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.