You've Got Your X-Number… Now What?

Strategies to Increase Your Confidence with Buprenorphine Prescribing in Primary Care

Soraya Azari MD
Scott Steiger MD

Disclosures

- Dr. Soraya Azari – Nothing to disclose
- Dr. Scott Steiger – Nothing to disclose

Background

- In surveys of waivered buprenorphine prescribers, a significant percentage do NOT prescribe
  - Mass. survey all waivered: 34% non-prescribers
  - Among addiction specialists (2003): 42% non-prescribers
  - Washington state rural trainees (2014): 72% non-prescribers
- Barriers Cited:
  - *Institutional*: Demanding induction period, no MD backup, lack of mental health/psychological support
  - *Education*: lack of training support
  - *Other*: 30 patient limit

Walley et al. JGIM 2008 Sep; 23(9):1393-98. Kissin et al. J Addict Dis. 2006;25(4):91-103.
Hutchinson et al. Ann Fam Med. 2014 Mar;12(2):128-33.

Objectives

- To review proper patient selection for buprenorphine and be able to educate patients how to do a home induction.
- To identify those patients with pain and co-occurring opioid use disorders for whom buprenorphine may be a preferred pharmacotherapy as part of a comprehensive management plan.
- To develop an approach to concerning behaviors that may arise in the patient taking buprenorphine.
- To be able to educate patients who are taking methadone how they, as their primary care physician, will help them transition to buprenorphine.

Acknowledgments

To our patients who are the basis of these case vignettes

Case 1

- A 37yo F MVA 7 years ago, subsequent chronic pain, now dependent on opioids and purchasing MS contin® off the street presenting for treatment.
- Several prior quit attempts unsuccessful. No formal treatment program participation.
- Housed with family. Employed full time. No history of psychiatric disease.
- Exam is notable for no withdrawal symptoms.
- Urine drug screen is positive for opiates.

Question

Which of the following is true about home induction?

A. Inc. risk of adverse events
B. Inc. risk precip. withdrawal
C. No excess risk w/home ind.
D. Rec'd by bupe guidelines

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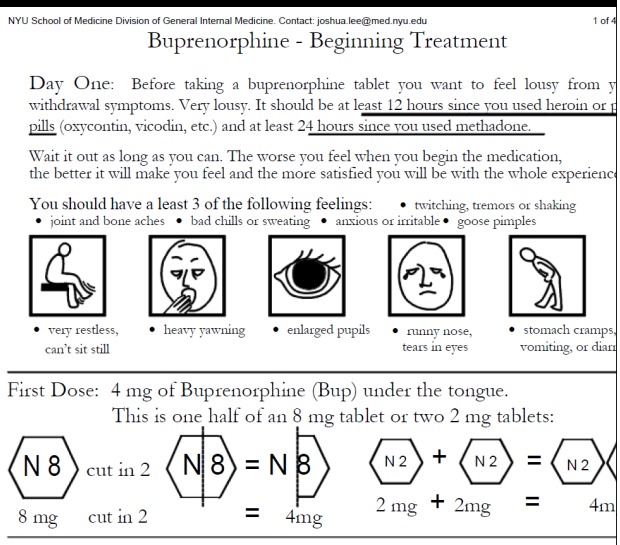
B. Inc. risk precip. withdrawal
C. **No excess risk w/home ind.**
D. Rec'd by bupe guidelines

Home Inductions

- Current evidence (low-moderate quality) shows no increased risk of adverse events
- Patient handout
- Getting through those 12+ hrs!
  - Prochlorperazine
  - Hydroxyzine
  - Trazodone
- What's It Like?
  - Naabt.org



NYU School of Medicine Division of General Internal Medicine. Contact: joshua.lee@med.nyu.edu 1 of 4

Buprenorphine - Beginning Treatment

Day One: Before taking a buprenorphine tablet you want to feel lousy from y withdrawal symptoms. Very lousy. It should be at least 12 hours since you used heroin or p pills (oxycontin, vicodin, etc.) and at least 24 hours since you used methadone.

Wait it out as long as you can. The worse you feel when you begin the medication, the better it will make you feel and the more satisfied you will be with the whole experienc

You should have a least 3 of the following feelings:
• joint and bone aches • bad chills or sweating • anxious or irritable • goose pimples • twitching, tremors or shaking

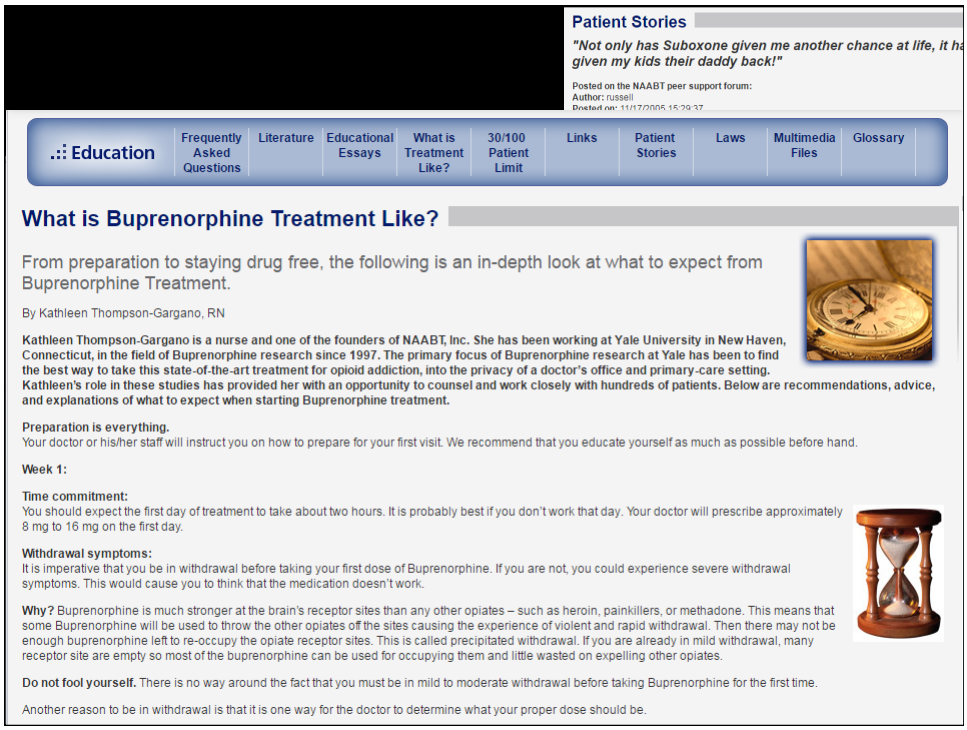
• very restless, can't sit still • heavy yawning • enlarged pupils • runny nose, tears in eyes • stomach cramps, vomiting, or diar

First Dose: 4 mg of Buprenorphine (Bup) under the tongue.
This is one half of an 8 mg tablet or two 2 mg tablets:

N 8 cut in 2 N 8 = N 8
8 mg cut in 2 = 4mg

N 2 + N 2 = N 2
2 mg + 2mg = 4m

Lee J. JGIM. 2009;24(2):226-32). https://www.naabt.org/education/what_bt_like.cfm



Patient Stories

"Not only has Suboxone given me another chance at life, it ha given my kids their daddy back!"

Posted on the NAABT peer support forum:
Author: russell

.:: Education | Frequently Asked Questions | Literature | Educational Essays | What is Treatment Like? | 30/100 Patient Limit | Links | Patient Stories | Laws | Multimedia Files | Glossary

What is Buprenorphine Treatment Like?

From preparation to staying drug free, the following is an in-depth look at what to expect from Buprenorphine Treatment.

By Kathleen Thompson-Gargano, RN

Kathleen Thompson-Gargano is a nurse and one of the founders of NAABT, Inc. She has been working at Yale University in New Haven, Connecticut, in the field of Buprenorphine research since 1997. The primary focus of Buprenorphine research at Yale has been to find the best way to take this state-of-the-art treatment for opioid addiction, into the privacy of a doctor's office and primary-care setting. Kathleen's role in these studies has provided her with an opportunity to counsel and work closely with hundreds of patients. Below are recommendations, advice, and explanations of what to expect when starting Buprenorphine treatment.

Preparation is everything.
Your doctor or his/her staff will instruct you on how to prepare for your first visit. We recommend that you educate yourself as much as possible before hand.

Week 1:

Time commitment:
You should expect the first day of treatment to take about two hours. It is probably best if you don't work that day. Your doctor will prescribe approximately 8 mg to 16 mg on the first day.

Withdrawal symptoms:
It is imperative that you be in withdrawal before taking your first dose of Buprenorphine. If you are not, you could experience severe withdrawal symptoms. This would cause you to think that the medication doesn't work.

Why? Buprenorphine is much stronger at the brain's receptor sites than any other opiates – such as heroin, painkillers, or methadone. This means that some Buprenorphine will be used to throw the other opiates off the sites causing the experience of violent and rapid withdrawal. Then there may not be enough buprenorphine left to re-occupy the opiate receptor sites. This is called precipitated withdrawal. If you are already in mild withdrawal, many receptor site are empty so most of the buprenorphine can be used for occupying them and little wasted on expelling other opiates.

Do not fool yourself. There is no way around the fact that you must be in mild to moderate withdrawal before taking Buprenorphine for the first time.

Another reason to be in withdrawal is that it is one way for the doctor to determine what your proper dose should be.

Case 1: induction progress

Day 1 (Fri): Decision to do home induction of buprenorphine-naloxone with 2-0.5mg pills given moderate tolerance.

- You prescribe #10 pills with instructions for home induction

Pharmacy calls: Buprenorphine denied by Managed Medi-Cal Plan.

Tips on Coverage & Getting Meds

- Medi-Cal coverage
  - Drug treatment is covered through a "carve-out" pharmacy will need to bill Medical FFS ("bill drug Medi-Cal")
  - Write x-license on secure rx if not there;
  - Write dx code (F11.20)
- Medicare Part D, private insurance prescription drug plans
  - Many require PA; call pharm for insurance ID & number (and put it in your note, if possible)
  - ICD-10 codes: F11.20 (opioid use disorder)
- Pharmacy stocking
  - Keep in mind some pharmacies may not stock bupe-nal, or only have one form (i.e., films)

Case 1 progress

- Day 1 (Fri): Decision to do home induction of buprenorphine-naloxone with 2-0.5mg pills given moderate tolerance.
  - You prescribe #10 pills with instructions for home induction
  - Pharmacy call! Buprenorphine denied by Managed Medi-Cal Plan provider had to call to inform pharm to bill drug Medi-Cal.
- Day 3 (Mon): Did not do induction yet, but got meds today and will do it "soon" → meaning tomorrow. Provider plans to talk to patient by phone in 2 days.
- Day 5 (Wed): Phone call: Patient induced successfully on buprenorphine. Only required 6-8mg daily (has 3 pills left). Make apt for Monday. Call in rx to last until Monday.
- Day 10 (Mon): Seen in clinic; urine drug screen positive buprenorphine, negative opioids. Prescribe 1 week supply.
- Day 17 (Mon): Doing well. Remains employed. Proud to be not buying street rx opiods. Urine drug screen appropriate. Dispense 2 week supply. Warm hand-off to behavioral health.

Case 1 Pearls

- Home inductions are feasible
- Anticipate pharmacy and coverage hiccups
- Remember pharmacies may only stock one formulation of bup-naloxone

Case 2

32 yo M chronic leg pain Multiple Exostoses Syndrome presents with his mother to new PCP for opioid management after orthopedist concerns about opioid use.

- Prescribed oxy 90 mg q6h
- Fired previous PCP who prescribed a rapid taper

32 yo M very high dose oxy

- No other meds
- Smokes 1 ppd, no other personal or FH SUD
- PE: VSS, pinpoint pupils, turbinates not inflamed, dysthymic affect, no signs injection

32 yo M high dose oxy

MD: "I am concerned you might have an opioid use disorder, which would benefit from treatment with buprenorphine."

Pt: "I'm not an addict. I want to come off, but I want to do this own my own"

Diagnosis of opioid use disorder

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

Opioid use disorder or pain?

- Tolerance?
- Withdrawal?
- Lots of time/effort spent obtaining drugs?
- Loss of control over use?
- Use despite negative consequences?

The 4 C's of Addiction

- **craving**
- loss of **control** of amount or frequency of use
- **compulsion** to use
- use despite **consequences**

32 yo M high dose oxy

- Rx 2 wk supply of oxy 30 #14 per day
- Rx naloxone inh and educated pt and fam on use

Ran out in 8 days. Acknowledges that wife is upset.

32 yo M high dose oxy

Induced to buprenorphine at home.

- Day 3 on 24 mg daily
- 1 wk F/U: he and wife are thrilled
  - "Still have pain, but it's actually better."
  - "Plus I can think straight."
- 4 wk F/U: been to PT, Pain Clinic, Psych
- 4 mo F/U: employed

Bup/nx treats chronic pain and opioid use disorder

VA retrospective cohort of 143 pts

- 67% retention
- APS scores improved

MI Pain Clinic case series of 95 pts

- 86% patients had improvement in pain, mood, function

Pade et al. *JSAT* 2012
Malinoff, *Am J Ther* 2005

OUD treatment necessary but insufficient

Whether MMTP or bup 31-46% mod-severe chronic pain

Tsui et al *Pain* 2011
Mark et al *J Subst Abuse Treat* 2013
Barry *Am J Addict* 2013
Stein et al *JGIM* 2015
Dunn *Drug Alc Dep* 2015

Case 2 Pearls

- Patients on chronic opioid therapy are at risk for developing opioid use disorder (OUD)
- Buprenorphine treats chronic pain in patients who are physically dependent on opioids
- Discuss treatment options for opioid use disorder BEFORE it's required
- Nice case series from Becker et al. 2016: http://ascpjournal.biomedcentral.com/articles/10.1186/s13722-016-0050-0

Case 3

- 46yo M severe opioid and cocaine use disorders.
- Lives with his mother, on parole.
- Disabled, not working.
- He periodically comes to appointments late, or gets agitated with staff, but generally keeps all appointments.
- Previously in residential treatment but "no longer interested in that," so maintained on bup/nx 24/6 mg
- Drug screens positive for buprenorphine and cocaine. Neg for opiates.

Which of the following represents the best course of action?

A. Stop buprenorphine
B. Rxs contingent on coc-neg urines
C. More freq. visits; ? pill count
D. Increase buprenorphine
E. Something else

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E. **Something else**

Defining Success

One the one hand…

- Opiate free
- Coming to appointments
- Participating in post-release enrichment programs
- Not incarcerated

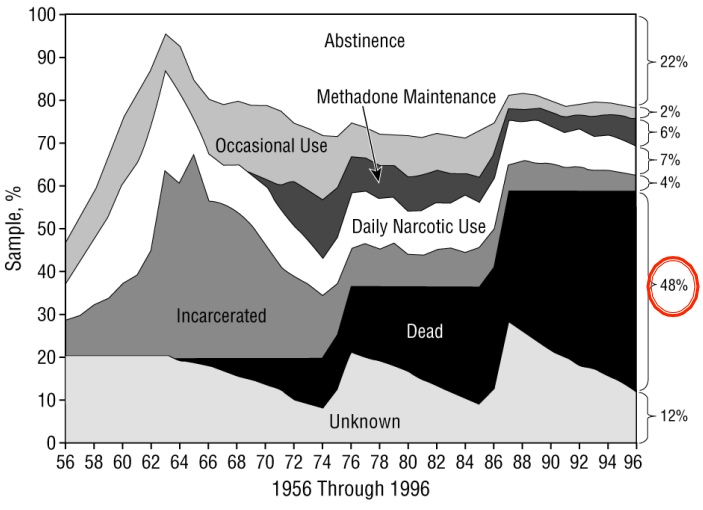
And on the other…

- Not engaging in other forms of treatment or counseling
- Ongoing cocaine use
- Occasional behavioral problems in clinic
- Not working

Predictors of success in opioid treatment programs:
-- Longer duration of treatment
-- Employment
-- Psychological stability
-- Dec illicit drug use

Hser et al. Arch Gen Psyhchiatry. 2001;58(5):503-508. Parmenter et al. Br J Gen Pract. 2013;63(612):e499-e505.

33 year follow-up of opioid addicted patients from CJ system in CA



Predictors of mortality

- etoh
- disability
- age
- yrs since 1st use

Hser et al, 2001.

Different substances require different responses!

Unhealthy alcohol or benzodiazepine use with consequences
- higher level of care

Cocaine / methamphetamine
- Characterize extent of stimulant use disorder,
- Offer treatment,
- Consider contingencies

- Urine negative for buprenorphine? – take history, decrease refill interval, pill counts, more frequent urine screens, (rare) observed dosing

Case 3 Continued

- You refill buprenorphine-naloxone and reinforce counseling groups as part of post-release program.
- 1 mo later: trauma to elbow and overlying cellulitis (you order xray and prescribe abx).
  - Urine is positive for cocaine, buprenorphine, and opiates.

Question

How would you manage this patient's case?

A. Stop bupe-nal
B. Mandate drug treatment
C. Close f/u, dec. refill interval

Question

How would you manage this patient's case?

A. Stop bupe-nal
B. Mandate drug treatment
C. **Close f/u, dec. refill interval**

Case Continued

- Rx bup/nx contingent on adherence to medical plan (xray, abxs, going to abscess clinic).
- Repeat urine positive for buprenorphine, cocaine, and opiates x2 more weeks
- Comes to your office after being awake "for 3 days" on cocaine. Elbow is hurting more, +abscess
- Referred to MMTP

Patient Selection

- **Good for buprenorphine**
  - No contra-indications to treatment
  - Expected to be reasonably compliant
  - Will follow safety precautions

Bupe = lower level of care

- **Not as good for buprenorphine**
  - Comorbid dependence on high doses **BZD** or other CNS depressants (i.e., **alcohol**)
  - Psychiatric comorbidity
  - Multiple previous treatments with *frequent relapse*
  - Significant medical disease
  - Psychosocial instability (i.e., safe storage)

McCance-Katz E et al. Am J Addict. 2010;19(1):4-16.

Don't Be Discouraged!

- Efficacy is good, not perfect
  - 1 year outcomes at a primary care practice in Baltimore:
    - **56%** in treatment at 1yr
    - 64% of those urines negative
    - Polysubstance use associated with tx retention
  - dec crim just activity & dec hosp.
- *By comparison*: study of pts with resistant HTN followed for 1 yr:
  - **57%** adherent to meds (defined as >80% use)

Daughterty SL et al. Hypertension 2012;60(2):303-9. Soeffing JM et al. J Subst Abuse Treat. 2009;37(4):426.

Case 3 Pearls

- Urine drug screens are essential to the monitoring of patients in treatment for opioid use disorder
- Don't think of abnormals as indicating treatment (provider) "failure," but as opportunities for discussion.
- "Successful" treatment reduces harm to patients
- Methadone maintenance treatment programs are effective for patients with opioid use disorder

Case 4

43 yo F on MMTP x11 years asks for help in "coming off."

- Dose 50 mg
- 1x/wk pick up schedule
- "liquid handcuffs"
  - Soon to be grandmother, wants to visit often

Case 4: 43 yo F in MMT

Which of the following features of her case are most consistent with a patient who's abstinent from opioids?

a) 43 years old
b) Weekly pickup schedule
c) 11 years in the program
d) 50 mg dose

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Methadonia: pt 1, it works!

One of the best studied interventions in medicine, effective in

- Retaining people in treatment
- Reducing use of heroin and other opioids
- Reducing use of cocaine
- Reducing risk of diagnosis of HIV
- Reducing risk of diagnosis of HCV
- Reducing criminal activity
- Improving control of HIV
- Improving control of TB

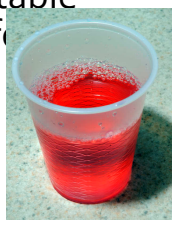
Methadonia: pt 2, it's regulated

Full agonist with variable, but long, half-life
- Peak plasma concentrations at 4 hours
- Target dose ~80-120 mg daily (Cochrane says 60-100)

Only legal through special clinics (*or while inpatient)*
- Day 1-3: 30, 40, 50 mg in clinics

DAILY observed dosing until patients are stable
- 3 months in program + 4 weeks tox neg f
  1 THB

WEEKLY (at least) counseling
Dose adjusted for missed visits



43 yo F methadone → bup?

TRANSITION?

- *Patient-centered*
- *Ready for lower level of care*
- *Open comm with MMTP*

STICK WITH MMTP

- *It's worked!*

43 yo F methadone → bup?

TRANSITION?

- *Patient-centered*
- *Ready for lower level of care*
- *Open comm with MMTP*

Other indications
- ?safety (QTc)

STICK WITH MMTP

- *It's worked!*

Other indications
- Structure is demonstrably helpful
- Other substance use
- Unstable in treatment

43 yo methadone to bup?

- Special release allows MD-MD communication
- Medical director approves and *welcomes back if fails induction*
- Office induction arranged for Monday with plan for DC methadone after Friday dose

43 yo methadone to bup?

- Brings in 2 full bottles on Monday, "I'm ready, Doc"
- COWS = 7, incl pupils 3 mm
- You strongly advise coming back tomorrow for induction.
- Staff runs to get you because "There's a woman out here asking for you. She looks like she's got an evil spirit trying to come out of her."

43 yo F methadone → bup? Not yet

- Takes methadone 40 mg, still unwell
- Rx clonidine, trazodone, loperamide, ondansetron
- Back to MMTP, retaining 1 wk PUS

Case 4 Take Home Points

- "Best" candidates for buprenorphine are stable on an effective treatment
- Communication with program is key
  - *Ask them to induce!*
- Lower dose = higher likelihood of successful induction

Summary

- Gaining confidence with buprenorphine prescribing comes with prescribing!
- Home inductions are safe & effective and more practical for many prim care clinics.
- Buprenorphine is a great option for a patient with chronic pain and an opioid use disorder.
- Urine drug screen monitoring is part of a person's treatment – don't interpret abnormalities as failure.
- Patients that "fail" buprenorphine have an excellent alternative: MMT
- Patients can be transitioned from methadone to buprenorphine. Consider dose & collaborate with MMT providers, if possible.