ED BUPRENEORPHINE PROTOCOL

Generic substitutions may occur on medications dispersed - unless order specifies "Do Not Substitute."

Height:_______ **Weight:** _____________

Allergies	

ED: Emergency Buprenorphine Treatment

Buprenorphine is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder. However, initiation of buprenorphine in patients with other opioids in their system may cause a precipitated withdrawal, which is a rapid and intense onset of withdrawal symptoms. Patient selection is important. Follow inclusion and exclusion criteria and see recognition and management of precipitated withdrawal below.

Inclusion: Opioid Use Disorder as defined by DSM V **and** >12-24 hours since last use of short acting opioids or >72 hours since last methadone use **or** Clinical Opioid Withdrawal Scale (COWS) ≥8

Exclusion: Severe acute pain requiring full opioid agonist, trauma or planned large surgeries that will need full opioid agonists, opioid intoxication

Use caution in patients with altered mental status/delirium/non-opioid intoxication and in those who use other CNS depressing substances and counsel on risk of respiratory depression.

Buprenorphine Dosing – INITIAL ENCOUNTER
Last reported opioid use: _______ (date/time)
Follow algorithm below for dosing

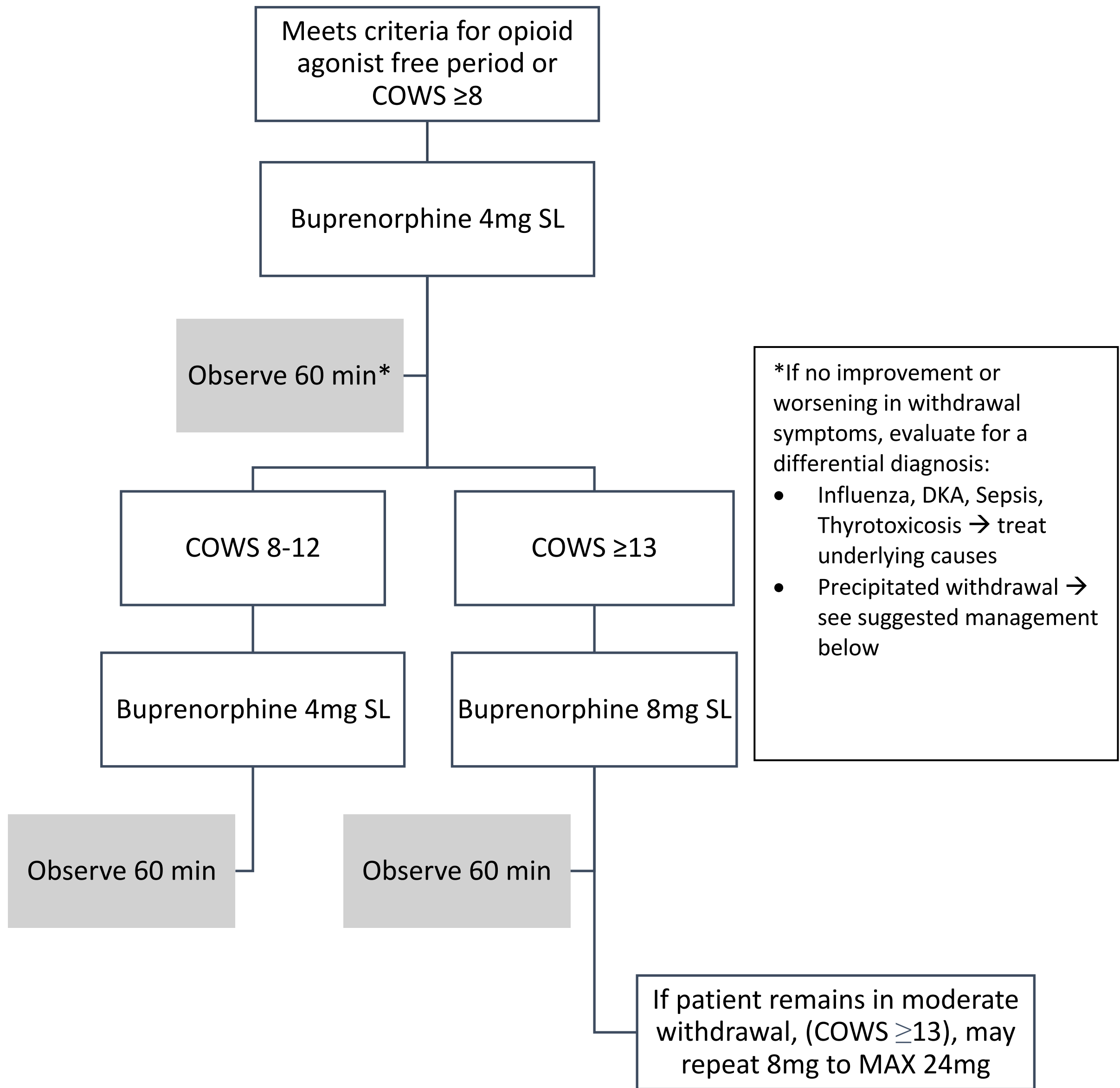
Laboratory Assessment
Note: Obtaining and result of labs should **not delay initiation of buprenorphine*

- ☐ Urine Drug Screen
- ☐ Alcohol level
- ☐ Pregnancy test, urine or serum
- ☐ Complete blood count
- ☐ Complete metabolic panel
- ☐ HIV, Hep B, and Hep C Panel

Medications*

- ☒ Buprenorphine 4mg SL ONCE STAT
- ☐ Buprenorphine 4mg SL ONCE PRN
- ☐ Buprenorphine 8mg SL ONCE PRN

**Many patients will achieve adequate symptom control with total dose of 12-16mg during initiation. Consider administration of total dose up to 24mg (if tolerated without sedation) during weekends and holidays to provide symptom control and extended duration of action to allow patient time to follow-up outpatient.*
Consider dose decreases/use of monoproduct with those in liver failure.



Supportive Care
May be used for the treatment of initial withdrawal symptoms or in the event of precipitated withdrawal

- ☐ Clonidine 0.1 mg PO q60 min PRN autonomic withdrawal symptoms x 4 doses. *Monitor SBP and HR*
- ☐ Ondansetron 4 mg PO q6h PRN nausea
- ☐ Ondansetron 4 mg IVP q6h PRN nausea unable to take po
- ☐ Loperamide 4mg po ONCE PRN diarrhea (initial dose)
- ☐ Loperamide 2mg po PRN after each unformed stool (MAX 16mg/day)
- ☐ Acetaminophen 650 mg PO q6h PRN
- ☐ Ibuprofen 400mg PO q6h PRN
- ☐ Hydroxyzine 25mg PO q4h PRN

Recognition and Management of Precipitated Withdrawal

After the initial buprenorphine dose, the patient should begin to have at least mild improvement in withdrawal symptoms within 60 minutes. If there is abrupt, significant worsening of withdrawal within 90 minutes of administration of buprenorphine, precipitated withdrawal should be considered, and management initiated.

☐ Continue providing buprenorphine 8mg according to the above protocol; and

☐ Choose medication(s) from the "Supportive Care" section that target withdrawal symptoms; and/or Lorazepam 1-2mg PO x1 or Lorazepam 1mg IV if severe agitation/pacing

Discharge Planning

☐ Overdose education with Naloxone kit/prescription to bedside. Offer this education and naloxone to any friend/family with patient as well.

☐ Information for follow-up care

You have an appointment with:

Buprenorphine Prescription UPON ED Discharge

Buprenorphine Dosing – SUBSEQUENT ENCOUNTER

Dosing based on dose received on INITIAL ENCOUNTER, Repeat COWS Score

☐ Buprenorphine 16 mg SL ONCE ONE

☐ Buprenorphine 8 mg SL ONCE ONE

Physician Signature: ______________________ Order Date & Time:______________

Nurse Signature: ______________________ Order Date & Time:______________

Nurse Signature: ______________________ Order Date & Time:______________

References

1. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015 Apr 28;313(16):1636-440.
2. Herring A, Perrone J, Nelson L. Managing Opioid Withdrawal in the Emergency Department with Buprenorphine. Ann Emergency Med. 2019; 73:481-487.
3. Herring A, Vosooghi A, Luftig J, Anderson E, Zhao X, Dziura J, Hawk K, McCormack R, Saxon A, D'Onofrio G. High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder. *JAMA Network Open.* 2021;4(7):e2117128. doi:10.1001/jamanetworkopen.2021.17128.
4. Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment in Emergency Departments. HHS Publication No. PEP21-PL-Guide-5 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.
5. Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63 Publication No. PEP21-02-01-002. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.
6. Sec. 1867. 42 U.S. Code § 1395dd. Emergency Medical Treatment and Labor Act (EMTALA).