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X-EXPRESS: BUPRENORPHINE PRESCRIBING FOR BEGINNERS

Jessica Merlin,MD, MPH,

Katie Fitzgerald Jones,APN, ACHPN

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X-Express: Buprenorphine Prescribing for Beginners

[video transcript]

00:08
And now it is my pleasure to introduce today's two speakers we have Dr. Jessica Merlyn and Katie Fitzgerald Jones. Dr. Marlon is an associate professor in the division of general internal medicine, and section of palliative care and medical ethics at the University of Pittsburgh. She's also director for the University of Pittsburgh challenges in managing and preventing pain or champ Clinical Research Center. Dr. Marlon is board certified in internal medicine, infectious disease, palliative care and addiction medicine. She's also PhD trained in behavioral science and an NIH funded clinician investigator. Her program of research focuses on the intersection of chronic pain and opioid misuse, or opioid use disorder across populations and setting especially among individuals with serious illnesses such as cancer. Dr. Marlon has been recognized nationally, with a soldier and scholars Leadership Award from the Cambia Health Foundation and with research awards from the American America Academy of hospice and palliative medicine, American Pain Society, and the Association for multidisciplinary education and research in substance use and addiction. She was recently awarded the 2022 Society of general internal medicine men Career Research Mentorship Award. Congratulations. Katie Fitzgerald Joan is a palliative and addiction nurse practitioner at the Veterans Affairs Boston healthcare system. She is also a PhD candidate at Boston College, Connell School of Nursing. Her clinical and research interests include improving pain, management and quality of life, as well as enhancing opioid safety and individuals with cancer and substance use disorder. While serving as palliative nurse director for the Dana Farber Cancer Institute at Brigham Women's Hospital, Katie developed a sustainable Palliative Care Nurse Practitioner fellowships, as well as an innovative palliative care program for older adults. Katie is also a veteran health Jonas mental health scholar and American Academy of Nursing Jonas health policy scholar, advocating nationally for equitable policy solutions that meet the needs of people living with chronic pain and addiction. She has authored several manuscripts and book chapters and has spoken nationally on the intersection between palliative care and substance use disorder. Over to you both.

02:39
Thank you so much, Lauren. And so I will get us started on first SE and I want to acknowledge that we don't exist in isolation. We are surrounded by very smart people, some of which are kind enough to develop this content with us and let us use some of their slides. Janet hos Zager Melissa Weimer and Julie Childers on next slide.

03:09
And Jesse and I both received some funding from the center to Advance Palliative Care as consultants and just last year did cambia scholar and I am an A by the UN INR. Next slide. Um, so a couple of objectives. Today, we're hoping that you'll describe the goals and principles of buprenorphine treatment for opioid use disorder, and other possible uses as well to explain the new training requirement in order to prescribe buprenorphine and have a better understanding of people and archaeans. Pharmacology review best practices for initiation, stabilization, and maintenance and discontinuation and discuss clinical cases that demonstrate how

buprenorphine treatment can be delivered in various clinical settings. Next slide. So why are we here today?

04:07
So what I'm curious what motivated you to attend? Okay, great. So about half of you aren't wavered yet. I'm hoping that we will change that. today because I will show you is quite simple to go through the waiver process. And hopefully for those who want some more experience in education, we will also provide that so do you plan to obtain a waiver to prescribe buprenorphine at the end of this course. That's the route no pressure I was actually going to just give you option A

04:46
No pressure, just kidding. Pressure.

04:53
Great, so four of you are off the hook. The others are in trouble. But those four that are not prescribers, you have a fundamental role and hopefully we will help you see that today. Okay, so I just want to get into policy a little bit, which is really exciting evolving space. Next slide. Um, so starting with the X waiver, which, if people don't understand the X waiver can be a deterrent to prescribing buprenorphine. So I think it's important that we break it down. So and also talk about the fact that this is an example of where you wouldn't confuse evidence for policy. I'm sorry, policy for evidence. So when you think about how the X waiver came to be in 2000, on buprenorphine, scheduled three substance was approved to initially be prescribed by physicians, they must they had to complete the DEA X waiver and they had to have a DEA license and then complete specific training. And then were granted the x as part of their DEA, they had to also attest to counseling services. And there were a patient limits which remain today of 30 102 75 patients. But the X waiver and buprenorphine prescribing really came about as aspect of racist drug policy, with people talking about the premise that methadone was inappropriate to control the south suburbia and spread of narcotic addiction. And if you can't, you know, hear the racial imagery in that, in that quote, I would encourage you to look back at that literature which about five years after data 2,091% of those that prescribe buprenorphine were white and college educated. And so it's a it's a prime example of structural racism, which is why it's so important to be ex Weaver to sort of fight against that barrier in itself. So in 2016, again, 16 years after as overdoses are continuing to rise, buprenorphine prescribing was expanded to nurse practitioners. And then physician's assistants, completing 24 hours of specialty training opposed to eight. And then this M nurse practitioners were initially only able to prescribe to 30 patients that this was expanded to 100 on if they met certain criteria. Next slide. So the important part of that, that other slide is people often say as a nurse practitioner, physician, physician's assistant, can I be wavered? You absolutely can. And states, I have full practice authority on New York being a recent one of those. You can also prescribe buprenorphine independently. In other states there with reduced or limited scope of practice, you might require your physician to the X wavered, which is an important point to really emphasize that this is very much a team sport. So what does the waiver workforce look like? And I think that this is really critical, because people often think to themselves, you know, if they see somebody with substance use disorder, I'll just send them to somebody that's X wavered.

And the important thing to really emphasize in this slide is that there's not a place to set them on. So you might be fortunate to be in a place where there are lots of X favored clinicians, but in general, the numbers of X waiver clinicians are quite low, so 5% of clinicians across the country are wavered. Jessie's work demonstrated that approximately 13% of palliative care workforces wavered. We're hoping, as a result of lots of these talks that this is changing. But even among those that are wavered, half, do not prescribe buprenorphine. And we'll talk about why that is, and 90% Treat less than 10 patients. And I'm proud to say that advanced practice providers are among the most expanded rapidly expanding waiver group. Next slide. So this is an exciting time to be doing this talk because since April of 2021, the training is no longer required to treat less than 30 patients. And remember the previous slide I said on average, a waivered. clinician is treating about less than 10 patients. So this is an important thing to think about because you will be able to to cover your panel with this 30 patient exemption waiver. And so if your reason for not being wavered is that the training takes too long, you no longer have an excuse, but you continue to have to opt in and that is by scanning this QR code or you can go to get waiver.com and complete the notice of it. intent, all you have to do is provide your license number, and your DEA number and you will be given your ex waiver in about a month and a half. And again, it only takes about five minutes. And one interesting thing about this new waiver requirements, so in the context of COVID-19, waivers, uptake has actually decreased. And despite these new training exemptions, the ex waiver workforce is not growing, to compete to outpace that, that diminished growth. So it's really important that we take advantage of this. And I think a big reason why the lever workforce is not growing, is because of many of the reasons that I will go on to next. Next slide. And so one important take home on here is we get from palliative care clinicians all the time, you know, I'm really interested in using buprenorphine, but I'm interested in using it for pain. And if I'm treating pain, why do I need an X waiver? And we feel like it's really important that you get an x ray or for several reasons. But a couple I will name off the bat. And we published this editorial in the Journal of palliative medicine just last month. But I think what this does is really improved the transparency. So if you say that, you know, I'm just using buprenorphine to treat pain and you are in fact using it for opioid use disorder, opioid misuse, you're really not. You know, being truthful. And I think this is hurting the science and it's hurting clinicians. Because what this is, is a really complex symptom cluster. And just saying you're treating one aspect and not another, doesn't quite capture the complexity. The other thing is that you're combating combating stigma you're not bothering you're not saying I'll treat this population, but I won't treat this other population, even though the medication is the same. So just prescribing buprenorphine helps catalyze your self efficacy and connect stigma against the medication and against people that use drugs. I can wholeheartedly say that being a buprenorphine prescriber has made me a better clinician, I am much, much better at prescribing buprenorphine for a host of indications I am a much better opioid prescriber in general. And I've learned some other tricks along the way. Like engaging people in shared decision making and using motivational interviewing. And so I really feel like getting a waiver has brought my practice to the next level. Next slide. So people say but it's so hard, you know, I don't I you know, we don't have the infrastructure to have this setup. And we're here to tell you that it's not that hard. And we do way more difficult things out of care. And all you need is a few new skills. Next slide. So this is a paper as I was saying, you know why? Why do people get wavered and then not prescribe? So we looked at barriers reported by palliative care clinicians, 100 of them like yourselves that were interested in buprenorphine, some had waivers and some about half had

waivers half didn't. And one reason they said they didn't prescribe buprenorphine was because that they were uncomfortable managing opioid use disorder and pain. Next slide. I think if you click again, and so buprenorphine, here, here's my answer to that buprenorphine as a first line management and people with pain and OCD. Jessie had just published a actually Jesse myself had just published two papers along those lines, one in JAMA Network open and one in JAMA oncology, that when people come into their serious illness with pre existing opioid use disorder, that really experts are reaching for buprenorphine as a first line analgesic to both address pain and odd. You know, something we come across a lot is buprenorphine isn't effective, and it's an ineffective people worry, it's ineffective as an analgesic and the post operative literature would suggest it is not my clinical experience would suggest it is not, and that buprenorphine is actually highly effective as slick doses and so that partial analgesic property of buprenorphine is up is mechanistically. How it acts but it is not actually a partial analgesic.

14:48
And we will shout that from the back as we proceed. It's also okay to add a full agonist to peep and morphine. It's not okay to go the other way around. But people were you know what if what If the buprenorphine doesn't work well, again, you can add analgesic on top of that. And what we see often in our practice, with patients with cancer, for example, that we continue to treat the opioid use disorder with buprenorphine as a background and then add a full agonist on top of that if, say, for example, that cancer progresses or a person needs an intervention, like a PCN tube, for example. Um, the other thing to really emphasize is that you don't have to do this alone. And, you know, I think we get so stuck in our ways around opioid prescribing for pain. And there are lots of other effective modalities for pain, including robust psychosocial support, and so we should really be making this a team sport. Next slide. So people have concerns about practice culture, the next button and this I think, This has important connotations that imply, you know, sort of entrenched stigma, just to sort of bring to the surface. Again, buprenorphine is no more difficult than prescribing opioids, it reinforces self efficacy, and catalyzes attitude change. So things I received about buprenorphine or people that use drugs have changed significantly since I've been prescribing, you will not become the default prescriber for your community. Again, the average x waiver clinicians prescribing to less than 10 patients and that prescribing buprenorphine will help improve app access and equity. Next slide. So people were uh, you know, I don't have the infrastructure I've in insufficient support, like. So I would encourage you to find mentors at your institution. When I first did my first buprenorphine initiation, I grabbed the addiction medicine fellow and made him come with me. And that was a really valuable experience. And we have partnered at the VA, some of the addiction fellows with the palliative care fellows for some cross pollination and mutual learning. And part of how you can stay ahead from this insufficient support is to plan ahead. So when you're starting buprenorphine, you know, it's important that you're in touch with the patient. And what I recommend is often splitting up that follow up. So one day, the pharmacist calls the patient another day, the nurse calls the patient then the social worker, and so that this is really everybody pitching in. And the important aspect of that is that everyone gets to see the person get better. And so you're not really working in isolation. If you were the 1x Waiver clinician in our practice, that is really going to be a hard model to sustain. And so I would encourage, you know, group practices to sit down and I'll get Weaver together. In addition to this, this webinar and other programs, there's also mentorship available through their clinical support system that is

free. And it can be helpful to think about buprenorphine initiation ahead of time what might be right for your practice. And your patient population. I think Jessie and I both tend to do home based initiations. One of the things that people reported in the survey was that they didn't have the clinic space, but that shouldn't be a deterrent. Again, home initiations are safe and effective. Next slide. So sort of the last one is patient facing challenges. And so people would say, you know, I want to use buprenorphine, but my patient never wants it. I'm sorry, you can look ahead. And so I would say, you know, I've never come across somebody where I recommend hospice and they say, Oh, my gosh, I can't wait to go on hospice. You know, there's a lot of things that people that we sort of help people work through ambivalence and role risk with resistance and starting buprenorphine may be one of those things, and that we really help people build their muscle as adaptive coping as palliative care clinicians. And thinking about substance use and an opioid use disorder and buprenorphine often helps people work through these challenges. And so I have full confidence that we can overcome some of these patient patient challenges. Next, slide. it over to Jessie.

19:39

Great, thank you so much. And there's a question in the chat that I didn't get to you. So Katie, I will leave that for you. Thank you Maria for that excellent question. And that was great. As always, Katie, it's always really fun to present with you on this. So we're gonna roll up our sleeves now and get started with boop, our favorite thing. Next slide. So which of the following is true about buprenorphine? Please vote. It does not provide significant pain relief. It blocks effective other opioids taking a full agonist while on view causes precipitated withdrawal. Adding a hydrosis tube well on an opioid agonist may result in precipitated withdrawal. So, the correct answer is that if you dump a whole bunch of buprenorphine and somebody who has full agonist on board, you may cause precipitated withdrawal. But there are ways to avoid that when you switch people from full agonist opioids to buprenorphine and we're going to cover that but it's totally permissible to put some full agonist opioid on top of buprenorphine for additional pain control. We do it all the time we get people PCAs In fact, in the hospital as an example, next slide. Okay, so let's talk about some of the unique aspects of buprenorphine. So buprenorphine is a partial opioid agonist. So when we talk about full agonist we're talking about things like that we, you know, traditionally prescribe a lot of so things like morphine, oxycodone, Dilaudid, etc. But buprenorphine is a partial agonist at the mu opioid receptor. So what does this really mean? So, as you can see on the right hand side of the slide, it means that for side effects, particularly respiratory depression, there's a ceiling effect, meaning that if you continue to go up and up and up, whereas with full opioid agonist, you are more and more and more likely to cause respiratory depression to cause sedation. With buprenorphine, that's actually not the case you hit the ceiling, and that's what makes it so much safer. So it's actually very, very hard to overdose on buprenorphine. I'm going to say this again in a later slide. But it's worth saying now that this does not because buprenorphine is a partial agonist does not mean it's a partial agonist for analgesia and Katie said that a minute ago, but it's worth saying like four times that, you know, it's a buprenorphine delivers significant analgesia and the partial agonist aspect is really what we talked about when talking about these adverse effects like respiratory depression, next slide. So, a couple other things that make buprenorphine unique, so it has a strong affinity for the mu opioid receptor, and it dissociates slowly, which may provide analgesia at relatively low doses. So I'll show you in a few minutes that some of the doses we use when we're just treating pain

are the microgram range where the doses that we use when we're treating opioid use disorder and pain together are in the milligram range. So and the FDA indication does not always match the clinical cues, which you'll see more in a minute. But this, you know, I wouldn't get too hung up on this, right? Because we use things off label all the time. In our practice, right? I mean, there's so much art to what we do that this should be totally in our comfort zone. The other thing to understand is that buprenorphine is often co formulated with Naloxone that's called Suboxone. And there's minimal sublingual absorption of the Naloxone component unless it's injected. So we're not giving people relax. We're not giving people a blocker and buprenorphine in and of itself is not a blocker. That's also a very common misconception that people morphine somehow blocks the effect of full agonist opioids similarly to Naloxone and that is not the case either. Next slide. So here it is. I say it again, partial new agonist does not mean partial analgesic. So for moderate to high dose buprenorphine products that we use to treat opioid use disorder. Again, it's okay to add full agonists to the buprenorphine, you may need higher doses of the full agonist, but you won't know that starting off, and so you should just do what you do with everybody, which is to start low and go slow to medium depending on the circumstances. But, but just be aware that you might end up needing more and that's okay. But as we've said several times, it is not okay to add buprenorphine to full agonist that may precipitate withdrawal. And there are plenty of ways to get around having to do that, and I will talk about that in a minute. So, buprenorphine is a new receptor agonist and a delta and kappa opioid receptor antagonist. And that is what is that to account that antagonism is thought to account for its antidepressant and anxiolytic properties. And so it's very common when we switch people over to buprenorphine that they're, you know, it's not you should also treat their depression or anxiety with conventional measures, but it's also a great way of improving depression and anxiety and somebody who you would like to keep on opioids because we know that full agonist opioids for example, cause incident depression in people prescribe them for long periods of time. And it can be used in patients with end stage renal disease on dialysis and cirrhosis. So in patients with decompensated cirrhosis, we do not use the Naloxone component. It's contra indicated, but there are only formulations that are similar in dose. Next slide. So let's go through some of the FDA formulations, FDA approved formulations for pain. So there's transdermal buprenorphine, which is known as blue trans. And then there's buccal. There's a buccal formulation known as fel Buga. It's important to kind of know what is on formulary where you are, if you're an inpatient, and to have a sense of what might be covered for your patients outpatient. And I saw that there were already some questions in the chat about insurance coverage. So we have lots of help for that. So please continue to hit us with those questions. So these are products that are so low dose in the you know, you can see 150 microgram barrel Buca. And you know, we routinely use like 10, Mike, you trans patch 20 might be trans patches. So these can be used in people who are opioid naive. So this is a great thing for somebody who is, let's say, an older adult, frail. And, you know, maybe on other medications that might might cause altered mental status, and you really just don't want to add another one on top of it, and you really want to start very low. And as I said, if these very low doses, it's an effective analgesic because of the slow dissociation property from the receptor, so and then when you have such low doses of buprenorphine, there's really no risk of precipitating withdrawal. And in fact, we exploit that fact to get people on higher doses of buprenorphine by starting with these low dose formulations, which I'll talk about in a minute. So and it's very similar to other opioid rotations, you can just stop the full agonist and start the buprenorphine. Or if you can, I'll just say that you can just start stop the full agonist

and start the buprenorphine. And then the off label issue with low dose buprenorphine initiations, which again, I'll talk about in a minute how to start using these low dose formulations. Starting really low like this, and then getting people on more substantial doses to treat comorbid pain and opioid use disorder. This can be really challenging because oftentimes, the you know, a one time you trans patch or two time do trans patch to get somebody onto a full agonist opioid for opioid use disorder or excuse me, people from a full agonist opioid onto buprenorphine for opioid use disorder, it won't be covered. So there are other ways to achieve fairly low doses that will be covered by insurance, which I'll show you next slide. So moderate to high dose buprenorphine products. So this comes as sublingual or tablet. It can be buprenorphine, Naloxone or buprenorphine alone. And again, the indication for buprenorphine alone, there are really two FDA indications one is decompensated cirrhosis, and the other one is pregnancy. But sometimes people will sort of insist that they have a negative reaction to the Nazism component, and I don't really get hung up on that I have found recently, that it's actually been easier to get approval for buprenorphine alone, whereas in the past, it was really hard. Unless the patient had an FDA indication, and that may vary geographically. For this, you need an X waiver. So when you're just treating pain with patches and Barbuda, and things like that, you don't need an X waiver. But for this, you need an X waiver. But as we talked about in the past I talked about earlier, just get the x waiver, because then you don't have to beat yourself up over Am I treating pain? Am I treating opioid use disorder? You know, and you don't run into this issue of, you know, using a drug just for some people and not for others, which we all know is really rooted in stigma and racism, right? So we use this off label these higher dose products off label for pain all the time. So this is typically when people come to us already on full agonist if somebody's taking 100 ML a day, you're not going to probably switch them to a view trans patch. And, you know, and that and that's it. So and for that, do you need an X waiver to treat comorbid opioid use disorder and pain? I don't know. I think that's an unanswerable question. But it doesn't matter. Just get your ex waiver, and then you don't have to ask the unanswerable question. And then, yeah, I think that last point was made last night. So next slide.

29:14
Hey, Jesse. Vanessa asked a great point. Maybe while people are answering this question. You can, you can let her know. But she asked it for dosing. Is there a max dose you have for pain or have you seen a ceiling effect?

29:28
Yeah, Katie knows I love this question. So V, the answer is that the maximum dose of buprenorphine is 32 milligrams. We don't really go above that. That's the package insert maximum dose. But conventionally people have rested at this sort of average of 16 milligrams because for opioid use disorder, the studies have shown that going above that does not add to does not have improved effect, improved effect. However, we are actually about to embark on a study now We're actually randomizing people who have comorbid opioid use disorder and pain, which is your question to higher dose buprenorphine, up to 32 milligrams a day versus whatever they came in on, which can be anything lower dose than 32 milligrams to see, to see if it hasn't benefit. Anecdotally, a lot of us do that I have patients on I've few patients on 32. I have many patients on 24. So we do that all the time. And it used to be that they would always require a PA and now at least in my area, it's just kind of sometimes requiring a PA, which is really nice, and

it definitely differs geographically. You know, in California and the Pacific Northwest, it's a lot easier to get those higher doses, but I don't know what the landscape is like in New York, but my guess would be that with a PA, it would be fine. Okay, so here's a case for you 28 year old non binary person with a diagnosis of ALS undergoing BMT with with the usual care that comes along with that history of severe OCD on buprenorphine, 12 milligrams per day. So a little less than average, but pretty reasonable for the last three years. He's not recently used opioids prescribed or non prescribed other than the buprenorphine. You were asked to see them before transplant to plan ahead. They're terrified of uncontrolled pain, which, you know, I hear a lot from patients in this situation. And they're also terrified of returning to use and having their opioid use disorder destabilized. And they're terrified of stepping buprenorphine in general, because they're terribly afraid of withdrawal. And as you know, if a patient's experience withdrawal before, it's usually pretty memorable, and they're usually pretty terrified of it happening again. So next slide. So how would you manage pain and someone on buprenorphine for opioid use disorder? Did you stop view and rotate to a full agonist until they are done with treatment? So if you've been rotating methadone that you prescribed, take over Butte and split the take over the beat prescribing and split the dose? So remember, this guy, this excuse me, this person was on 12 milligrams a day once daily. So would you split the dose, continue to split the dose and add a full agonist? Wow, this is either this group is a came came this way, or maybe we've already influenced you this much, but this is fantastic. So most people would start up and I would say that, you know, we pulled experts in a Delphi study similar situation and, you know, there was some hesitancy around starting Bupa, and there wasn't really a clear diagnosis of opioid use disorder. But the thing about this case, and this is actually a case from my clinic, is that there seems to be some issue with loss of control, which is a really key, you know, this taking more opioid than prescribed and, you know, sometimes you don't figure this out after just one visit. Sometimes it takes multiple times for that to really gel in your mind that okay, this person can't control their use of the opioid. And, you know, so if you ended up using buprenorphine off label for opioid misuse, and it turns out, they didn't have an opioid use disorder, but they're safer on the buprenorphine. I still call that a win. But, you know, oftentimes, you put people like this and buprenorphine and they kind of stabilized and you realize, oh, okay, so their depression is better, their relationships with their family are better, all these things are better, they probably have an opioid use disorder after all. And so that's actually what we did with this patient. And she's she's, well, I'll tell you how she doing in a few minutes. I don't want to spoil it. Next slide.

33:35

So this is just a helpful pneumonic that you may have heard before about how to diagnose opioid use disorder, of course, there's the usual DSM criteria, but the things that you can just sort of off the top of your head ask patients. So usually, when you ask people about cravings, they know what you mean, loss of control is often something that we observe. And, you know, like I said, I think in this case, you know, she might not have said, I've lost control, but you can observe that she can't keep her opioid use to what you've asked her to do unintended consequences of opioid use. And I think she was having some of these without really relaying them. And it was much more obvious when we started on buprenorphine, that these things kind of improved. And then compulsive use so use of it, you wouldn't physically hazardous situations, which again, is often something that we might observe in somebody that they might not

recognize themselves. Next slide. Why consider view? Next slide? So right, in its case, exactly. difficulty controlling prescribed opioids. You can click through all these just for efficiency sake. Did you Oh. So do you remember what I meant by contact with street drugs? Oh, so I mean, in this case, this patient is actually I can't remember what it meant, but I'm just gonna go right past that because we're running late on time, decreases craving for sure. And some evidence even for people who use cocaine and improves mood, as I said before helps with stability. And actually Bupa is thought to be better for hyperalgesia as well. So if that's a concern, switching somebody to Pete is really nice. Next slide. Why have you over methadone? So, difficulty controlling prescribed opioid use is really bad news with methadone prescriptions, right, because of the unpredictable HalfLife and longish half life of methadone. And then, you know, if you're really treating somebody for AUD, it's supposed to be through a licensed methadone clinic, which, you know, I'm assuming you are not if you're here. And so, you know, daily dosing in a setting like that is, is not great for people with serious illness. And it's actually not great for a lot of people. It's not a very flexible system. And there's a lot of national policy work, tried to change that. And we already said there's no evidence that methadone is superior to beat for pain. Next slide. So how do you start somebody on buprenorphine? So like we did in her she already had stopped her full agonist she came in, in withdrawal, perfect. You look for a cow's between eight and 12. And you can do that, you know, if the person is the person is has a cow's between eight and 12, that's great. If not, then you can tell them to go home and wait until they're in more withdrawal than they currently are. Most people know what this feels like, right? You give first dose and repeated one to two hours. And up titrate effective dose over one to three days, there's actually a buprenorphine home induction app, which that is the little picture on the right. And there are lots of algorithms for this that you can like handouts that you can actually give patients that will basically walk them through how to do this next slide,

36:56
Jesse, and Paula asked, How long do you usually wait before stopping the full agonist?

37:04
It depends. I mean, there are times right when you want to continue the full agonist, that's one thing to keep in mind is that you can actually just continue the full agonist if you think somebody is going to continue to need it, but it's I'm sorry, I'm thinking about low dose initiation. Is that the question about low dose

37:22
initiation? I think it's about classic initiation. So if you're gonna stop the full agonist, how long do you wait, before you start buprenorphine?

37:30
I'm sorry, yeah, so it's 12 to 18 hours, I have to be a moderate withdrawal. So but the thing is, like if somebody is been using fentanyl, for example, which is basically ubiquitous at this point, out in the wild, you know, sometimes people don't go into withdrawal for 24 or 4872 hours, because it's so lipophilic, and it just sticks around. So in those cases can be a little bit more difficult. But if you're just switching somebody over from like, morphine or oxycodone or something, that it's 12 to 18 hours.

38:01
Yeah. And I usually have them stop in at night that like the night before, and then you know, schedule them if I'm gonna see them, you know, in clinic, you know, the afternoon and the I think the important thing is not how long it's, it's to measure it using those cows score.

38:17
Exactly, exactly. So you know, those timeframes are sort of estimates. But especially with fentanyl, being so ubiquitous, you really do want to do a count score.

38:28
Next slide. And there is a sound score as well as self opioid withdrawal score.

38:34
That is a very good point. That is a very good point and some of the algorithms that are out there, including I mean, if we'd be happy to send this to you, one that that we use is has like sort of instructions for people on how to determine if they're in withdrawal. Next slide. Oh, no, precipitated withdrawal. So, you know, people I feel like precipitated withdrawal is almost kind of become an excuse to just not start people on buprenorphine, precipitated withdrawal is not deadly. It can be uncomfortable. Yes, people can, you know, develop a lot of anxiety around precipitated withdrawal, but it's manageable. And you know, the treatment for precipitated withdrawal is actually giving more buprenorphine to kind of overwhelm the receptors with buprenorphine. And so, you know, you just have to talk people through how counterintuitive that is. But you know, it's actually also very uncommon, as I think you'll see on the next slide, next slide. Yeah, it's really low one to 2%. So if you do this enough, you'll probably see it. But not very often. So don't let that one to 2% deter you from even trying Next slide. So she, this patient, she tolerated her classic initiation at home. We she has very poor internet access. So we basically manage her by cell phone. And so We called her once a week and then tried to see her in person when we can when she's able to get transportation. She had some anxiety concern about the transition, but in a month she was just overall so much better and she won't say that it's the buprenorphine. We also started doing the last team somewhere along the way, but I don't care if she thinks it's the buprenorphine you know, I know that people know. She doesn't have to like admit that to me, that's fine. And she intermittently is on full agonist for procedures and she no longer runs out early and she's had no further positive cocaine yet your cocaine positive urine next slide.

40:39
Okay, low dose

40:41
initiation. Thanks for the clap hands. 50 year old women with melanoma and bony met stable disease and prognosis years and immunotherapy pain is treated with oxycodone. At a decent dose, she intermittently use non prescribed substances and has difficulty with running out early. She reports using non prescribed opioids because when she runs out early, she's in withdrawal and so she has to do something to treat her withdrawal. And her recent urine drug test was

positive for cocaine and fentanyl, which was a surprise to her. But meth, cocaine, marijuana cannabis is all you know, possible to be contaminated with fentanyl. So that's a very important thing to make sure your patients know about, and oxycodone. Next slide. So what is low dose initiation? So basically, the idea here is administering small and gradually increasing doses of buprenorphine while continuing or tapering of full agonist over a two to seven day period. And there is a growing literature about why this should work. And for the in the interest of time, I won't go into the pharmacology on this, but just to say that there are numerous published case series about this, showing that it does work and that it is safe. So usually with these protocols, the initial doses are less than two milligrams of sublingual buprenorphine. I mentioned before that sometimes we'll use nutrients patches, you can imagine those are very small doses. And so that's an easy, easy thing to do. But the problem is in the outpatient setting, it's very hard to get nutrients covered. So we do this in the inpatient setting, we use nutrients and people use Well, you could just depends on what you might have on formulary. But in an outpatient setting, I get people to milligrams strips and have them cut them into quarters, and most people can handle that. So so yeah. Next slide.

42:42
So

42:43
why do Lotus initiation as opposed to classic initiation? So, you know, back in the old days before Lotus initiation, was recognized as a valid approach, and by the old days, I mean, two or three years ago, you know, it was always a really hard sell to be like, Okay, so, you know, you could do what Katie suggested, and some people will do that, okay, I'll just go for 24 hours without my view, and I'll come to clinic. And that works. For some people, it's great to have that option. But to tell people, you'd have to be in withdrawal to start this medicine, a lot of people for for a lot of people that just have non starter, that's just not something they're willing to do, understandably so. So that's the first major point. It also allows people to continue on their full agonist without stopping them whatsoever, which is great. If that's something that you want to do. Meth, it helps with transitions from methadone, because with methadone, you have you have to have people stop it for many days in order for them to really be in withdrawal. The same is true with fentanyl. And, and the idea is to really reduce the risk of precipitated withdrawal from synthetic opioids that have it especially with synthetic opioids that have unpredictable clearance, as I've mentioned, next slide. So her usual dose is oxycodone 30 milligrams four times a day and then she has other adjuvants on board as well. How would you proceed? I guess this is a polling question. Question. We also kind of have the answer on this slide. So but I guess, why don't what what would you do? Would you do a classic initiation? Would you do a low dose initiation? What do you think? How do you think you would guide her?

44:30
But I'm going to assume that

44:31
people drink the low dose initiation kool aid that is, you know, what I would do and somebody who has no desire to stop their full agonist and go into withdrawal. So here's a really good this is

from well Becker's, sort of seminal paper on this. There have been like I said, several protocols published but this is one that we really like. And basically you're starting with point five B ID of buprenorphine, which again is two milligrams cut into core orders and you can see that you're continuing the oxycodone at the usual dose for three days, then you're cutting it in half, and then you're stopping it. There's no magic to this, if you're really worried that somebody's gonna go into precipitated withdrawal, because they're using meth them because they're on methadone, for example, or they're using fentanyl, you just kind of elongate this and and it works just as well. Next slide. Um, I've covered most of this, I'm gonna just skip this. So she tolerated the low dose initiation using strips she didn't have precipitated withdrawal, which is what happens most of the time. Her pain was did well on 40, Id she you know, you could titrate to higher but she was doing fine at 40 ID. She was upset about the transition for a while change is really hard. You know, and I know you all know this, people don't actually put in for a while and you know, change is hard. She doesn't really think she ever had an initial problem with opioids. You know, she continues to use socially a few times a year, but now you have put her on a medicine that is much less likely to cause her to have an overdose. And actually, if she uses fentanyl intentionally or inadvertently makes her less likely to overdose from that, so that's great. So and then you educate her about harm reduction in a variety of ways. Like even if you're using cocaine and you don't think you're going to overdose, it might have fentanyl in it. So don't use alone. Use with somebody who has access to Naloxone who could help reverse you if you need it. Next slide.

46:41
All right, I wanted to just add one more thing to what you said, Jesse, the more I keep, the more I do low dose initiations, it doesn't matter what I do with the whole agonist, opioid doesn't matter whether I stopped the long acting short acting first. That's a place where I give people control what mainly and what really is the most important part is slowly titrating up the abuse. So it doesn't matter whether they're on long acting or short acting, it's it's really that art of of slowly introducing the bueb so you don't precipitate withdrawal.

47:16
Yep. And giving people control over some aspect of this is so important. These are folks who often have so little control over so much that's going on in their lives that if you can give them control or pieces of this, it's I agree, super helpful,

47:28
right? And I just use what people have, you know, if they have seven days worth, then I do the initiation over seven days, if they have three days worth and they don't want another prescription. We work with that too. So I'm an opportunist. On so case for on this keeps coming up in the chat. But what do you do with somebody that doesn't have an opioid use disorder? So this this is a person with COPD, PTSD, frailty, suffers from chronic multisite joint pain. This person is in my VA practice almost every week. A person like this has been on 120 of morphine for more than a decade. He wants to get off opioids. One question in the chat was, you know, what are the advantages of doing this? Well, he's getting older, push being prescribed long term opioids. I think, you know, Jesse and I both think of it as sort of an important comorbidity on and so he keeps falling. He's worried about falling, but he's really not tolerating a taper. So he's

getting tired, he's having anxiety, he's having increased pain, he's restless. And, you know, this is a person where people are being can be really helpful. As I think about these patients. Often, sometimes they don't meet criteria for opioid use disorder, but they have a syndrome that some people refer to as complex, persistent opioid dependence. Jesse, maybe you can throw one of those papers in the chat. But just this idea of, you know, they're on opioids, and it's not going well. And so you're sort of stuck in this in between spot where you taper and they're not doing any better. And so how do you proceed, and so we'll talk about buprenorphine being an important intervention. Next slide. So opioid decisions just are always about balancing individual risks and benefits. And so when we think about the harms, in this case, you know, we could easily march them out. But often people have benefits and it's important to play lip service to those as well. And give people shared decision making next slide. Um, so again, we've sort of touched on these points, but why why buprenorphine? Nate had asked in the chat is buprenorphine firstline opioid for people and I think you know, it's a tool. It doesn't have to be first time for everyone. But in this case why buprenorphine there's less hyperalgesia, it might in fact help his mood long. Depression is associated with long term opioid use, improve mental clarity and false. There's data that in older adults in safety and the risk of overdose in older adults is really growing. Next slide. And so if you look at this tapering flow sheet, this is from the Health and Human Services, and you can see buprenorphine is indicated for people who aren't tolerating in opioid taper with and without opioid use disorder. I will say, you know, a caveat is rapid tapers are never indicated. But I think there's a lot of patients that present to us, you know, not wanting to be on long term opioids. And buprenorphine can be an important tool to help get them off or even to substitute with a lesser risk medication or even one that's better tolerated. Next slide.

51:07
Um, so this gentleman, even though he was on 100, of morphine equivalents, we were actually able to get him on a 20. Mike, you trans patch. You trans is generally indicated for people on less than 80 of Oh, me. But often in an older adult, I give it a try. And I think that equal analgesic chart with buprenorphine, you know, we don't use it, we don't recommend it. And so often, where things shake out is kind of a mystery. So I just follow the patient and I escalate as needed. And we started with, you know, 10 and slowly tapered his full agonist and then went up to 20. And now he's fully off. And he really wishes he made this transition a long time ago. Five. So, next slide. I think we've had an exciting conversation both here and in the chat. Hope that your takeaways are that obtaining your ex lever is critical. prescribing buprenorphine is really a team effort. There are many uses low dose and traditional initiations work and there are lots of resources to help you. So where you learn.

52:18
Wonderful, thank you so much for those attendees who are still with us. Please join me in thanking our presenters for this excellent session today.

[End Transcript]