SAFETY AND EFFICACY OF BUPRENORPHINE
Numerous outpatient clinical trials comparing efficacy of daily buprenorphine to placebo, and to methadone

Many of these studies used sublingual liquid form of buprenorphine (so adjust dose accordingly when using tablets)

Typical primary outcome measures – treatment retention, opioid urine results
These studies conclude:

Buprenorphine more effective than placebo
Buprenorphine equally effective as moderate doses of methadone (e.g., 60 mg per day)
• Buprenorphine’s effects on heroin self-administration:
  ▪ Inpatient study with opioid dependent volunteers (men; n=10), maintained on placebo or buprenorphine (SQ)
  ▪ Dose of buprenorphine was up to 8 mg/day
  ▪ Allowed to self-administer IV heroin using an operant task
Heroin Self-Administration During Buprenorphine Maintenance Declines with Buprenorphine Dose

(Mello and Mendelson, 1980, Mello et al., 1982)
Maintenance Treatment Using Buprenorphine

- **Buprenorphine’s effects on heroin self-administration** (Mello and Mendelson, 1980) continued:
  - Early study showing that buprenorphine could suppress heroin self-administration
  - Also shows a dose effect for buprenorphine (although only one subject on the 4 mg dose)
  - Suppressed significant (but not all) heroin self-administration
Maintenance Treatment Using Buprenorphine

- **Comparison of different doses of sublingual buprenorphine:**
  - Multi-site (n=12), 16 week outpatient study in USA
  - Primarily a comparison of 8 vs. 1 mg/day SL buprenorphine solution; also included 4 and 16 mg conditions (n=736)
  - 1 mg condition meant to be a placebo-like comparison
  - Randomized, double-blind
Maintenance Treatment Using Buprenorphine

- **Comparison of different doses of sublingual buprenorphine:**
  - Primary outcome measures for the study:
    - Treatment retention
    - Illicit opioid use as determined by urine testing
    - Self-reports of opioid craving
    - Global ratings of functioning made by patient and staff
  - Safety outcome measures also collected and reported
Different Doses of Buprenorphine: Opiate Use

% Ss With 13 Consecutive Opiate Free Urines

Buprenorphine dose (mg)

(Ling et al., 1998)
Mean Heroin Craving: 16 Week Completers

Week of Study

Mean Craving Score

1 mg

4 mg

8 mg

16 mg

(Ling et al., 1998)
Maintenance Treatment Using Buprenorphine

- **Buprenorphine-methadone flexible dose comparison:**
  - 16 week outpatient randomized, double-blind clinical trial, single site (n=164)
  - Utilized double-blind flexible dosing procedure (50-90 mg/day of methadone, 8-16 mg/day SL buprenorphine solution)
Buprenorphine – Methadone: Treatment Retention is Equivalent for the Two Medications

(Strain et al., 1998)
Buprenorphine – Methadone: Opioid Urine Results are Similar: Fewer Opioid Positive Urine with Treatment

(Strain et al., 1998)
Buprenorphine, Higher Dose Methadone, LAAM: Treatment Retention Similar

(Johnson et al., 2000)
Buprenorphine, Methadone, LAAM: More Opioid Negative Urines with Therapeutic Doses of Opioid in Maintenance Therapy

(Johnson et al., 2000)
Withdrawal Using Buprenorphine

Studies have primarily looked at buprenorphine maintenance, not withdrawal

In general, withdrawal using opioids (e.g., methadone) has had poor outcomes

Results with buprenorphine may be better (may have a milder withdrawal syndrome)
• Buprenorphine maintenance vs. withdrawal:
  - Double-blind, random assignment to:
    - 16 mg/day SL buprenorphine tablets, or
    - 6 day buprenorphine withdrawal followed by placebo
  - 20 patients per group
  - Used tablets of buprenorphine, placebo

Kakko et al. 2003
• **Comparison of buprenorphine maintenance vs. withdrawal:**
  - First week of study was inpatient; study lasted one year; take home doses allowed after 6 months of treatment
  - Outcome measures included
    - treatment retention
    - urine samples that were collected under supervision and tested three times per week
    - ASI scores
• Comparison of buprenorphine maintenance vs. withdrawal:
  - All participants also received a relatively rich set of psychosocial treatments
    - group and individual counseling
    - assistance with various social service agencies (for example, for housing and employment)
Buprenorphine
Maintenance/Withdrawal: Retention

Approx. 75% of patients remained in treatment for 200 days.

4 of the patients in the withdrawal group had died by overdose at study completion.

(Kakko et al., 2003)
Overview to Safety

Highly safe medication (acute and chronic dosing)

Primary side effects: like other mu agonist opioids (e.g., nausea, constipation), but may be less severe

No evidence of significant disruption in cognitive or psychomotor performance with buprenorphine maintenance

No evidence of organ damage with chronic dosing
Overdose with Buprenorphine

Low risk of clinically significant problems

No reports of respiratory depression in clinical trials comparing buprenorphine to methadone

Pre-clinical studies suggest high doses of buprenorphine should not produce respiratory depression or other significant problems

Overdose of buprenorphine combined with other drugs may cause problems (reviewed below)
Benzodiazepines and Other Sedating Drugs

Reports of deaths when buprenorphine injected along with benzodiazepines:

Reported from France,
- Mono buprenorphine tablets are available
- Patients dissolve and inject tablets.
- Some of the deaths occurred in those who injected buprenorphine and benzodiazepines (alprazolam and flunitrazepam),
- Death a result of a pharmacodynamic interaction.
  (Kilicarslan and Sellers 2000, Maxwell and McCance-Katz, 2010)

Probably possible for this to occur with other sedatives as well
Drug Interactions: Benzodiazepines and Other Sedatives

- Deaths associated with the combination of buprenorphine and a benzodiazepine underscore the importance of clinicians being cautious in their prescribing.

- Outpatient clinical trials with buprenorphine conducted in the US with strong potential of abuse of BNZ drugs and the lack of a pattern of adverse events provides evidence that the use of buprenorphine and a benzodiazepine can occur safely.

- At the same time, reports show that there is a risk associated with buprenorphine and benzodiazepine abuse (especially by injection).

- A balance between these two lines of evidence should guide clinical decision making.
Medications that Share the CYP 450 3A Metabolic Pathway

Buprenorphine is metabolized mainly by cytochrome P450 3A4, and has the potential to affect and be affected by numerous other medications (inhibitors, inducers, or substrates) that use the same enzyme system, including:

- Nifedipine
- Erythromycin
- Rifampin
- Oral contraceptives
- Certain anticonvulsants (such as phenytoin, carbamazepine, and phenobarbital)
- Certain antidepressants (paroxetine, fluvoxamine, nefazodone, and certain tricyclic antidepressants)
- Grapefruit juice

A more complete list of drug interactions for the P450 3A4 system is also available at www.drug-interactions.com.
Drug Interactions

- Buprenorphine has not been shown to have a significant interaction with a number of HIV medications that have a variety of effects on CYP 450 3A4.
- Methadone, however, has been shown to have several adverse drug interactions with these medications.
- Clinically significant interactions have only been reported between:
  - buprenorphine and atazanavir/ritonavir (increased buprenorphine levels)
  - buprenorphine/rifampin (reduced buprenorphine levels/withdrawal).
Combination tablet containing buprenorphine/naloxone is safe and indicated.

But, avoid prescribing buprenorphine products with an opioid antagonist such as naltrexone – for example, in a patient with combined opioid and alcohol dependence.

While buprenorphine has a low level of physical dependence, it may be possible to precipitate withdrawal with opioid antagonist in buprenorphine-maintained patients.
The combination of an opioid agonist with buprenorphine should be viewed as a possible contraindication

Use caution if combining an opioid agonist (for example, morphine for pain relief) with buprenorphine – possible that buprenorphine could precipitate withdrawal under certain circumstances
Rationale for Buprenorphine/naloxone

• When taken sublingually
  ▪ Buprenorphine will be well absorbed
  ▪ Naloxone absorption will be minimal

• If taken intravenously
  ▪ Naloxone 100% bioavailable
  ▪ Precipitated withdrawal occurs in opioid maintained patients
PEAK EFFECTS – MEAN (±SD)
Mendelson J., et.al. Biol Psychiatry 1997;41:1095-1101

Bad Drug

Sickness

Buprenorphine placebo, Naloxone placebo
Buprenorphine 0.2 mg, Naloxone placebo
Buprenorphine 0.2 mg, Naloxone 0.1 mg
Buprenorphine placebo, Naloxone 0.1 mg
Mean Peak Amount

Would Pay for Drug

Naloxone 0.00 ± 0.00

Placebo 0.00 ± 0.00

Buprenorphine 11.90 ± 7.00

Bup/Nal 1.90 ± 3.70

Buprenorphine

Naloxone

Bup/Nal

Placebo

Intoxication (0-100)

Withdrawal (0-100)

Minutes
Adding Naloxone to Buprenorphine

- Does not diminish the effectiveness of sublingual buprenorphine but
- Attenuates opiate agonist effects in
  - Methadone patients
  - Untreated opioid dependent individuals
- Probably will have little effect on intravenous buprenorphine abuse in buprenorphine/naloxone treated patients
Summary

• Buprenorphine/naloxone is effective for the treatment of opioid dependence, maintenance more effective than pharmacologic withdrawal (detoxification)
• Buprenorphine/naloxone has a good safety profile but caution should be used in patients abusing sedatives (benzodiazepines)
Summary (continued)

• Buprenorphine/naloxone combination is the preferred form for unsupervised dosing
• The addition of naloxone to buprenorphine will likely decrease its abuse potential in patients receiving μ agonists (e.g. heroin, methadone) but this form could be abused and diverted in non-dependent individuals
Questions and Comments?
LAWYER, BEGINNING TO USE DAILY
Case 3 Lawyer, beginning to use daily Clinical Management

Mr. Smith is a forty–year-old man who comes to your office asking to be treated with buprenorphine. He is a criminal defense attorney in private practice, and he knows about buprenorphine because you are treating some of his clients. His goal is to use buprenorphine during the week and occasionally use heroin (by snorting) on the weekend. He has used heroin for the past 5 years.

For the past 6 months, he has used heroin primarily on the weekend, but he is concerned now because he has begun to use small amounts of heroin daily. If he doesn’t use heroin, he gets loose stools, is irritable, and has difficulty getting and staying asleep. He has no desire to completely stop heroin use, but he doesn’t want to use it during the week.

His passion is playing jazz and he has organized a band. He says that heroin use is common in the club where his band plays. All the members of the band use heroin and many of his friends who come to the club also snort or inject heroin. He rarely buys heroin, as his friends usually give it to him.
Case 3 Lawyer, beginning to use daily – cont’

His only other drug use is marijuana and alcohol (3-6 drinks/night on the weekend), again primarily used on the weekend. He has never been arrested or had significant medical consequences from his heroin use. He is not married. He has a 14-year-old son who he has supported and sees often.

What is the diagnosis?

Is this patient a candidate for treatment with buprenorphine?

What are the treatment goals?

What is the initial treatment plan?
CLINICAL USE:

INDUCTION, STABILIZATION AND MAINTENANCE DETOXIFICATION
Agenda

I. Induction
II. Stabilization/Maintenance
III. Medically Supervised Withdrawal (detoxification)
IV. Summary
Dose of buprenorphine at which the patient:

- No opioid withdrawal symptoms
- No cravings
- Minimal or no side effects
- Discontinue or markedly reduce use of other opioids
Bup Induction: Access to Medication

Three options:

1. Patient fills prescription for the first day’s dose and brings medication to the office where it will be administered

2. Keep supply of medication in the office for induction

3. Patient fills a prescription for home induction
Option 1:

• Give patient prescription for the first day’s doses
  ▪ Patient fills prescription and brings back to the office

• Risk of a delay with the first day’s dosing and that a patient might not return with the prescription
Bup Induction: Access to Medication

Option 2:

- Supply of buprenorphine in the office: you must keep the records required by federal and state law for maintaining supplies of controlled substances for administration or dispensing

- Those records may be audited by the DEA
Bup Induction: Access to Medication

Option 3:

• Review instructions for home induction with patient

• Send them home with instructions, follow-up appointment, and a prescription for medicine
Bup Induction: Office Logistics

- Consider scheduling office induction earlier in the day
- Some offices prefer inductions earlier in the week
Buprenorphine Induction – Day 1

- **Key to Success**: avoid precipitated withdrawal at induction

- **Solution**: mild to moderate withdrawal at time of first buprenorphine dose
Buprenorphine Induction - Day 1

Instruct the patient to abstain from any opioid use
- 12-16 hours for short-acting opioids
- 24 hours for sustained-release opioid medications
- 36 hours for methadone

For methadone transfer:
- Stabilize on 30mg (1-2 weeks)
- Last day on methadone cut dose to 15mg
- Next day – no methadone
- Following day – buprenorphine induction
Buprenorphine Induction - Day 1

- Patients dependent on short-acting opioids (e.g. heroin/oxycodone/hydrocodone)
- Instruct patient to abstain from any opioid use for 12 to 24 hours prior to induction visit
  - Arrive in mild-moderate withdrawal at induction visit
- Use opioid withdrawal scale (COWS > 8)
  - document and assess severity of withdrawal
  - track the patient's response to first day’s dose
Clinical Opiate Withdrawal Scale (COWS)

- Resting Pulse
- Sweating
- Restlessness
- GI Upset
- Tremor

- Pupil Size
- Bone or Joint Aches
- Yawning
- Anxiety or Irritability
- Gooseflesh
- Runny Nose
  or Tearing Eyes
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Patient's Name: ___________________________</th>
<th>Date and Time __ / __ / <em><strong>:</strong></em>_______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for this assessment: ____________ ___________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting Pulse Rate: ___________________________</th>
<th>GI Upset: over last ½ hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>5 Multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past ½ hour not accounted for by room temperature or patient activity.</th>
<th>Tremor observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
<td>0 tremor</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness Observation during assessment</th>
<th>Yawning Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>5 Unable to sit still for more than a few seconds</td>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil size</th>
<th>Anxiety or Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pupils pinned or normal size for room light</td>
<td>0 none</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
<td>1 patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
<td>2 patient obviously irritable anxious</td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint aches If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored</th>
<th>Gooseflesh skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
<td>3 piloerrection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/ muscles</td>
<td>5 prominent piloerrection</td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny nose or tearing Not accounted for by cold symptoms or allergies</th>
<th>Total Score ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td></td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td></td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td></td>
</tr>
</tbody>
</table>

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Initials of person completing Assessment: ___________________________
If patient is not in opioid withdrawal on arrival in office:

- Assess time of last opioid use
- Consider either having patient return another day or wait in the office until you see evidence of withdrawal
Bup Induction: Patient Education

- Sublingual tablets and films must be held under the tongue several minutes to dissolve.

- Buccal delivery films take fewer minutes to dissolve and are stuck to the buccal mucosa.

- Instruct to:
  - Start with a moist mouth, avoid acidic drinks (coffee or fruit juice).
  - Avoid using nicotine products as this interferes with absorption.
  - Don’t talk with the sublingual medication.
  - Keep dissolving medicine under tongue.
  - Don’t swallow until entire tablet or film is dissolved. You can swallow with the buccal medicine.
Buprenorphine Induction - Day 1

First dose: 2 to 4 mg SL buprenorphine/naloxone:

- Monitor in office for 1+ hours after first dose.
- Relief of opioid withdrawal symptoms should begin within 30-45 minutes after the first dose.
- Re-dose every 2-4 hours, if opioid withdrawal subsides then reappears
- Aim for dose of 8 - 12 mg. in the first 24 hours
Buprenorphine Induction - Day 1

• If opioid withdrawal appears shortly after the first dose buprenorphine may have precipitated a withdrawal syndrome.

• Greatest severity of buprenorphine-related precipitated withdrawal in the first few hours (1-4) after a dose, with a decreasing (but still present) set of withdrawal symptoms over subsequent hours.
Buprenorphine Induction - Day 1

If a patient has precipitated withdrawal consider:

• Giving another dose of buprenorphine, attempting to provide enough agonist effect from buprenorphine to suppress the withdrawal, OR

• Stopping the induction, provide symptomatic treatments for the withdrawal symptoms, and have patient return the next day.

Since the latter risks losing the patient, the first option is preferred
Buprenorphine Induction - Day 2

- Have patient return to the office
- Assess opioid use, symptoms since first dose
- Adjust dose accordingly:
  - Raise dose if there were withdrawal symptoms after leaving your office
  - Lower dose if patient was over-medicated
- Continue adjusting dose by 2 - 4 mg increments until an initial target dose of 12 - 16 mg is achieved
  - Resolution of craving and withdrawal
If continued dose increases are requested after reaching 16 mg, wait for 5-7 days to reassess before any further dose increase
  - Reassess technique in taking dose
- Most patients can be stabilized between 12 and 16 mg
- The standard range is 8 to 16 mg
- The maximum recommended daily dose is 32 mg; doses in this range increase the risk of diversion.
- Most insurance companies limit daily doses to 24 mg
Buprenorphine Induction: Patients Not Physically Dependent on Opioids

Examples:

• A patient at high risk for relapse to opioid use, such as a person recently released from prison

• A patient struggling with sobriety on long acting naltrexone who wants to transition

• A patient who has never met criteria for physiological dependence (tolerance or withdrawal) but meets DSM 5 criteria for opioid use disorder
Buprenorphine Induction: Patients Not Physically Dependent on Opioids

- First dose: 2 mg SL buprenorphine
- Monitor in office for 2+ hours after first dose
- Gradually increase dose (2 mg/day) over several days as needed
- Stabilize at dose that eliminates craving; typical dose may range from 6 mg to 16 mg
Home Induction or Unobserved Induction to Buprenorphine

- Convenience for some patients and providers
- Similar outcome for safety and efficacy
- 42% of primary care doctors in 2007 used this as their primary induction method
Home Induction: Multiple Approaches But Subtle Clinical Variance

- Teach patient about how bup/nx works and how it is absorbed
- Teach COWS scale and typical withdrawal symptoms
- Start scoring 12 hours after heroin or opioid pills and 24 - 36 hours after last illicit methadone use
- Self administer 4 mg bupre/nx when COWs score 12 or >
- Self score again in 1-3 hours. If still scoring 12- 16, self administer another 4 mg dose.
Home Induction

- Measure withdrawal symptoms a third time on Day #1, 6-12 hours after 1st dose.
  - If still at a COWS score of 12 - 16, take a final 4 mg dose.
  - Total Limit on day #1 = 12 mg.

- Day #2 - If you wake up and you feel OK, take the total dose you took on Day #1 (either 4 mg, 8 mg or 12 mg).

- If you wake up and you are still withdrawing (COWS 12-16), take Day #1 dose plus 4 mg.

- Day #3 - 5 - phone discussion or office visit with prescriber, nurse, etc to gauge dosing strategy.
I. Induction
II. Stabilization/Maintenance
III. Medically Supervised Withdrawal (detoxification)
IV. Summary
Buprenorphine: Stabilization/Maintenance

- Expect average daily dose will be somewhere between 8 and 24 mg of buprenorphine
  - **most patients will not require more than 16 mg**
- Consider divided doses at higher dose range
Effects of Buprenorphine Dose on $mu$ Receptor Availability

MRI

Bup 00 mg

Bup 02 mg

Bup 16 mg

Bup 32 mg

Binding Potential ($B_{\text{max}}/K_d$)

Slide Courtesy of Laura McNicholas, MD, PhD
Agenda

I. Induction
II. Stabilization/Maintenance
III. Medically Supervised Withdrawal (detoxification)
IV. Summary
Buprenorphine: Detoxification

- Studies have primarily looked at buprenorphine maintenance, not detoxification
- Detoxification associated with poor outcomes
- Some studies indicate higher detoxification completion rates with buprenorphine and milder withdrawal symptoms
- To improve outcomes, always consider transfer to ER naltrexone post detox (after 7-10 days free of opioids, buprenorphine or methadone)
Buprenorphine: Detoxification

- Buprenorphine has been used in three ways for withdrawal from opioids (Parran et al. 1994)
  - Short-period (rapid) withdrawal (\(\leq 3\) days), often conducted on an inpatient basis
  - Moderate-period withdrawal (4-30 days), usually conducted on an outpatient basis
  - Long-period withdrawal (\(\geq 30\) days)
Buprenorphine: Detoxification

Rapid Detoxification In <= 3 Days

➔ Reports show buprenorphine suppresses opioid withdrawal signs and symptoms (better than clonidine).

➔ Long-term efficacy is not known, but likely poor
  - Day 1: 8 - 12 mg SL
  - Day 2: 8 – 12 mg SL
  - Day 3: 6 mg SL

Buprenorphine: Detoxification

Detoxification Over 4-30 Days

- Fewer studies of bup for such time periods
- Suppresses signs and symptoms of withdrawal
- More effective than clonidine over this time period
- Long-term efficacy is poor with a high rate of return to opioid misuse
## NIDA-CTN Buprenorphine Detoxification Protocol

<table>
<thead>
<tr>
<th>Study Day</th>
<th>Buprenorphine-Naloxone (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4 + additional 4 as needed</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
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<td>5</td>
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<td>9</td>
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<td>10</td>
<td>4</td>
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<tr>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>2</td>
</tr>
</tbody>
</table>
Detoxification Over >30 Days

- Not well studied

- Literature on opioid detoxification can provide guidance.
  - It suggests longer, gradual detoxifications are more effective than shorter detoxifications.

- Taper more rapidly down to 8 mg, then taper more slowly.
I. Induction
II. Stabilization/Maintenance
III. Medically Supervised Withdrawal (detoxification)
IV. Summary
Monitor patient during induction:
- Assess for withdrawal
- Do not dose until COWS is at least 8 or >
- Recommend observation after the first dose
- Many patients do well with home induction

Efficacy of detoxification poor, but if you must…
- Withdrawal from buprenorphine may be milder than withdrawal from other opioids
- Probably best if conducted over longer periods
Patient Confidentiality, Medical Records, Office Policies and Procedures
Outline for This Talk

I. PATIENT CONFIDENTIALITY
II. Medical Recordkeeping
III. Office Policies and Procedures
Purpose

The logic behind federal and state regulations is that persons with substance abuse problems are more likely to seek and succeed at treatment if they know their need for treatment will not be disclosed unnecessarily.
Scope of the Law

- Restricts disclosure and use of patient-identifying information
- Patient-identifying information is anything that reveals a person is receiving, has received, or has applied for substance abuse treatment.
- Cannot disclose participation in substance abuse treatment – but can disclose identity under some circumstances
  - Includes current, former, and deceased patients
Exceptions

- Internal communications
- Consent
- Anonymous or non-patient identifying information
- Qualified service organization agreement
- Crimes on premises or against personnel
Exceptions (continued)

- Medical emergencies
- Mandated reports
- Research
- Audit and evaluation
- Court orders
HIPAA and Substance Abuse Treatment

• HIPAA shifts control of health information from providers to patients (to a great degree).
• Covers providers who transmit health information electronically (essentially everyone).
• Key feature of HIPAA is the definition of “Protected Health Information” (PHI) – individually identifiable information (e.g., name, date of birth, Social Security Number).
HIPAA and Substance Abuse Treatment

- HIPAA establishes rules regarding PHI (for example, regarding patient notification, protection of information, disclosure, and research).
- These rules are, in some ways, a movement toward the substance abuse confidentiality regulations (i.e., making general confidentiality regulations more like those used in substance abuse treatment programs).
Confidentiality of substance abuse treatment is more stringent than typical regulations for doctor-patient relationship.

Disclosure of information requires special consent of patient; other circumstances may allow disclosure.
Outline for This Talk

I. Patient Confidentiality
II. MEDICAL RECORDKEEPING
III. Office Policies and Procedures
History Portion of the Record

- Much of what should be recorded by the admitting physician is normally gathered as a part of the initial interview with any new patient seen in the office setting.
- The history portion of the record should document aspects of the patient that may influence the decision to use buprenorphine (as shown on the next slides).
THE MEDICAL RECORD SHOULD DOCUMENT:

- Medications prescribed
- Inventory and dispensing of controlled substances
- If medication is being dispensed from the office, a record of what is dispensed should be in the patient’s record (in addition to a separate inventory of medication kept in the office).
THE TREATMENT PLAN SHOULD DOCUMENT:

✓ Diagnoses and how they were determined
✓ Treatment goals
✓ Determination of medication to be used
✓ How medication will be used
✓ Psychosocial services needed/recommended
✓ Signature of patient and provider
WHEN PLANNING TO PRESCRIBE BUPRENORPHINE FOR OPIOID DEPENDENCE TREATMENT, DOCUMENT:

✓ Evidence showing patient has opioid use disorder using diagnostic criteria (e.g., DSM-5)
✓ Length and severity of patient’s opioid use disorder
✓ Number, type, and intensity of previous treatments for opioid use disorder
✓ Any legal consequences to the patient because of opioid use
Prior to starting the patient on buprenorphine, obtain and document the patient’s informed consent.

DOCUMENT EACH OF THE ELEMENTS OF CONSENT:
- ✓ Adequate information was given
- ✓ Patient is competent to process information
- ✓ Consent was given freely and voluntarily
INSURANCE COMPANIES:
✓ May seek to review the medical records to determine if the treatment was medically necessary.
✓ Are required to have the patient’s consent for disclosure of treatment. If disclosure to the insurance company includes information about substance abuse treatment, the consent must contain the appropriate elements specified in the Code of Federal Regulation.
Alteration of Records

❖ Records can be legitimately changed in prescribed ways:
   • Words crossed out (not erased)
   • Date and initials of writer entered at correction site
   • New or changed information inserted

❖ Investigators and attorneys are trained to detect aberrations.
Storage of Records

- Currently, DEA regulations require maintenance of records for at least 2 years. State regulations or accrediting bodies may require longer periods.
- Can be kept at a central location (but must notify DEA).
- Must be kept in a locked, secure place when not in use.
Summary

- Detailed and clear documentation is important for the well being of both the patient and the physician.
- The record is a legal document that may be reviewed by outside agencies.
Outline for This Talk

I. Patient Confidentiality
II. Medical Recordkeeping
III. OFFICE POLICIES AND PROCEDURES
Necessary Resources: Referrals

✓ Different levels of substance abuse treatment services:
  • Group counseling programs
  • Methadone treatment programs
  • Partial hospitalization
  • Intensive outpatient

✓ Psychiatric or medical services

✓ Self-help groups such as AA, NA in your community
Necessary Resources: Urine Toxicology Exams

✓ Capacity to get valid urine test results
✓ Collection procedures (in office or off-site)
✓ If off-site testing, system for shipment of specimens
✓ Procedures if you will do on-site testing
Necessary Resources: Coverage

✓ Be realistic – one person providing 24 hour coverage, 7 days per week is not sustainable.
✓ Covering physician should be knowledgeable and experienced using buprenorphine, and be familiar with your office policies and procedures; if she or he will prescribe buprenorphine, then she or he needs a DATA waiver.
You can keep buprenorphine in the office and dispense it to patients if you comply with the DEA (and any State) rules for keeping and dispensing a supply of it.

These strict requirements may be a disincentive to keeping buprenorphine in the office.

May be easier to write a prescription for first doses of buprenorphine (for induction).
Working with Office Staff

✓ Train all personnel who have contact with patients (e.g., receptionists, nurses, billing staff).

✓ Staff should have a positive, non-judgmental, and therapeutic attitude toward patients with opioid dependence.

✓ At the same time, office procedures and patient interactions should be designed to minimize the chance for patients to mislead the physician and staff.
Information for the Patient

✓ Provide written information.
  • Information about buprenorphine (e.g., brochure)
  • Copy of rules/expectations to be signed by patient
  • Physician’s name, address, phone number, office hours
  • Emergency contact information
  • Payment procedures