Is my patient appropriate for ED Buprenorphine?

Has Opioid Use Disorder (OUD)
- tolerance, withdrawal, cravings, negatively impacting life, unable to stop or control use
  The patient is interested in buprenorphine treatment
  The patient has no absolute contraindications
  Methadone within 7 days, using prescribed opioids for pain, altered mental status, overt liver failure

Is my patient in opioid withdrawal?
- Last use of a short acting opioid (heroin, fentanyl) 8-12 hours ago
- Has signs of opioid withdrawal (COWS ≥ 8) or says they are in moderate withdrawal

Discharge home for home induction
- no buprenorphine in ED
  - Prescribe buprenorphine/Naloxone 8 mg/2 mg; Disp: 14 films for 7 days, no refills. Indication: Opioid Use disorder (On Rx write an X before your DEA # or write your DEA-X)
  - Provide Naloxone or script
  - Give Home induction instructions

Emergency department induction
- Buprenorphine sublingual 8 mg *
- 1 hour

Patient better?
- YES

Discharge home
- Prescribe buprenorphine/Naloxone 8 mg/2 mg; Disp: 14 films for 7 days, no refills. Indication: Opioid Use disorder (On Rx write an X before your DEA # or write your DEA-X)
- Provide Naloxone or script
- Give ED induction instructions based on ED dose (8 mg or 16 mg)

Patient better?
- NO
  - Consider alternate causes, including precipitated withdrawal

Provide harm reduction
- Naloxone or script
- Harm reduction info
- Harm reduction supplies if available
- Let the patient know the ED can start them on buprenorphine when they are ready

* can start with 4 mg sublingual if withdrawal is very mild
Maximum dose for ED induction is 16 mg
Absolute contraindications

Isolated accidental overdose without prior opioid use
ex: patient uses cocaine and had accidental opioid exposure

Known end-stage liver disease
cirrhosis or LFTs > 5x normal

Methadone in past 7 days

Concurrent opioid medication for pain

Altered mental status
intoxicated, psychosis, delirium

Special Considerations

Concurrent benzodiazepines and psychiatric medications
Combining these medications with buprenorphine may lead to increased sedation but is not an absolute contraindication. Buprenorphine is safer than continued heroin use.

Patients that are pregnant or breastfeeding may be treated with the same ED protocol with buprenorphine. Consider OB/GYN consult to help arrange outpatient follow up

Isolated single overdose in patients with a history of OUD.
Patients with normal or low opioid tolerance may require smaller maintenance dosing of buprenorphine (e.g., patients with OUD released from prison).
Common Questions

Isn't it trading one drug for another? Like insulin for diabetes, buprenorphine is a treatment for a disease process that can stabilize patients and save lives. It halves 1-year mortality of opioid use disorder.

Isn't buprenorphine dangerous? Buprenorphine is safer for a patient than continuing to use illicit opioids

What if I'm not certain they can get follow up? Outpatient follow up is important but should not prevent you from giving buprenorphine to ED patients with Opioid Use Disorder

Isn't buprenorphine dangerous? Buprenorphine is safer for a patient than continuing to use illicit opioids

Common Patient Concerns

Previous adverse reaction to buprenorphine
Ask if the buprenorphine precipitated withdrawal. If this was the case, discuss with the patient how to avoid this, which includes waiting until sufficient time has past since last use as well as waiting until withdrawal symptoms are moderate.

For example, you could say: “Buprenorphine will make people sick if they still have opioids on board - but it will make you feel better if you're in withdrawal. You should only start it if you are feeling withdrawal.”

Buprenorphine "didn't work" before
This is often due to incorrect administration. Ask the patient how they took the medication. Buprenorphine needs to be held under the tongue for 15 minutes without smoking or drinking.
Precipitated Withdrawal

Can occur if buprenorphine is given too early after last opioid use and patient is not experiencing withdrawal or if the patient is on a long-acting opioid like methadone.

TREATMENT

Continue induction with enough buprenorphine to overcome withdrawal:
2 or 4 mg sublingual every hour until symptoms improve

If the patient does not want to continue with buprenorphine:
Symptomatic treatment (clonidine, lorazepam, ondansetron)
Encourage home induction next day

Tips

The worse the withdrawal, the better buprenorphine works.

Tell the patient upfront that they must wait until they experience withdrawal to start buprenorphine. This can help prevent them from precipitating withdrawal. The COWS score can be used to help quantify withdrawal, but sometimes it helps to explain this to the patient and ask them if they are withdrawing enough for buprenorphine.