Buprenorphine/naloxone (Suboxone®) for Opioid Use Disorder

Site Applicability

St. Paul's Hospital, Mount Saint Joseph Hospital, Crosstown Clinic and Foundry Vancouver-Granville

Practice Level

Basic Skill**:** RN, RPN, LPN

- Recommended Education:
  - LearningHub Course 20551: Buprenorphine-naloxone (suboxone)

Need to Know

- Buprenorphine/naloxone is considered first-line opioid agonist treatment (see Definitions) for opioid use disorder because of its low risk of sedation and overdose, and minimal drug interactions. Due to its slow onset and long duration of action, individuals who are opioid dependent do not experience sedation or euphoria at the appropriate dose.
- Buprenorphine, a partial opioid agonist, is the active medication in Suboxone®; naloxone (which is an opioid antagonist and not bioavailable when absorbed sublingually) is combined to prevent diversion (it may cause withdrawal if injected or snorted).
- Buprenorphine has a high affinity for opioid receptors and displaces other opioids (e.g., morphine, methadone). Improper assessment and administration can lead to precipitated withdrawal (see Definitions).
- The Clinical Opiate Withdrawal Scale (COWS) (Appendix A) is used to assess patients for withdrawal symptoms prior to initiating a standard Suboxone® induction and for precipitated withdrawal post administration, and to monitor withdrawal symptoms during a low-dose induction.
- Patient education related to medication administration and precipitated withdrawal must be provided prior to induction. It is essential that patient education is provided on how to take the medication appropriately.
- SUBOXONE may be ordered as a tablet or a film. Please see Appendix B for specific administration instructions for SUBOXONE film.

Quick Links:

- Standard sublingual inductions
- Low Dose sublingual inductions

Differences in induction approaches:

Standard Induction	Low-dose Induction
Patient must stop all other opioids	Patient does not need to stop other opioids, and will likely be prescribed other opioids
Treatment depends on Clinical Opiate Withdrawal Scale (COWS) monitoring and scoring	Initiating Suboxone® is not dependent on a specific COWS score
COWS used to assess a patient's degree of withdrawal from opioids to determine readiness to be started on Suboxone®	May or may not include COWS scoring for monitoring and assessment purposes
Patient must be in moderate to severe withdrawal (i.e., COWS score over 12) to take first dose	Patient does not need to be in withdrawal to take first dose
Higher doses prescribed (1 to 2 tablets at a time)	Small doses (as little as 1/4 tablet - 0.5 mg buprenorphine at a time in the beginning)
Patient achieves therapeutic dose in 1 to 2 days	Patient achieves therapeutic dose over 7 days

Protocol - Standard Induction

Prescriber Orders:

- A PowerPlan or written prescribers order will be completed by the provider for standard induction. The medication will appear on the Medication Administration Record (MAR).
- **It is important to note that the medication will appear in "Scheduled" medications with a default time BUT the first dose cannot be given until the patient is in moderate to severe withdrawal** as measured by the COWS scale, usually a score of 13 or above. This helps to prevent precipitated withdrawal.
- For standard inductions, the **provider will want to verify the COWS score**, by assessing the patient **prior to administration of the first dose**. Plan with the provider accordingly.

Assessment & Interventions:

- Assess patient using the Clinical Opiate Withdrawal Scale (COWS) (Appendix A) at first sign of opioid withdrawal.
- Assess patient Q2H until COWS score is 9, then Q1H until COWS score is greater than 12.
- **Once COWS score is greater than 12,** notify the prescriber for verification and to **ask if they want to assess the patient before administering the first dose**, and then proceed with giving buprenorphine/naloxone dose as ordered.
- **Provide patient education, on how to take doses appropriately**, the tablets can take up to 10 minutes to dissolve completely sublingually. See Patient and Family Education section for required education.
- Assess patient, using COWS, 30 and 60 minutes post dose:
    - **If the COWS score increases** (this may indicate the patient is experiencing precipitated withdrawal), notify prescriber immediately to make a plan and reassure patient that these symptoms will pass and provide support
    - **If the COWS score remains the same or decreases**, proceed with induction orders and titrate dose as prescribed. The frequency of dosing may depend on the COWS score after each dose administered

Protocol – Low-dose Induction

Low Dose buprenorphine induction involves administration of small doses of buprenorphine/naloxone, increasing over 7 days, while the patient is still taking other opioids. This lowers the risk of precipitated withdrawal and can be easier to manage in patients receiving opioids to treat acute pain.

- **It is essential that the patient take all doses of buprenorphine/naloxone** so that they can safely reach target dose by Day 7 (12 mg)
- Ensure that all **doses are taken as ordered sublingually** (i.e., fully dissolved under the tongue which can take up to 10 minutes). See Patient and Family Education section for required education

Maintenance Phase

Assessment & Interventions:

- Assess patients on a maintenance dose of buprenorphine/naloxone for effectiveness of treatment. Maintenance therapy is usually at doses of 12 to 24 mg.
- Sample assessment questions:
    - *Are you having any withdrawal or cravings throughout the day?*

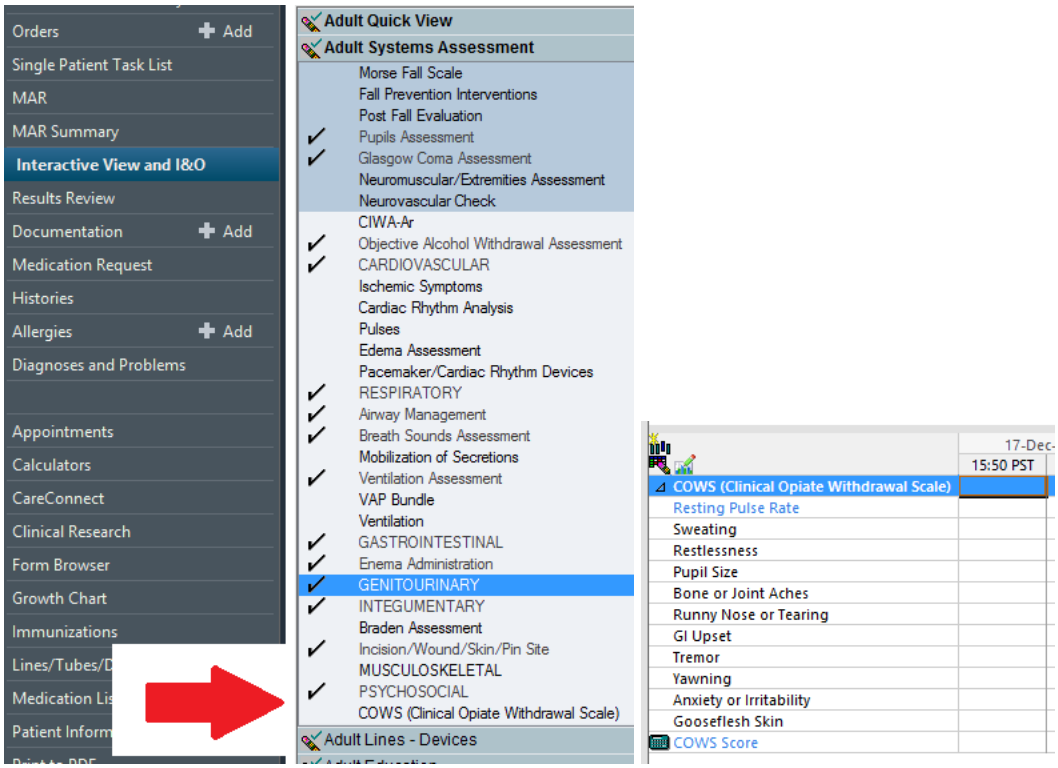
- *Do you have any concerns about your treatment?*

- Any concerns that should be brought forward to the prescriber.

If patients are still using non-prescribed opioids, provide information and education about harm reduction and interventions. (e.g., Take Home Naloxone kits should be offered to all patients on buprenorphine/naloxone.

Documentation

- Document withdrawal on the Clinical Opiate Withdrawal Scale (COWS) (see Appendix A). Located in Cerner PowerChart within 'Interactive View and I&O' under 'Adult Systems Assessment', and available via the print shop/SCM for non-Cerner sites



- Document medication given on MAR (buprenorphine-naloxone, dosage, route, time and signature)

- Document all significant findings in a nursing narrative note, including patient/family education provided. For sites without Cerner, document in the Interdisciplinary Progress notes.

Patient and Family Education

- The patient should be informed, prior to induction, about precipitated withdrawal and how it can be avoided (e.g., under-reporting last use can put patient at high risk for intense onset of withdrawal).
- Advise patient that the sublingual tablet must dissolve completely, which can take **up to 10 minutes**. Instruct patient not to swallow their saliva or the pill and to refrain from talking, eating or drinking fluids while the pill is dissolving.
- Advise against smoking cigarettes or drinking coffee for 1 hour prior to taking the medication, if possible, as being adequately hydrated will help the medication dissolve completely.
- In the hospital setting, patients will be monitored closely throughout the induction phase to ensure precipitated withdrawal is avoided.
- Provide patient with educational handout when appropriate (Appendix C)
- Offer Take Home Naloxone kit

Other Patient Supports

- Subjective Opiate Withdrawal Scale (SOWS) can be printed from: https://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf (can help patients determine their own level of withdrawal)

Related Documents

- B-00-11-10125 - Philosophy of Care for Patients and Residents with Substance Use
- BCCSU & MOH Guideline for the Clinical Management of Opioid Use Disorder
- VCH/PHC Buprenorphine-Naloxone (Suboxone) patient education handout (PHEM website)
- B.C. College of Nurses and Midwives. Harmonized Practice Standard for Registered Nurses and Nurse Practitioners, Registered Psychiatric Nurses and Licensed Practical Nurses: Medication Administration (2023)

Additional Education

- Addiction Care and Treatment Online Course (free) through UBC CPD

References

1. British Columbia Centre on Substance Use and B.C. Ministry of Health. (2017). *A guideline for the clinical management of opioid use disorder.* Retrieved from http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf
2. D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone

treatment for opioid dependence: a randomized clinical trial. *JAMA*, *313*(16), 1636-44.

3. Hämmig, R., Kemter, A., Strasser, J., von Bardeleben, U., Gugger, B., Walter, M., Dürsteler, K. M., 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*, 99–105. http://doi.org/10.2147/SAR.S109919

Definitions

Opioid agonist treatment: Opioid agonist treatment refers to the use of a substitution opioid to manage opioid use disorder. Methadone and buprenorphine are both long-acting opioids that are used in opioid agonist treatment. Opioid agonist treatment has been shown to reduce mortality, drug use and retain patients in treatment.

Precipitated withdrawal: Precipitated withdrawal can occur when someone is given an initial dose of buprenorphine/naloxone when they are not in moderate to severe opioid withdrawal. In this circumstance, the high affinity partial opioid agonist buprenorphine will displace the full agonist opioid (e.g., heroin, fentanyl, morphine) from the receptors causing a rapid decrease in receptor activity and the precipitation of opioid withdrawal symptoms.

Appendix A: Clinical Opiate Withdrawal Scale (Form)

Providence HEALTH CARE

CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

Flowsheet for measuring withdrawal symptoms during buprenorphine/naloxone induction.

For each item, write in the number that best describes the patient's signs or symptom. **Complete both pages.**

Score on the apparent relationship to opiate withdrawal.

* 6 2 1 8 *

Flowsheet

Date: _____

	SCORE											
Time:												
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* **0** pulse rate 80 or below **1** pulse rate 81 to 100 **2** pulse rate 101 to 120 **4** pulse rate greater than 120												
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* **0** no report of chills or flushing **1** subjective report of chills or flushing **2** flushed or observable moistness on face **3** beads of sweat on brow or face **4** sweat streaming off face												
Restlessness *Observation during assessment* **0** able to sit still **1** reports difficulty sitting still, but is able to do so **3** frequent shifting or extraneous movements of legs/arms **5** Unable to sit still for more than a few seconds												
Pupil size **0** pupils pin point or normal size for room light **1** pupils possibly larger than normal for room light **2** pupils moderately dilated **5** pupils so dilated that only the rim of the iris is visible												
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* **0** not present **1** mild diffuse discomfort **2** patient reports severe diffuse aching of joints/ muscles **4** patient is rubbing joints or muscles and is unable to sit still because of discomfort												
Subtotal Score												
Nurse initials												

- Flowsheet continues on page 2 -

If you initial this form, you must complete the Interdisciplinary Signature Sheet at the front of the patient chart.

Providence HEALTH CARE

CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

Flowsheet for measuring withdrawal symptoms during buprenorphine/naloxone induction.

For each item, write in the number that best describes the patient's signs or symptom. **Complete both pages.**

Score on the apparent relationship to opiate withdrawal.

Date: _____

	SCORE											
Continued from page 1 **Time:**												
Runny nose or tearing *Not accounted for by cold symptoms or allergies* **0** not present **1** nasal stuffiness or unusually moist eyes **2** nose running or tearing **4** nose constantly running or tears streaming down cheeks												
GI Upset: *over last ½ hour* **0** no GI symptoms **1** stomach cramps **2** nausea or loose stool **3** vomiting or diarrhea **5** Multiple episodes of diarrhea or vomiting												
Tremor *observation of outstretched hands* **0** No tremor **1** tremor can be felt, but not observed **2** slight tremor observable **4** gross tremor or muscle twitching												
Yawning *Observation during assessment* **0** no yawning **1** yawning once or twice during assessment **2** yawning three or more times during assessment **4** yawning several times/minute												
Anxiety or Irritability **0** none **1** patient reports increasing irritability or anxiousness **2** patient obviously irritable or anxious **4** patient so irritable or anxious that participation in the assessment is difficult												
Gooseflesh skin **0** skin is smooth **3** piloerection of skin can be felt or hairs standing up on arms **5** prominent piloerection												
TOTAL score												
Nurse initials												

Score: 5 to 12 = mild
13 to 24 = moderate
25 to 36 = moderately severe
more than 36 = severe withdrawal

If you initial this form, you must complete the Interdisciplinary Signature Sheet at the front of the patient chart.

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Appendix B: Administration of SUBOXONE Film

- For induction, SUBOXONE film should be administered sublingually. Once induction is complete (typically within 2 days), patients can be switched between buccal and sublingual administration without significant risk of under- or over-dosing. However, patients should be monitored for symptoms of under- or over-dosing when switching between sublingual and buccal sites of administration.

  Medication administration route is determined by the provider. Refer to the order.

- Advise patients to moisten their mouth prior to administration. The film should remain either under the tongue or inside of the cheek depending on route of administration until it is completely dissolved.

- For **sublingual** use, when more than one film is necessary to achieve the prescribed dose, the additional film should be placed under the tongue on the opposite side from the first film avoiding overlapping or stacking the films. If a third film is necessary to achieve the prescribed dose, it should be placed under the tongue after the first two films have dissolved.

- For **buccal** use, when more than one film is necessary to achieve the prescribed dose, an additional film should be placed on the inside of the opposite cheek. If a third film is necessary to achieve the prescribed dose, it should be placed on the inside of the right or left cheek after the first two films have dissolved.

- No more than two films should be administered at the same time.

- SUBOXONE film should be used immediately upon opening and not stored for any length of time. Avoid manipulating the film with wet hands.

From product monograph Indivior UK Limited. March 2023. Accessed at https://pdf.hres.ca/dpd_pm/00069997.PDF

Appendix C: VCH/PHC Buprenorphine-Naloxone (Suboxone®) patient education handout

MEDICATION CHOICES – *Information for Patients and Families*

Vancouver CoastalHealth | Providence HEALTH CARE

Promoting wellness. Ensuring care. How you want to be treated.

Buprenorphine-Naloxone (Suboxone®)

Who should take Suboxone?

Suboxone (buprenorphine-naloxone) is prescribed for people receiving treatment for opioid addiction. Opioids are substances like heroin, morphine, hydromorphone, and oxycodone. Suboxone helps people avoid using opioids. It helps reduce withdrawal symptoms and cravings for opioids.

Why would my doctor recommend Suboxone instead of methadone?

- You may want more freedom with your medication schedule. Many people who take Suboxone can, over time, start taking their doses at home. (This is not the case for everyone.) With methadone you must take the medication at the pharmacy every day.
- Suboxone is less likely to cause an overdose than methadone. It is also less likely to interact with other medication you may be taking such as antibiotics, antidepressants, and HIV medication.
- If you need to change medications in the future, it is easier to switch from Suboxone to methadone than the other way around.

How do I take Suboxone?

- Suboxone usually comes as a pill. You put it under your tongue and keep there until it is gone. This can take up to ten minutes. The medication does not work if you swallow the pill, or swallow your saliva, while the pill is dissolving. Never inject Suboxone. Doing this could lead to withdrawal.
- When you start Suboxone, you will have to take it in the presence of a health care professional, like a doctor, nurse, or pharmacist.
- Before you start Suboxone you have to wait at least 12 hours since you last used opioids. You need to be experiencing withdrawal symptoms. If you don't wait until you're feeling 'dope sick', at least 12 hours since the last time you used, Suboxone can make you feel even worse.

What if Suboxone doesn't work for me?

If you feel that Suboxone isn't working for you, talk to your doctor or nurse. You can decide together if you should change your dose or try something different.

How long should I continue taking this medication?

Most people can expect to take Suboxone for at least a year or longer. Taking it for a year significantly increases your chances of abstaining from opioid use. When you and your doctor decide it is time to stop taking Suboxone, your dose will probably be lowered slowly. This is done over several months.

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When can I start taking Suboxone at home?

You and your doctor will decide together if, and when, take-home doses are the right choice for you. This will depend on finding the right dose with few side effects. It also depends on how you are doing with your overall addiction treatment.

Is there anyone who shouldn't take Suboxone?

- If you are pregnant or breastfeeding, or have serious problems with your liver, you will need to work with a specialist doctor to decide if Suboxone is right for you.
- Suboxone can interact with certain drugs and medications in dangerous ways. These interactions can give an overdose that can cause death unless you get immediate medical care. Alcohol and certain medications (such as Valium and Ativan) can make you extremely sleepy. They can slow your breathing to dangerously low levels. It is extremely important that you talk to your doctor about alcohol use and all other medications you are taking.

What should I avoid while taking Suboxone?

- ***Do not drive, operate heavy machinery, or perform any other dangerous activities*** until you know if this medicine makes you sleepy.
- ***Do not drink alcohol or take tranquilizers or sedatives*** (medicines that help you sleep) while using Suboxone.

What are the possible side effects of Suboxone?

Call your doctor or get medical help right away if:

- you feel faint, dizzy, confused, or have any other unusual symptoms.
- your breathing gets much slower than is normal for you.

These can be signs of an overdose or serious problem.

Suboxone may cause liver problems. **Call your doctor right away if**:

- your skin or the white part of your eyes turns yellow (jaundice).
- your urine turns dark.
- your bowel movements (stools) turn light in color.
- you don't feel like eating much food for several days or longer.
- you feel sick to your stomach (nausea).
- you have pain in your lower stomach.

Persons/Groups Consulted:

PHC Practice Consultants, Professional Practice Office

Developed By:

Clinical Nurse Specialist, Substance Use, PHC

Revised By

Nurse Educator, Substance Use

General Nurse Educators, Medication Management, Medication Safety

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