Introduction to Buprenorphine Initiations
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Background

The most challenging part of buprenorphine management is often the initiation of medication. This is due to buprenorphine's unique pharmacology as a partial opioid agonist and its stronger affinity for the mu opioid receptor than full opioid agonists. This means that if a person with a full agonist occupying their opioid receptors takes buprenorphine, the buprenorphine will displace the full agonist from the receptor, leading to precipitated withdrawal (a very uncomfortable and strong opioid withdrawal syndrome, similar to administering naloxone). Thus, traditionally it has been advised that a person initiating buprenorphine stop their short acting opioid (such as heroin, oxycodone, etc) 12-24 hours prior to initiating buprenorphine, waiting up to 72 hours for a longer acting opioid such as methadone.

The introduction of fentanyl into the drug supply has complicated this practice. Fentanyl can stay in the fat tissues of the body for longer than other opioids, and can continue to occupy opioid receptors for longer than other opioids. This duration of time is variable person to person, making it difficult to standardize an appropriate length of time to wait before initiating buprenorphine. This has led to a newer practice of starting a very low dose of buprenorphine and slowly increasing the dose over time, while still using the person's full agonist of choice during the initiation process.

Types of initiation and patient selection

There are three broadly used methods for initiating buprenorphine. Note that both are very safe and effective as home-based initiation. A third strategy (#3 below) is being explored but currently not used widely in the outpatient setting. All strategies are most effective with check-ins from a clinical staff member during the initiation process. See accompanying documents for example instructions.

1. Traditional initiation: patient stops their full opioid for 12-72 hours (depending on type of opioid used), experiences withdrawal symptoms, and then begins buprenorphine. Withdrawal support medications can aid in this process.
    a. Consider in the following scenarios
        i. Patient does not have the ability to access more full opioid agonist
        ii. Patient wants to fully stop use of their full opioid agonist immediately
        iii. Patient feels overwhelmed/confused by low dose initiation instructions
2. Low dose initiation (also described as low dose buprenorphine with opioid continuation or "microdosing"): patient initiates very low dose of buprenorphine (typically starting at 0.5mg), slowly increasing the dose daily over a period of time while continuing to use their full opioid agonist at their usual dose. Continuation of the full opioid agonist is vital to success with this strategy. Only after the period of initiation is over (typically 7 days, though 3 day protocols are also used at times) does the patient stop their full opioid

agonist. When carried out correctly, the patient should never experience any withdrawal symptoms.

   a. Consider in the following scenarios
      i. Patient has struggled with precipitated withdrawal in the past while using a traditional initiation
      ii. Patient is living in a setting (such as outdoors) in which going through withdrawal symptoms in a safe and comfortable place is not feasible
      iii. Patient is using primarily fentanyl

3. Macrodosing/High dose initiation: patient stops their full opioid agonist for 8-48 hours (depending upon specific protocol) and experiences withdrawal. In contrast to the traditional initiation, dosing escalates rapidly on the first day to reach 24-32mg buprenorphine.
   a. Consider in the following scenarios
      i. Rapid stabilization is needed
      ii. Patient has high opioid tolerance
      iii. Patient does not have access to more full agonist or does not wish to continue it any longer

Tips and tricks

- Discuss with the patient what has/has not worked for them in the past. By now, many will have had experience with buprenorphine in the past.
- Always offer opioid withdrawal support medications, for any type of initiation. If pursuing traditional or high dose initiation, encourage patient to start withdrawal support medications prior to their most significant withdrawal symptoms. Discuss with patients which medications are helpful for which symptom.
- For low dose initiation, it is vital that the patient continue their full opioid agonist during the process, otherwise they will experience withdrawal symptoms (this would not be from precipitated withdrawal, but typical withdrawal from not having sufficient mu opioid receptor occupancy).
- Offer check-in by phone or video from clinical staff within the first 24-48 hours of initiation.
- After discussing initiation instructions, ask the patient to repeat back/teach back so you can troubleshoot any areas that need clarification. This can also readily be done by a trained nurse or peer support person.
- Provide printed patients instructions with diagrams and images.

Examples (note in any scenario, shared decision-making is paramount)

- Patient who reports snorting mostly “blue pills” (fentanyl) and experienced precipitated withdrawal when last attempting to start buprenorphine → suggest low dose initiation
- Patient who is using her mother’s prescribed oxycodone (and is quite certain they are prescribed, thus not fentanyl) and who has never tried buprenorphine in the past. Her friend is with her, offering support during her withdrawal symptoms → suggest traditional initiation, waiting 12-24 hours after last opioid use

- Patient presenting to you 12 hours since their last opioid use, already in mild withdrawal → suggest traditional initiation
- Patient who reports that they want their last use of opioids to be just before they walked into your clinic. They have experienced precipitated withdrawal in the past when trying to start buprenorphine, but are not interested/willing to continue their full opioid agonist during a longer initiation → suggest traditional initiation (or high dose if likely has high tolerance/using exclusively fentanyl)
- Patient who is living in a tent or couch surfing, with no easy access to a bathroom or bed → suggest low dose initiation