



As the primary medical contact point for many of these patients, we have the opportunity to save lives.

What is Buprenorphine?

- Partial mu opioid agonist and kappa/delta antagonist that binds with high affinity
 - » Out-competes other traditional opioids for the same receptors
 - » Can prevent withdrawal symptoms and cravings for those with addiction/dependence
 - » Provides pain relief with very little risk of respiratory depression
- The first-pass effect is large
 - » Doses are given sublingually or subcutaneously as a depot injection or implant
 - » Combined with naloxone (Suboxone) to prevent IV use
 - » Available as a single agent (Subutex) for patients intolerant of suboxone, often used in pregnancy
 - » Transmucosal (Belbuca) and transdermal (Butrans) buprenorphine are low-dose versions generally used to treat pain
- Schedule III medication
- FDA approved for both opioid use disorder and pain

Do I need special licensure?

- No, X-DEA waivers are no longer required
- If you have an active DEA, you may prescribe buprenorphine like any other controlled substance

Contraindications

- Buprenorphine, like other opioids, should not be combined with benzodiazepines if possible
- Hepatically metabolized, cannot be used with serious liver dysfunction
- Should not be combined with heavy alcohol use

How is sublingual Suboxone (buprenorphine-naloxone) dosed?

- Rx is a combination of buprenorphine and naloxone dosage in a 4:1 ratio, available in 2/0.5 mg, 4/1 mg, 8/2 mg, 16/4 mg dosages
 - » Most patients stabilize on a dosage of 16–24 mg of buprenorphine daily or split into two to three doses based on indication
 - » Pain responds better to divided dosing
- Generally sublingual strips or tablets
 - » Reinforce with patients that these must be allowed to absorb in the mouth
 - » Ineffective if swallowed
- 1 mg of SL buprenorphine is approximately 30–40 MME
 - » Due to the ceiling effect of buprenorphine, the risk of overdose is lower than a full opioid agonist

Screening prior to initiation

- Patients should have an assessment of liver function including a CMP and hepatitis screening
- Discuss full addiction history/use of other substances

Initiating therapy

- Many patients will initiate therapy with the Emergency department in acute withdrawal and follow up with primary care physicians for continued therapy
- If initiating therapy, please see the SAMHSA guide regarding specifics to consider at samhsa.gov

Monitoring

- Patients should be seen every few weeks or once per month during initiation, then a minimum of every three months once stable
 - » Assessed for symptoms and compliance with regimen
- UDS every 3–6 months, in addition to CMP at least annually
- Send intranasal Narcan with refills
- Encourage patients to participate in addiction therapy/support
- Reinforce local resources