

Clark Center: Quick reference guide for prescribing Suboxone (buprenorphine/naloxone)

Guidelines for Suboxone Initial Evaluation:

- Confirm opioid use disorder dx.
- Obtain substance use hx
 - ✓ All drugs used, included alcohol, nicotine, benzodiazepines
 - ✓ Age and amount of first use, current use
 - ✓ Any periods of abstinence
 - ✓ Treatment hx
 - ✓ Goals
- Obtain UA results
- Order any labs needed (Renal panel, liver panel)
- Rule out contraindications
 - ✓ Allergy to Suboxone
 - ✓ Pregnancy
 - ✓ Severe liver dysfunction
 - ✓ Acute Alcohol intoxication
 - ✓ Not in withdrawal

General Suboxone guidelines:

- Tablets may be used (cheaper) and may be split if needed.
 - Tablets—2mg and 8mg
 - Film--, 4, 8 and 12mg
- May take up to 10 min to dissolve completely (no talking, smoking, or swallowing at this time)
- Absorption may be better with moistened mouth
- Naloxone prevents IM/IV diversion of drug and is not active when taken SL.
- Max dose prescribed at Clark Center is 24mg
- Explain to client that we typically do not replace lost or stolen RXs or RXs of Suboxone that are “dropped in the toilet” or “dropped down the sink”. The later is up to the prescriber but is a one-time replacement not to be done again.
- Remember that you don’t have to prescribe someone Suboxone just because they request it. You are the prescriber. Utilize your knowledge to determine that safest treatment course for the client. Don’t be afraid to utilize Suboxone but trust your gut.
- Psychosocial treatments are encouraged but not required to be on Suboxone.

Induction

- Confirm client is in partial withdrawal (or has been on this previously and relapsed).
 - ✓ This can be done with verbal s/s self-reported by client.
 - ✓ Can be done with COWS score > 12.
 - ✓ Confirm no long-acting opioids used for >30 hours. May have to send clients home and have them come back.
 - ✓ If not in partial withdrawal, can be potentially sent into precipitated withdrawal. Symptoms of precipitated withdrawal include:

- ❖ Similar to opiate withdrawal (increased heart rate, sweating, agitation, diarrhea, tremor, unease, restlessness, tearing, runny noses, vomiting, goose flesh)
- ❖ Can range from mild to severe
- ❖ Can be very distressing and discouraging for patients.
- ❖ Largely reversible with higher doses of Suboxone or another opioid
- ❖ Avoid by ensuring adequate withdrawal before induction, starting Suboxone at a lower dose and reassessing more frequently.
- ❖ Can manage some with clonidine. Avoid benzodiazepines.
- Give Suboxone SL 2-4mg advise clients to take one and reassess withdrawal symptoms after 2-4 hours. If not gone, may take up to twice daily until seen again. In cases where client has high opiate use, up to TID dosing can be used. Usually RX will state something like “Suboxone 2mg/0.5mg – Place 1 film/tablet SL q day – may increase to BID or TID (whichever you feel is appropriate) depending on cravings until next appointment”.
- Day 2 or second visit: Review how client felt dose impacted withdrawal symptoms. If adequate symptom relief is not achieved, may increase dose by same way as above.
- Continue to follow client every couple of days/weekly until adequate or max dose is achieved.
- During appointments, assess for side effects such as constipation, cravings.
- Client is to be seen monthly.
- Can give a week RX with 3 refills to make a monthly RX if there is concern over client having a 30-day supply.

Maintenance

- Goal = no withdrawal between doses. Ideal dose is equal or less than 12mg. 24mg is max dosing.
- Monitor for taking medication and not selling via UAs/self-report.
- Monitor UAs randomly
- We do not stop medications typically due to illicit use of substances. However, if client tests positive continually for benzodiazepines or especially opiates, should look at stopping Suboxone due to risk for respiratory depression.
- We do not use UAs as a punitive action but more as a safety precaution.