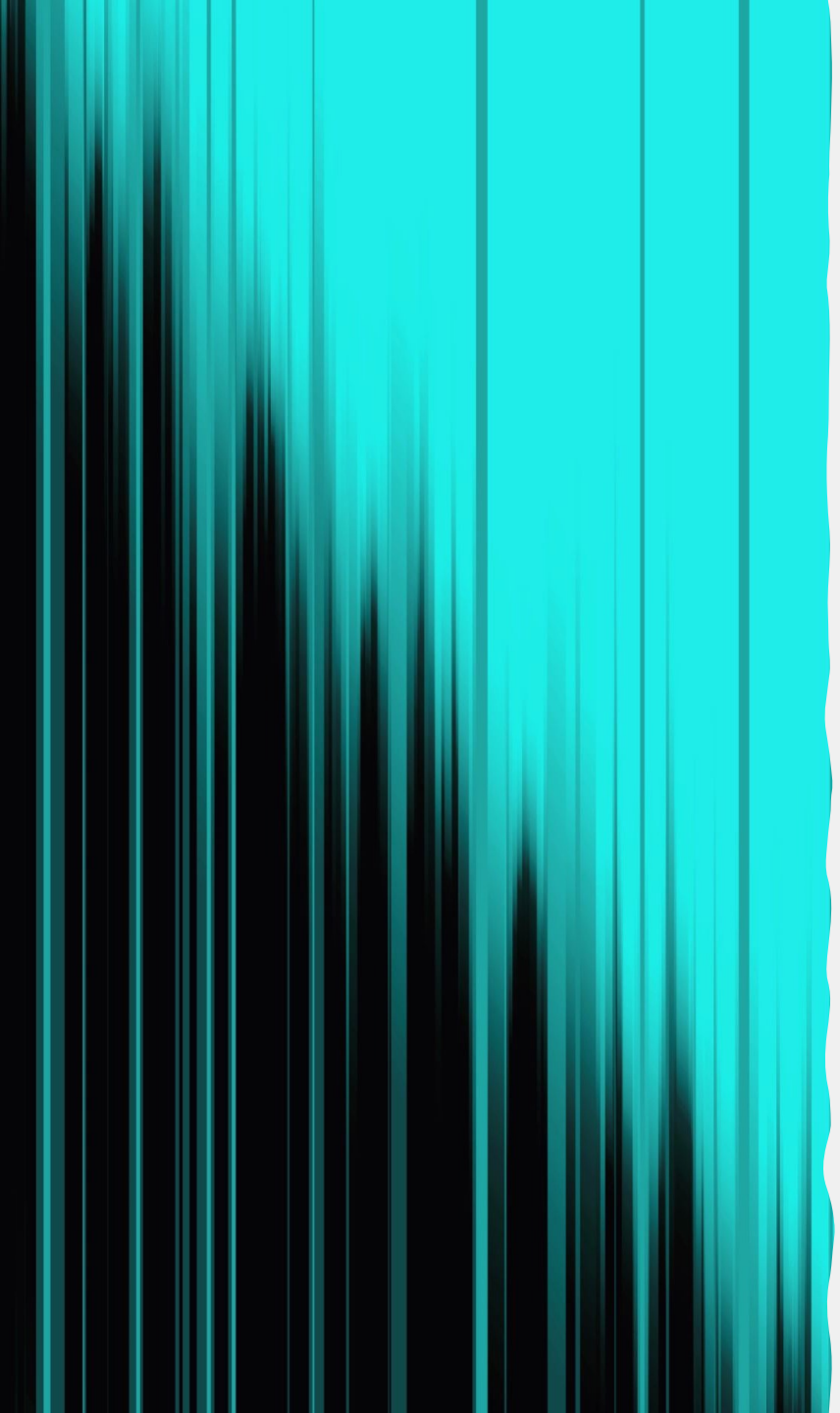

Treating opioid use disorder in the fentanyl era

NMAFP Summer Seminar 2024

Valerie Carrejo, MD FAAFP FASAM
Professor, UNM Family Medicine
Program Director, Addiction Medicine Fellowship

OBJECTIVES

- Know how to screen for and identify opioid use disorder (OUD)
- Know how to discuss treatment options for opioid use disorder
- Know how to incorporate buprenorphine prescribing into primary care
- Know how to transition to buprenorphine for co-occurring pain/OUD

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Do you treat patients with opioid use disorder in your practice?

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If yes, then what is your comfort level with prescribing buprenorphine?

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If no, then why not?

free text answer

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The Opioid Crisis Continues

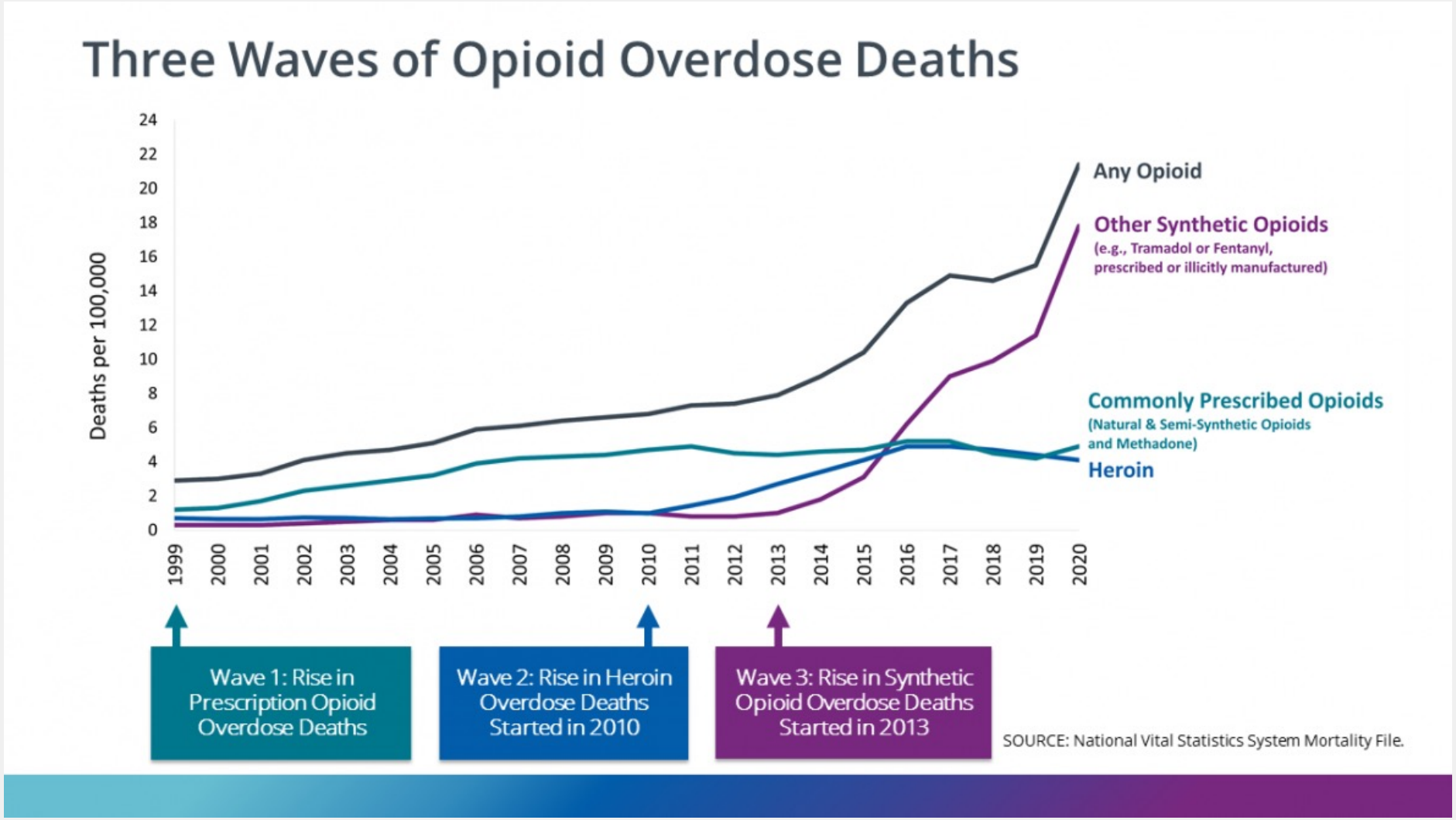
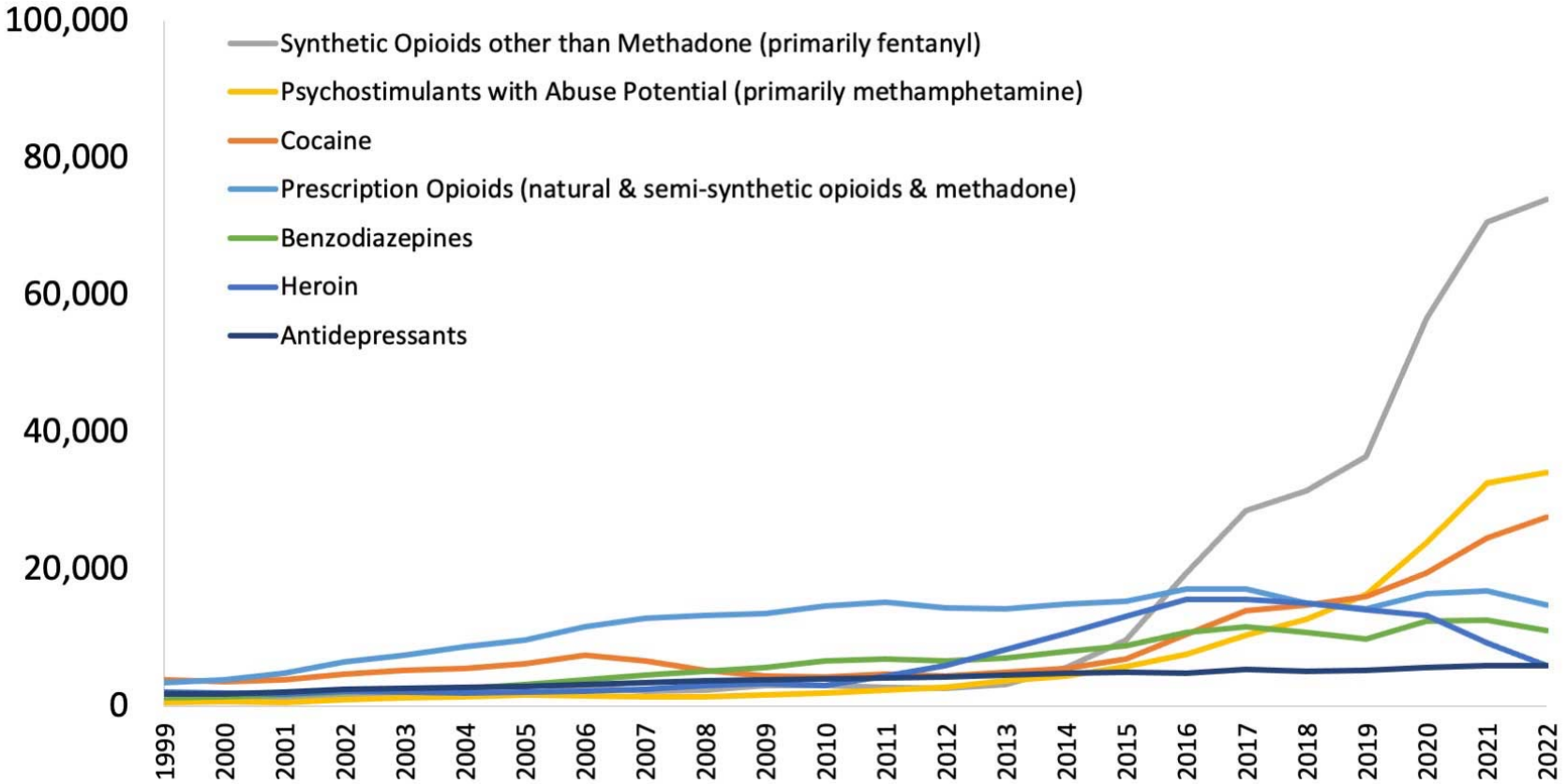


Figure 2. National Drug Overdose Deaths*, Number Among All Ages, 1999-2022



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

DEA Update

DEA Update on Buprenorphine Prescribing Waivers

In a January 12, 2023 letter to registrants announcing and detailing the changes, the Department of Justice's DEA stated, "our goal is simple: we want medication for opioid use disorder to be readily and safely available to anyone in the country who needs it. The elimination of the X-Waiver will increase access to buprenorphine for those in need."

Opioid Use Disorder: Screening and diagnosis

Stages of Care

1

Screening

- Assess patients for OUD
- Assess readiness for change/treatment

2

Intake

- Diagnostic interview
- Physical exam
- Diagnostic testing such as drug screen, labs

3

Induction

- Start medication
- In office vs home induction

4

Stabilization

- Dose adjustments to suppress cravings and prevent relapse

5

Maintenance

- Ongoing therapy

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Which of the following is the current USPSTF recommendation for screening for unhealthy drug use?

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USPTSF Recommendation Updated 2020

Population	Recommendation	Grade
Adults 18 years and older	**The USPSTF recommends screening by asking questions about unhealthy drug use in adults 18 and older.** Screening should be implemented when services for accurate diagnosis, effective treatment and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens)	B
Adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents.	I

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Screening

The NIDA Quick Screen

FIRST introduce yourself and establish rapport

Ask about *past year* drug use

How many times in the past year have you used alcohol, tobacco, nonmedical prescription drugs or illicit drugs?

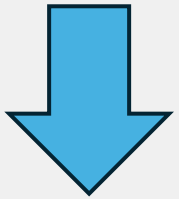
Never is a negative screen

Any other answer is a positive screen → further assessment

Meet Jane

- Jane is a 26 yo female who comes into your office to discuss anxiety and getting off pills.

Stages of Care



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Intake for evaluation

- Intake
  - Primary goal is to establish a medical record for the patient's suitability for office-based treatment for opioid use disorder.
  - Should be done by trained medical staff
    - Behavioral Health providers
    - Residents
    - Advanced practice providers
    - Physicians

Intake details

- Complete history is important
- Document the patient's diagnosis of opioid use disorder
- Document desire for office-based treatment
- Assess for any *untreated* psychiatric conditions that might interfere with treatment

Documenting Opioid Use Disorder

- DSM-V criteria
- Substance Dependence Assessment form
- Clear documentation using above criteria documented in the progress note

Opioid Use Disorder

Severity

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 mor more symptoms

*Tolerance and Withdrawal not considered to be met for those taking opioids solely under appropriate medical supervision

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Intake

- Thorough medical history, family history and social history should be done
- Drug abuse history
  - When began using drugs
  - What drugs have been used
  - What is the route of administration
    - Smoking, snorting, IVDU
  - Past treatment history
  - Legal or other problems related to drug use

Intake

- Physical exam is recommended
- Bloodwork is recommended prior to starting bup/nlx treatment
  - Ascertain other medical conditions
    - Anemia, HIV, Hepatitis C
  - Establish baseline liver function
  - No need to wait for results to start medication
- Urine drug screens are recommended
  - Verify opioid use, look for concurrent drug use
  - Require special tests to find fentanyl

Jane’s story

- Began using pain pills as a teenager. Used at parties, but then started using more frequently
- She transitioned to smoking blues with her friends at the age of 18 because it was more accessible. Soon she was using daily
- She thought blues were oxycodone but now thinks it is fentanyl
- She gets sick if she doesn’t use after about 6 hours
- She has never sought treatment before but tried “subs” from a friend when she couldn’t get her blues and it made her sick
- She has been incarcerated once for trafficking pills

More history

- PMH: otherwise negative
- Psychiatric Hx: she endorses anxiety and depression but does not have a formal psychiatric diagnosis
- PSH: tonsillectomy as a child
- FH: negative
- Soc Hx: lives in town with her boyfriend, she works part-time as a cashier. + tobacco use daily, 1ppd. No alcohol use. She has used cocaine and methamphetamine in the past, but not regularly. Daily use of blues. She relies of friends or the bus for transportation.
- Labs: normal, negative HIV/HCV -

Opioid Use Disorder: Discussing Treatment Options

Models of treatment

- Inpatient Treatment Centers
- Outpatient Treatment Centers
- Office-Based Treatment
- Patient-Centered Office-Based Treatment

Medication	Mechanism of action	Phase of treatment	Formulation	Common dose range	Regulation/ Availability	Things to consider
Methadone	Agonist	Detox and maintenance	Oral	Detox 40mg/day Maintenance 80-160mg/day	Outpatient treatment centers	Daily dosing QT-prolongation payment
Buprenorphine	Partial agonist	Detox and maintenance	Sublingual	2-32 mg/day	DEA CS III office-based treatment	
Long-acting Bupe	Partial agonist	Maintenance	Injectable	varies	DEA CS III Office-based treatment	REMS required
Naltrexone	Antagonist	Maintenance	Oral	25-100mg/day	Office-based treatment	No opioid exposure
Long-acting Naltrexone	Antagonist	Relapse prevention and maintenance	injectable	380mg IM	Office-based treatment	No opioid exposure

Choosing and OUD Medication

- Currently, no empirical data indicate which patients will respond better to a certain OUD medication
- Considerations
  - Prior response to medication
  - Medication side effect profile
  - Patient use of other substances
  - Patient occupation
  - Coverage of medication
  - Housing and transportation needs

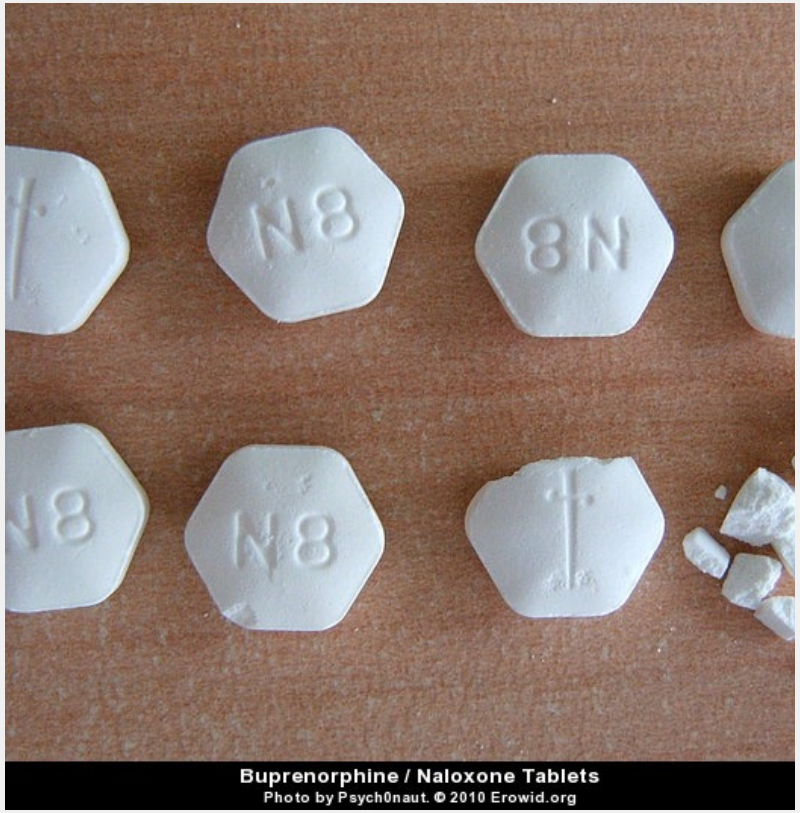
Outpatient Treatment Programs (OTP)

- Outpatient treatment programs are governed and certified under 42 Code of Federal Regulations
- Administer FDA-approved medication assisted therapy
  - Methadone
    - By law, only a SAMHSA-certified treatment program can dispense methadone for treatment of OUD
    - CS II, full mu agonist
    - Reduces opioid cravings and withdrawal and blunts or blocks effects of opioids
  - Buprenorphine
    - CSIII, partial mu agonist
    - Suppresses and reduces cravings for opioids
  - Naltrexone
    - Not controlled substance, full opioid antagonist
    - Blocks the euphoric and sedative effects of opioids
- Must provide counseling and other behavioral therapies
- Must provide counseling on prevention of HIV

Office Based Treatment

- Buprenorphine products can be prescribed by any clinician with current DEA registration that includes Schedule III
- SAMSHA encourages all clinicians to treat patients within their practices who require treatment for opioid use disorder
- Many resources are available to support clinicians
  - SAMSHA
  - PCSS-MAT

Opioid Use Disorder: Integrating into Primary Care



Focus on Buprenorphine/Naloxone

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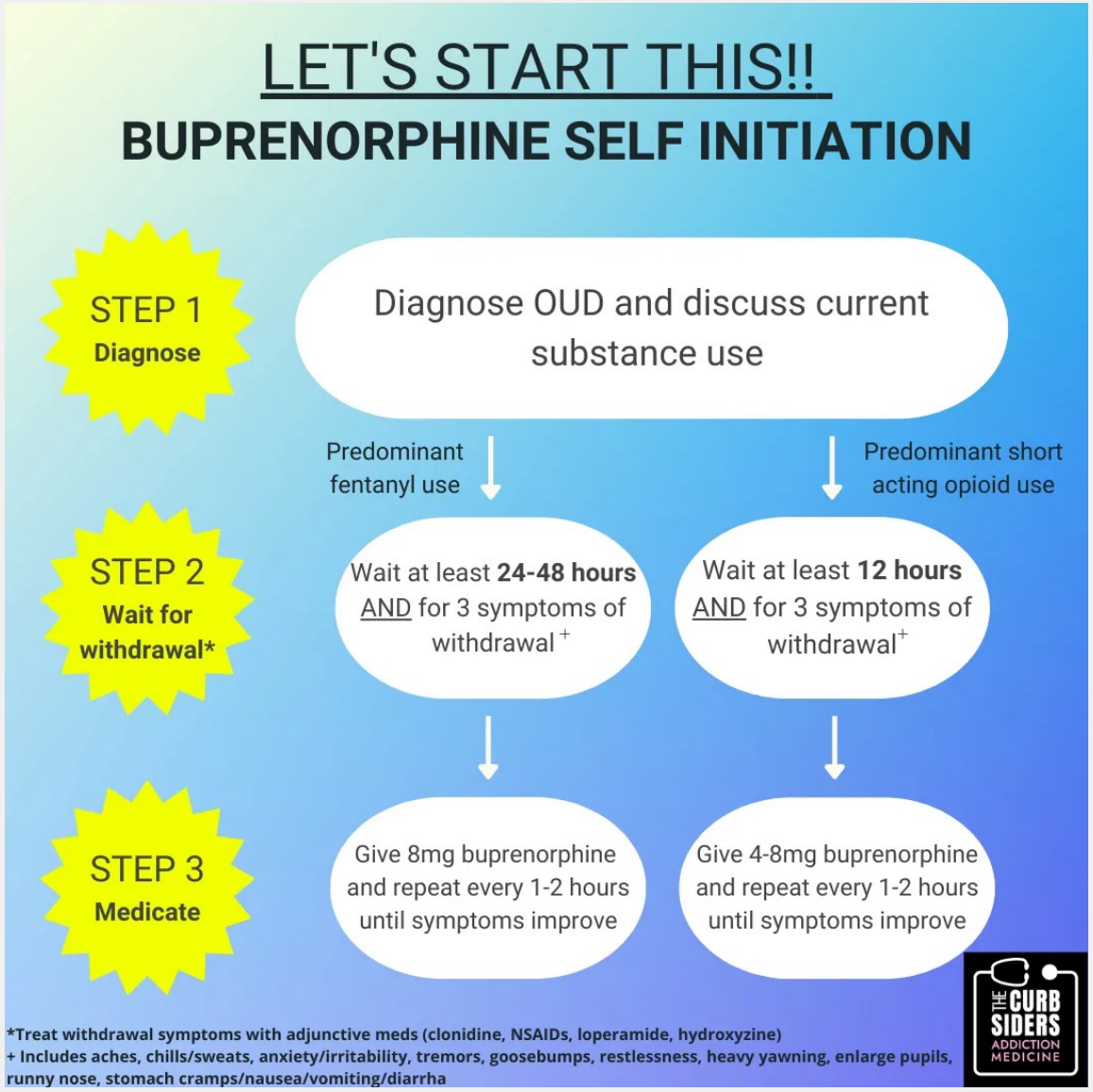
Office-based treatment

- You determine to try office-based treatment with buprenorphine
- Initiate treatment agreement
- Discuss induction options



Treatment Agreement

- It is recommended that you have a treatment agreement for the patients on buprenorphine
- Similar to a controlled substance agreement
- May want to include clause about
  - Counseling
  - Avoiding potentially harmful substances (benzos, alcohol, sedatives)
  - Safety in pregnancy
  - Common “violations”
    - Concurrent drug use
    - Missed appointments
    - UDM “cheating”

Induction

- Office-based induction
  - Recommended in past
  - Not always feasible
  - Good for patients who have never tried Bup/Nx
  - Patient needs to be instructed to arrive in mild-moderate withdrawal
- Home induction
  - Now standard practice
  - Easier for patients
  - Easier for the providers with very busy schedules
  - Patient needs to be given clear dosing instructions and a contact number for any problems, questions or concerns
  - Close office or phone contact recommended

Clinical Opioid Withdrawal Scale (COWS)

Patient's name:_____	Date and time:____/____/____:_____
Reason for this assessment:_____	
Resting pulse rate:_____beats/minute Measured after patient is sitting or lying for one minute	**GI upset:** Over last half-hour
0 pulse rate 80 or below 1 pulse rate 81 to 100 2 pulse rate 101 to 120 4 pulse rate greater than 120	0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: Over past half-hour not accounted for by room temperature or patient activity	**Tremor:** Observation of outstretched hands
0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: Observation during assessment	**Yawning:** Observation during assessment
0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit stil l for more than a few seconds	0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size	**Anxiety or irritability**
0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or joint aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored	**Gooseflesh skin**
0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing: Not accounted for by cold symptoms or allergies	**Total score:**_____ The total score is the sum of all 11 items
0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Initials of person completing assessment:_____

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

GI: gastrointestinal.

Reproduced from: Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs 2003; 35:253.

Short Opiate Withdrawal Scale				
Please put a check mark in the appropriate box for each of the following conditions in the last 24 hours:				
Description	None	Mild	Moderate	Severe
Feeling Sick				
Stomach Cramps				
Muscle Spasms/Twitching				
Feelings of Coldness				
Heart Pounding				
Muscular Tension				

Traditional Induction dosing

- Assess for adequate withdrawal
- Start with 4mg dose
- Leave until completely dissolved then spit or swallow the saliva
- Monitor for worsening symptoms of withdrawal
- May dose an additional half tablet if symptoms persist
- Maximum dose for first 24 hours is 16mg buprenorphine/naloxone
  - Some patients may need 20mg for comfort of severe symptoms
- Day 2- begin with full dose from prior day

Emerging dosing options

Microdosing

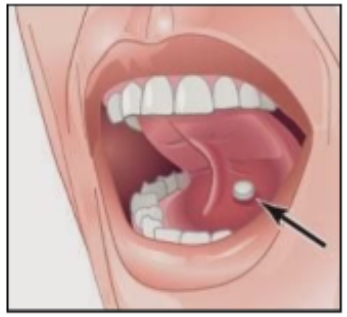
- Start buprenorphine at tiny doses
- Assume the patient will need opioid agonists for several days
- “Bernese method”

Macrodosing

- Uses rapid and higher doses of bup/nx during induction on first day
- Patient still needs elevated COWS score
- 24mg, 32mg or even 64mg
- Next day, able to start standard dose of 16-24mg

Microdosing

For patients who use fentanyl, here is how to use micro-dosing to get started on buprenorphine:



Gradually introduce bup over a week (easier)

- To prepare yourself for stopping fentanyl in approximately one week, gradually introduce bup to avoid experiencing induced withdrawal.
- Notify family and friends who will support you in the process, so they can check in on you often.

Slow micro-dosing schedule

When taking bup, always let it fully absorb under the tongue

1. Day 1: 0.5mg (1/4 of a 2mg tablet or filmstrip) once
2. Day 2: 0.5mg (1/4 of a 2mg tablet or filmstrip) twice per day
3. Day 3: 1mg (1/2 of a 2mg tablet or filmstrip) twice per day
4. Day 4: 2mg (1 full 2mg tablet or filmstrip) twice per day
5. Day 5: 2mg (1 full 2mg tablet or filmstrip) 3 times per day
6. Day 6: 4mg (2 full 2mg tablet or filmstrip) twice per day
7. **Day 7: Last day of fentanyl use** (try to use as little as possible) and take 4mg of buprenorphine (1/2 of an 8mg tablet or 8mg filmstrip) 3 times per day, or every 4 hours as needed to control withdrawal symptoms.
8. *It is OK to stay at one of the steps above for 2 or more days if needed, before moving on to the next "Day" step.
9. Day 8: Begin taking 2 or 3 of the 8mg tablets or strips per day.

You will get a phone call to make an appointment in a clinic to help you continue this medication.

If you still feel bad despite the Bup, or have any symptoms that make you worried, go to the ER.

Macrodosing

Here's how to start Buprenorphine ("Bup", "Suboxone®", "Subs")

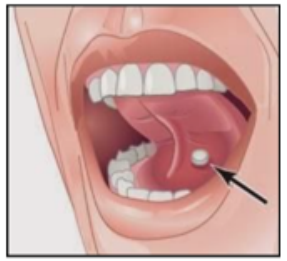
Getting started on Bup (pronounced like "byoop") has helped many people quit using pills (oxycodone, hydrocodone, etc.), heroin and fentanyl.

Baseline good safety practices:

a. Always be careful if you continue to use heroin, opioid pills, fentanyl, etc.!
   - Use no more than you need to at a time treat withdrawal symptoms.
   - Never use heroin or diverted or illicit opioid pills by yourself.

b. Always have naloxone "Narcan®" nasal spray readily available.

c. Don't treat withdrawal symptoms or cravings with alcohol, benzodiazepines (Xanax®, alprazolam, Valium®, diazepam, Ativan®, lorazepam, clonazepam, etc.), cocaine or methamphetamine – this is more dangerous.



Wait, Withdraw, Dose

1. Plan ahead. Take a day off work and have a place to rest.
2. You must wait 24 hours after last fentanyl use, AND until you have SEVERE withdrawal symptoms.
3. Put an 8mg table or strip UNDER your tongue.

Wait, Withdraw, Dose

Day 1:

1. Wait at least 24 hours after last use of fentanyl AND until you feel bad from these severe withdrawal symptoms: anxiety/restlessness/shaking, body aches, sweating, twitching, fatigue, yawning, runny nose/tearing eyes, abdominal cramping/diarrhea/nausea.
   Prescription medications can help you tolerate these withdrawal symptoms – consider asking your provider if your body can safely take the following medications for nausea and anxiety: ondansetron for nausea, and for anxiety: clonidine, gabapentin, and hydroxyzine.
2. Place 8mg tablet or strip under your tongue -- and allow to completely dissolve. DO NOT SWALLOW the pill or film (or it won't work well). At least 30 minutes after placing the first tab or strip, put another 8mg tablet or strip under your tongue. Repeat this dosing every 30 minutes until your withdrawal symptoms have resolved. This may require 8 separate doses, a total of 64mg of buprenorphine.

Day 2:

The next day, begin putting 8mg (1 strip or tablet) under your tongue twice daily.

You will get a phone call to make an appointment in a clinic to help you continue this medication.

If you still feel bad despite the Bup, or have any symptoms that make you worried, go to the ER.

Precipitated withdrawal

- Common pitfall and reason many patients don’t succeed on bup/nx
- Occurs due to the replacement of full opioid receptor agonist with a partial agonist that binds with a higher affinity
- Symptoms like opioid withdrawal
- Avoid by ensuring adequate withdrawal before induction
  - COWS >12
  - Fentanyl may require a higher COWS and lower doses of bup/nx

Is it precipitated withdrawal or worsening withdrawal?

- “Street” fentanyl
  - Highly lipophilic
  - Rapidly cross blood brain barrier
  - Action is very short
  - Half-life is very long
  - Drug supply is unpredictable/unsafe

Is it precipitated withdrawal or just withdrawal?

Precipitated withdrawal

- Rapid onset within10min
- Withdrawal syndrome
- Dilated pupils
- Goosebumps
- Can’t sit still
- Nausea, vomiting, diarrhea

Untreated withdrawal

- Severe anxiety
- Sweating
- Continued symptoms of withdrawal
- Objective signs may not be present

Untreated withdrawal is much more common

- Patients need higher starting dose
- Look for objective signs of opioid withdrawal
  - Pupils dilated
  - Gooseflesh
- COWS ~12
- No fentanyl for at least 24 hours
- Starting dose of 8-16mg
- Setting expectations is key to success
- Use supportive medications

Symptom	Drug	Dose
Anxiety	Hydroxyzine lorazepam	25-100mg PO q 6-8 hr PRN 1mg q 4-6 hr PRN
Hypertension, Tachycardia	Clonidine	0.1-.02mg q 6-8 hrs PRN. Taper if needed day for >7 days
insomnia	Trazodone	50-100mg qhs (up to 300mg)
Diarrhea	Loperamide	4mg po initial dose, then 2mg prn (max 16mg/day)
GI cramps	Dicyclomine	10-20mg q 6-8 hrs PRN
Nausea, vomiting	Ondansetron	4mg q 6hrs PRN
Muscle cramps	Cyclobenzaprine	5-10mg q 8 hrs PRN
Myalgias, Arthralgias	Acetaminophen Ibuprofen	1000mg q 6-8 hrs PRN 600mg q 6hrs PRN

Jane is determined a good candidate

- After discussion, Jane wants to try office-based treatment
- You determine she can probably do a home induction because she has tried Bup/Nx on the streets before
- You give her a 7-day supply of medication and home dosing instructions

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Stabilization

- Induction is completed when the patient experiences no withdrawal symptoms
- Stabilization is the “fine-tuning” of the Bup/Nx dose
- Goal is to find the minimum dose necessary to hold the patient in treatment, suppress opioid withdrawal and suppress other opioid use

Stabilization

- Most patients stabilize on 16-24 mg buprenorphine per day (range 4mg to 32mg)

- Dose adjustments should occur every 3 to 7 days to allow for steady-state levels

Jane returns after successful induction. She is taking 24mg bupe dose. Her withdrawal symptoms are under control but she has significant cravings. She has not used fentanyl in 10 days. What are next steps?

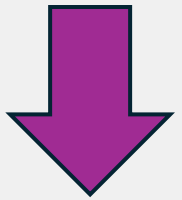
Stabilization

- Very fragile time for the patients
- Dose adjustments are very commonly needed
- Great time to begin psychosocial counseling
  - Individual counseling
  - Group therapy
  - NA or AA
  - SMART recovery
  - Online recovery services

Counseling

- Thoughts for your clinic
  - Who can you refer to for counseling?
  - How will you verify the patient has attended?
    - Trust the patient
    - Signature sheet
    - Verify appointments attended in your system
  - Do you need a release of information to discuss the patient's care with the counselor?

Stages of Care



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Maintenance

- Prevent opioid withdrawal symptoms
- Suppress opioid cravings
- Prevent use of self-administered opioids
- Duration of the maintenance phase depends on the individual needs of the patient
  - May be weeks to years
- Continue regular office visits
  - Frequency may decrease with time

Long-Acting Buprenorphine Options

Brand Name	Sublocade	Brixadi
Molecular name	RBP-6000	CAM2038
Route of administration	Subcutaneous	Subcutaneous
Duration of effect	1 month	1 week or 1 month
Dosage	100 and 300mg	8, 16, 24, 32 mg weekly 64, 96, 128mg monthly
Long-acting technology	ATRIGEL delivery system	FluidCrystal injection depot
Location	Abdomen	Buttock, thigh, abdomen, upper arm
Storage	Locked, refrigerated	Locked, room temperature

Medically supervised withdrawal

- Not recommended in most patients
- Some patients will progress from stabilization to medically supervised withdrawal
- The Bup/Nx dose should be slowly tapered at a rate that both physician and patient consider acceptable
- Patients should be prepared fro mild, transitory withdrawal symptoms
  - Fatigue, anorexia, irritability, insomnia, anxiety

Patient-Centered Care

Best practices in patient-centered care for OUD

- Use of RNs or other support staff to conduct patient intakes
- Allow home inductions
- Provide patients with after-hour support
- Engage clinical pharmacists and advance practice providers
- Provide trauma-informed and culturally competent care
- Utilize point-of care urine drug screens when possible
- Utilize treatment agreements
  - May or may not be beneficial in treatment outcomes
  - Helpful with “difficult” patients

Chronic Pain and Opioid Use Disorder

Mr. Jones

- 62yo male with chronic pain secondary to previous trauma history. He was injured during a fall from a second story doing construction many years ago. He is on oxycodone 30mg QID for pain.
- Mr. Jones says the oxycodone is no longer working for his pain and he wants to get off the pills.
- He has been on oxycodone for many years and endorses needing higher and higher doses over the years.
- He is afraid of not having medication because he does have withdrawal symptoms when he doesn’t take his oxycodone.

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Does Mr. Jones meet criteria for opioid use disorder?

ⓘ Start presenting to display the poll results on this slide.

Opioid Use Disorder

Severity

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 mor more symptoms

*Tolerance and Withdrawal not considered to be met for those taking opioids solely under appropriate medical supervision

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

More on Mr. Jones

- After more questioning, Mr. Jones does say that he has had to miss family events due to not having his medications
- He admits to taking oxycodone from friend when he ran out of pills and could not fill yet
- He says he has never had an overdose, but his wife is worried about him because he sometimes seems “drugged”

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Now with more history, does Mr. Jones meet criteria for opioid use disorder?

ⓘ Start presenting to display the poll results on this slide.

Mr. Jones

- Tolerance and Withdrawal: don’t count
- Impaired control
  - Took medications from a friend because he ran out
- Social Impairment
  - Has had to miss family events
- Risky Use
  - Wife is concerned about oversedation

- Opioid Use Disorder: mild

Opioid → Bupe conversions

- Traditional induction dosing or microinduction dosing
- Difficult to determine direct dose conversion
- Start slow, monitor withdrawal and oversedation
- Most references show sublingual buprenorphine ~30 MME
- Consider using buprenorphine patch
  - Butrans 7/5µg/hr
  - Change every 7 days

Resources for providers

ASAM
THE e-LEARNING CENTER
Your Educational Portal for Addiction Medicine

SAMHSA
Substance Abuse and Mental Health Services Administration

PCSS
Providers Clinical Support System

Questions?