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