Bup Management in Pain Patients

It's similar, yet different

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Agenda

- Steps in approach to pain patients
- Communication skills
- Benefits/potential harms of bup
- What’s available, pharmacology
- Patient education
- Induction protocol, dosing
- The EMR and DEA
- Other stuff
Steps For Approaching Chronic Pain

• Get records
• Identify / treat any local pain generators
• Promote healthy behaviors, increased physical activity
• Find and treat comorbid psychiatric illness
• Restore sleep
• Understand the continuum from pain to opioid use disorder in these patients
Clinician – Patient Communication About Treating the Pain with Bup

- Likely outcomes of treatment
- Unlikely outcomes of treatment
- Past experiences, influences on outcomes
- Why change is necessary
- Roles and expectations of both of you
Having the Tapering Talk

- Patients need to understand why this is necessary, especially if patient has been compliant. “This is not about law or policy. I want to help you get better.”
- Trust is essential. Let them know you are with them and will not abandon them.
- Make the patient feel “heard.” Negotiate a bit if necessary.
Why buprenorphine is essential

- Butrans® / Belbuca® / Suboxone® / Subutex®
  Zubsolv® / Generic bup/naloxone tablets/
generic bup tablets / Sublocade

- Analgesia, long-acting, safety, mood, addresses “protracted abstinence” and “chronic persistent dependence”

- When to consider transdermal bup

- Role of buccal bup (Belbuca)

- SL bup/naloxone
Bup in Pain vs. OUD

- Taper current opioid first
- No use of COWS for induction
- Lower induction doses
- Lower final doses
- Divided (not daily) dosing to maximize analgesic effect
- Dealing with benzos, carisoprodol (Soma), Z-drugs.
- What about marijuana?
Induction

• Where? office; Later, when you are comfortable, home. hospital?

• Converting from short-acting, intermediate opioid formulations – how long to wait. Rx for rarely needed for symptoms. Other ways…

• Converting from long-acting (fentanyl, methadone): “bridging,” not lengthy withdrawal

• Office procedure (forms at download site), education (SL med, CSA, Start-Talking form, rules we follow)
## Bup Target Dosing

<table>
<thead>
<tr>
<th>Recent MME opioid dose</th>
<th>Total SL Bup dose/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50</td>
<td>0.5-3 mg</td>
</tr>
<tr>
<td>50-150</td>
<td>3-6</td>
</tr>
<tr>
<td>&gt; 150</td>
<td>6-8</td>
</tr>
</tbody>
</table>

Use divided dosing (TID-QID) – cut films/tabs

Higher vs lower dose in above ranges – depends...
Follow-up

• Follow-up intervals, time visits between refills

• Writing proper prescriptions
  ➢ exact fill dates and expected duration up to 28 days with or without refills
  ➢ Rx “for pain” when using regular DEA and insurance permits

• MAPS for each rx (MI state law); urine testing

• Taper of benzos; taper of bup

• Keeping records in case of a DEA visit
Peri-Procedure Management

- Tradition
- Forget tradition – do not stop bup
- UM recommendations on download site
Back-up!

- Michigan Opioid Collaborative
- Phone call and email help availability
  - Plan for when you will see the patient
  - We are there to help if you are feeling unsure about a situation or what to do
Questions and More Info

My email: danielbe@umich.edu

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Reading and practice tools: bit.ly/berland-downloads