1 Assess the need for treatment
For persons diagnosed with an opioid use disorder, first determine the severity of patient’s substance use disorder. Then identify any underlying or co-occurring diseases or conditions, the effect of opioid use on the patient’s physical and psychological functioning, and the outcomes of past treatment episodes.

Your assessment should include:
- A patient history
- Ensure that the assessment includes a medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports.
- Access the patient’s prescription drug use history through the state’s Prescription Drug Monitoring Program (PDMP), where available, to detect unreported use of other medications, such as sedative-hypnotics or alcohol, that may interact adversely with the treatment medications.
- A physical examination that focuses on physical findings related to addiction and its complications.
- Laboratory testing to assess recent opioid use and to screen for use of other drugs. Useful tests include a urine drug screen or other toxicology screen, urine test for alcohol (ethyl glucuronide), liver enzymes, serum bilirubin, serum creatinine, as well as tests for hepatitis B and C and HIV. Treatment should not be delayed awaiting lab results.

2 Educate the patient about how the medication works and the associated risks and benefits; obtain informed consent; and educate on overdose prevention.

3 Evaluate the need for medically managed withdrawal from opioids
Those starting Buprenorphine must be in a state of withdrawal.

4 Address co-occurring disorders
Have an integrated treatment approach to meet the substance use, medical and mental health, and social needs of a patient.

5 Integrate pharmacologic and nonpharmacologic therapies
All medications for the treatment of the opioid use disorder should be prescribed as part of a comprehensive individualized treatment plan that may include counseling and other psychosocial therapies, as well as social support through participation in mutual-help programs. Treatment should not be withheld in the absence of psychosocial counseling.

6 Refer patients for higher levels of care, if necessary.

There is potential for relapse & overdose on discontinuation of the medication. Patients should be educated about the effects of using opioids and other drugs while taking the prescribed medication and the potential for overdose if opioid use is resumed after tolerance is lost.
Buprenorphine Quick Start Guide for In Office Induction

**Initial Assessment**
- History and Physical
  - Concurrent medical issues and substance use
  - Medication history (with review of the PDMP)
  - Allergies
  - Mental health status and social history
  - Social history

- Lab Workup
  - CBC, CMP, HIV, hepatitis A, B & C
  - Urine drug testing, and consider pregnancy & STD screen

- Referral
  - Refer to specialists as indicated
  - Refer to counseling
  - Refer to case management

- Provide Patient Education
  - Treatment goals and medication education
  - Side-effects
  - How to store medication at home
  - Patient should update provider with new medications or other changes
  - Establish open communication

- Discuss Safety Concerns
  - Altered tolerance to opioids on buprenorphine/suboxone
  - No co-administration of alcohol or benzodiazepines
  - Alert provider if planning pregnancy or pregnant
  - Planned procedures that may require opioid analgesia

**Day One (Induction)**
- Last opioid use >6-12 hours ago
- Moderate Withdrawal (COWS >12)
- Give First Dose of
  - Buprenorphine/Naloxone
  - (2 – 4mg)
- After 1 Hour
  - Monitor for precipitated withdrawal
  - If present, treat symptoms
  - Attempt induction 24 hours later

- 2 – 4 Hours Later
  - Withdrawal Symptoms Relieved?
  - Yes
    - Prescribe one dose
    - Return to clinic on day two for observation and review
  - No
    - Give further 2 – 4mg dose

- 2 – 4 Hours Later
  - Withdrawal Symptoms Relieved?
  - Yes
    - Prescribe one dose
    - Return to clinic on day two for observation and review
  - No
    - Give further 2 – 4mg dose, up to 8mg total

**Day Two**
- Give day 1 dose and additional 2 – 4mg up to 16mg total
- Adequate symptom relief achieved
  - After induction?
  - Yes
    - Induction Complete - Give induction dose as ongoing dose, and review in 1 day
  - No
    - Give further 2 – 4mg dose, up to 15mg

- 2 – 4 Hours Later
  - Withdrawal Symptoms Relieved?
  - Yes
    - Induction Complete - Give induction dose as ongoing dose, and review in 1 day
  - No
    - Give further 2 – 4mg dose, up to 15mg

**Maintenance**
- Consider further 2 – 4mg dose, up to 15mg
- Patient Stable On Current Dose?
  - Yes
    - Continue once daily dosing with regular review
  - No

- Perform monthly urinary drug screens, and check PDMP regularly. Ensure on-going attendance at counseling and support groups. When patient stable on medication, assess readiness for take-home dosing.