Buprenorphine Induction Strategies

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Rapid Access Addiction Medicine Clinic

The RAAM Clinic

Suboxone & Naltrexone

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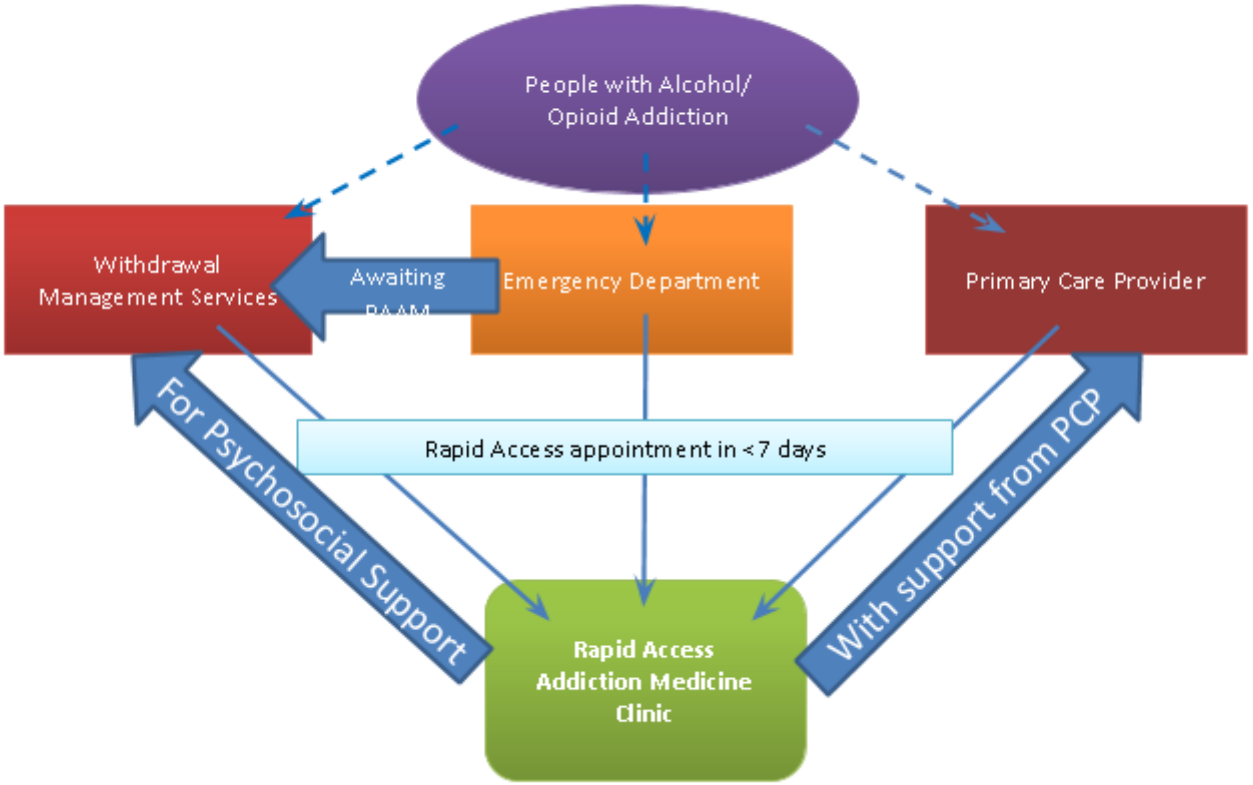
META:PHI Care Pathway



Induction Scenarios

1. Standard Induction
2. Microdose Induction
3. Methadone Conversions
4. Fentanyl Induction
5. Home Inductions

Presents in Withdrawal

- 35 year old male using HydroMorphone IDU several times a day
- Last used 12 hours ago
- COWS score 18 (moderate withdrawal)

Standard Induction

- 35 year old male using HydroMorphone IDU several times a day
- Last used 12 hours ago
- COWS score 18 (moderate withdrawal)

- Buprenorphine 2 mg to start
- Then 2 mg q1h until comfortable to 12 mg
- Follow up on day 2 and titrate up to 16 mg

Presents in No Withdrawal

- 35 year old male using HydroMorphone IDU several times a day
- Just used before clinic
- COWS score 2 (no withdrawal)

Bernese Method (Buprenorphine Microdoses).pdf - Adobe Reader

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CASE SERIES

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method

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Substance Abuse and Rehabilitation
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Robert Hämmig[1]
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Background: Buprenorphine is a partial μ-opioid receptor agonist used for maintenance treatment of opioid dependence. Because of the partial agonism and high receptor affinity, it may precipitate withdrawal symptoms during induction in persons on full μ-opioid receptor agonists. Therefore, current guidelines and drug labels recommend leaving a sufficient time period since the last full agonist use, waiting for clear and objective withdrawal symptoms, and reducing pre-existing full

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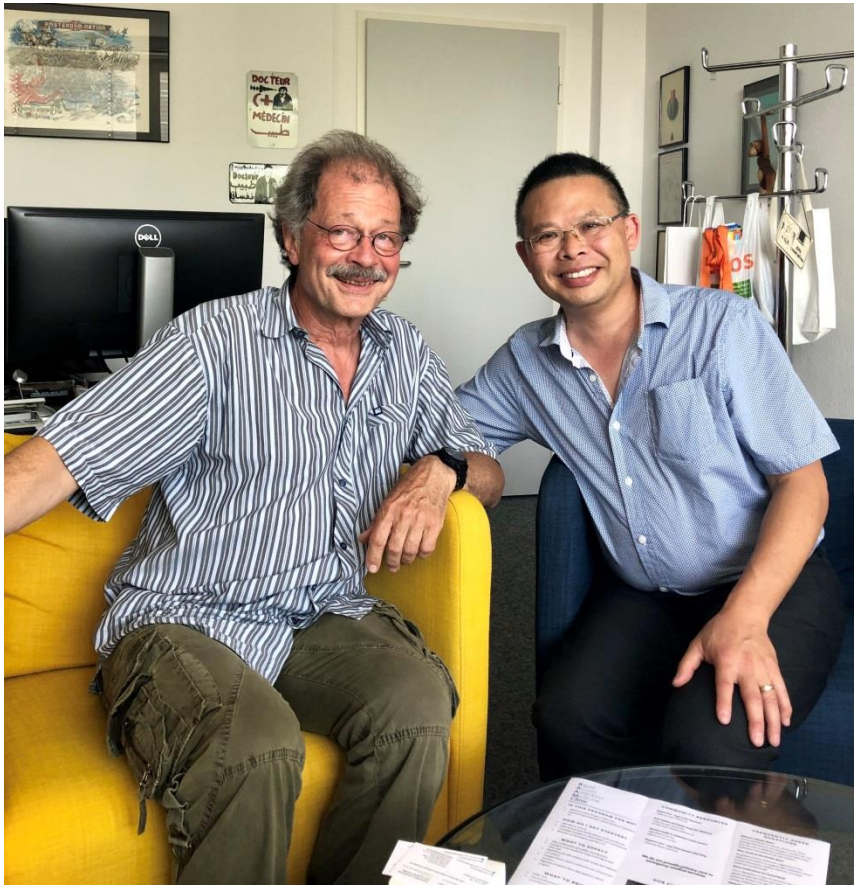
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Buprenorphine/Naloxone Microdosing: The Bernese Method

A Brief Primer for Clinicians

Dosing schedules adapted from the PHS Health Care Columbia Street Community Clinic and St. Paul's /VGH/RAAC clinicians

The theoretical background of this method is based on the following hypothesis:

- Repetitive administration of very small buprenorphine doses with sufficient dosing intervals should not precipitate opioid withdrawal
- Because of the long receptor binding time, buprenorphine will accumulate at the opioid receptor
- Over time, an increasing amount of a full μ-agonist will be replaced by buprenorphine at the opioid receptor

- References:
- Hämmig, R., Kemter, A., Strasser, J., von Bardeleben, U., Gugger, B., Walter, M., Dürsteler, K.M. and
- Vogel, M., 2016. Use of microdoses for induction of buprenorphine treatment with overlapping full opioid
- agonist use: the Bernese method. *Substance abuse and rehabilitation*, *7*, p.99. [see attached]
- *Dosing schedules adapted from the PHS Health Care Columbia Street Community Clinic and St. Paul's*
- */VGH/RAAC clinicians*

Canadian Mental Health Association
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Thames Valley Family Health Team

Buprenorphine/Naloxone Microdosing: The Bernese Method

A Brief Summary for Primary Care Clinicians

Disclaimer:

Microdosing principles are currently not included in any clinical practice guidelines for the management of Opioid Use Disorder, rather it is an off-label practice that has been included in clinical practice amongst addiction specialists. It is therefore important to obtain informed consent prior to initiating it with a patient. Microdosing is frequently used at the London Rapid Access and Addictions Medicine (RAAM) Clinic with good results.

What is Microdosing?

The Bernese Method uses the principle of Microdosing to initiate a patient onto buprenorphine/naloxone (bup/nlx) maintenance therapy. The theoretical background of this method is based on the following hypotheses:

1) Repetitive administration of very small buprenorphine doses with sufficient dosing intervals (e.g. 12 hours) should not precipitate opioid withdrawal
2) Because of the long receptor binding time, buprenorphine will accumulate at the opioid receptor
3) Over time, an increasing amount of a full μ-agonist will be replaced by buprenorphine at the opioid receptor

Therefore, overlapping induction of buprenorphine with ongoing use of opioids, from the unregulated drug market or prescription, including maintenance doses of a full μ-agonist (e.g. methadone or sustained release oral morphine), should be possible without precipitating severe opioid withdrawal. Mild withdrawal symptoms may be experienced during the induction.

Although dosing schedules vary, principles of the Microdsoing method include:

1) Prescriber starts with a low dose of buprenorphine, overlapping with other opioid use
2) Small daily buprenorphine dose increases
3) Abrupt cessation of opioid use at sufficient dose of buprenorphine

Why use it, and who is a good candidate?

Microdosing may have considerable advantages despite taking longer for the overall induction than the traditional protocol. It may be useful for most patients. In more detail:

- It may be helpful for patients fearing withdrawal or experiencing severe symptoms during conventional induction, or who have failed conventional induction due to inability to tolerate withdrawal symptoms

May 2019

Microdose Induction

- 35 year old male using HydroMorphone IDU several times a day
- Just used before clinic
- COWS score 2 (no withdrawal)

- Day 1 Bup 0.5 mg bid
- Day 2 Bup 1 mg bid
- Day 3 Bup 2 mg bid
- Day 4 Bup 3 mg bid
- Day 5 Bup 4 mg bid
- Day 6 Bup 5 mg bid
- Day 7 Bup 6 mg bid

Microdose Induction

- 35 year old male using HydroMorphone IDU several times a day
- Just used before clinic
- COWS score 2 (no withdrawal)

- After Bup 4 mg can start decreasing the other opiate
- After Bup 12 mg can d/c all opiates
- After Bup 12 mg titrate up to comfort

Methadone Conversion

Methadone Conversion

- 35 year old male using Methadone 70 mg
- Asks to switch to Buprenorphine
- COWS score 0 (no withdrawal)

Methadone Conversion

- 35 year old male using Methadone 70 mg
- Asks to switch to Buprenorphine
- COWS score 0 (no withdrawal)

- After Bup 4 mg can start decreasing Methadone by 10 mg/day
- After Bup 12 mg can d/c all remaining Methadone
- After Bup 12 mg titrate up to comfort

Methadone Conversion

	Buprenorphine	Methadone
Day 1	0.5 mg bid	70 mg
Day 2	1 mg bid	70 mg
Day 3	2 mg bid	70 mg
Day 4	3 mg bid	60 mg (start decreasing)
Day 5	4 mg bid	50 mg
Day 6	5 mg bid	40 mg
Day 7	6 mg bid	30 mg
Day 8	12 mg od + titrate up	Stop Methadone
Day 9	16 mg od	Follow up in one week

Methadone to Sublocade

- Stable dose of Buprenorphine 8-24 mg/day for 7 days
- Wait until totally comfortable and all EDDP Metabolite is gone
- Loading doses of 300 mg x 2 (28 days apart)
- Maintenance dose 100 mg q28 days

Methadone to Probuphine

	Buprenorphine	Methadone (mg)
08-Jun-20	0.5 mg od	26
09-Jun-20	0.5 mg bid	26
10-Jun-20	1 mg bid	26
11-Jun-20	2 mg bid	26
12-Jun-20	3 mg bid	20
13-Jun-20	4 mg bid	10
14-Jun-20	8 mg od	0

Fentanyl

- No withdrawal – proceed with Microdose Induction

- Lots of withdrawal – start at BUP 2 mg and increase by 2 mg q1h (BUT sometimes had **precipitated withdrawal with a 2nd BUP 2 mg dose**. Microdose up from BUP 2 mg)

Fentanyl

- No withdrawal – proceed with microdosing induction
- Advise not to use Street Fentanyl (many substitute with other opiates)
- Reassess at BUP 4 mg and decide:
  - Continue BUP microdosing to 8 mg
  - Proceed with a Standard Induction

Hybrid Induction

- 35 year old male using Street Fentanyl several times a day
- COWS score 8 (mild withdrawal)

- Start with Bup 2 mg
- Try 2nd dose Bup 2 mg if some improvement
- If there is any precipitated withdrawal, finish with Microdose from that point
- Suggest stopping Fentanyl use, but ok to use other less potent short acting opiates

Home Inductions

- Patient using opiates
- Give the patient Buprenorphine 2 mg tabs x 6
- Teach how to use the COWS (SOWS)
- Start taking Bup 2 mg when in lots of withdrawal and then q1h prn
- Re-assess in RAAM Clinic the next day

Macro-Induction

- Typically a Fentanyl user presenting in lots of withdrawal
- Buprenorphine induction to Sublocade injection in 3 hrs

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