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BUPRENORPHINE PRESCRIBING FOR BEGINNERS

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Buprenorphine Prescribing for Beginners

[video transcript]

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00:38
Awesome, thank you for the introduction. I'm so happy and pleased to be here. I would encourage you guys to, you know, put your questions in the chat. So, and we will be attending to the questions as we go through the presentation. And I like an interactive session. I'm sure you guys do as well. So let me get started. I have no disclosures. So we have several learning objectives. I'm going to describe the core principles of buprenorphine treatment for opioid use disorder, discuss the pharmacology of buprenorphine seen as compared to other medicines for odd, less buprenorphine prescribing recommendations and the guidelines, and then identify best practices, I feel this is the most important part where you can, you know, really get into the details about buprenorphine and association, those stabilization, maintenance and discontinuation. I would like to spend the most amount of time there. I have lots of, you know, I could talk about cases, if you have cases or, you know, problems, I would save it for that piece and we can discuss, you know, any problems you may have in taking care of patients. All right. So why are we here, and this is a very exciting time because we've been talking about this for so many years, and that's the removal of the buprenorphine waiver, especially in the setting where all the opioid overdoses are increasing if you really look at it, especially for synthetic opioids, which is Tramadol fentanyl is illicit fentanyl in particular. But for commonly prescribed opioids. If you look at the curve, which is right here, it has sort of been flat. So the opioid overdoses are really driven by synthetic opioids in particular, we have fentanyl, and now we have, you know, the Trank, the xylazine, which is being used with other substances.

02:35
Okay, and so

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82% of all opioid overdose deaths into 2020 involves synthetic opioids. And this excludes methadone, which is also a synthetic opioid. And this is a big deal, because there was a time when this percentage was really, really small. We're talking about, you know, figure in teens, and now it's over 82%.

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And so,

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I think at this point, we all know that methadone and buprenorphine is life saving. It's interesting if this was not for opioid use disorder, if this was another substance, for example, CHF, and diabetes. And if you look at the graph, like the bar chart, and the reduction in deaths, if this was for another disease, this would have been the news, like we have a medicine that decreases mortality, mortality, by this percentage, everyone should use it. But unfortunately, we know this and still, there are many prescribers that are not using it as frequently or there's some prescribers who don't use it at all. So the principles of buprenorphine describing, of course, it reduces mortality. It reduces transmission of blood borne viruses because they use you know, patients use less IV drugs, it improves, improves overall health, reduces illicit opioid use reduces community harm, so in all it has a lot of benefit. The therapeutic effects of buprenorphine, you know it is a medication that is treated it that is used to treat or UD so it reduces or eliminates opioid cravings. It prevents opioid withdrawal. And so if you have buprenorphine on board and you use heroin or fentanyl, it blocks the effect of other opioids reduces the high for them. And it's unlikely to cause a euphoric effect which you might get with other opioids. And having been in the practice of prescribing buprenorphine for a long time. The patients how they're describing on buprenorphine is I feel normal. And I have some patients who go to work. Nobody would know you know that they're using buprenorphine or not. It doesn't sedate patients, and they feel really normal and it does not treat other stuff. Since use disorders, and we can get into this again in the question answer session a little bit, but what if my patient is using buprenorphine and they're cocaine positive, you know, the urine is positive for cocaine. And that's where it's important to remember buprenorphine treats or Ud. It doesn't treat cocaine use disorder. So we have to be very, you know, careful on how we interpret urine drug testing, and not unnecessarily penalize our patients for what we find. So, principles of buprenorphine treatment, we really want to meet our patients where they're at. And this is where the principles of harm reduction come in. And it's interesting, I was talking to someone, because treating patients who have substance use disorder, they might have other substance use disorder. And I know many prescribers who are like, Oh, but this patient also has alcohol use disorder. The way I like to think of it is anyone who's on buprenorphine, if they're not on buprenorphine, they will be on heroin, or they will be using fentanyl. And so being on buprenorphine absolutely is hands down safer than any other illicit substance. So I like to approach this patient treatment with philosophy of harm reduction. So for example, I have a patient who uses heroin every day, and I started buprenorphine, and they don't become abstinent, but instead, they reduce their heroin consumption from five days a week to two days a week, that's a success, they have reduced the days of illicit, you know, substance consumption. So that is a win. And so you've reduced the risks around illicit drug use just because of the frequency of the use. And this saves lives. We all know that. And so I approach my patients treatment with harm reduction philosophy. So this is what low barrier means low threshold threshold means that you meet patients where they're at. Similarly, if a patient needs treatment, trying, there are some places where you can initiate treatment on the same day, again, meeting the patient where they're at, is, is helpful, and you know, improves patient

outcomes. And it's part of a biopsychosocial model of care. So, treatment is one piece of medicine is one piece, and there are other pieces as well, that can help a patient improve. So the pharmacology is very exciting. It's a partial agonist. What does that mean? And this took me actually a long time to understand, and so partial agonism. The example that I like to use is what is methadone and what is heroin. They're all full agonist, which basically means as your opioid dose increases, your opioid effect also increases. So there is a linear relationship. However, when you really think about buprenorphine, it has a linear relationship up to a certain point, and then it plateaus. So no matter how much buprenorphine you take, after that point, the effect does not linearly linearly increase. And that in a way is productive, especially for respiratory depression, knowing that after a certain amount of buprenorphine no matter how high the dose goes, the the respiratory depression, for example, will not increase which is not so true with the full app opioid agonists. Okay, any questions around that? So this is the graph that I was talking about. So linear relationship with, you know, full opioid agonist, but partial agonist such as buprenorphine. There is a linear relationship, and then there's a plateau. Okay. Moving forward, so what what does that mean? So what it means is, let's say if I was using heroin, and somebody gives me buprenorphine, I will go into precipitated withdrawal. And there's a reason for it. The reason being because buprenorphine is a partial agonist, it's going to displace the opioid. And so this curve is going to sort of like shift downwards, and that is going to cause withdrawal. Okay. Now, on the contrary, because buprenorphine has a high affinity to the immune receptors, if I already have buprenorphine on board, and somebody gives me heroin, or somebody gives me morphine, I will not go into opioid withdrawal, just because my immune receptors are already blocked with buprenorphine. If you have questions around that, please put it in the chat because it did take me some time to understand this. And I'm happy to explain it again. Okay, so now we get into the actual, you know, interaction, so the interactions are rare. So of all the opioids I actually feel safer prescribing opioids versus let's say, oxycodone, or morphine or methadone, I feel it's safer to prescribe buprenorphine just because it is, you know it has less interactions. So buprenorphine is metabolized to Northview and other meta metabolites through you know, to the CVP, which is in the liver system. Okay, and then we have to remember the risk of overdose and depression is lower with buprenorphine, but it's not zero. So for example, if they are overdoses there are overdoses that involve buprenorphine, but those overdoses usually have other substances in addition to the buprenorphine, so it's usually buprenorphine or benzos buprenorphine or another substance. So that is important to remember that yes, overdoses can occur with buprenorphine, although the risk is low, and usually it is if you call use it with other substances. Okay. So, like I said, let's say if a patient comes into the hospital, usually if you want to prescribe buprenorphine, you have to wait until they're in withdrawal, a certain amount of withdrawal, I should say mild to moderate withdrawal. They have to have five features of withdrawal before you prescribe buprenorphine just because of this risk of withdrawn. Now in the era of fentanyl that has complicated things a little bit more. Because if you're using illicit fentanyl or the fentanyl you might be like this is a short acting opioids illicit fentanyl behaves like a long acting opioids so patients can be in withdrawal. And if you give buprenorphine they can still go into withdrawal and precipitated withdrawal. Because of this fentanyl acts as a long acting opioid. There have been other strategies, for example, micro dosing that I'm going to discuss later on, not at this moment that has sort of like helped give

buprenorphine earlier to patients, even though they might not be in withdrawal to prevent precipitated withdrawal. Now, the side effects that are experienced with buprenorphine are similar like any other opioid, but the risk of the side effects is less. The one side effect that patients do complain to me is nausea, and you know, in some instances vomiting, but these symptoms of nausea and vomiting go away, as the patients consistently use one strategy to counteract this adverse effect is I usually tell them you know, once the medicine has completely resolved, use a cough drop or use a sour candy, which will improve the taste in the mouth and help with you know the symptoms of nausea.

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Now, this is what the formulations look like for opioid use disorder. Now I want to be very careful to describe these are the formulations that are used are approved, FDA approved for all UD, there are other formulations that are approved for being but these formulations. So for example, the film or the tablet, which is pictured here, is approved for OCD, and the dosage of the buprenorphine in the formulation is in milligrams versus for pain, the formulations that are approved, which are patches or a buccal film, it's in micrograms. On the right hand side. As you can see, we have the extended release injection. So we have the monthly injections, which is sublocade. And the newly approved weekly injection, which is called brig Saudi, it just got approved recently, and the last few weeks. Okay, we talked about that. So, fortunately, living in New York state, New York State Medicaid has a single formulary. So it applies for both fee for service and managed care. And so I think the need for prior authorization has been reduced tremendously. I still have to do prior authorizations for some of our Medicare patients, but I have noticed a significant reduction for my Medicare patients. So how do you actually tell the patient to take it, it's a fountain, okay, it's literally a very thin film. So what I tell my patients is make sure that your mouth is moist, meaning you can have a glass of water, and then you place the film under your tongue and you wait for it to completely dissolved. And while it's dissolving, you shouldn't be eating, talking, drinking or smoking. And I already warned them. It has a terrible taste. Okay, so be warned. And then I tell them about the cough drop or a sour patch that they can use. So best practices of you know an association. Now anyone because the waiver, the ex waiver requirement is gone. Any clinician who has a DEA can now prescribe buprenorphine. But at this moment I also want to tell you if you're getting your DEA renewed this year, you will have to complete an eight hour training which is still a requirement. It's just once in your life. You have to do that eight hour training, but the but the requirements to apply apply for the waiver, which was called the ex waiver has been eliminated, which is awesome. Okay, so this is very interesting because we use, we providers use lots of terminologies in our daily, you know, clinic encounters on how we address our patients. And some of this is like saying, Oh, your urine is dirty or clean. So you have to remove these words dirty or clean. Instead, clinicians have to be objective, your urine is positive for X, Y, and Z, or your urine is negative for xy and z versus using clean or dirty. And similarly, you know, saying, Oh, my God, you know, you are clean now. And it's interesting, because I don't use that terminology anymore. But my patients continue to use, you know, Doctor, I'm clean now. And what I tell them is, you know, I don't like to use that terminology, I would say you're abstinent, you know, you were always clean. So I also tried to sort of like help patients change their own terminology. And remember, this is not a choice or a

moral failing, addiction should be treated as any other chronic medical problem. And coming from someone who was also a primary care physician, the reward of treating patients with use disorder or addiction is really rewarding. And when patients change their lives, it's, it's one of the most the highlights of my career, I can easily say that. So these are some of the words I you know, try to avoid abuser, or addict, or, you know, how, in our, how we present patients, or this 48 year old addict, instead, we try to differentiate the disease from the person. So that's called the person first language, and that should be used for other diseases as well. It's not a 48 year old diabetic, it's a 48 year old man with diabetes. Similarly, this is a 48 year old man with substance use disorder or opioid use disorder. There are lots of similar words we use and for chronic pain, and we should make our you know, we should try our level best to avoid these words. Okay, now, who should I prescribe these patients, you know, prescribe buprenorphine to? So the first thing is they need to have an opioid use disorder. And for diagnosis, you use the DSM five criteria, which is easily available. And what it really gets into is to see if they have craving, they continue to use a substance without negative despite negative consequences, and then they exhibit tolerance and withdrawal. You know, there is no absolute contraindication to buprenorphine, an allergy is really, really rare. And you can even prescribe it to people who are interested in treatment, you have to explain the risks and benefits of buprenorphine. I would also add, I know this is odd, primarily for you, oh god, I also take care of a lot of patients for pain. And patients who are in high doses of opioids who have uncontrolled pain, sometimes I switch them to buprenorphine for better pain control, but that we can talk again later. So So for someone who's starting out, the best patient would be, you know, if you're trying to refill for a colleague, or you know, the patient is good at transferring from another practice. So just because if you want to get your feet wet, those are some of the patients that you want to start off with, or they've had a past treatment of buprenorphine, or they even using illicit buprenorphine. And that's a very interesting concept. So experience with non prescribed buprenorphine. I want to pause here for just a second and talk about that. You know, how we fear and I think one of the fears of providers is if I prescribe buprenorphine, what if buprenorphine ends up on the street? Guess what? The buprenorphine that ends up on the street is probably saving someone's life, or is probably being used for managing withdrawal symptoms. So if you have patients, I have patients come to me who are like, Yep, I got buprenorphine on the street. I really liked it. And I actually now want to get treatment for buprenorphine. So that buprenorphine on the street actually helped patients to engage with care to engage with treatment. Now patients who are pregnant, you might want to get help, especially as a new prescriber, you do want to get expertise or an expert to weigh in, or if somebody is on methadone and wants to switch to buprenorphine, I wouldn't recommend that patient for a new prescriber. Now for me, I've been prescribing for many years I would feel comfortable and prescribing to both pregnant and patients on methadone or switching from metal

20:00
Don't do buprenorphine.

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So again, this is what the DSM five criteria looks like. So this is physical dependence, which I mentioned tolerance and withdrawal, they have impaired control, which means or in other words, in some places is described as use of a substance despite negative consequences, meaning because of that substance that relationships are falling apart, or you know, they're losing their job, or they're experiencing other negative consequences, and they still continue to use it. And then physical dependence meaning, you know, they use substances and they have physical, they have experienced physical hazards or psychological or physical harm, and they still continue to use it. And you can diagnose it as mild, moderate, or severe, depending on how many criteria is fulfilled. Now for buprenorphine prescription checklists, some of the things that I do recommend is always look up the PDMP make sure that they're not using prescribed opioids, just because if they're using prescribed opioids, and you give them buprenorphine, they might go into withdrawal. So that's one thing you always want. And this is not just for, let's say, buprenorphine, even if I prescribe a new medication for diabetes, before the patient leaves the office, you want to make sure that there's insurance coverage, or let's say, if you have a busy practice, and you cannot find out about the insurance coverage, give them a day or two, you know what I'm going to check on your insurance. And then I will let you know if you know insurance is covered or not something like that. You also give them a number that they can call if they have a problem with the prescription, and you try to schedule your office visits to coincide with the refills. I have a list of my patients in my epic, which is you know, all my active patients. This is for review, and DEA and the seven years that I've practiced, nobody has come and looked at the list. But it's just it also helps me organize, like how many of my patients have up like how many patients I'm taking care of it helps me to have that list. So, so standard given off unionization, it's interesting if you really look at the history in the past, you would ask the patient to come and withdrawal in your office, and then you would give buprenorphine, and you would see if they go into withdrawal or not and manage the withdrawal. So this was called observed buprenorphine and association. But since then, we do home inductions, which are unobserved, basically saying, you know, we're going to give you a set of instructions, you're going to go home, and you're going to do it on your own. And it has been successful as successful as observed. And that's all that I've been doing. I haven't done a single observed and Association. I do it all the time at home. And remember patients who have or UD, they're very well experienced with the symptoms of withdrawal. So you know, obviously you give them a checklist, or you know, if you have five symptoms of withdrawal, they already know that they already know how to manage their withdrawal, so you can tell them when to initiate buprenorphine. I'm going to go into I'm going to show you the actual patient handout, but they're fully aware of what to do. You can also add medications that help with withdrawal. So for example, clonidine helps with anxiety, ibuprofen, may help with body aches and pains. You can also give loperamide if they are having diarrhea, or Trazodone for anxiety. So there are a bunch of other adjuncts you can prescribe if they're experiencing, you know, withdrawal symptoms. Now, this is very interesting. You know, if somebody is taking a short acting opioid analgesic, usually it's like, you know, wait for 12 hours, and then when you go into withdrawal and you fulfill the five withdrawal symptoms, that's when you start buprenorphine. Methadone and fentanyl is more tricky because although it says 48 to 72 hours, it's sometimes can be prolonged, especially in patients who have a higher BMI, at least in my experience, it's it is sometimes

longer. So somebody is taking a long acting opioid other than methadone, heroin, it's 24 hours of holding that opioid before you start buprenorphine. But for methadone and fentanyl, it might be longer. And then you follow up with the patient in one week, to see how they're doing. Okay, so I think I described this in a second, mostly. So what you tell them is, you know, stop your full agonists wait for withdrawal, okay, and then you give them the checklist of the withdrawal symptoms, you take the first dose of buprenorphine, and you can wait and see if your symptoms improve. And you can repeat that in one to two hours and see if you're feeling better. Then on day two, you don't go through the whole process again, you start off with the doors that you needed on the first day. So for example, on the first day, the total dose that you needed was eight milligram AMS on day two, you will start off with eight milligrams. And then if there's a need to adjust, you can take an additional, you know, film on buprenorphine. So this is what the checklist look like. It has very clear instructions. These are the opioid withdrawal symptoms, and you suppose to sort of like have five before you go forward. And it has details and you know, mentioned here along with, you know, a picture, all of this will be shared, we also have resources at the site, which is Bitly. Montefiore view, and you can share this with your patients. There are also smart phrases that, you know, instead of typing out the whole thing, you can also put in a smart phrase, and it will auto populate for those of you who have an electronic medical record, and your health systems. And I always recommend checking in on the patient through phone call the next day just to see how they're doing, and then follow up with them in one week. This doesn't have to be like a weekly thing. It's usually in the initial period that you follow up in one week. If they're doing well, if they're on a stable dose, then you'll follow up with in one month, and so on. Okay, again, if you have any questions, feel free to put it in the chat. Now Lodos in the session I'm really excited about because this has changed a lot of things. So instead of saying, Hey, you have to wait for 12 hours, or you have to wait for 24 hours. And in particular if patients also have been telling someone to wait it out is hard. So you can actually start buprenorphine at lower doses without waiting for the withdrawal symptoms. So how we do that is to give doses of buprenorphine in less than two milligrams. Now you might ask the lowest dose of a film is two milligrams. How do you tell your patients to take lower than that. So there are several strategies, and I will go through them. And if it's confusing, again, put it in the chat. I'm happy to talk about it. So you can use if you remember, I mentioned the formulations that are approved your pain is in micrograms. So for example buccal film is in micrograms or transdermal patches are in micrograms. So for the initial stage or the initial few days, you can give them those formulations. The only problem with that is insurance coverage. Like oh, you're using a pain formulation. And now you want to switch to, you know, an O UD formulation that sometimes puts hurdles. So what we do in our clinic is we cut the film into four pieces, and we use that to microdose. Now I want to just tell people, this is something that you wouldn't do as a new prescriber. This is when you get comfortable. That's when you would start thinking about micro dosing, but I just want to mention it here. And this is especially helpful for my patients who have been and not necessarily have moderate to severe or Ud. I use this to switch them to buprenorphine. So let's say if somebody is on high doses of oxycodone, or morphine, I will use this micro dosing strategy to switch them. We have protocols, we have nice tables, we even have patient handouts that's all available to you. That goes into more detail. And I think this is a helpful strategy, especially in the current era when patients are using fentanyl, which if you

remember I told you acts as a long acting opioid. Okay, how are we doing? Any questions that I need to answer? There are

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two questions that I like to pose to you at this moment. So the first when should a patient be on buprenorphine versus buprenorphine naloxone? We get patients that claim Naloxone causes headache or that they are allergic to Naloxone. I think the formulation with naloxone is much safer. So prefer patients be on that when possible.

29:08
Yeah, so this is very interesting. I do get a lot of patients like that. I would say I would encourage you to prescribe buprenorphine Naloxone I want to explain one thing to us to everyone is in Alloxan piece also throws patients off because they think it counteracts the buprenorphine, even providers come up to me with that question. So the Naloxone does not get absorbed into the body or I should say, very, very little Naloxone gets absorbed when you use it. sublingually however, if you were to scrape off the buprenorphine from the film and inject it, that's when the Naloxone would act and prevent buprenorphine from acting. So yes, I do get that from my patients. I have to tell you, the one time that I do use buprenorphine is when I'm trying to microdose them and somebody Patients are sensitive in their symptoms that oh my god, I tried buprenorphine Naloxone, it gave me you know, withdrawal or whatever I might use the buprenorphine only product for switching over in the initial stage. And then for maintenance, I use buprenorphine naloxone. So that's the other thing that you can use if your patient is very insistent that they're very few allergies, by the way, so I feel the allergy that they describe is I'm not sure if it's the nausea and vomiting that they think is the allergy or the symptoms of withdrawal that you're thinking is allergy, because those withdrawal and discomfort feelings are not necessarily coming from locks on it might just be because it's switching from one substance to another. That's why they're experiencing mild withdrawal from it. But yes, I have used buprenorphine in the initial stages and then transition them to buprenorphine naloxone. The other thing that I tell them is that the symptoms of this nausea and other symptoms will go away as you stay consistently on buprenorphine. I mean, buprenorphine naloxone.

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Thank you. The second question that we have, can you provide a list of ancillary meds and the typical dosing for withdraw? Yes, we can also follow up with participants if you don't have these on the top of your head.

31:26
No, I mean, can tell you. So this ibuprofen usually 800 milligrams three times a day, and I'm, in our, I believe our handout that we have, and including the resources, it's in it too, but usually it's ibuprofen, you can use Trazadone, you can use carnitine. And then loperamide, sometimes dicyclomine, which helps with cramps. Those are the more common usually most of my patients don't even need it. But I do prescribe them clonidine, and I will pro fan just in case they needed. I do not prescribe benzos. That's another question that may come up. I do not prescribe benzos

are patient for the management of opioid withdrawal, sometimes inpatient, some providers do use benzos to manage, you know, the anxiety component around withdrawal, but I don't prescribe that at all. Instead, I use the clonidine or the other is hydroxyzine, which is atarax to manage the withdrawal symptoms, and those doses and everything should be in the patient handout.

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I think we are caught up on questions relevant to this portion. Okay. So yeah, thank you.

32:37
Okay, thank you. All right. So this is the piece that I was talking about. The impact of fentanyl and in association fentanyl has really changed you know, how we practice or treat patients, you know, with buprenorphine. So this was a very interesting study that was done in which they looked at urine samples, and measured the fentanyl and nor fentanyl, which is a byproduct. And guess what, look at this range. It range from 10 to 26 days for some patients. So it can definitely act as a long acting. And I've experienced similar things. Excuse me for methadone. Methadone is another substance that you know, hangs around, especially in fat cells. And this too, is lipo philic. So it hangs around in the flat fat cells for a very long time.

33:28
Okay.

33:32
So usually the precipitated withdrawal and look at this, it's one to 2%. But in this one to 2%, they will tell you, Oh my God, it was so awful. And you will remember it and then you will be afraid, but I encourage you not to be afraid and happens but look at this one to 2% 98% of the time patients do just fine. And again, I've been doing this for so many years and most of the time it is a success. But fentanyl has complicated like I said, just because of the presence of fentanyl. You have to think about this. I feel a little bit more but this is a pretty recent study. So one to 2% is the number of precipitated withdrawal. Now labs so in the first with it, you should do labs, for example, all of the, you know, infectious diseases, but you don't have to wait for the results because my management is not going to change. If this patient is HIV positive or Hep C positive. Am I not going to prescribe buprenorphine? No, I would still prescribe buprenorphine. So this is not going to help all change my management is good to know so that I can adjust things but it will not change my management. What about the doc sizzles? Again, this doesn't change my management and it's a single data point. They might be using multiple substances. And again buprenorphine only treats or UD it doesn't you treat cocaine use disorder. It doesn't have treat any other use disorder. So that's something to remember. And having your patient be on let's say buprenorphine plus blank you can put in any other substance is much safer than being on heroin and fentanyl plus blank, whatever substance they're on. So that's how I like to approach my patients treatment. So urine drug screening and confirmation, I do like to see that my patients are using buprenorphine, and you can confirm it by sending a urine GCMs which is grass chromatograph mass spec straw spectroscopy, and you look for the ratio. So

buprenorphine gets converted to nor nor buprenorphine, so the nor buprenorphine has to be higher than buprenorphine. I've had on occasion a patient. This is like really rare, maybe one in like 60 or 70 patients who are going to dip buprenorphine in the urine. So you're looking for a buprenorphine positive result. Now you might, the one thing that I would tell you is let's say if my patient comes in and is negative for buprenorphine doesn't mean I'm not I'm going to stop prescribing buprenorphine, it does mean that I'm not going to have a conversation. Look, I'm prescribing you buprenorphine. What are you doing with the buprenorphine or you're taking your buprenorphine? It doesn't seem like you're taking it based on the results of the urine. Do you need to be on a higher dose? Maybe that dose is not enough. So I do like to whatever the results of the urine drug tests are I use it as a talking point to talk about further steps. Okay, so the buprenorphine administration pearls. So prescribe buprenorphine, eight milligram firms, I don't like to use tablets that take a longer time to dissolve for at least one to two weeks, until the patient returns to see you. So the dose that you give, the amount that you give in your prescription has to be enough for it to last, you know that amount of you already talked about the ancillary medications, you give a call back number, and you make sure that you follow up with them. And always make sure that you call the pharmacy so that you know that the insurance covers it or not. Now the pharmacy pulls usually now this is very interesting. I've been experiencing that many pharmacies actually have not been stocking oxycodone or other opioid agonist I find it less so for buprenorphine. But still, you want to make sure that your pharmacy has a stock of buprenorphine, so call them and tell them, hey, I'll be prescribing buprenorphine to these patients regularly. And so that they can keep it in stock. We have a few pharmacists that we are really good terms with. And you know, they can call us if they have a problem. And we always call them and you want to make sure that they your patients are able to pick up on the same day. Okay. Now, best practices for stabilization, maintenance, and discontinuation. A stabilization occurs in the first two to four weeks. You want to follow up with them regularly in the beginning. So for example, weekly if they're doing well, you increase the frequency of the visits to every two weeks and then monthly. We can also do telehealth visits, I believe the FDA. The federal government or I think the DEA someone has allowed it to continue so telehealth can continue but the in there you have to have an initial in person visit for you to continue via telehealth. And then you can adjust the buprenorphine dose. So for example, when a patient comes to you at one week, if it's not enough, they think they're still having opioid cravings, you can increase, you know, to I think the insurance usually covers up to 24 milligrams, most patients end up around 16 milligrams, but they can end up higher. Actually, there's a really good point. So I do have some patients who are on 32 milligrams, and that is literally, I can count them on my fingers. And for that you need prior authorizations, and most of them also have chronic pain. So I increased it beyond 24 to 32. Just so that I could manage their chronic pain, but for that you have to get prior art. So duration, you know, I tell my patients, you know what, the longer you stay, you know, the longer you'll you'll be fine and there has been data like you know, if patients get off medications, you know, their risk of overdose increases. So you you tell them but that doesn't prevent me from saying that, you know, if you want to come down on your doors, I'll be happy to do that. If you want to come off it completely. I will support in whatever way I can. But my recommendation is that you continue on as long as possible. and the rest I think we discussed. Now for complex cases, especially in the beginning, you might want to get

some, you know, input from addiction medicine specialist. But soon you will get the, you know, hang of it. And you may even be able to treat the complex patients. And by complex I mean like, for example, I have patients who have multiple substances, or have chronic pain plus or UD, that I can manage. So, during maintenance visits, what do I usually discuss, I usually tell them how you're doing, you know, how is your life going? Have you been able to get back and leading, you know, a normal life, which means going to work or improving your relationships? Are you feeling fulfilled, you know, how can I help you, you want to make sure that they're taking the buprenorphine. And if they want referral to mental health, you offer them it's not a requirement. But if they want the I'm happy to send them for mental health services. And then discontinuation. Usually it's long term, that's the recommendation. But if they want to do it, you taper it slowly. You offer psychosocial support, and then you can completely get off it. You know, I think I already discussed the polysubstance piece, you know, in which I feel comfortable in prescribing. So the New York State buprenorphine best practices, this was developed with OSRS. And I recommend that you guys should read it. It's it fills gaps and provide some clinical guidance, especially if you have questions. So again, initial assessment extensive is not necessary. So yes, I order labs but not necessary, I do a urine tox. I don't change my management based on these two things. And ideally, we should be able to prescribe the same day that we see a patient so let's say if a patient comes in, I can give them the instruction so they can start up nor Fein at home the same day, if it's possible. We talked about poly substance already, counseling is not required. But if they want it if the patient wants it, definitely refer them and continue treatment for as long as possible, you know, risk of return to illicit opioid use is very high when treatment is discontinued. But again, I, I have a discussion with a patient around this, and I support them and I tell them what my recommendation is and then we make a decision together. So all in all, buprenorphine treatment for OCD, it reduces mortality. It reduces illicit opioid use. It improves patient's general health and well being. And I'm so excited that the training and river requirement to prescribe has gone so if you were to go today to your back to your clinic or tomorrow, you can prescribe patients. Buprenorphine starting today or tomorrow, which wasn't the case a few months ago. And it can be initiated and should be initiated in Oh, God. Actually, one thing that I didn't tell you guys is the proportion of patients with OCD who ended up getting treatment with any medication for OCD, I believe is only around 11%. So any patient that we encounter who has OCD, whether it's inpatient, or in your primary care clinic, that's an opportunity to treat this patient with a life saving medication. And then it should be done both inpatient and outpatient.

43:30
Okay, so, questions?

43:33
Perfect, thank you so much for that comprehensive presentation. There are a few questions that I'll get us started with. First, do you have experience with stretching out sublocade injections for patients who are motivated to wean off buprenorphine? And then coupled with this question is a larger question around how you talk to patients who are unhappy about the prospect of abusing medications for opioid use disorder for long stretches of time. Yeah, okay.

44:02
So those are very, very good question. So I personally have not used sublocade, but one of my colleagues use sublocade because this patient wanted to come off it. So let's say if somebody is taking buprenorphine, sublingual, you can give them a sublocade injection, and that patient that I know of got the sublocade injection, and that was it. Because the sublocade injection, if you look at the graph, it slowly tapers off. So it very nicely helps patients come off it completely. So yes, it can be done. And it's a very, you know, interesting time. And then the second question was, yes. How do patients feel? I'm like, this is a life saving medicine. So for example, I have so many patients on hypertension medication, I don't take them off, they're on it for life. I don't take patients off diabetes medicine, some of them are on it for life. So especially, you know, knowing that being on being off, man Medication can put you at risk for overdose, I would I encourage my patients to stay on it, but I have a dialogue around it like, what are you afraid of? Like? What are your fears of being on this medicine? Is it causing you side effects? Many patients think of this is like, Oh, I'm just switching heroin for this. But this medicine allows you to sort of engage in at work and engage with your friends and family in a more productive way than an illicit substance, which is more up and down. And it saves lives. So sometimes I even share the data with them if they're interested.

45:41
Thank you. Next question. Do you give the patient the cows or cells to monitor when to start up?

45:50
So I think one is, this is an interesting, I'm just trying to remember what the differentiation is because one needs to look at the pupils, I would definitely not give them the head. So we have the one. So I believe that the South, which is basically subjective, so I will not ask the patient to look at the pupil size, because I don't think they'll be able to do that. So we have a list of those criteria. It's actually in their handout in the patient handout. And it's it's something really simple. So for example, I'm experiencing you know, body aches and pains and I am tearing or, you know, I am getting diarrhea or you know, so it has symptoms that the patient would be able to understand.

46:34
Thank you,

46:38
is getting to nuke 24 milligrams on the first day of induction common.

46:45
It's not common, but I've had patients who have gone on to 20 for the first day. It's rare, but mostly it's like, oh, I went up to X amount, but that wasn't enough. So on my day, the second

day that I'm calling, I'm actually telling them to go up on it. But yes, I've had some patients who have gone up to 20 for the first day.

47:05
The next question we have is how has xylazine contamination affected timeline for buprenorphine induction, if at all.

47:13
So it is really interesting. So xylazine, if you should all remember is not an opioid and Naloxone actually does not reverse the Aladeen overdose. And that's interesting because even though we suspect xylazine overdose, we still recommend giving patients naloxone. And why is that because many times patients are using xylazine in conjunction with another substance which is usually an opioid, so they might use xylazine and fentanyl xylazine are heroin. So yes, the Naloxone would reverse that piece of it. Now, how has it complicated because patients who are taking xylazine, their symptoms might not for example, withdrawal symptoms might not improve with buprenorphine, I'm assuming because again, buprenorphine is an opioid, and xylazine is not an opioid, so they might describe symptoms that are not improving with buprenorphine. And so that's something to look out for. But I would treat them the same way, I would still make sure that they're on buprenorphine, it might make that take them longer to feel better.

48:24
We have another two part question related to discontinuation. Do you ever use view trans patches for discontinuation taper? Is supplicate the best option for patients who want to get off Suboxone?

48:37
Again, a very good question. So beauty brands, just remember, yes, you can definitely use it, but it's in a very, very small dose. So for example, if you're tapering a patient, and they taper to, let's say, two milligrams of the film, then yes, you can get up your trans batch to sort of like technically discontinue, you cannot go from like, let's say 16 milligrams of buprenorphine film to the BJU trans patch because the change is so much I personally have not done that. Most of my patients have continued being on buprenorphine. I've had patients who went off buprenorphine, relapsed and then went back on buprenorphine, but I haven't used it. I haven't used neutrons but you can technically use. So again, come down to two milligrams, and then you can switch.

49:28
Thank you. We are all caught up on questions for now. Just another reminder to please put any questions you have in the chat. One just came in. Can you talk about your experience using buprenorphine or buprenorphine Naloxone for pain management without AUD?

49:44
I Taenia.

49:47
Yes, absolutely. So I do this a lot. It's I have patients who are who have sickle cell disease. I have patients who have been on high high doses of Oh Boyd's. And you know, when I see them in the clinic, their pain is not well controlled with, you know, their opioid agonist that's when I think of switching them to buprenorphine. And again, I would say it might not be the medication for all patients, but for some patients, it has really changed their lives like the pain is better control. Remember, buprenorphine is a partial agonist, so less likelihood of opioid induced hyperalgesia. So in patients who already have opioid induced hyperalgesia, buprenorphine can help counteract it and make their symptoms better. i The only advice I would give you is patient has to be motivated and you have to stick through at least I would say a month when you do the switch, because it takes a while for patients to adjust to buprenorphine, and really feel an improvement in their symptoms.

50:54
Or any other key pearls or ideas you'd like to share with the audience, please do and if not, we can end a few minutes early today.

51:02
I think the only thing I would say is this encourage everyone to prescribe buprenorphine it's very rewarding the first time it's the most hard as with anything else in life, but I strongly encourage you to try it at least.

[End Transcript]