

Advanced Buprenorphine Initiation Strategies

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Disclosure Information

- ◆ Presenter 1: Andrew Herring, MD
 - ◆ Presenter 1 Commercial Interests: No Disclosures
- ◆ Presenter 2: Laura Kehoe, MD, MPH, FASAM
 - ◆ Presenter 2 Commercial Interests: Path CCM, Stock Options; Indivior, Advisory Board
- ◆ Presenter 3: Melissa Weimer, DO, MCR, DFASAM
 - ◆ Presenter 3 Commercial Interests: Path CCM, Stock Options; CVS Health, Advisor

Learning Objectives

- ◆ Describe the unique pharmacology of fentanyl and its analogues
- ◆ Describe the current evidence regarding buprenorphine initiation in people using high potency synthetic opioids like fentanyl.
- ◆ Discuss the rationale and potential risks and benefits of novel buprenorphine initiation strategies.

**This workshop is for an ADVANCED audience*

Workshop Outline

- ◆ Review of Background
- ◆ Case presentation 1
 - ◆ Discussion in small and large groups
- ◆ Case presentation 2
 - ◆ Discussion in small and large groups
- ◆ Case presentation 3
 - ◆ Discussion in small and large groups
- ◆ Wrap Up

Buprenorphine Clinical Considerations Document

American Society of Addiction Medicine

Clinical Considerations Document

Treatment of Opioid Use Disorder with Buprenorphine:

Clinical Considerations for Treatment of Individuals with OUD

using High Potency Synthetic Opioids



Background

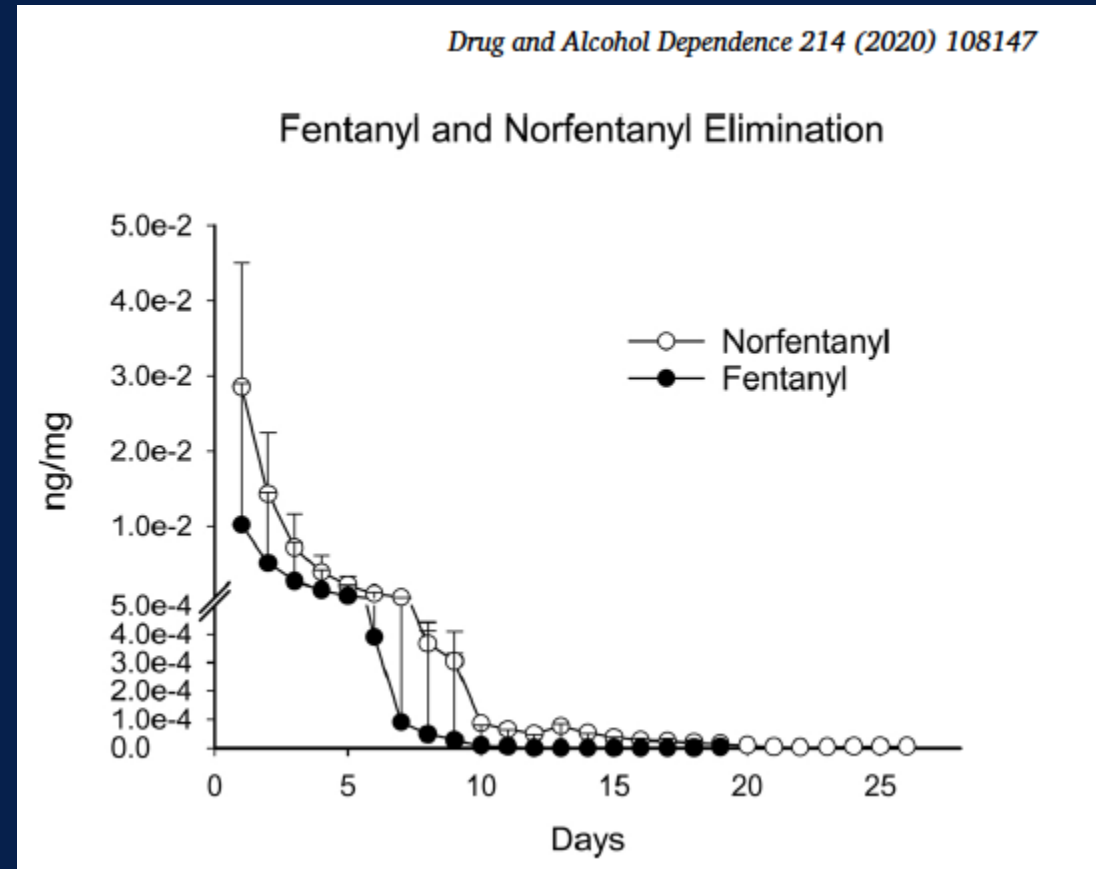
- ◆ In the United States Buprenorphine initiation guidance for outpatient treatment of opioid use disorder was codified in SAMHSA TIP #40
- ◆ Since then the scope of OUD has increased dramatically with buprenorphine induction occurring on a scale never imagined in the 2000's
- ◆ Outside of carefully selected office or treatment center populations, buprenorphine initiation now occurs with street medicine teams, on inpatient units, and Emergency Departments
- ◆ Given this explosion in growth, there is now renewed interest in variations on the traditional buprenorphine initiation plan

2023 vs 2000

- ◆ Fentanyl and its analogues now ubiquitous
- ◆ Stimulant co-use increasing common and as high as 90% in some populations
- ◆ Additional synthetics such as xylazine are common in some regions.
- ◆ Diverse population with OUD—rural, urban, race/ethnicity
- ◆ Homeless and other social determinants substantially more common

Characteristics of “Fentanyls”

- ◆ **Fast onset and high potency**
 - ◆ Fentanyl rapidly crosses the blood-brain barrier
 - ◆ 50-100 x more potent than morphine
- ◆ **Short action**
 - ◆ Fentanyl levels rapidly decline due to redistribution to body fat
- ◆ **Sequestration leads to fentanyl accumulation**
 - ◆ Chronic use causes accumulation in adipose
 - ◆ Unknown changes to withdrawal course



Huhn, A.S., Hobelmann, J.G., Oyler, G.A. and Strain, E.C., 2020. Protracted renal clearance of fentanyl in persons with opioid use disorder. *Drug and alcohol dependence*, 214, p.108147.

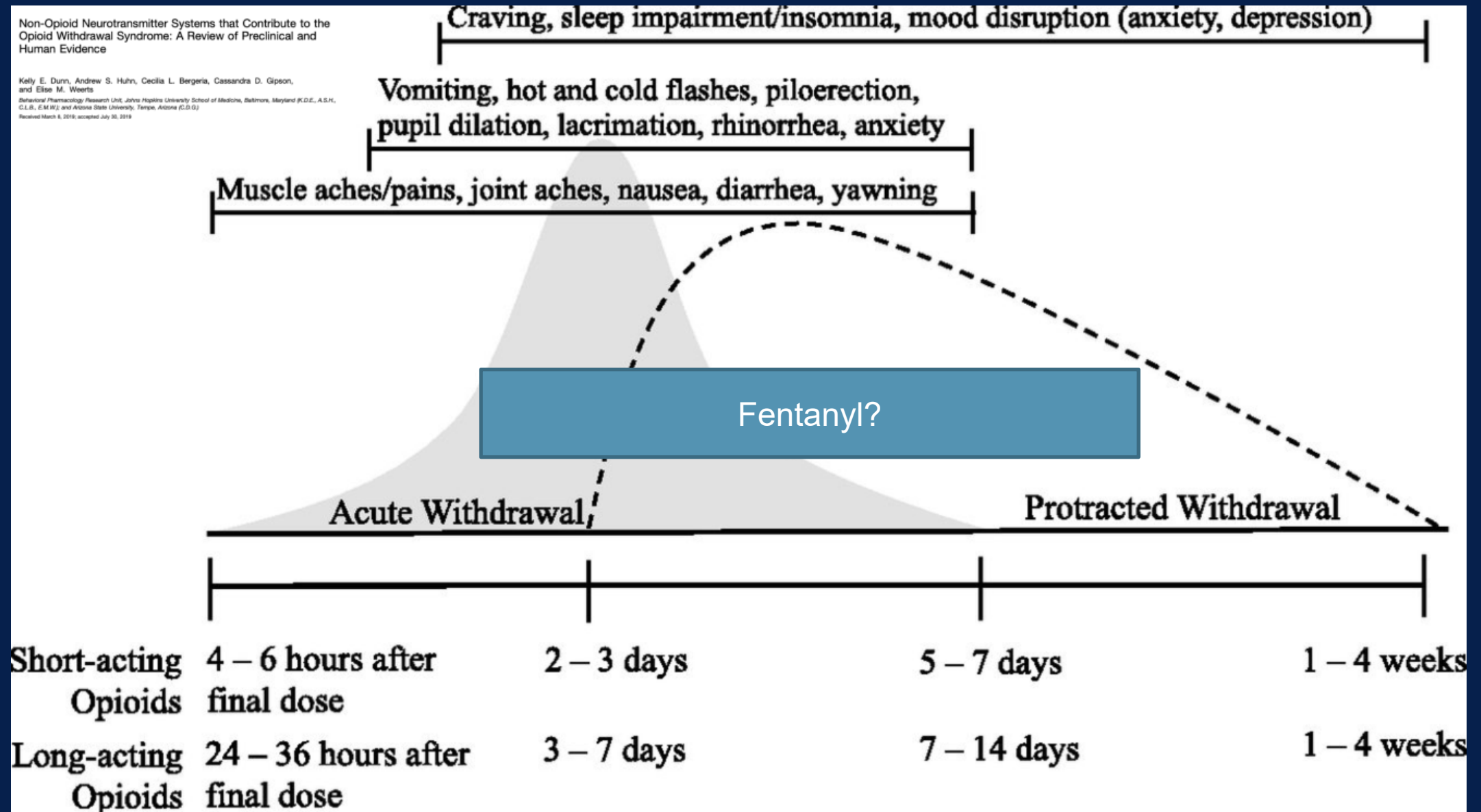
Variable withdrawal course

Non-Opioid Neurotransmitter Systems that Contribute to the Opioid Withdrawal Syndrome: A Review of Preclinical and Human Evidence

Kelly E. Dunn, Andrew S. Huhn, Cecilia L. Bergeria, Cassandra D. Gipson, and Elise M. Weerts

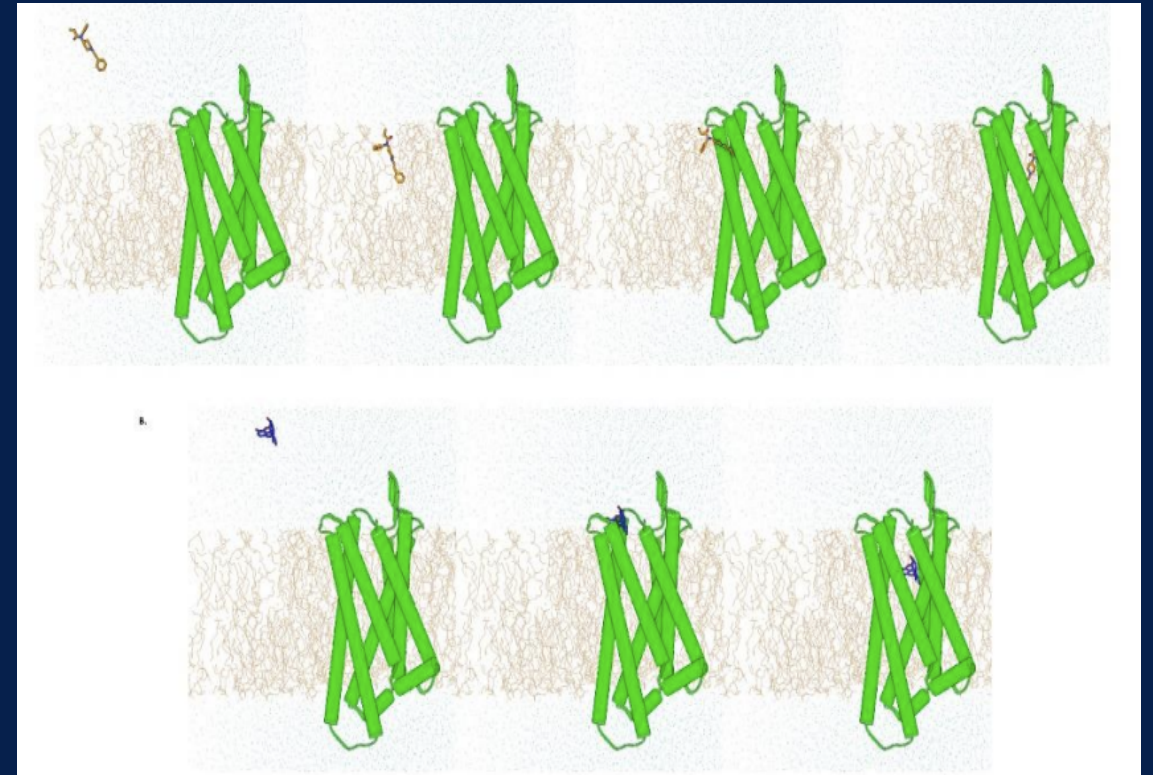
Behavioral Pharmacology Research Unit, Johns Hopkins University School of Medicine, Baltimore, Maryland (K.E.D., A.S.H., C.L.B., E.M.W.) and Arizona State University, Tempe, Arizona (C.D.G.)

Received March 8, 2016; accepted July 30, 2016



Anomalous pharmacologic properties

- High in vitro and in vivo potency
 - High lipid solubility increases potency
 - Possibly higher efficacy
 - Affinity is similar to other opioids
- Large volume of distribution and high concentration at the mu receptor
- Low cross tolerance
- Induction of muscle rigidity
- Reduced sensitivity to naloxone



Fentanyl lipid binding compared to morphine

Kelly, et al. The anomalous pharmacology of fentanyl. BJP, 2021.

New Phenotype of Illicit Opioid Use

- ◆ Very high potency

PLUS

- ◆ Variable/Extended metabolism (unpredictable withdrawal course)

PLUS

- ◆ Stimulant co-use



<https://pubs.asahq.org/anesthesiology/article/136/4/618/118216/Advances-in-Reversal-Strategies-of-Opioid-induced>

Caulfield, Mackenzie Duncan Gregory, et al. "Transitioning a patient from injectable opioid agonist therapy to sublingual buprenorphine/naloxone for the treatment of opioid use disorder using a microdosing approach." *BMJ Case Reports* CP 13.3 (2020): e233715.

Concerns and Questions

- ◆ **“I can’t wait long enough”** Patients are unable to tolerate abstinence long enough to allow sufficient withdrawal to develop permit successful buprenorphine initiation with standard dosing.
- ◆ **“It doesn’t work for me”** Patient withdrawal symptoms persist despite buprenorphine initiation.
- ◆ **“It makes me sick”** patients reports precipitated withdrawal

Emerging Strategies

◆ Low Dose Buprenorphine with Opioid Continuation (LDB-OC)

Traditional buprenorphine initiation expects abstinence from full opioid agonists

Work in pain medicine and addiction medicine suggest that buprenorphine can be escalated during full opioid agonist continuation

Emerging Strategies

◆ High-dose buprenorphine

Traditional buprenorphine involves gradual dose escalation over 2-3 days

Observed Buprenorphine dose-response suggests rapid escalation to a 24-32 mg SL on day 1 of treatment is well tolerated

Emerging Strategies

◆ Precipitated Withdrawal

Buprenorphine demonstrates both additive opioid agonist effects and competitive antagonism

When antagonism effects predominate “precipitated withdrawal” manifests clinically

Multifactorial based on interaction between patient factors, setting, opioid, and buprenorphine

Defining precipitated withdrawal

- ◆ What is it?
 - ◆ Not increased discomfort or anxiety
 - ◆ Not a small increase in COWS (<5 points)
 - ◆ Rapid increase in objective signs of withdrawal
 - ◆ *Yawning, rhinorrhea, diaphoresis, piloerection, lacrimation, vomiting*
- ◆ Risk Factors
 - ◆ Opioid tolerance and physical dependence, genetics, comorbidities, prior poor buprenorphine experience, other substances used (particularly alcohol, sedatives, psychostimulants, and xylazine)

Differential Dx

- ◆ **Undertreated Withdrawal**
 - ◆ Bup agonism insufficient to match tolerance/dependence
- ◆ **Other substance intoxication or withdrawal**
 - ◆ Alcohol, benzodiazepines, xylazine
- ◆ **Other medical condition**
 - ◆ Sepsis, DKA, thyrotoxicosis etc...

If worse or no improvement consider:
Undertreated withdrawal: occurs with lower starting doses and heavy tolerance; improves with more bup (addl 8-16 mg)

Other substance intoxication or withdrawal: stimulant intoxication, alcohol/benzo/xylazine/GHB withdrawal. Continue bup, manage additional syndromes.

Bup side-effect: nausea, headache, dysphoria. Continue bup, treat side-effects with supportive medications.

Other medical/psychiatric illness: anxiety, sepsis, influenza, DKA, thyrotoxicosis, etc. Continue bup, manage underlying condition.

If sudden/significant worsening, consider precipitated withdrawal:
Sudden, significant worsening of withdrawal after bup or full antagonist (e.g. naloxone)--see box below

Retrospective description of prospective High-dose protocol implementation at 16 EDs in California

Precipitated withdrawal was rare $\leq 2\%$



Research Letter | Substance Use and Addiction

High-Dose Buprenorphine Initiation in the Emergency Department Among Patients Using Fentanyl and Other Opioids

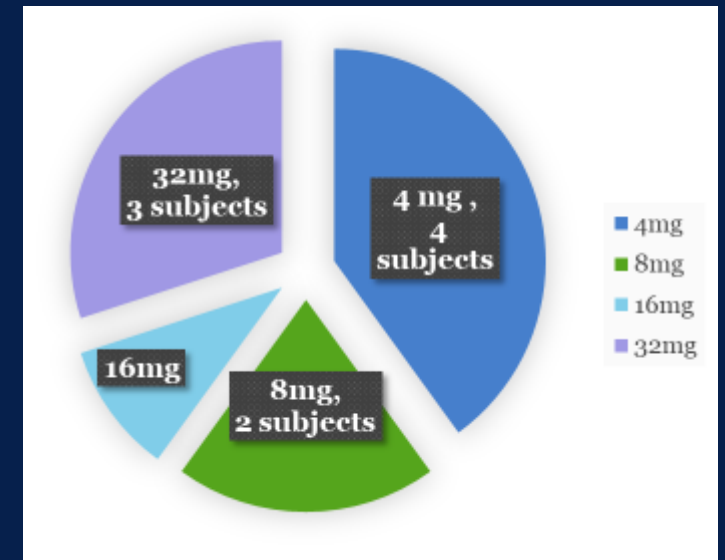
Hannah Snyder, MD; Brendon Chau, MPH; Mariah M. Kalmin, PhD; Melissa Speener, MPH; Arianna Campbell, PA; Aimee Moulin, MD, MAS; Andrew A. Herring, MD

Table 2. Treatment Characteristics of CA Bridge Study Participants

Characteristic	Participants, No. (%)		
	Fentanyl use		Total (N = 896)
	Yes (n = 87)	No (n = 809)	
Response to administered buprenorphine ^c			
Improved condition	32 (72.7)	325 (72.5)	357 (72.6)
Induced sedation	0	1 (0.2)	1 (0.2)
Adverse events ^e	1 (2.3)	3 (0.7)	4 (0.8)
Precipitated withdrawal	2 (4.5)	6 (1.3)	8 (1.6)
Follow-up treatment engagement ^f			
7-14 d	44 (50.6)	369 (45.6)	413 (46.1)
30 d	36 (41.4)	301 (37.2)	337 (37.6)

Level Setting- Tremendous Variability

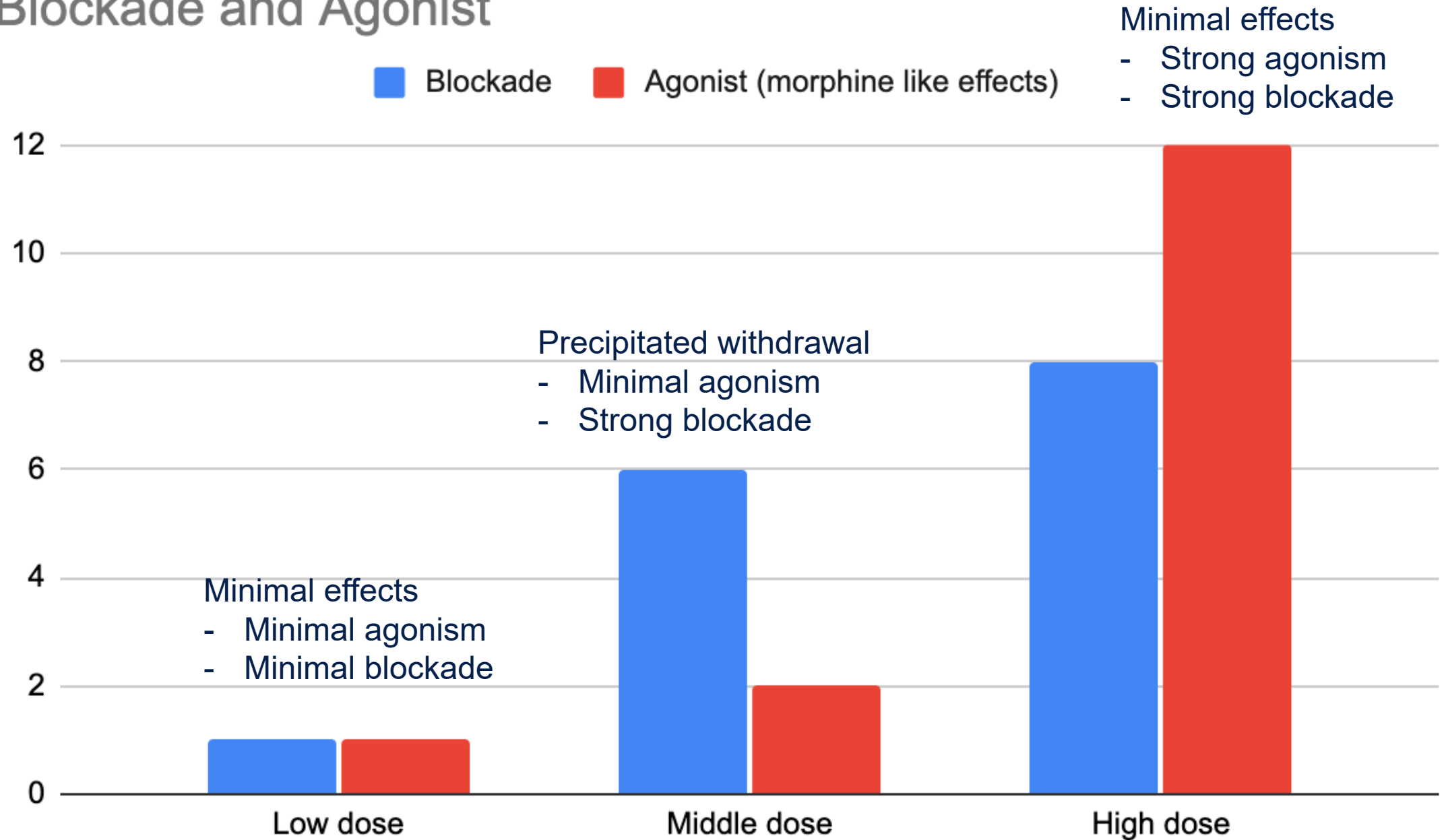
- ◆ Rosado, Walsh, Strain, et al.
 - ◆ Defined POW as peak visual analog scale of “Bad Effects”, pupil diameter dilation and Withdrawal Signs Score
 - ◆ POW varied in individuals given buprenorphine 24 hours after methadone 100mg
 - ◆ 30% had no bad effects with 32 mg SL Bup
- ◆ Herring, et al. ED observed initiation
 - ◆ Of 579 cases, 5 cases of POW



Rosado, et al. Drug and alcohol dependence, 2007

Herring, et al. JAMA Open, 2021

Blockade and Agonist



LDB-OC

Continue agonist & ramp up buprenorphine with low doses

- ◆ Administering small and gradually increasing doses of buprenorphine while continuing/overlapping a full agonist opioid over 2-7 days
- ◆ Initial doses: typically <2mg buprenorphine
- ◆ Many cases & case series (n ~ 250)
- ◆ Various buprenorphine formulations used
 - ◆ Intravenous
 - ◆ Buccal film
 - ◆ Transdermal patches
 - ◆ SL film or tabs



1 pager

Guiding Principles for Low Dose Buprenorphine Initiation



Choose the appropriate clinical setting



Initiate at a low buprenorphine dose



Titrate the buprenorphine gradually



Continue the full opioid agonist, even if non-medical



Communicate clearly and frequently monitor



Pause or delay buprenorphine if withdrawal occurs



Prioritize Care Coordination

A few different Opioid Continuation protocols

Day of transition	Becker, et al. <u>Bup/nlx</u> dose	Terasaki, et al. <u>Bup/nlx</u> dose	Weimer, et al. <u>Buccal Bup</u> + <u>Bup/nlx</u> Hospital Based
1	<u>Bup/nlx</u> 0.5mg BID (+ OA)	<u>Bup/nlx</u> 0.5mg daily (+ OA)	<u>Buccal Bup</u> 225mcg (+OA)
2	<u>Bup/nlx</u> 1mg BID (+ OA)	<u>Bup/nlx</u> 0.5mg BID (+ OA)	<u>Buccal Bup</u> 225mcg BID (+ OA)
3	<u>Bup/nlx</u> 1mg TID (+ OA)	<u>Bup/nlx</u> 1mg BID (+ OA)	<u>Buccal Bup</u> 450mcg BID (+ OA)
4	<u>Bup/nlx</u> 2mg TID (+ OA)	<u>Bup/nlx</u> 2mg BID (+ OA)	<u>Bup/nlx</u> 2mg BID (+ OA)
5	<u>Bup/nlx</u> 4mg TID (+ OA)	<u>Bup/nlx</u> 4mg BID (+ OA)	<u>Bup/nlx</u> 4mg BID (+ OA)
6	Full transition complete	<u>Bup/nlx</u> 4mg TID (+ OA)	<u>Bup/nlx</u> 4mg TID (+ OA)
7		Full transition complete	Full transition complete

Teraski, et al. Pharmacotherapy, 2019

Becker, et al., Annals of IM, 2020

Weimer, et al. JAM 2021

High Dose Buprenorphine Initiation

- ◆ Does not remove expectation of opioid discontinuation and abstinence
- ◆ Accelerates dosing once withdrawal has begun with initial target of ≥ 24 mg SL in 1 or two doses.
- ◆ Many cases & case series (n ~595)
- ◆ Rationale
 - ◆ Minimize period of undertreatment / rapidly maximize agonism
 - ◆ Maximize protection against overdose

A few different HDB protocols

- ◆ Wait 36-48 hours from last use → give >16mg at one time
- ◆ Wait 6-12 hours from last use → give >24mg at one time
- ◆ Overdose -> naloxone -> give >16mg at one time
- ◆ Give more buprenorphine if/when COWS >12

Naloxone to High Dose Buprenorphine Initiation

- ◆ EMS Two large cases series from California and New Jersey
- ◆ Case reports from Emergency Department
- ◆ Reports of at home initiation with patient self-administration of Naloxone then, 24mg of Buprenorphine

TABLE 2 - Chronology of Transition From Fentanyl to Buprenorphine-naloxone

Event	Time Elapsed, min	Time Between Events, min	COWS*
Last use of fentanyl	120 min prior		0
Premedication with clonidine 0.2 mg and gabapentin 600 mg	0	120	0
4 mg (1 spray) intranasal naloxone	36	36	NS†
GI upset ("stomach not feeling right")	38	2	NS
COWS measured	42	4	9
Vomiting (2 episodes of vomitus, 3 episodes of dry heaving)	45	3	NS
24/6 mg sublingual buprenorphine-naloxone at once	50	5	28
Buprenorphine-naloxone fully dissolved. Subjective withdrawal symptoms 0-10; he states that he is at a 4. Feeling tired.	60	10	NS
Discontinued visit to sleep	65	5	NS

*Clinical Opioid Withdrawal Scale (COWS), excluding heart rate.

†COWS not scored.

Randall, A Hull I; Martin S. Enhancing Patient Choice: Using Self-administered Intranasal Naloxone for Novel Rapid Buprenorphine Initiation. Journal of Addiction Medicine , September 23, 2022.



A Plea From People Who Use Drugs to Clinicians: New Ways to Initiate Buprenorphine are Urgently Needed in the Fentanyl Era

Kimberly L. Sue, MD, PhD, Shawn Cohen, MD, Jess Tilley, and Avi Yocheved

J Addict Med. 2022 Jul-Aug 01;16(4):389-391.

Case 1

- ◆ 27 yo female with 10yr hx severe OUD, uses fentanyl IV, hx of necrotizing fasciitis, numerous OD, GAD.
- ◆ Goals: abstinence and transition to ER Buprenorphine
- ◆ “I’m desperate. Please help me.”
- ◆ She is terrified of POW, having experienced it numerous times
- ◆ Adamantly opposed to methadone
- ◆ Asks to try LDB-OC initiation after a friend successfully transitioned onto bupe
- ◆ She works part time and is living with her parents

Poll

- ◆ How long after her last fentanyl use can she start low dose buprenorphine, 0.5 mg?
- ◆ A) immediately – no need to wait
- ◆ B) once COWS 8-12
- ◆ C) once COWS 13-15
- ◆ D) 24 hours after last fentanyl use

Case 1 continued

- ◆ Day 1:
 - ◆ You explain LDB-OC initiation process, steps, document shared decision making
 - ◆ You review and provide her with patient handout, and send Rx buprenorphine with instructions
 - ◆ You administer 0.5 mg buprenorphine/naloxone in clinic which she tolerates well
 - ◆ You arrange daily phone check in
 - ◆ You reinforce harm reduction strategies and provide safer equipment

Case 1 continued

◆ Day 2:

- ◆ she was fine the first night, but experienced POW sx after her dose this am
- ◆ she was confused between the 2 and 8 mg films prescribed and inadvertently took a $\frac{1}{4}$ of the 8 mg film (2 mg)
- ◆ she misunderstood the directions about what to do with fentanyl and decreased her dose

Question: Thoughts on next steps?

Outpatient LDB-OC pearls for practice

Shared decision making with patient, clear information

Ensure ongoing access to full agonist opioid and continue as long as needed

- Do not taper down, or withdrawal will ensue, irrespective of buprenorphine
- This includes any full agonist opioid
- If they do not have ongoing opioid, do not employ LDP

Provide a bubble pack if possible

*Clear and frequent communication with patient

- Provide them with handout for reference, daily call
- Reminder: do not taper down the full agonist
- Help with cutting buprenorphine strips/bubble packs if possible
- Problem solve with them
- Provide comfort meds prn
- Harm reduction
- Cheerlead!

*Pause or slow if withdrawal symptoms or challenges

Case 1 continued

- ◆ Day 3-5:
 - ◆ Restart process, pre-medicate with lorazepam
 - ◆ Tolerates well, experiences a little flushing, restlessness day 5, anxious about advancing
 - ◆ You slow process and repeat current dose for a couple days, encourage comfort meds
- ◆ Day 7-10:
 - ◆ Process slowed, continue 8 mg daily x 2 days, increase to 12 mg day 9.
 - ◆ Stops fentanyl and advances bupe to 16 mg by day 10
 - ◆ Day 10 returns to clinic, and receives Buprenorphine ER and tolerates well without any withdrawal
 - ◆ Supplemental buprenorphine films given
 - ◆ Tolerating well, continues with monthly Buprenorphine ER SQ, engaging, with markedly decreased fentanyl use

Wrap Up

- ◆ Terminology and language are important
- ◆ Low dose buprenorphine initiation leading the way given current drug supply, limited ability to traditionally induce
- ◆ Shared decision making with patients is critical
- ◆ Can be utilized with any full agonist including illicit opioids, but prescribed, safe supply ideal
- ◆ LDB-OC initiation should be used as a guide and adjusted prn
- ◆ Anticipatory anxiety about POW is real: liberalize comfort meds
- ◆ Harm reduction education and support key
- ◆ Don't forget methadone as a treatment option

Case 2

- ◆ A couple using fentanyl (2gm per day smoked) for the last 9 months presents in withdrawal to the urgent care asking “to get off this stuff”
- ◆ They report their withdrawal as “terrible” and they report no use in 24 hrs
- ◆ On inspection, pupils are small, forehead is dry, HR is 70s, both are sitting still
- ◆ After MI and engagement further history is revealed

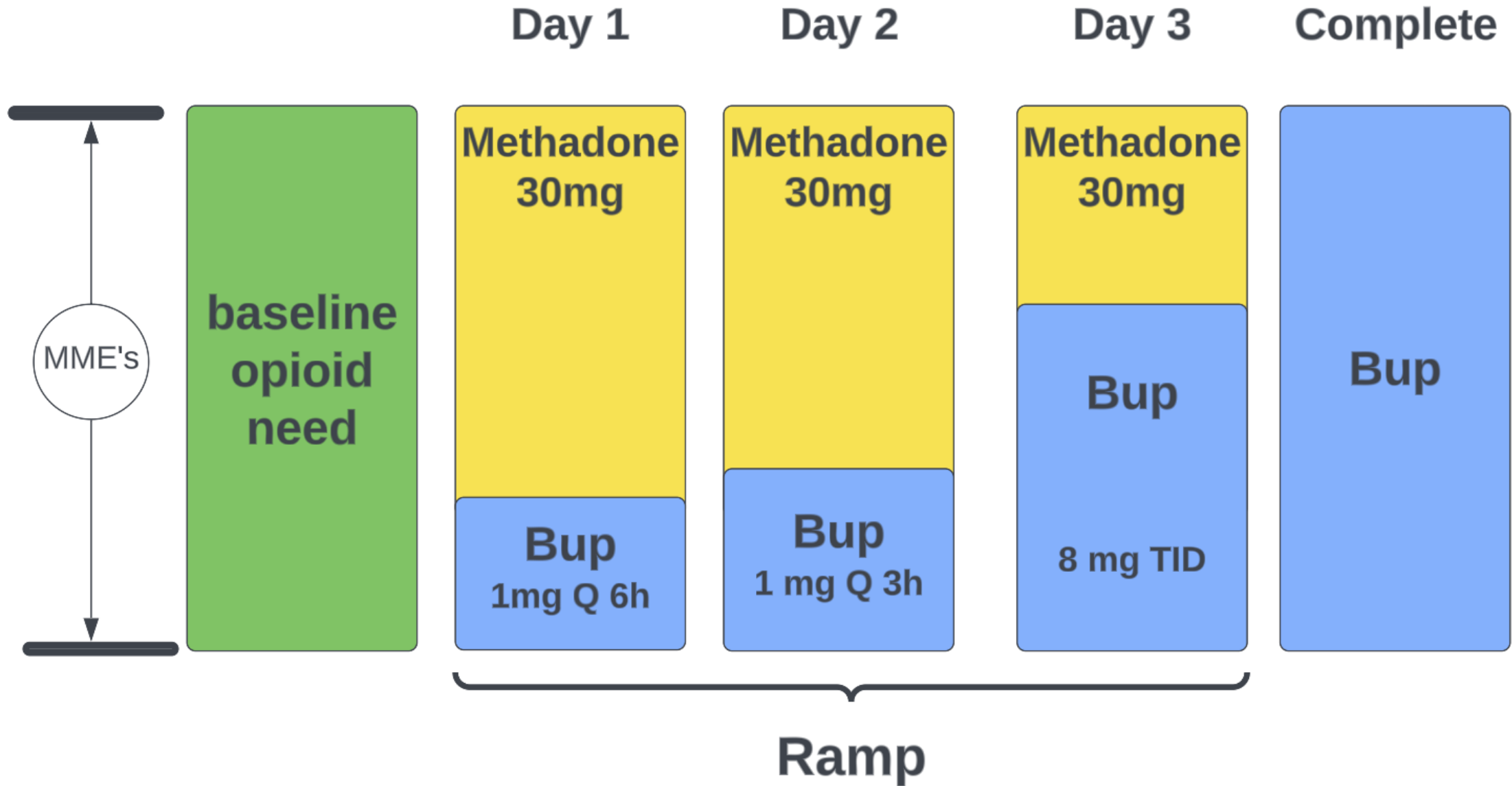
Case 2

- ◆ Overnight self administered “a few” hydrocodone 10mg tablets
- ◆ Woman has chronic back pain and anxiety

Shared decision making

- ◆ Option 1 – LDB-OC
- ◆ Option 2 – Supported abstinence + lots of motivational interviewing and then High-dose

Option 1 – LDB-OC using DEA exemption



The “kick pack” is back!

1. Tailor to the patient
2. Motivate
3. Drive placebo effect and inspire determination

Supportive medication (non-benzo, non-barbiturate)

Drug	Class/action	Target
Ibuprofen 400mg PO Q6hrs	NSAID	Pain
Loperamide 4g PO Q4hrs	Gut opioid stimulant	diarrhea
Clonidine 0.3 mg QID	Alpha-2 agonist	Anxiety, restlessness
Gabapentin 900mg TID	Gaba+ reduces CNS excitation	Anxiety
Ondansetron 4mg PO Q 4hs	5-HT3	nausea
Baclofen 20mg TID	GabaB agonist	anxiety , tremor
Pramipexole 0.25 mg TID	Dopamine D3 agonist	Restlessness and depression
Trazodone 100mg PO	5-HT2 and alpha-1 antagonist	Sleep
Ketamine 20-50mg PO	Indirect Opioid agonist, NDMA	Pain, dysphoria. (need compounding pharmacy)

Resolution

- ◆ Male partner – discontinued opioids and received ER Buprenorphine SQ next day and “felt great”
- ◆ Female partner- arrived “feeling terrible”
 - ◆ received 16mg and felt OK;
 - ◆ received a second 16mg SL and felt terrible again
 - ◆ Administered single dose of ketamine and lorazepam then fell asleep
 - ◆ Awoke feeling well and was discharged after 6 hrs in the ED

Case 3

- ◆ 32 yo female with severe OUD, uses fentanyl IV, intermittent cocaine use, history of recent opioid overdose
- ◆ Presents with opioid withdrawal (COWS 8), large abscess on her left forearm, severe pain in the arm.
- ◆ She would like buprenorphine treatment but has had POW before and does not feel ready to start buprenorphine.
- ◆ She is uninsured and unhoused

Poll

- ◆ **Which full agonist is ideal for low dose buprenorphine transition?**
- ◆ A. Oxycodone
- ◆ B. Morphine
- ◆ C. Methadone
- ◆ D. ER Morphine
- ◆ E. Any of the above would work

Case 3 – LBD-OC

◆ Day 1

- ◆ Start methadone 40mg + oxycodone IR
- ◆ Begin low dose buprenorphine ramp up
- ◆ Adjuvant treatments + acetaminophen + NSAID

◆ Day 2 – 4

- ◆ Continue methadone, do not exceed 50-60mg; continue oxycodone
- ◆ Continue LDB

◆ Day 5

- ◆ Give buprenorphine 24mg, follow up ER SQ Buprenorphine (if amendable)
- ◆ Stop all full agonist opioids

Case 3 – HDB option

- ◆ Stabilize patient with short acting opioids
 - ◆ Oxycodone IR 20mg every 4 hours scheduled
 - ◆ Clonidine, hydroxyzine, acetaminophen, ibuprofen, trazodone
- ◆ Stop opioids at 10pm on 2nd day of hospitalization
- ◆ At 9am on 3rd day, give her 24mg of buprenorphine at once
 - ◆ Patient tolerates well, pain is improved
- ◆ At 3pm, give patient 300mg of ER SQ buprenorphine

	<i>FASTEST</i> ----- <i>SLOWEST</i>				
	HDB	Standard*	LDB-OC, rapid	LDB-OC, slow	LDB-OC to HDB
Indications	-High opioid tolerance -Quick stabilization needed	-Patient able to tolerate opioid withdrawal -Use of prescribed opioids -Lower opioid tolerance	-Intolerance of opioid withdrawal -Able to manage non-prescribed supply	-Concomitant pain -Not able to tolerate other initiation strategies -Highly structured setting	-Concomitant pain -Not able to tolerate other initiation strategies -Highly structured setting
Need for withdrawal?	Yes	Yes	No	No	No
Opioid continuation?	No	No	Yes	Yes	Yes
Initiation Dose (Buprenorphine SL formulation)	>12 mg	4-8 mg, max of 12 mg on day one	0.5mg-1mg	0.25 mg-0.5 mg	0.25 mg-0.5 mg
Duration of initiation	1-2 days	1-3 days	3-5 days	5-10 days	5-10 days
Ease	Easy	Moderate	Difficult	Difficult	Difficult
Cost	Low	Low	Moderate	Expensive	Expensive
Other considerations	Can occur in any setting	Can occur in any setting	Requires more oversight and support	Requires oversight and support, best suited for ASAM 3.7 or 4.0 LOC	Requires oversight and support, best suited for inpatient setting

	Low Resources-----		-----High Resources	
Situation	Outpatient, Limited Resources	Emergency Department	Outpatient, Highly Resourced ^o	Residential/Hospital Setting \pm
Opioid withdrawal – COWS >8 with one objective sign of opioid withdrawal	HDB	HDB	HDB	HDB
Opioid withdrawal – COWS <8	Wait + supportive meds	Wait + supportive meds	Wait* + supportive meds	LDB-OC
Acute pain + opioid withdrawal, COWS <8	LDB-OC <i>consider higher level of care</i>	LDB-OC	LDB-OC	LDB-OC
Transition from methadone (dose <150mg)	OTP methadone + LDB-OC	Administer confirmed daily dose as needed, <u>refer back to OTP</u>	OTP methadone + LDB-OC	Methadone + LDB- OC

HDB = High Dose Buprenorphine, initial dose ranging from 12-32 mg on day 1

LDB-OC = Low dose buprenorphine initiation with opioid continuation

*Continuation of illicit opioid consumption with LDB-OC approach may be considered in cases where discontinuation and opioid cessation is not acceptable to the patient.

^o Extended nursing and/or medical monitoring

\pm Includes ASAM Levels of Care 3.7 (medically managed rehab), 4.0 (hospital setting)

Final Takeaways/Summary

- ◆ Individualize your approach
- ◆ Each approach has risks and benefits that should be discussed with patients
- ◆ Consider the safety of opioid continuation in patients without close follow up
- ◆ Consider the HDB approach a way to quickly stabilize individuals at very high risk

References

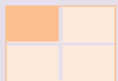
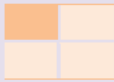
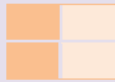

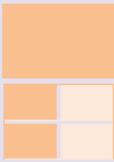
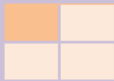
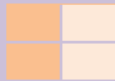

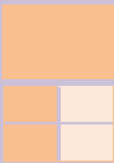
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Resources

A Guide for Patients Beginning Buprenorphine Treatment With the Bernese Method at Home (Days 1 – 5)

- Main goal is to ease you into buprenorphine treatment slowly while trying to prevent precipitated withdrawal.
- Use of full agonist opioids (oxycodone, heroin, fentanyl, etc.) can continue until day 6 of induction.
- You can continue using the same amount (you are NOT required to decrease drug use but you can if tolerated).
- Continue with the buprenorphine even if drug use is stopped/restarted before day 6.
- The idea is to slowly increase buprenorphine levels up to the desired dose of 12 mg per day (day 7).
- This method should cause minimal withdrawal symptoms.
- Call the MGH Bridge Clinic if you experience withdrawal symptoms or if you have any other questions/concerns.

Once you are ready, follow these instructions to start the medication:

	Day 1	Day 2	Day 3	Day 4	Day 5
Total Daily Dose	0.5mg daily	0.5mg twice daily	1 mg twice daily	2 mg twice daily	3 mg twice daily
# of 2mg films	1/4 Film	1/4 Film x 2	1/2 Film x 2	1 Film x 2	Return to Clinic 1 + 1/2 Film x 2
Morning					
Evening					

Days 1-5: Total of 6.75 films (2mg strength) will be used. Your first prescription will include 7 films.

Days 6-7: Back to clinic on Day 5 for appointment. Your second prescription will include 8mg films for easier dosing.

A Guide for Patients Beginning Buprenorphine Treatment With the Bernese Method at Home (Days 6 & 7)

- Main goal is to ease you into buprenorphine treatment slowly while also trying to prevent precipitated withdrawal.
- The idea is to slowly increase buprenorphine levels up to the desired dose of 12 mg per day (day 7).
- Use of full agonist opioids (oxycodone, heroin, fentanyl, etc.) should stop on day 6
- This method should cause minimal withdrawal symptoms.
- Call the MGH Bridge Clinic if you experience withdrawal symptoms or if you have any other questions/concerns.

After returning to clinic, finish the regimen using 8 mg films:

		Day 6	Day 7
Total Daily Dose		4 mg twice daily	8 mg in the AM, 4 mg in the PM
# of 8mg films		<u>STOP</u> other opioid use 1/2 Film x 2	1 Film AM 1/2 Film PM
Morning			
	Evening		

Days 1-5: Total of 6.75 films (2mg strength) will be used. Your first prescription will include 7 films.

Days 6-7: Back to clinic on Day 5 for appointment. Your second prescription will include 8mg films for easier dosing.