are not comfortable with management, arrange for transfer to a prescriber who is comfortable. Write a script for buprenorphine without naloxone to last until they have an appointment.
- Send in a prescription for prenatal vitamins.
- Make a referral for prenatal care if you will not be providing it yourself.

Early Refills

- Ask the patient why they need an early refill.
- If they are overtaking, find out if their dose is too low and adjust if needed. This is the most common reason.
- If they have lost the prescription or had it stolen, make sure that they have taken steps to prevent it from happening again.
    - Consider doing a refill if this happens once. If it happens recurrently, the patient needs to take steps to prevent it from happening.
    - Patient may need more frequent visits, with shorter prescriptions.

Missed Appointments

- If it is a one-time occurrence, send in a script for a few days and reschedule the appointment.
- If it is recurrent, determine why and work with patient on fixing the problem:
    - Lack of transportation. See if they are eligible for transportation through their insurance. (Medicaid will provide non-emergency transport to appointments with 72-hour notice.)
    - Poor executive function with disorganization – this is common in patients with substance use disorder. Counseling can often help with this.
    - Shame/embarrassment about having relapsed and fear of being scolded if they come in. Try to be compassionate with patients who have relapsed. Work on not shaming them.
    - Fear of medical appointments/history of medical trauma. Refer for counseling.
    - Lack of commitment to treatment. While this can occur, it is important to rule out the above causes before assuming this is the reason they are not showing up for appointments. The fact that patients are showing up is a huge step in wanting help.
- Some clinics allow patients to be able to walk in for their appointment for buprenorphine. This will not work in all clinical settings.

Buprenorphine Mono-Product "Subutex"

A common question asked is, When should I prescribe buprenorphine mono-product (formulations without naloxone)?

- During pregnancy the standard is currently to prescribe buprenorphine mono-product (because of a lack of data evaluating teratogenic potential of sublingual naloxone in pregnancy).
    - However, there is a growing body of literature (case series) indicating that the combination medication (bup/nx) is safe in pregnancy.
    - Thus, some centers will prescribe bup/nx to pregnant women who continue to misuse buprenorphine mono-product (e.g. injecting).
    - Other options for pregnant women include using injectable depot buprenorphine ("Sublocade") when feasible.
- Some patients seek the mono-products because it is more easily misused (e.g. injected).
- Buprenorphine has a much lower street value than full mu agonist opioids (e.g. as low as $ 5 for an 8/2 mg film strip), but mono-product has a slightly higher street value.
    - However, there also appears to be a subset of patients who truly do not tolerate bup/nx well, and seem to absorb the SL naloxone well, or respond more markedly to it, resulting in more significant headaches, nausea, or other symptoms of opioid withdrawal.
        - These patients will not be compliant with bup/nx, and will drop out of treatment.
        - Alternative options for non-pregnant include:
            - Transition the patient to injectable forms of buprenorphine (e.g. Sublocade), if that can be performed in one's practice, and if the patient has insurance which covers the cost of Sublocade.
                - [Generally, Medicaid in New Mexico now covers Sublocade, but there may be a prior authorization (PA) process.]

- Commercial insurance may have a more arduous PA process.
- If the patient is "self-pay" this may not be feasible. This also may be cost prohibitive due to high associated co-pays/deductibles.

▪ Prescribe buprenorphine mono-product. However, while this may be completely appropriate for the patient, it should be noted that:

- A prior authorization (PA) may be required, and there may be insurance resistance (even from Medicaid – for not very sound reasons). The PA process may take a few weeks.
- Should be selective in deciding which non-pregnant patients to transition to mono-product (as the PA process may become exhaustive).
- Because of the greater opportunity for misuse of the mono-product, it is not unreasonable to at least initially require more frequent visits (shorter duration prescriptions), and more frequent urine drug testing.

- Lastly, note that even if a patient is injecting the buprenorphine mono-product, the patient is still safer in treatment with buprenorphine, than if the patient were misusing heroin, fentanyl, or oxycodone etc.

Moving to a Higher Level of Treatment

- Consider moving to a higher level of treatment if the patient is continuing to use opioids while on buprenorphine, and dose has been optimized.
  - The patient should be involved in this decision.
    - For some patients, using heroin once a week is the best they have done in years, and they are happy with that.
    - For other patients, one-time use is enough that they want to increase treatment.

Injectable Buprenorphine

- Injectable buprenorphine is useful for patients who get good relief of their cravings and withdrawal symptoms, but not enough to completely stop using.
- Injectable buprenorphine is also useful for patients who struggle to take a pill every day.
- Injectable buprenorphine is especially useful for patients who are motivated to stop while in the office, but then frequently skip doses in between visits.
- Injectable buprenorphine is a good option if they patient does not have a good place to store medication, especially if there are children in the house.
- Injectable buprenorphine can also be a good option if you are concerned about diversion.

Methadone

- Methadone can be quite useful in patients who have chronic pain not relieved by buprenorphine.
- It is also useful in patients who are not getting good relief of cravings and withdrawal symptoms on buprenorphine.
- It can also be useful for patients who need more structure.

Inpatient

- Consider inpatient treatment in patients with significant psychosocial dysfunction, housing issues, continued use despite medication, or use of multiple drugs.

Discontinuation of Treatment

The following are NOT reasons to discontinue treatment:

- Pregnancy
- Urine drug screens positive for illicit drugs
- Patient has been on buprenorphine a certain length of time

- It is recommended that the clinician caution patients from discontinuing medication early in treatment. Rates of relapse are unacceptably high following discontinuation.

Rapid Discontinuation

- Generally to be avoided, as this approach often incurs a high rate of return to illicit opioid use and suicide.
- However, consider for select patients who are going to be incarcerated or going into an abstinence-only inpatient program.
- Decrease dose by ½ tablet every 2-3 days until off, generally over a 2-week time period.
- Can give acetaminophen/NSAID's, hydroxyzine, Imodium, ondansetron to help with symptoms.

Gradual Discontinuation

- This is for patients whose opioid use disorder is stable and would like to get off the medication and is at lower risk for return to use/relapse
- Evaluate their stability overall, including living situation, sources of support, frequency of relapses, psychiatric and medical co-morbidities, and commitment to getting off.
    - Decrease by ½ tablet every other day (e.g. on MWF) for 2-4 weeks, then every day (the ½ tablet reduction is complete).
        - Repeat the process as above for however long it takes.
    - Mild withdrawal symptoms are common and will generally abate without treatment.
    - Cravings are more worrisome. If they are significant, it is worth considering whether to continue with discontinuation.
    - The patient should be involved in the decision making. Patients will often times hit plateaus. The last few decreases are often the hardest.
- For any patient who is discontinuing buprenorphine, it is important to review risk of relapse and decreased tolerance, including the risk of overdose. Ensure the patient has naloxone at this stage.
- Make sure the patient knows that they can return to start buprenorphine if needed.
- Also consider placing the patient on long acting injectable naltrexone following discontinuation to provide a safety net.

Rapid Medically Managed Withdrawal "Detox"

- "Detox" is done frequently, but it is rarely successful in helping the patient achieve long-term sobriety unless accompanied by intensive psychosocial treatment.
- (The "detox" approach can actually increase a patient's overdose risk, due to reduced tolerance, and abrupt return to use after period of abstinence.)
    - Only recommended in very specific circumstances, including patient going into incarceration or abstinence-based in-patient program
    - The usual detox is over two weeks.
        - Start at 8mg twice daily x 2 days, then 6 mg twice daily x 2 days, then 8 mg daily x 2 days, then 6 mg daily x 2 days, then 4 mg daily x 2 days, then 2 mg daily x 2 days, then 1 mg daily x 2 days, then stop.
- This is a common dosing schedule for correctional facilities which use buprenorphine strictly for safer, more humane withdrawal management.

Frequently Asked Questions

What dose do I use?

- It is generally recommended to start at 12-16 mg daily.
- Some patients who have been trying to stop prescription opioids, but cannot seem to get below ~ 60mg/day of oxycodone or hydrocodone, may do well at lower doses.

How much is too much?

- The majority of patients do well with 12-16mg/day.
- Higher doses have not been well-studied, although it is commonly thought that they are not of benefit.
- Most insurance plans limit outpatient buprenorphine to 24 mg daily.
    - For patients truly needing doses above 24mg/day, consider:
        - Changing to an injectable formulation.
        - Referral to an OTP (e.g. a methadone clinic) – either for methadone treatment or for higher daily dose buprenorphine treatment (as some OTPs will dose patients at 32 – 40mg/day).
            - Unfortunately, for patients who do well at higher doses of buprenorphine, many insurance plans, including New Mexico MCD plans will not fill prescriptions above 24mg/day.

Should I use tablets or films (for bup/nx)?

- Some patients have a very strong preference (either related to taste, or the greater ease with which the films can be cut/divided).
- Often, the buprenorphine product will be determined by their insurance coverage.
- Insurers generally prefer the bup/nx tablets, as these are usually lower cost than the bup/nx film (all are available as generic).
    - If all else is equal, use the films, but if the patient really prefers tablets, it is reasonable to use them.

How often should I see patients?

- It is common to see patients weekly for the four weeks, then every 2 weeks for 4-8 weeks, then monthly.
- After a year where the patient is stable, providers will often go to every other month.
- If a patient is struggling, it often makes sense to bring them in more frequently.

My patient is pregnant! What do I do?

- DO NOT STOP BUPRENORPHINE.
- If you are not comfortable with management, arrange for transfer to a prescriber who is comfortable. Write a script for buprenorphine without naloxone to last until they have an appointment.
- Send in a prescription for prenatal vitamins.
- Make a referral for prenatal care.

What do I do if a patient lies about urine drug screen results?

- Because of shame, many patients will not acknowledge use. Many patients are also worried that their buprenorphine will be discontinued.
- It can be frustrating to us as clinicians when patients lie.
    - However, it can be helpful to remember that many of our patients are not always truthful, not just our substance use disorder patients.
- Patients on blood pressure medications claim they are taking them regularly when they haven't filled them in 9 months. Patients are not always honest about what they're eating.
- We understand that patients are sometimes less than truthful because they are embarrassed or worried that we won't like them. We need to extend grace to all our patients in these circumstances.
    - In general, it is recommended to try to cultivate a relationship where the patient feels comfortable talking about use.
    - An occasional lie is not uncommon. It is reasonable to continue the buprenorphine if the patient is getting benefit despite this.

What do I do if my patient's urine is negative for buprenorphine metabolites?

- Some providers check metabolites regularly. This is usually a send-out test.
- A test that is negative for metabolites is obviously concerning for diversion.
- In the past, providers often discontinued buprenorphine automatically for this, but currently, we recommend discussing with the patient to find out what happened.
- There are some patients for whom it is a one-time mistake, and it may be reasonable to continue the buprenorphine with the understanding that it can't happen again.
- Discuss what the results showed.
- If the patient acknowledges that they put a pill in the urine, discuss the circumstances, and why it happened.
- If the patient doesn't acknowledge it, make it clear what the results showed and that it can't happen again.
- Recurrent urines that are negative for buprenorphine may be a cause for discontinuation after attempting other strategies discussed above.

How do I make sure patients are not selling/diverting their medication?

- It is impossible to prevent this 100%, but there are some basic steps to take.

1) Make it clear from the start that this is unacceptable and will result in discontinuation of buprenorphine.
2) Check the urine for buprenorphine metabolites.
3) Consider pill counts if there is a concern.
4) Be careful using doses above 16mg. Make sure there is good reason.
5) Use the combination product unless there is reason not to.
6) If there is a strong concern that patient is diverting, but they also seem to do well on buprenorphine, change them to the injectable buprenorphine.

Can I start buprenorphine if patient has a negative urine drug screen for opioids? Is someone who is not currently using opioids but has a history of OUD a candidate for buprenorphine?

- Yes. If there is a history of opioid use disorder and the patient has a concern about relapse, it is reasonable to start buprenorphine even if they are not currently using.
- Common situations where this occurs are patients who are coming out of incarceration or patients coming out of abstinence-based inpatient programs.
- It can also occur in patients with a history of OUD undergoing stressful life events.
- Patients rarely lie about having an OUD.
- It is also important to understand the limitations of most POC urine drug screens (generally ELIZA tests):
    - An "opiate" assay generally will detect heroin, morphine, codeine, hydromorphone, and hydrocodone (if patient uses enough hydrocodone).
    - Most "opiate" assays will not detect oxycodone use, unless the patient uses very high doses of oxycodone.
    - Fully synthetic opioids, such as fentanyl and methadone require specific assays. An "opiate" assay will never detect fentanyl or methadone.
    - Most POC tests due not include a fentanyl assay, and fentanyl is rapidly becoming the most prevalent illicit opioid in use in the community.
- Buprenorphine is a semi-synthetic opioid, but a derivative of thebaine. It also requires a specific assay.

When should I consider Injectable buprenorphine?

- Consider Injectable buprenorphine in patients who are continuing to use opioids despite being on therapeutic doses of buprenorphine.
- Injectable buprenorphine is useful for patients who get good relief of their cravings and withdrawal symptoms, but not enough to completely stop using.
- It is also useful for patients who struggle to take a pill every day.
- Injectable buprenorphine is especially useful for patients who are motivated to stop while in the office, but then frequently skip doses in between visits.
- Injectable buprenorphine is a good option if they patient does not have a good place to store medication, especially if there are children in the house.
- Injectable buprenorphine can also be a good option if you are concerned about diversion.

My patient is using benzos or alcohol. Is this a contraindication to use of buprenorphine?

- The use of benzodiazepines or alcohol is far more dangerous in combination with heroin, fentanyl or opioid pain pills.
- The FDA recommends prescribing buprenorphine in this situation but monitoring carefully.
- Evaluate the patient for benzodiazepine use disorder (BUD) and alcohol use disorder. If present, consider:
    - Adding medication treatment for AUD (e.g. gabapentin, acamprosate, or topiramate)
    - Taking over the benzodiazepine prescribing, with the goal of treating the BUD, and gradually weaning down their benzodiazepine doses.
- Recommend discontinuing alprazolam (“Xanax”) and transitioning patient to clonazepam or diazepam.
    - Connecting to psychosocial treatment for both

How do I manage someone with a difficult withdrawal/difficult induction to buprenorphine from fentanyl?

- If you know ahead of time that someone has been using fentanyl, you may wish to refer to a more experienced colleague or call the New Mexico Poison Center for expert assistance and referral.
- Consider microdosing.
- The "macrodose" approach (single large dose induction) which may work well when transitioning from heroin or oxycodone, does not seem to work as well with transitions from fentanyl.
    - If there is fentanyl on board, wait longer (at least 18-24 hours) and for a higher COWS score, 13-15.
    - Can give acetaminophen/NSAID's, hydroxyzine, Imodium, ondansetron, and clonidine to help with symptoms.
    - If symptoms of withdrawal worsen mildly, have them take medications for symptoms, and take another 2mg in 60-120 minutes. Continue to take 2mg every 60-120 mg until symptoms resolve.
    - If symptoms worsen significantly, have them take medications for symptoms and wait another 2-4 hours to take next dose.
    - Alternatively, they can take buprenorphine every 30 minutes, which will eventually improve symptoms.
- Like the "macrodose" approach above, taking buprenorphine every 30 minutes may incur a rough transition of precipitated withdrawal, and some patients will give up, and return to using fentanyl.
    - Feel free to call the poison center for help with this, as this can be quite tricky.

Should I require counseling for my patients on buprenorphine?

- It is not recommended to withhold buprenorphine prescriptions if patients are not participating in counseling.
- Buprenorphine has good evidence for OUD with and without counseling.
- However, most patients will benefit from counseling or meetings (peer support).
- Patients can be encouraged to attend counseling or meetings by the following:
    - Allowing more time between appointments for patients who are attending
    - Contingency management
    - Discuss regularly with the patient and find out what they would find helpful
    - Know the local resources for patients