# Buprenorphine:
# The Ins and Outs

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## Suggested Reading:

Martin, S, MD, EdM, Chiodo, Lisa, PhD, Bosse, Jordan, MS, RN, Wilson, Amanda, MD (2018) *The Next Stage of Buprenorphine Care of Opioid Use Disorder,* The Annals of Internal Medicine; Vol. 169: pp. 628-635

Objectives for Learning Outcomes:

Following my presentation, participants will be able to apply :

1. The history and pharmacology of Buprenorphine.
2. Integrating Buprenorphine therapy for OUD into their practice.
3. The mechanics of Buprenorphine office visits.
4. Coding and billing for visits.
5. A case scenario run-through.

*If handouts are not included in the session, they were not provided by the presenter.*
*The presenter may choose to provide handouts at the time of the presentation.*

# BUPRENORPHINE:
## The Ins and Outs

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I have no conflicts of interest to disclose.

## Objectives

1. About the drug
2. Integrating into your practice
3. Mechanics of visits
4. Coding and billing
5. Getting your DEA waiver
6. … and a run-through

## A Long Time on the Shelf

- Invented 1966 researchers Reckitt Benckiser UK
- 2002 FDA-approved for treatment of OUD
- First office-based therapy for opioid addiction

Why so long?
- Societal prejudices on maintenance therapy vs abstinence
- Community perceptions of addiction
- Medicalization vs criminalization of addiction
- Patient choice vs provider authority

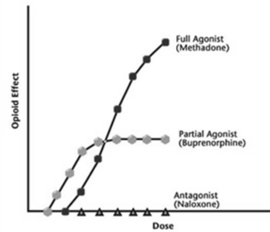
## Buprenorphine Basics

- Sublingual tablet or film
- Partial mu-opioid receptor agonist
- Very high affinity for receptors, can displace full agonist opioids and precipitate florid withdrawal
- Requires period of abstinence before starting
- Schedule III drug
- Mostly metabolized via liver – CYP3A4
- Avoid use if severe liver impairment
- Can use in CKD, but caution in dialysis pts – may need to be re-dosed
- Half-life 24-32 hours

## Buprenorphine Benefits in OUD

- Deeply suppresses drug cravings
- Prevents withdrawal
- Reduces euphoric effects of other opioids (by maintaining high level tolerance)
- Reduces spread of HIV and hepatitis
- Decreases criminal behaviors
- Reduces mortality risk due to OD
- Allows return to productive lifestyle
- Also has excellent analgesic effect
- No respiratory depression

## Ceiling Effect at 24-32 mg/day




## Buprenorphine Benefits – Newer Evidence

- Also a kappa-opioid receptor (dysphoria) antagonist
- Reduces depressive symptoms
- Provides sense of well-being
- Decreases suicidal ideation
- May be indicated for treatment-resistant depression

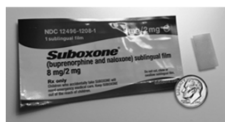
## Buprenorphine Adverse Effects

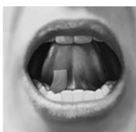
- Fatigue
- Headache
- Nausea
- Constipation
- Insomnia

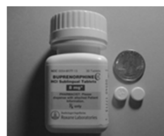
- Not a panacea for every chronic pain patient with OUD

## Subutex vs Suboxone

- Buprenorphine mixed with Naloxone in ratio of 4:1
- Naloxone not absorbed SL or PO – it passes through inert
- Present in combination only to prevent misuse by injecting, smoking or snorting
- Naloxone *will* reverse the effects of Buprenorphine as well as other opioids on board
- Caution reported Naloxone “allergy”







## Buprenorphine Cost

*About $45-75 per month for #30 8 mg tabs – cash, no insurance*

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*About $45-75 per month for #30 8 mg tabs – cash, no insurance*

GoodRx | Type your drug name (like Atorvastatin, Sildenafil, etc) | How GoodRx Works | Discount Card | More | Help | Sign In

Latuda (lurasidone HCl) tablets
Eligible patients can pay as little as a $15* copay per month
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INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS; and SUICIDAL THOUGHTS AND BEHAVIORS
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**Buprenorphine** Generic Butrans, Buprenex, Subutex

BUPRENORPHINE is a pain reliever. It is used to treat moderate to severe pain. The lowest GoodRx price for the most common version of buprenorphine is around $86.90, 73% off the average retail price of $325.63. Compare opioid Agonist/Antagonists.

Prescription Settings | buprenorphine (generic) | sublingu... | 8mg | 60 sublingual tablets | SHARE

**Coupon Notice:** This drug is a controlled substance. Note that some pharmacies may not honor coupons for controlled substances.

Prices | Medicare | Savings Tips 2 | Drug Info | Side Effects | Images | Latest News 3

Prices and coupons for 60 sublingual tablets of buprenorphine 8mg

Lowest prices near Kingston, WA

| Pharmacy | Est retail price | Price | |
|---|---|---|---|
| Albertsons | $320 est retail price | $86.90 with free coupon | GET FREE COUPON |
| Safeway | $335 est retail price | $86.90 with free coupon | GET FREE COUPON |
| Bartell Drug Co | | $88.25 with free coupon | GET FREE COUPON |
| Fred Meyer Pharmacy | $281 est retail price | $95.95 with free coupon | GET FREE COUPON |

SAVINGS TIP
**Fill a 90-Day Supply to Save** See Tips

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**Buprenorphine / Naloxone** Generic Suboxone Tablet, Suboxone Film

Buprenorphine/naloxone (Suboxone Film, Suboxone Tablet) is an expensive drug used to treat certain types of drug dependence. This drug is more popular than comparable drugs. It is available in both brand and generic versions. Generic buprenorphine/naloxone is covered by most Medicare and insurance plans, but some pharmacy coupons or cash prices may be lower. The lowest GoodRx price for the most common version of buprenorphine / naloxone is around $154.70, 71% off the average retail price of $548.29. Compare opioid Agonist/Antagonists.

Prescription Settings | buprenorphine / naloxone (generic) | sublingu... | 8mg/2mg | 60 sublingual tablets | SHARE

**Coupon Notice:** This drug is a controlled substance. Note that some pharmacies may not honor coupons for controlled substances.

Prices | Medicare | Savings Tips 2 | Drug Info | Side Effects | Images | Latest News 6

Prices and coupons for 60 sublingual tablets of buprenorphine / naloxone 8mg/2mg

Lowest prices near Kingston, WA

| Pharmacy | Est retail price | Price | |
|---|---|---|---|
| Walgreens | | $154.70 with free discount | GET FREE DISCOUNT |
| Albertsons | $566 est retail price | $158.90 with free coupon | GET FREE COUPON |
| Safeway | $577 est retail price | $158.90 with free coupon | GET FREE COUPON |
| Fred Meyer Pharmacy | | $164.61 with free coupon | GET FREE COUPON |

## Who Is a Good Candidate for Buprenorphine?

- You'd be surprised at how many patients are appropriate
- Desire for sobriety vs just staving off withdrawal
- Relatively safe and stable living environment
- Ability/willingness to pursue plan of sobriety
- Also co-morbid chronic pain, with opioid and benzo co-dependence
- *Possibly* ANY at-risk, chronic pain, opioid dependent patient – but not a panacea

## Pregnancy and Breast-Feeding

- Crosses placenta
- Buprenorphine safe and effective for mother and fetus, with reduced severity neonatal abstinence syndrome in newborns (compared to Methadone or Heroin)
- Usually prescribed without Naloxone (Risk Factor C) to avoid unnecessary exposure
- Present in breast milk – but Buprenorphine has very poor oral absorption
- Breastfeeding may prevent NAS and provide slow, natural wean

## Duration of Therapy

- Short-term treatment with rapid taper associated with high risk of relapse (> 80%)
- Long-term (years) maintenance therapy is usually indicated
- Think chronic disease model of care

## Acute Pain Management in Patients on Buprenorphine

- Often not necessary to stop Buprenorphine
- Mild-moderate pain, add non-opioid analgesics – get creative
- Moderate-severe pain, up-titrate Buprenorphine to max of 32 mg/day
- Can use small doses short-acting full agonists – IV Morphine, Fentanyl
- Regional anesthesia
- For planned surgery, can stop Buprenorphine 12-18 hours beforehand – prepare to treat some withdrawal on arrival

## Getting Started in Your Practice

- Train schedulers to be on lookout for patients seeking OUD care and book appropriately
- Help them develop a script for patients
  - Please don't come to your appointment in withdrawal
  - No prescription at first visit
  - Bring trusted friend or family member to be accessory ears, note taker
- 30-60 min initial visits, limit focus to OUD – code based on time
- 15-20 min F/U visits
- All-staff meetings to openly discuss fears, assumptions, implicit bias, emergency plans
- Consider having a patient in recovery come to speak with staff and answer questions

## Educating Community Colleagues

- Network with local BH/SW providers (? clergy, counseling students)
- Hospital medical staff meetings
- Speak with ED colleagues
- What to do with pts who've run out of Buprenorphine?
- How should they contact you about your patients?
- Managing acute pain in Buprenorphine patients

## Office Mechanics

- MA rooming details (not a pain visit)
- Review the common vocabulary you will both use with patients
- ”Favorite” orders in EMR:
  - Urine tox screens
  - Narcan, Plan B, Hep A and B immunizations
  - HIV, Hep C screening
  - BH referrals
- Educational materials and links to 12-step groups
- PMP check process

## Obtaining an Addiction History

- Tell me the story of how you became addicted. Just start at the beginning and tell me the story …
- When did you *have* to transition to heroin?
- How much ___ do you need to feel normal?
- How long can you go without using before you feel sick?
- When and how much do you need to get to sleep, to get through work, when you’re especially stressed?
- What other drugs do you use … sometimes?
- What other treatments or programs have you tried to get sober?

## Patient Education

- Encourage note taking
- “Dot phrases” to blow education into discharge paperwork
- Review pharmacology of buprenorphine – many misconceptions on street
  - Side effects
  - How interacts with illicits
  - Acute pain management
- Describe your treatment vision and plan
- Reinforce long duration of therapy
- Leave lots of time for questions

## Rules of the Road

- Prescribe at first visit? Pros and cons
- Contracts – yes or no?
- Regular urine toxicology screening
- ? adjunct behavioral health sessions
- ? 12-step meetings

- “Dot phrases” to blow in adjunctive care offerings into discharge paperwork

## Discuss Other Options

- Finding other Buprenorphine prescribers
- https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- Methadone maintenance programs
- Naltrexone

## Urine Toxicology

- In-house or send out ok
- Probably don’t need at first visit
  - “tell me what we’ll find in your urine today…”
- Thereafter, consider obtaining urine sample at every visit, and processing periodically
- Lab medicine/pathologist is your friend
- What to do with aberrant results?

## Induction

- Home induction is safe and appropriate
- 18-24 hours out from last opioid (longer for Methadone)
- Typically start 2-4 mg with patient moderate withdrawal, dose and observe for 2 hours, redose every 2 hrs as needed
- 8 mg max on Day #1
- Most stabilize on 8-16 mg per day, dosed once or twice a day
- Rx 3-5 day estimated supply, with phone check-in 24 hrs, return visit 3 days
- Then F/U 1 week, and weekly for first few weeks
- Then longer intervals, eventually monthly

## Transition from Methadone

- Methadone half-life many days
- Taper Methadone to 30 mg or less daily to avoid precipitating withdrawal with Buprenorphine
- One study at Methadone 100 mg, repeated small doses Buprenorphine avoided precipitated withdrawal

## Maintenance Therapy

- Remember, you are managing a chronic disease
- Prescriptions only with office visit
- Review new life stressors, psychiatric and medical issues since last visit
- Review Buprenorphine efficacy and side effects
- Openly discuss relapses (or almosts)
- "Let's look at your notebook"
- Reconsider benefits of 12-steps and/or behavioral health
- Urine samples
- Eventually CAN discuss dose taper – but not essential

## Patient History Dictates Intensity of services Needed

- Polysubstance use
- Dual psychiatric diagnoses
- Previous failed treatment attempts
- Safety of recovery environment
- Readiness for change
- Co-morbid medical illness

May need more support than you can provide

## Coding and Billing – ICD-10

- F-codes = Mental, Behavioral, Neurodevelopmental Disorders

- *F11.2 Opioid Dependence*
- *F11.21 Dependence in remission*
- F11.22 Dependence with intoxication
- F11.23 Dependence in withdrawal

## Coding and Billing – E/M Time-Based

Most initial visits are time-based (counseling and coordinating care)

New Patient 99204 (45 min)/99205 (60 min)

Established Patient 99215 (40 mins)

## Coding and Billing – E/M Complexity

- F/U visits usually 99213-99214 based on complexity
- Interpreting results of urine toxicology
- Address comorbid depression, anxiety, personality disorders
- Address chronic pain diagnoses
- Assess and manage chronic liver and kidney disease
- Consider conditions requiring medications which may interact with Buprenorphine
- Comorbid substance use disorders (tobacco)

## Buprenorphine Waiver Training for APP's

- PCSS (Providers Clinical Support System) funded by SAMHSA
- https://pcssnow.org/
- "Pharma free"
- Total of 24 hours
- Live, or half and half (webinar counted as live) first 8 hours
- 16 hours of follow-on modules

## APP Waiver

- 24 hours of training – FREE, provides 24 AANP/AAPA Category 1 CE credits
- Then complete DEA Waiver "Notice of Intent" form
  - Completed training, and
  - Have capacity to refer patients for counseling and social services
- Notification reviewed within 45 days (usually receive response in couple weeks)
- 30 patients in first year -> 100

## PCSS - Free Volunteer Clinical Mentors

## Remember – Exception to Waiver Rule

Any hospital provider may bridge a patient already on maintenance Buprenorphine during inpatient hospitalization for a medical/surgical indication.

## Case Scenario - Colleen

- You are an ARNP in a small town community practice. You've just been granted your Buprenorphine waiver by the DEA. You have been matched with an ARNP clinical mentor via PCSS.
- 37 yo female pediatrician in small town 8 miles away – new pt to your practice – 60 min time slot
- No significant past medical history
- Strong family history substance abuse
- Over-used Percocet prescribed following arthroscopic knee surgery 4 years ago. Ortho prescribed for 6 mos then became alarmed and stopped.
- Continuous illicit use of prescription Oxycodone for 4 years, always orally, buying on weekends on street in big city an hour away. 160 mg/day.

## Case Scenario - Colleen

- Initially used for that unexpected warm euphoric feeling, when tired, for pick-me-up, when feeling down, angry, after arguing with spouse. Now takes just so she won't get sick and to feel "normal."
- Bought heroin for *first time* last week when she couldn't access Oxycodone and was feeling really sick – smoked it in a pipe. Scared her badly. Desperately wants help.
- Is she a good candidate for you to prescribe Buprenorphine/Naloxone?

## Case Scenario - Colleen

- What components would comprise your physical exam?
- What lab tests would you order?
- How much Buprenorphine/Naloxone would you prescribe and how would you describe how to use it?
- How long should she wait after her last Oxycodone before taking Buprenorphine/Naloxone?
- How long after induction should you see her again?
- What adjunctive components of her treatment would you recommend?
- What E/M code would you use for her first visit?

## Questions?
## Thank you for listening!

Feel free to contact me.

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