John Reudy Clinic: Buprenorphine/naloxone (Suboxone®) for Opioid Use Disorder

Site Applicability

John Ruedy Clinic (JRC), SPH

Practice Level

Basic Skill: **RN, RPN.** Dispensing sublingual buprenorphine/naloxone -

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

Need to Know

- Buprenorphine/naloxone is considered first-line opioid agonist treatment (OAT; see Definitions) for opioid use disorder (OUD) 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 is the active medication in Suboxone® that helps with craving and withdrawal symptoms; naloxone (which is an opioid antagonist and not bioavailable when absorbed orally) is combined to prevent diversion (it may cause withdrawal if injected or snorted).
- Buprenorphine is a partial agonist with high affinity for opioid receptors and displaces other opioids (e.g., methadone, heroin). If the patient initiates the medication too early (i.e., previously used opioids remain in their system), it can lead to precipitated withdrawal (see Definitions). Providing patients with education on how to avoid this is essential.
- 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 for withdrawal symptoms during a micro-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.

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

Provider Orders:

- JRC provider will determine that the patient is a clinically appropriate candidate for standard induction. They will enter an order for buprenorphine/naloxone in Profile EMR.
- **It is important to note that the medication cannot be given until the patient is in moderate to severe withdrawal** as measured by the COWS, usually a score of 13 or above. This helps to prevent precipitated withdrawal.

Assessment & Interventions:

- If first dose(s) is to be taken in clinic, assess patient using the COWS (Appendix A)
- **Once COWS score is greater than 12,** notify the provider for verification and to **ask if they want to assess the patient before administering the first dose**, and then proceed with administering 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.
- If first dose(s) are administered in clinic, 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 the provider immediately to make a plan and reassure the patient that these symptoms will pass and provide support.

- **If the COWS score remains the same or decreases**, proceed with in-clinic induction orders and provide patient education on how to take 'to go' doses appropriately. 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 (12 mg) by Day 7
- 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:

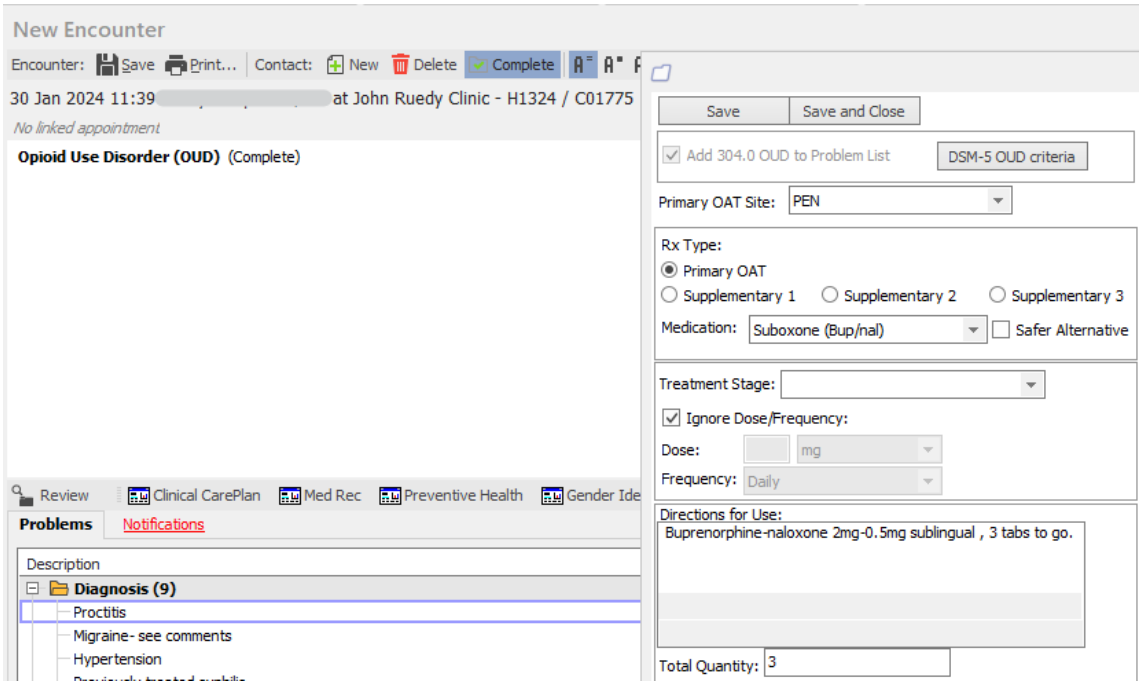
- Assess patients on a maintenance dose of buprenorphine/naloxone for effectiveness of treatment. Maintenance therapy is usually at doses of 12 to 24 mg.
- Follow up may be done by telephone, questions to ask include:
  - *Are you having any withdrawal or cravings throughout the day?*
  - *Do you have any concerns about your treatment?*
- Any concerns identified should be brought forward to the provider. If provider is not available, please inform the Doctor of the day (DOD)

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

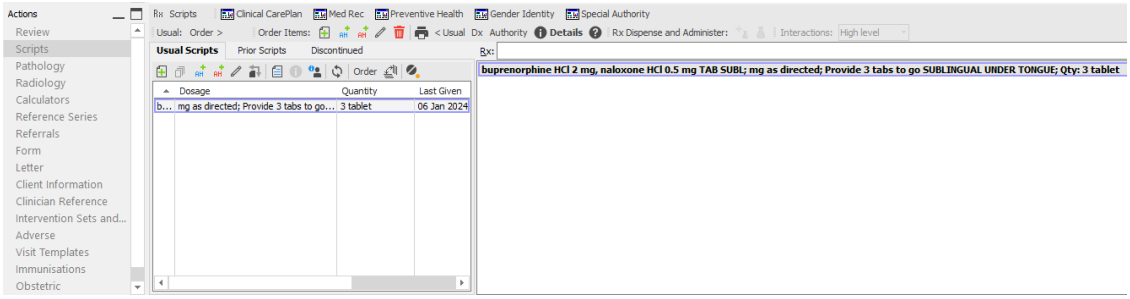
Steps

Step I. Review order:

In EMR, the provider will order *buprenorphine-naloxone* in the OUD Form. Once the order for buprenorphine-naloxone is entered in Profile EMR, review the order.



The order entered in the EMR will show under the scripts tab:



Step II. Access Narcotics Lockbox & provide patient education:

Take medication out of narcotic lockbox and document the removal of the medication on the narcotic record.

Provide buprenorphine/naloxone education handout to patient:

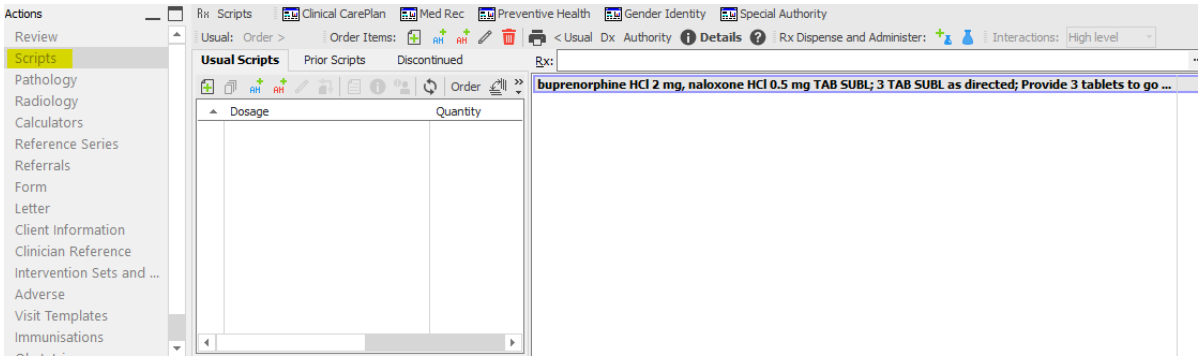
- Explain to the patient that *buprenorphine* is the active medication. *Naloxone* is combined to prevent diversion and injection (it may cause precipitated withdrawal if injected/snorted). If taken sublingually, the naloxone remains inactive
- Inform patient of what precipitated withdrawal is and how it can be avoided, especially if previously using long-acting opioids (they will need to wait longer to start the medication)
- Explain that the worse the patient feels (i.e., minimum 3 withdrawal symptoms) before starting the medication, the better it will make them feel after they take it

- Advise patient that the **sublingual** tablet must be **FULLY dissolved**, which can take **up to 10 minutes**. Instruct patient not to swallow their saliva or the tablet, and to refrain from talking, eating or drinking fluids while the tablet is dissolving. Inform patient if they swallow, chew, or take tablet with fluid, **it will have no effect**
- If they have been on buprenorphine-naloxone before, remind them of the administration process
- Discuss and confirm with patient their plan for follow-up
- Consider Vancouver Detox referral if patient interested
- Consider Transitional Care Centre (TCC) referral for patients without stable housing

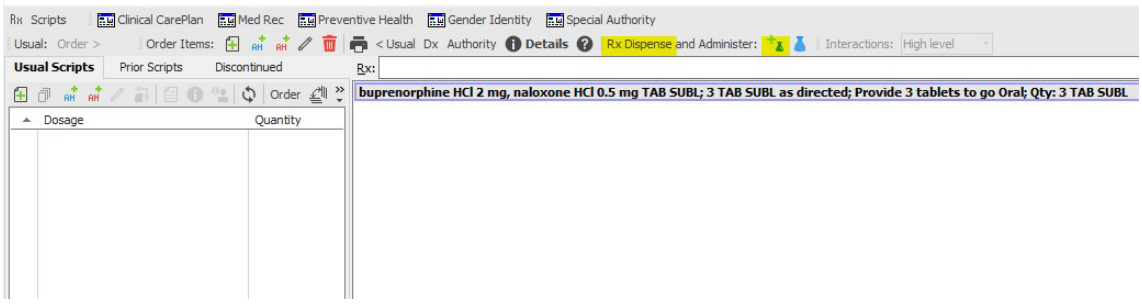
Step III. Complete dispensing and documentation process:

Nurses must follow the B-00-13-10167 - Dispensing Medications (Nurses) protocol and BC College of Nurses and Midwives Dispensing Medications Standards.

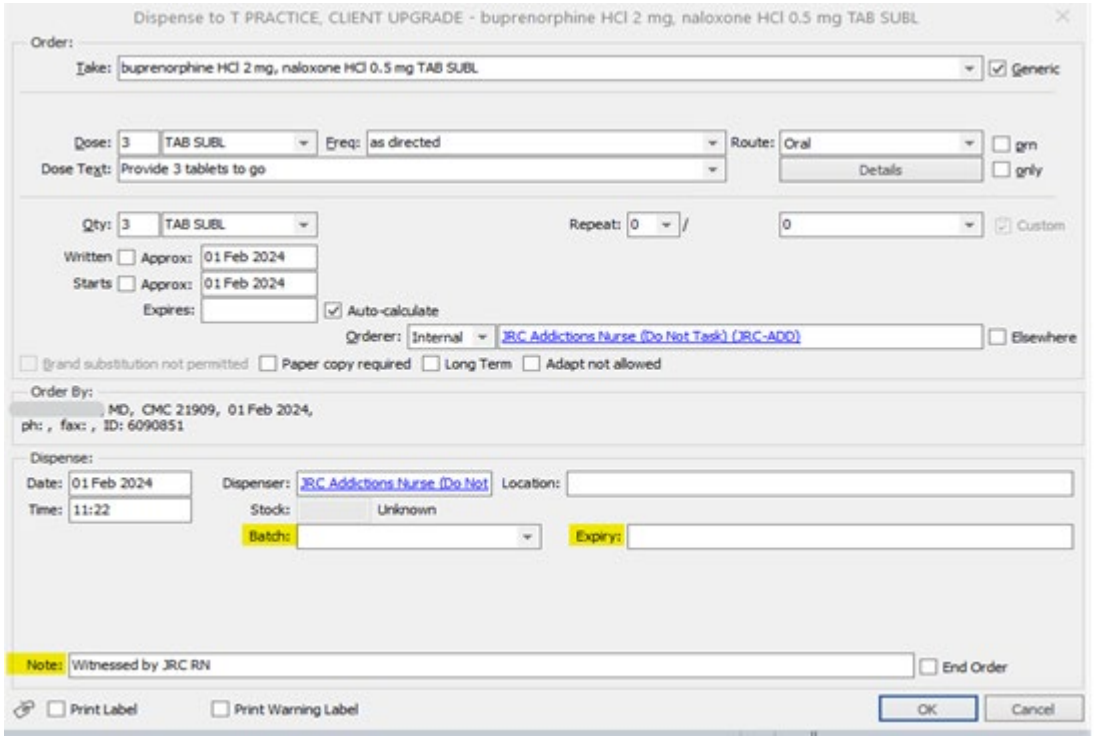
Locate script in EMR: Under actions tab, choose scripts tab to locate the order



To document dispensing from EMR: Highlight the order and then hit the dispense icon



This will open the Dispense screen and auto populate the order. Complete the batch and expiry fields and then hit the okay icon. Document the witness name in the note section.



- Complete dispensing label as per nurse dispensing protocol (B-00-13-10167 - Dispensing Medications (Nurses).
- Complete patient education and document same in the progress notes.

Step IV. Complete a TMU Entry in Medinet:

- Open patients Medinet account via EMR tab or login to the Medinet website : www.medinet.ca
- Select Full profile from the left side list
- Select Med Update/reversal
- Choose Update and enter DIN 66128346
- On the medication update screen, complete medication update fields that include:
    1. **Quantity:** The number of tabs dispensed
    2. **Days Supply:** Write the days supply given based on Prescriber orders (typically will be 1)
    3. **Directions:** Write Standard Regime, 2 mg tabs, take home
    4. **Intervention Code:** Choose the top one in drop down list: Consulted prescriber and filled RX as written
    5. **Clinicians Name:** Choose provider name from the drop down list
    6. Select **Update**

  A JRC TMU Practice Pointer can be found on the medication safety page under the ambulatory section: https://connect.phcnet.ca/clinical/nursing/medication-resources

Other Patient Supports

- Suboxone® Patient Information sheet can be printed and provided to patient (Appendix B) https://phc.eduhealth.ca/media/PHC/DA/DA.100.M468.PHC.pdf)
- 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)
- Patients offered Suboxone to go should also be offered Take Home Naloxone kits

Related Documents

- B-00-11-10125 - Philosophy of Care for Patients and Residents Who Use Substances
- B-00-13-10167 - Dispensing Medications (Nurses)
- BCCSU & MOH Guideline for the Clinical Management of Opioid Use Disorder
- VCH/PHC Buprenorphine-Naloxone (Suboxone) patient education handout (PHEM website)
- BC College of Nurses and Midwives Practice Standard for Registered Nurses and Nurse Practitioners: Medication Administration (2020) https://www.bccnm.ca/

Additional Education

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

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.

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.

Appendices

Appendix A: Clinical Opiate Withdrawal Scale
Appendix B: VCH/PHC Buprenorphine-Naloxone (Suboxone®) patient handout

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.

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.

Form No. PHC-NF457 (R. Aug 9-17) Page 1 of 2

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.

Form No. PHC-NF457 (R. Aug 9-17) Page 2 of 2

Appendix B: VCH/PHC Buprenorphine-Naloxone (Suboxone®) patient 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.

DA.100.M468.PHC (Jul-17) Page 1 of 2

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:

General Nurse Educators, Medication Management, Medication Safety, PHC

Developed By:

Clinical Nurse Specialist, Substance Use, PHC

Practice Consultant, Pharmacy Nursing & Medication Management, PHC

Nurse Educator, Substance Use

Nurse Educator, Urban Health Outpatient Clinics

Initial Effective Date:	29-FEB-2024
Posted Date:	29-FEB-2024
Last Revised:	29-FEB-2024
Last Reviewed:	29-FEB-2024
Approved By:	PHC
	Professional Practice Standards Committee
Owners:	PHC
	Urban Health