National Pain VA-ECHO

Veteran Centered, Team Based, Integrated and Whole Health Oriented Care

VA-ECHO
Veterans Administration
Extension for Community Healthcare Outcomes

Initiating Buprenorphine for the Treatment of Chronic Pain – Buprenorphine Formulations and Clinical Considerations

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She graduated with her Doctor of Pharmacy from Massachusetts College of Pharmacy. Then she completed a PGY-1 Pharmacy Practice Residency at Tufts Medicine's Melrose Wakefield Hospital followed by a PGY-2 Psychiatric Pharmacy Residency at the Captain James Lovell Federal Health Care Center in North Chicago, IL..

The views and opinions expressed in this presentation are those of the authors and do not necessarily reflect the official policy or position of any agency of the United States government, including the Department of Veterans Affairs.

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She graduated with her Doctor of Pharmacy from Creighton University in Omaha, NE. Then she completed a PGY-1 Pharmacy Practice Residency at the Meriter Hospital in Madison, WI and went on to complete a 2-year fellowship in Clinical Pharmacy Outcomes at The University of Colorado Skaggs School of Pharmacy in collaboration with Kaiser Permanente Colorado.

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Objectives

After this session, the learner should be able to:

- Highlight select buprenorphine treatment principles
- Describe 'stop and go' buprenorphine initiation method for chronic pain
- Summarize buprenorphine + full agonist overlap method for chronic pain
- Describe how buprenorphine initiation approaches can be integrated as part of a Veteran-centered, team-based, Whole Health oriented care plan for the treatment of chronic pain

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Clinical Case 1

- JR is a 49 y/o veteran with relevant past medical history (PMH) of chronic low back pain & fusion after a Humvee accident in 2001. No history of SUD/OUD.
- Pt has been prescribed opioids since the fusion in 2001; on varying full agonist opioids & varying doses over the years. Highest dose was Oxycodone SA 40mg Q8h + oxycodone IR 10mg TID PRN; taking 225mg MEDD as of 2020
- Pt attempted to self-taper from 2020-2022 d/t waning benefit and "being tired of taking so much of this stuff" but was unable to taper below oxycodone SA 20mg Q8h + oxycodone IR 5mg TID (~112.5mg MEDD) d/t increased pain impacting function.

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Clinical Case 1

- Pt is in a rural area & delays in mail have caused the pt to repeatedly go w/o medication for 2-3 days a time; pt endorses withdrawal w/missed doses. Describes withdrawal as "annoying" but states that he does not find it distressing and "it's just part of taking these meds- it is what it is"
- Pt has never been trialed on a buprenorphine product & has no contraindications
- Pt has limited dexterity in his hands d/t the accident and has difficulty splitting tablets.

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Clinical Case 2

- YA is a 66 year old pt w/a relevant PMH of chronic neck and bilateral shoulder pain stemming from a work-related accident 31 years ago on a construction site.
- Pt has been on a full agonist opioid regimen of morphine ER 30mg Q12h + hydrocodone-apap 5-325mg, 2 tabs TID PRN (MEDD 90mg) for the last 7 years
- Pt has been experiencing waning benefit from his medications for the last 18 months and has been requesting dose increases to his PCP which his PCP has declined d/t MEDD of 90mg

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Clinical Case 2

- Pt lives in the metro area near the medical center and picks up medications onsite d/t experiencing a mail delay during a blizzard which caused symptomatic withdrawal and subsequent panic attack which he describes as “intolerable and a nightmare”. Pt has multiple alarms on his phone so ensure he never misses a dose d/t this withdrawal event.
- Pt has never been trialed on a buprenorphine product and has no CI’s
- Pt has a tablet splitter at home and has high health literacy and takes great ownership in his healthcare and shared decision making

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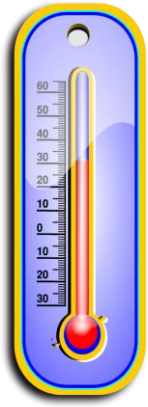
Temperature Check (Poll)

In general, do you feel comfortable prescribing or recommending buprenorphine for pain management for your patients?



A. Yes
B. No
C. "What's your definition of 'comfortable'"…?

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Brief Buprenorphine Background

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Buprenorphine Basics

First approved in 1985 for treatment of moderate-severe pain

Mu opioid receptor *partial* agonist; has a high affinity, slow dissociation rate

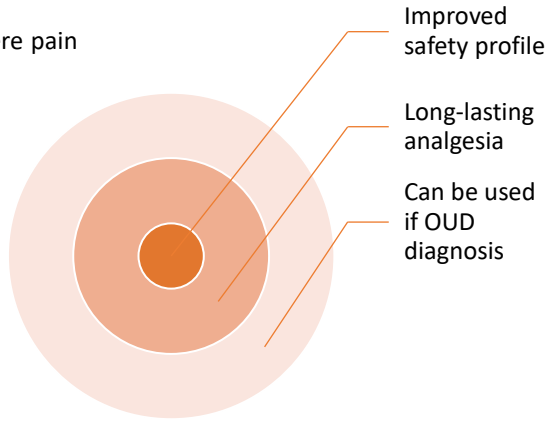
- Greater analgesic coverage
- Improved safety profile compared to full agonists

Kappa and Delta receptor antagonist

- Decreased risk of constipation
- Reduced potential for misuse
- Less dysphoria
- Possible reduction in hyperalgesia

Opioid receptor-like 1 (ORL1) full agonist

- Additional analgesic benefits



•Dahan A. Opioid-induced respiratory effects: new data on buprenorphine. *Palliat Med.* 2006;20 Suppl 1:s3-8.
•McLaughlin JP, Marton-Popovici M, Chavkin C (2003). Kappa opioid receptor antagonism and prodynorphin gene disruption block stress-induced behavioral responses. *J Neurosci.* 23(13):5674—83.
•Mental Health Daily. 2 new kappa opioid receptor (KOR) antagonist for depression. mentalhealthdaily.com/2014/12/19/2-new-kappa-opioid-receptor-kor-antagonists-for-depression/. Accessed January 5, 2018.
•Opioid Agonists, Partial Agonists, Antagonists: Oh My! (pharmacytimes.com); Webster L, Gudin J, Raffa RB et al. *Pain Medicine.* 2020; 21(4): 714-723.

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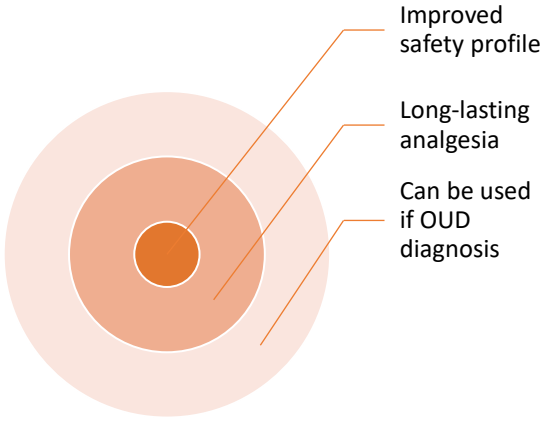
Rationale for Buprenorphine

- Potential for quicker taper off full agonist opioids
- Addresses neurobiological adaptation
- Demonstrated effectiveness for chronic pain management
- Multiple studies in opioid use disorder literature demonstrate improved functioning and effectiveness following discontinuation full opioid agonist use



Guillod P, Edens EL, Becker WC. JAMA Intern Med. 2017;177(1):17-18. Becker WC, et al. J Subst Abuse Treat. 2015; 48(1):128-31

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Buprenorphine Basics

- Buprenorphine is an important consideration in the medical management of chronic pain (as well as opioid use disorder)
  - But it is just one part of a comprehensive treatment plan!
- When considering introducing buprenorphine, be clear about indication for treatment
  - Pain
  - OUD
  - Pain + OUD

Note: physiologic opioid dependence ≠ OUD

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Buprenorphine Basics

- Talk to your patients about what is important to them when considering starting buprenorphine or rotating to buprenorphine
  - Speed of rotation
  - Ability to understand complex medication instructions
  - Manual dexterity if needing to split tablets
  - Ability to tolerate full dissolving of tablets or films
- Consider total daily dose of full agonist opioids when selecting a buprenorphine product

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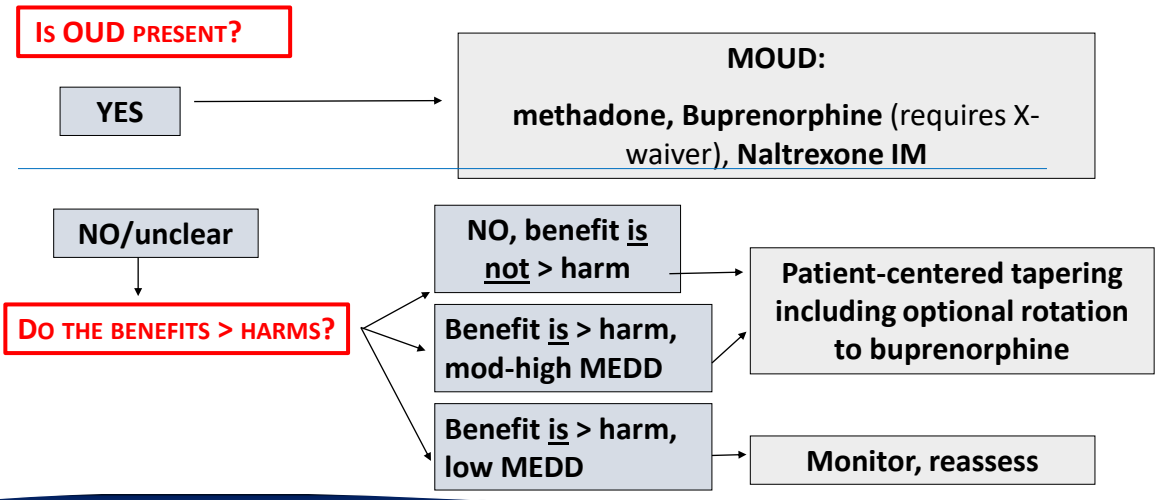
Formulating a Treatment Plan



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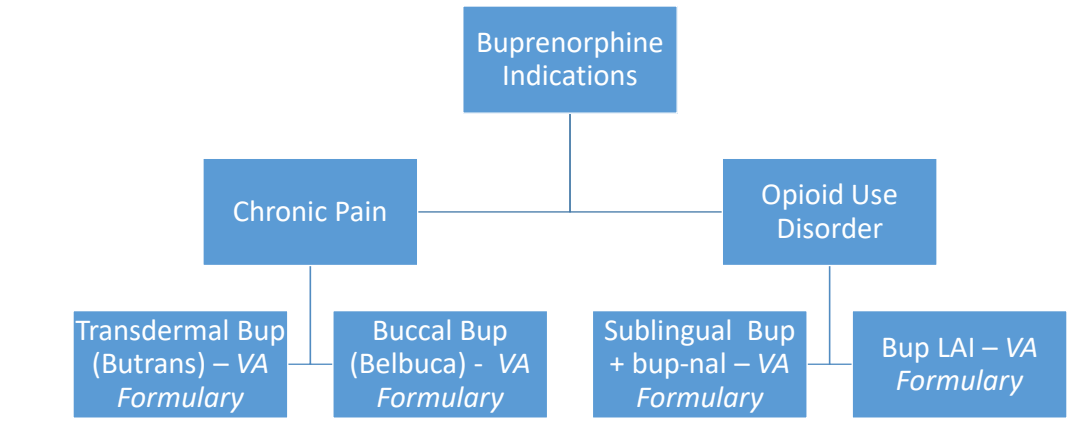
Buprenorphine FDA Indications & Formulations

Sublingual buprenorphine may be used off-label for pain, but transdermal and buccal buprenorphine (other than buccal bup/naloxone) cannot be used off-label for OUD



******REGARDLESS OF INDICATION, BUPRENORPHINE-NALOXONE PRESCRIBER MUST HAVE AN X-WAIVER******

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Buprenorphine Products Available

Brand Name	Generic Name	Formulation	FDA-Approved Indications	Bioavailability	Elimination Half-Life
Suboxone™	Buprenorphine and naloxone	Sublingual film	Treatment of opioid dependence	~30%	24 to 42 hours
Subutex®	Buprenorphine	Sublingual film	Treatment of opioid dependence and are preferred for induction.	~30%	31 to 35 hours
Zubsolv®	Buprenorphine and naloxone	Sublingual tablet	Treatment of opioid dependence	~30%	24 to 42 hours
Bunavail™	Buprenorphine and naloxone	Buccal film	Treatment of opioid dependence	~30%	16.4 to 27.5 hours
Sublocade®	Buprenorphine	Abdominal subcutaneous injection	Treatment of moderate to severe opioid use disorder	100%	43 to 60 days
Probuphine®	Buprenorphine	Implant for subdermal administration (6 month implant)	Maintenance treatment of opioid dependence in patients who have achieved prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine-containing product	31.3%	24 to 48 hours
Buprenex®	Buprenorphine	Intravenous or intramuscular	Management of pain severe enough to require opioid therapy	100%	1.2 to 7.2 hours
Butrans®	Buprenorphine	Transdermal delivery system	Management of pain severe enough to require around-the-clock, long-term opioid treatment	~15%	~26 hours
Belbuca™	Buprenorphine	Buccal film	Management of pain severe enough to require around-the-clock, long-term opioid treatment	46 to 65%	11.2 to 27.6 hours

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Table 2
Sublingual dosing approximations for alternative buprenorphine formulations[a]

Buprenorphine Formulation	Dose	Approximate Buprenorphine SL Tablet Equivalency	Conversion Determinants
Transdermal patch	5 μg/h 10 μg/h 15 μg/h 20 μg/h	0.25 mg 0.5 mg 0.75 mg 1 mg	PK modeling predicts equivalency of 20 μg/h patch and 600 μg buccal film and has been used to extrapolate SL equivalencies
Buccal film	75 μg 150 μg 300 μg 450 μg 600 μg 750 μg 900 μg	0.25 mg 0.5 mg 0.75 mg 1 mg 1.25 mg 1.5 mg 2 mg	Buccal absorption 2 times greater than SL absorption, thus doubling buccal dose may approximate the SL dose equivalent
Long-acting injection	100 mg 300 mg	24 mg >24 mg	PK data suggest 100 mg monthly steady-state dose similar to 24 mg SL

Abbreviation: PK, pharmacokinetic.
[a] Conversions provided are approximations and should always take clinical information into account.

Hickey T, Abelleira A, Acampora G et al. *Med Clin North Am.* 2022; 106(1): 169-185.

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FDA Drug Safety Communication: Buprenorphine Transmucosal

- As of 1/12/22 the FDA announced that dental problems have been reported w/multiple formulations of buprenorphine that are dissolved orally
- These dental concerns include: tooth decay, cavities, oral infections, and loss of teeth
- Despite these risks, the FDA does NOT recommend action in all patients due to possible therapeutic benefits w/treatment and instead recommends mitigation strategies

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FDA Drug Safety Communication: Buprenorphine Transmucosal

FOR PATIENTS:

- Continue taking buprenorphine as prescribed; do not suddenly stop taking the medication w/o talking to the healthcare team as this can lead to serious consequences.
- Stopping suddenly can cause withdrawal symptoms; in people being treated for opioid use disorder, this could trigger a re-use (relapse) event that could result in overdose and death

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FDA Drug Safety Communication: Buprenorphine Transmucosal

FOR PATIENTS:

- Patients using buprenorphine medicines dissolved in the mouth should take extra steps to help lessen the risk of serious dental problems. After the medicine is completely dissolved, take a large sip of water, swish it gently around your teeth and gums, and swallow. You should wait at least 1 hour before brushing your teeth to avoid damage to your teeth and give your mouth a chance to return to its natural state.
- Inform your health care professional if you have a history of tooth problems, including cavities. Schedule a dentist visit soon after starting this medicine and inform your dentist that you are taking buprenorphine, and schedule regular dental checkups while taking this medicine. Your dentist can customize a tooth decay prevention plan for you. Notify both your health care professional and your dentist immediately if you experience any problems with your teeth or gums.

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FDA Drug Safety Communication: Buprenorphine Transmucosal

FOR PROVIDERS:

- Health care professionals should be aware the benefits of buprenorphine medicines clearly outweigh the risks and are an important tool to treat OUD. When combined with counseling and other behavioral therapies, this comprehensive MAT approach is often the most effective way for treating OUD, and can help sustain recovery and prevent or reduce opioid overdose.
- Ask patients about their oral health history prior to prescribing treatment with a transmucosal buprenorphine medicine. These serious dental problems have been reported even in patients with no history of dental issues, so refer them to a dentist as soon as possible after starting transmucosal buprenorphine.

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FDA Drug Safety Communication: Buprenorphine Transmucosal

FOR PROVIDERS:

- Counsel patients about the potential for dental problems and the importance of taking extra steps after the medicine has completely dissolved, including to gently rinse their teeth and gums with water and then swallow. Patients should be advised to wait at least 1 hour before brushing their teeth.

- Dentists treating someone taking a transmucosal buprenorphine product should perform a baseline dental evaluation and caries risk assessment, establish a dental caries preventive plan, and encourage regular dental checkups

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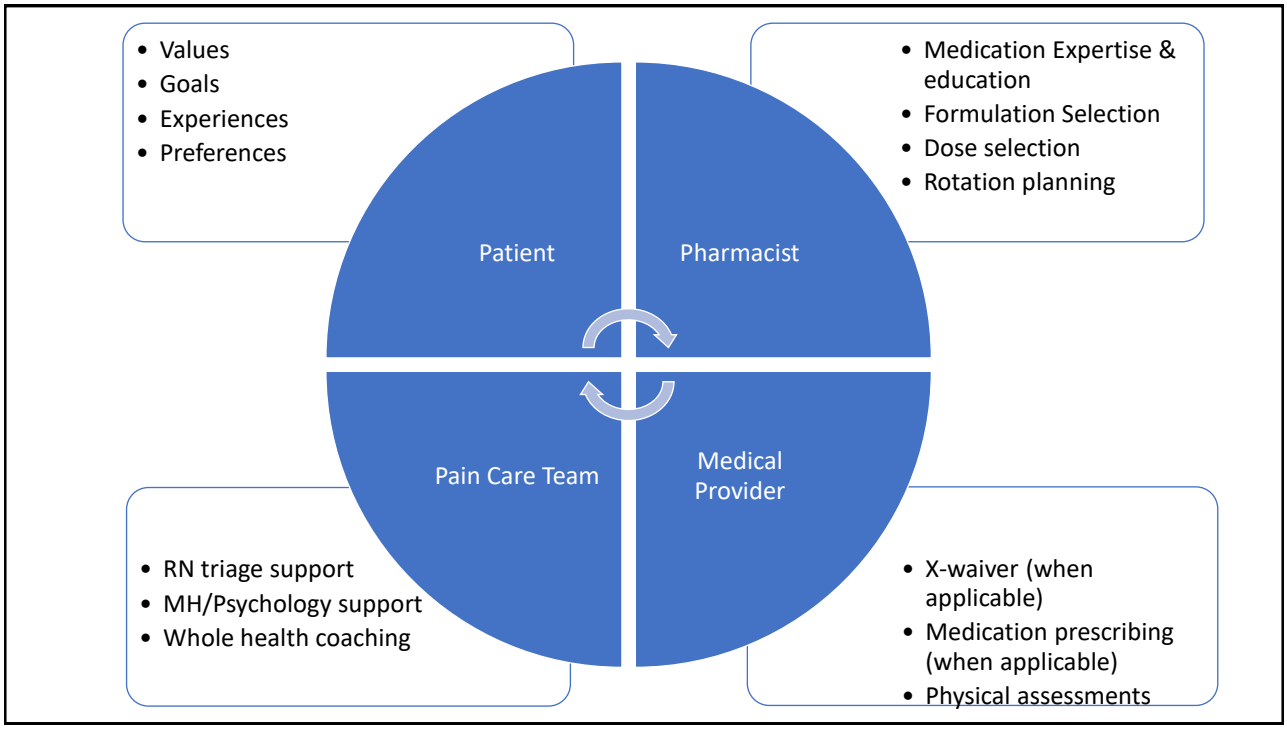

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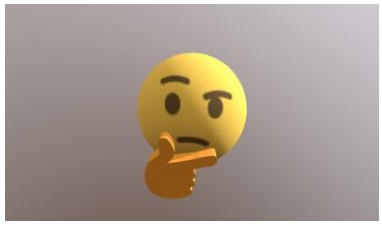

Ok great - we've decided it's safe/appropriate…now what?

Buprenorphine in clinical practice: review of 2 distinct initiation pathways

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Method 1: "stop and go"

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Method 1: "Stop and Go"

When to start buprenorphine/naloxone

- Start buprenorphine/naloxone when a pt presents with a score **higher than 14** on the "Short Opioid Withdrawal Scale"

- Waiting to be in withdrawal will help prevent a more uncomfortable feeling called "precipitated withdrawal" due to bup/nal's high systemic exposure/bioavailability compared to other buprenorphine formulations

SUGGESTED TIME SINCE LAST USE:

It should be at least 12 hours since short-acting opioids (oxycodone, morphine, , hydrocodone, fentanyl (tabs/powder/IV), or heroin)

It should be at least 24 hours since long-acting opioids (oxycodone SA, morphine SR, morphine SA, fentanyl TDS, or methadone).

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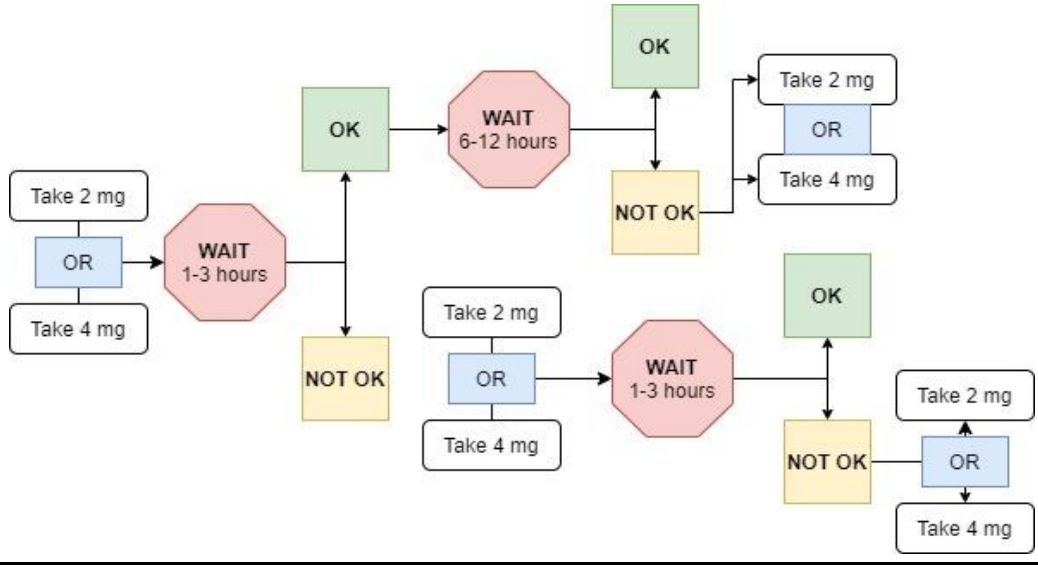
Method 1: "Stop and Go"

Do not take more than 12 mg of buprenorphine/naloxone on **Day 1**



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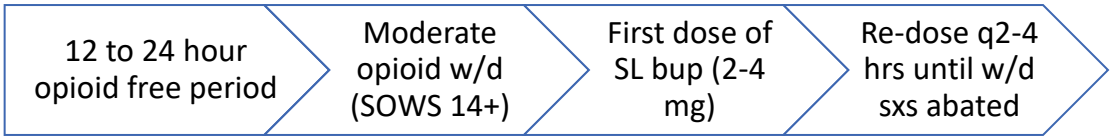
Method 1: "Stop and Go" Summary

Presents a barrier to buprenorphine initiation



- Day 1 of initiation may be done in clinic or at home
- Maximum dose on day 1 typically 8-12mg
- If w/d persists at end of day 1, may provide symptomatic treatment
- Dose is further adjusted over the next several days

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Butrans and Belbuca Initiation & Dosing

Brand	Butrans® (transdermal patch)[5,7]	Belbuca® (buccal film)[5,8]
Strengths	5, 7.5, 10, 15, and 20 mcg/hour	75, 150, 300, 450, 600, 750, and 900 mcg
PADR	Required	Required
X-waiver	Not required	Not required
REMS	Must complete an accredited continuing education program to prescribe: https://opioidanalgesicrems.com	
Initial dosing*	• **Opioid-naïve:** 5 mcg/hour patch • **<30 mg MEDD:** 5 mcg/hour when next dose is due • **30-80 mg MEDD:** taper to <30 mg MEDD[c], then 10 mcg/hour when next dose is due • **>80 mg MEDD:** may not be adequate analgesia, consider buprenorphine buccal film • Change patch and rotate site every 7 days	• **Opioid-naïve:** 75 mcg film 1x daily or q12 hr, as tolerated • **<30 mg MEDD:** 75 mcg film when next dose is due, 1x daily or q12 hr • **30-89 mg MEDD:** taper to <30 mg MEDD[c], then 150 mcg q12 hr when next dose is due • **90-160 mg MEDD:** taper to 30 mg MEDD[c], then 300 mcg q12 hr when next dose is due • **>160 mg MEDD:** may not provide adequate analgesia, consider referral to X-waivered provider for buprenorphine/naloxone • Apply film to mucosa every 12 hours

https://dvagov.sharepoint.com/sites/vhaacademicdetailing/Education Materials/Forms/GroupbyCampaign.aspx?id=%2Fsites%2Fvhaacademicdetailing%2FEducation Materials%2FPain Management%2FProvider Education%2F10-1497_Provider_BuprenorphineforChronicPain_P97020%2Epdf&parent=%2Fsites%2Fvhaacademicdetailing%2FEducation Materials%2FPain Management%2FProvider Education

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Clinical case 1: revisited

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Case 1: JR

- You discuss buprenorphine with the pt and he is amenable to rotation at this time
- You review several ways to rotate from oxycodone SA + IR and the pt reports "let's just get it over with!"
- You bring up the "stop and go" method & reinforce starting buprenorphine once he has been off oxycodone for specific periods of time OR based on withdrawal symptoms & pt says "I'm off oxycodone and in withdrawal frequently anyway because of the mail – it doesn't stress me out since I know the outcome will be to get off oxycodone".

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Poll:

CURRENT REGIMEN: oxycodone SA 20mg Q8h + oxycodone IR 5mg TID

How would you counsel this Veteran on when to start buprenorphine for chronic pain based off his current regimen?

A. At least 12 hours after the last dose of all oxycodone products
B. At least 24 hours after the last dose of all oxycodone products

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A. At least 12 hours after the last dose of all oxycodone products
B. At least 24 hours after the last dose of all oxycodone products

- Pt is on oxycodone SA AND IR so he would need to wait at least 24 hours d/t the SA component

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Clinical Pearls Method 1: Stop and Go

- Full agonist opioid (FAO) dose does **not** clearly correspond to final buprenorphine dose that pt may require
  - We can 'ballpark it' but each pt is different
- Type of buprenorphine product chosen is patient specific based on a number of factors but use total daily FAO MEDD as a guide
  - **Link**: Academic Detailing Buprenorphine Formulations Chart
- Buprenorphine-naloxone even when used for pain requires the provider to be X-waivered

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Method 2: overlapping (low dose buprenorphine initiation)

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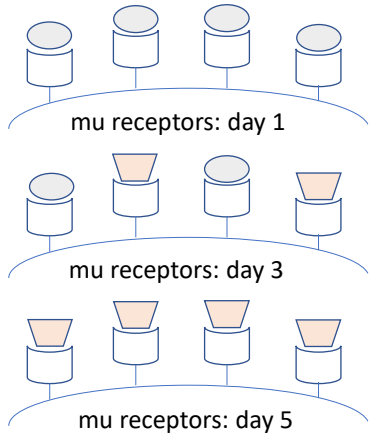
Method 2: Overlapping Initiation

- Concomitant administration of full agonist opioids (FAO) and buprenorphine
- Gradually introduce more buprenorphine over several days
- Buprenorphine continues to displace FAO
- Upon completing overlap period, mu receptors now primarily occupied by buprenorphine



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Method 2: Overlapping Initiation

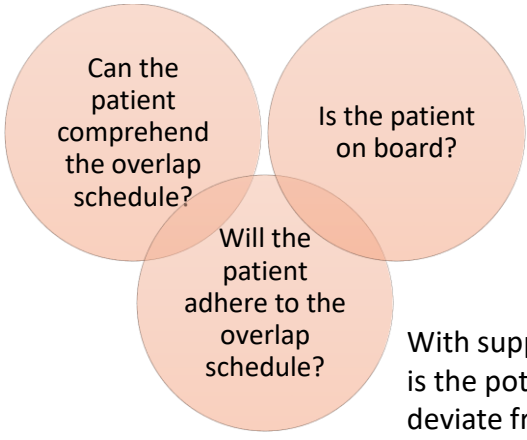
Barriers associated with the "stop & go" approach

- Transition to buprenorphine has typically required a 12-24 hours without opioid consumption and subsequent withdrawal
- In-clinic initiations require patient travel while in opioid withdrawal, now complicated by COVID pandemic
- At-home initiations requiring frequent symptom-driven dose adjustments may be difficult for patients to navigate

Overlap (low-dose) initiation can remove existing barriers to starting buprenorphine

Method 2: Overlapping Initiation

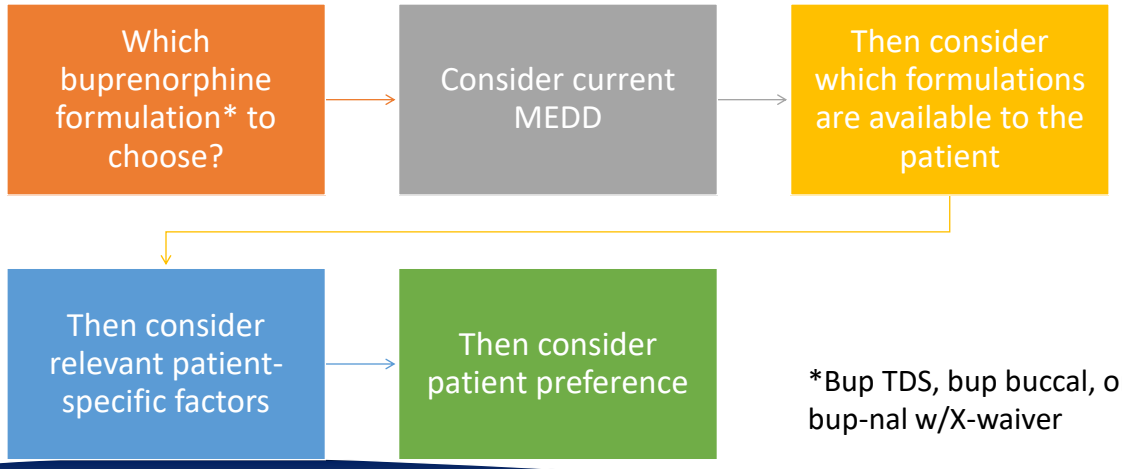
Clear, written instructions outlining overlap plan should be provided



Patient buy-in is imperative going into difficult transitions

With supply of FAO on hand, there is the potential patients may deviate from plan

Method 2: Overlapping Initiation



*Bup TDS, bup buccal, or bup-nal w/X-waiver

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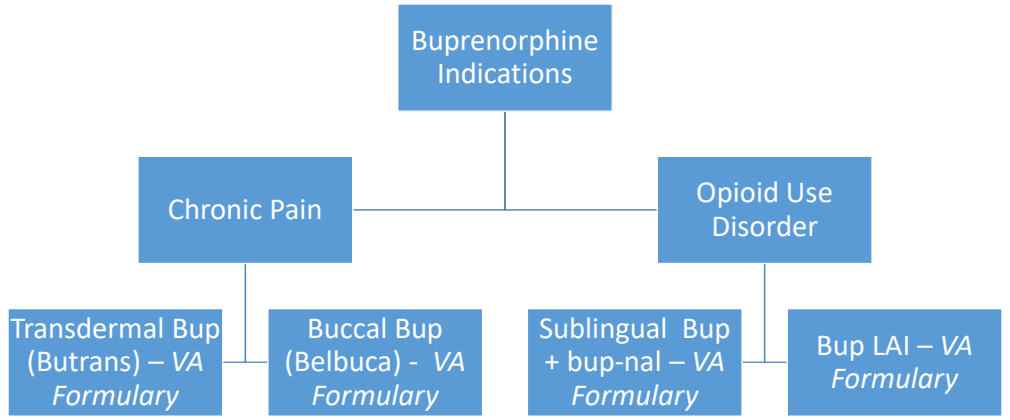
Buprenorphine FDA Indications & Formulations

Sublingual buprenorphine may be used off-label for pain, but transdermal and buccal buprenorphine (other than buccal bup/naloxone) <u>cannot</u> be used off-label for OUD



******REGARDLESS OF INDICATION, BUPRENORPHINE-NALOXONE PRESCRIBER MUST HAVE AN X-WAIVER******

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Method 2: Overlapping Initiation

Sublingual	▪ Many ways to individualize dose and regimen ▪ Allows for switch from higher MEDDs ▪ Inexpensive ▪ Requires X waiver to prescribe in VA
Transdermal	▪ Dosing is less flexible ▪ Allows for very low doses ▪ Can be used for very gradual low-dose bup starts ▪ Patch adhesion and dermatitis are common complaints
Buccal	▪ Dosing can be flexible, particularly useful for lower dose range ▪ May be ideal for inpatient initiations to avoid split sublingual tablets

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Method 2: Overlapping Initiation

"Mini" overlap initiation for Butrans patch:

- Day 1: apply Butrans at MEDD corresponding dose / continue FAO
- Day 2: Butrans remains in place / reduce FAO dose by 50%
- Day 3: Butrans remains in place / stop FAO
- Day 4 onward: adjust buprenorphine dose as needed

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Method 2: Overlapping Initiation

	30-59 mg MEDD		60-89 mg MEDD		90-120 mg MEDD		121-160 mg MEDD	
Day	Full agonist opioids	Buccal Bup	Full agonist opioids	Buccal Bup	Full agonist opioids	Buccal Bup	Full agonist opioids	Buccal Bup
1	Continue	150 mcg BID (300 mcg TDD)	Continue	150 mcg BID (300 mcg TDD)	Continue	300 mcg BID (600 mcg TDD)	Continue	300 mcg BID (600 mcg TDD)
2	Continue	300 mcg BID (600 mcg TDD)	Continue	300 mcg BID (600 mcg TDD)	Continue	300 mcg QAM + 600 mcg QPM (900 mcg TDD)	Continue	300 mcg QAM + 600 mcg QPM (900 mcg TDD)
3	Continue	450 mcg BID (900 mcg TDD)	Continue	450 mcg BID (900 mcg TDD)	Continue	600 mcg BID (1200 mcg TDD)	Continue	600 mcg BID (1200 mcg TDD)
4	Continue	450 mcg BID (900 mcg TDD)	Continue	600 mcg BID (1200 mcg TDD)	Continue	600 mcg QAM + 900 mcg QPM (1500 mcg TDD)	Continue	600 mcg QAM + 900 mcg QPM (1500 mcg TDD)
5 (+)	STOP	450 mcg BID (900 mcg TDD)	STOP	600 mcg BID (1200 mcg TDD)	STOP	600 mcg QAM + 900 mcg QPM (1500 mcg TDD)	STOP	900 mcg BID (1800 mcg TDD)

MEDD, morphine equivalent daily dose; Bup, buprenorphine; BID, twice daily; TDD, total daily dose; QAM, every morning; QPM, every evening.

https://dvagov.sharepoint.com/sites/vhaacademicdetailing/Education Materials/Forms/GroupbyCampaign.aspx?id=%2Fsites%2Fvhaacademicdetailing%2FEducation Materials%2FPain Management%2FProvider Education%2F10-1497_Provider_BuprenorphineforChronicPain_P97020%2Epdf&parent=%2Fsites%2Fvhaacademicdetailing%2FEducation Materials%2FPain Management%2FProvider Education

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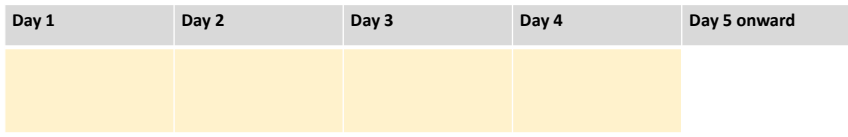
Method 2: Overlapping Initiation
Patient on <80mg MEDD

KEY

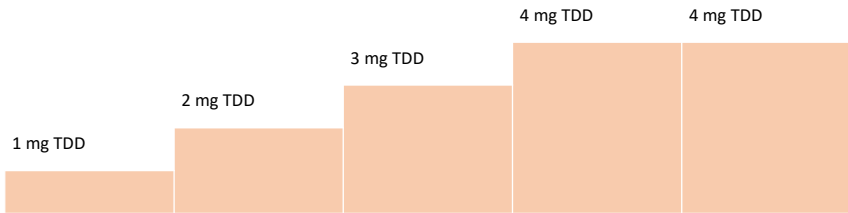
Full agonist

SL buprenorphine-naloxone



TDD = total daily dose

NOTE: The lowest effective dose of buprenorphine should be maintained. Should patients stabilize (no symptoms of opioid withdrawal, pain is at a tolerable level) before reaching the proposed end dose, it is not necessary to proceed with further buprenorphine dose escalations.



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Method 2: Overlapping Initiation
Patient on 80-150mg MEDD

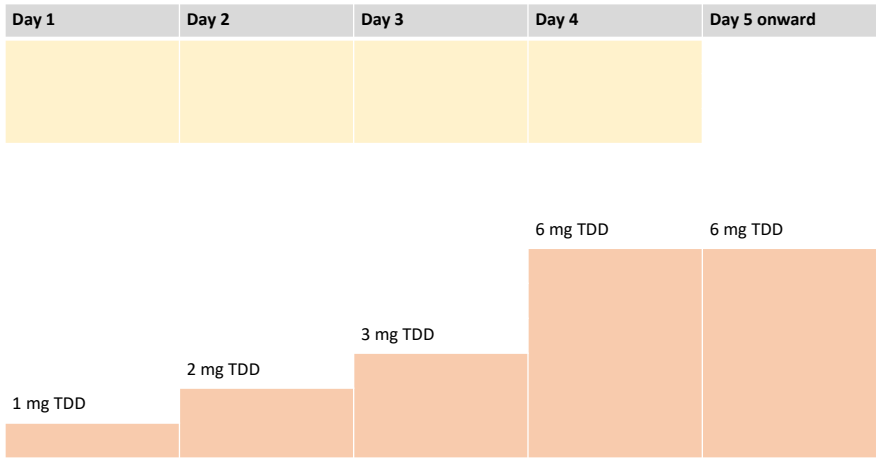
KEY

Full agonist

SL buprenorphine-naloxone

TDD = total daily dose

NOTE: The lowest effective dose of buprenorphine should be maintained. Should patients stabilize (no symptoms of opioid withdrawal, pain is at a tolerable level) before reaching the proposed end dose, it is not necessary to proceed with further buprenorphine dose escalations.



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Method 2: Overlapping Initiation
Patient on >150mg MEDD

KEY

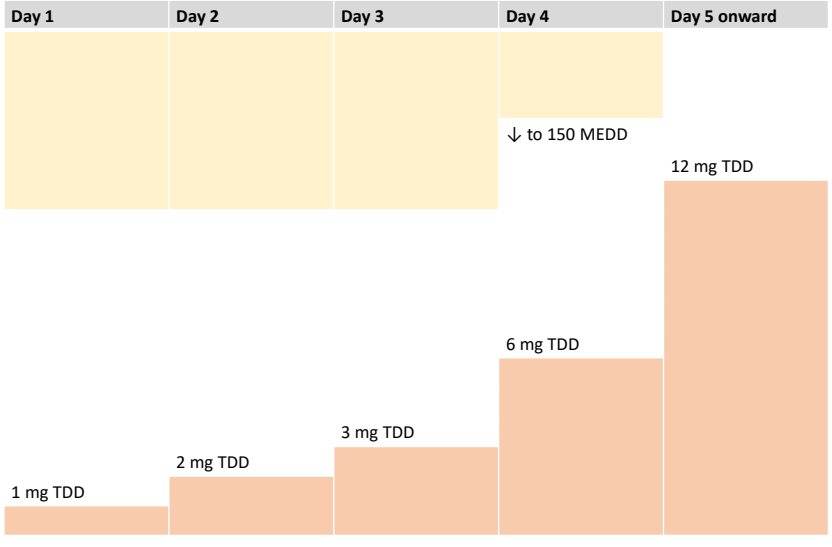
Full agonist

SL buprenorphine-naloxone

TDD = total daily dose

*For patients on > 150 mg MEDD, we recommend a taper to 150 mg MEDD on day 4.

NOTE: The lowest effective dose of buprenorphine should be maintained. Should patients stabilize (no symptoms of opioid withdrawal, pain is at a tolerable level) before reaching the proposed end dose, it is not necessary to proceed with further buprenorphine dose escalations.



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Clinical case 2: Revisited

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Case 2: YA

- You discuss buprenorphine with the pt and he is amenable to rotation at this time
- You review several ways to rotate from morphine ER + hydrocodone-apap and the pt expresses hesitation with intentional withdrawal
- You bring up the “overlap” method & reinforce that this will require several days of dose changes and includes the need to split tablets several days in a row & pt says, “I already split a lot of my tablets anyway & I use my phone to keep me on track with my medications and I haven’t missed any doses of any medication for months. I will make sure I’m staying on track with these dose changes.”

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Poll:

CURRENT REGIMEN: morphine ER 30mg Q12h + hydrocodone-apap 5-325mg, 2 tabs TID (scheduled)

Which buprenorphine formulation(s) could we use for this patient?

A. Sublingual buprenorphine/naloxone
B. Butrans (transdermal)
C. Belbuca (buccal)
D. Sublocade (extended-release injection)

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Poll:

CURRENT REGIMEN: morphine ER 30mg Q12h + hydrocodone-apap 5-325mg, 2 tabs TID (scheduled)

Which buprenorphine formulation(s) could we use for this patient?

A. Sublingual buprenorphine/naloxone
B. Butrans (transdermal)
C. Belbuca (buccal)
D. Sublocade (extended-release injection)

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Clinical Pearls: Method 2- Overlapping

- The overlap case example uses buprenorphine-naloxone due to provider familiarity with dosing as well as dosing flexibility
  - Using buprenorphine transdermal or buccal products can be considered, but require dispensing of multiple strengths and calculating equivalent buprenorphine systemic exposure
- Imperative that patients have a clear road map for what the overlap schedule entails day-by-day
- Frequent check ins with prescriber, pharmacist, or team RN can help ease anxiety and allow for timely adjustments to buprenorphine dosing

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Summary & Closing Thoughts

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Wrap Up

- Buprenorphine is just one part of a comprehensive treatment plan!
- When considering introducing buprenorphine, be clear about indication for treatment [Pain vs. OUD vs. Pain + OUD]
- Talk to your patients about what is important to them when considering starting buprenorphine or rotating to buprenorphine
- Set realistic expectations – these transitions come with an adjustment period, may start off a bit rocky and that's ok!
- Consider total daily dose of full agonist opioids when selecting a buprenorphine product
- Consider prescribing opioid withdrawal symptomatic treatment for patients to have on hand
- Don't hesitate to reach out for guidance/back up!
  - Academic detailing website has several resources

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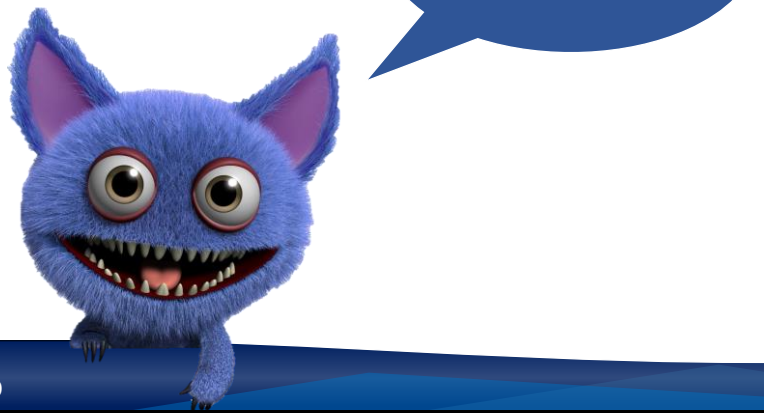

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