Microdosing and Extended-Release Buprenorphine

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Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.
Why Consider Microdosing?

• Compared to methadone maintenance, buprenorphine has:
  • fewer medication interactions
  • no concern for QTc prolongation
  • greater ease of access than methadone (esp. in rural communities and residential treatment programs)
  • Lower overdose risk in patients with polysubstance use (esp. concurrent sedative-hypnotic or alcohol use)

• However, **Bup can be difficult to initiate** both for patients currently on methadone and patients using non-prescribed opioids due to risk for precipitated withdrawal (esp. in patients who have experienced this before)

Ghosh, Klaire, Tanguagey, Manek, Azar, 2019
Marteau, McDonald, and Patel, 2015
Problems with Traditional Bup Induction

- **Traditional induction** requires the need for “opioid washout,” waiting for moderate opioid withdrawal before starting Bup (12-24 hours for diacetylmorphine, at least 72 hours for methadone if at 40mg or less).
  - This necessary withdrawal period poses an intolerable barrier to treatment initiation for many.
  - *Still* carries risk of worsening withdrawal when Bup is started, particularly with longer-acting agents.
  - Further complicated if the patient has chronic or acute pain treated with opioids.

Ghosh, Klaire, Tanguage, Manek, Azar, 2019
Additional Trouble with Fentanyl

• Rapid onset, short duration of action
• Old pharmacokinetic studies relied on single/limited dose administration, resulting in half-life of 1.5 to 7 hours
• However, fentanyl is highly lipophilic, and so for those chronically exposed to fentanyl we see increased volume of systemic fentanyl distribution and slow dissipation
  • “mean time to fentanyl clearance from urine was 1 week and norfentanyl clearance was nearly 2 weeks” (similar to THC)
• This may explain difficulty in traditional bup inductions in patients using illicit fentanyl despite waiting until they are in moderate to severe withdrawal based on COWS (sometimes waiting over 48 hours)
• Non-pharmaceutical fentanyl/fentanyl analogues have unknown pharmacokinetics/pharmacodynamics, may be even more lipophilic

Huhn, Hobelmann, Oyler, and Strain, 2020
Randhawa, Brar, and Nolan, 2020
Basic Concept of Microdosing

1. Continue full mu-receptor agonists (illicit or prescribed)
2. Introduce Bup (with its long half life, high mu-receptor affinity, but only partial mu-receptor agonism) as slowly and gently as possible to avoid precipitated withdrawal
3. As Bup is slowly increased, the full agonist is gradually displaced by Bup, which greatly limits the potential for and severity of precipitated withdrawal
4. Eventually, Bup becomes the dominant opioid at central mu-opioid receptors (eg taking up more than 50% of receptors), at which point the full agonist can be discontinued or rapidly tapered off
What About the Full Agonist?

- Theoretically, no need to cross taper down the full agonist during this time
  - Bup slowly out-competes the full agonist, reducing the amount of full agonist that has purchase on the mu receptors, even if full agonist total daily dose remains consistent
  - Bup slowly “tapers” the full agonist down by outcompeting it
  - Still, many protocols recommend reducing full agonist dose as much as tolerated before starting
Multiple Microdosing Protocols

- **Many methods** published in case reports and case series
  - Different timelines
  - Various formulations of Bup (SL, transdermal, buccal, IV)
  - Different patient populations (OUD, chronic pain, inpatient vs outpatient)
  - Some taper full-agonists down to a particular MME prior to starting Bup
  - Some taper full agonist while Bup is titrating up, some keep full agonist at full dose until Bup reaches 8-12 mg/day and then simply discontinue the full agonist
# The Forerunner: The Bernese Method

<table>
<thead>
<tr>
<th>Day</th>
<th>Buprenorphine (sl)</th>
<th>Street heroin (sniffed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.2 mg</td>
<td>2.5 g</td>
</tr>
<tr>
<td>2</td>
<td>0.2 mg</td>
<td>2 g</td>
</tr>
<tr>
<td>3</td>
<td>0.8+2 mg</td>
<td>0.5 g</td>
</tr>
<tr>
<td>4</td>
<td>2+2.5 mg</td>
<td>1.5 g</td>
</tr>
<tr>
<td>5</td>
<td>2.5+2.5 mg</td>
<td>0.5 g</td>
</tr>
<tr>
<td>6</td>
<td>2.5+4 mg</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>4+4 mg</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>4+4 mg</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>8+4 mg</td>
<td>0</td>
</tr>
</tbody>
</table>

**Abbreviation:** sl, sublingual.

Limitations of the Bernese method

• Study was done in Switzerland, and 0.2 mg SL Bup formulation is not available in the United States

• 2 mg dose is smallest available in the US (both film and tab), can quarter it to 0.5 mg
## Modified Bernese

<table>
<thead>
<tr>
<th>Day</th>
<th>Buprenorphine dosage</th>
<th>Methadone dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.5 mg(^a) SL once/day</td>
<td>Full dose</td>
</tr>
<tr>
<td>2</td>
<td>0.5 mg(^a) SL twice/day</td>
<td>Full dose</td>
</tr>
<tr>
<td>3</td>
<td>1 mg SL twice/day</td>
<td>Full dose</td>
</tr>
<tr>
<td>4</td>
<td>2 mg SL twice/day</td>
<td>Full dose</td>
</tr>
<tr>
<td>5</td>
<td>4 mg SL twice/day</td>
<td>Full dose</td>
</tr>
<tr>
<td>6</td>
<td>8 mg SL once/day</td>
<td>Full dose</td>
</tr>
<tr>
<td>7</td>
<td>8 mg SL in A.M. and 4 mg SL in P.M.</td>
<td>Full dose</td>
</tr>
<tr>
<td>8</td>
<td>12 mg SL/day</td>
<td>Stop</td>
</tr>
</tbody>
</table>

SL = sublingually.

\(^a\)For our buprenorphine formulation, one-quarter of a 2-mg sublingual strip was used.
Buccal Bup Microdosing

- Belbuca 225 mcg = 0.5 mg SL Bup
- Essentially a modified Bernese method but using Belbuca for first three days avoid cutting any SL strips
- Belbuca is only FDA-approved for chronic pain so limited outpatient use for microdosing

**TABLE 2.** Buccal Buprenorphine Induction Strategy

<table>
<thead>
<tr>
<th>Day</th>
<th>Buccal Buprenorphine Film Dose</th>
<th>SL Buprenorphine/Naloxone Film Dose</th>
<th>Full Opioid Agonist Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>225 mcg PO once (75 mcg film + 150 mcg film)</td>
<td>2 mg SL BID</td>
<td>Full dose</td>
</tr>
<tr>
<td>2</td>
<td>225 mcg PO twice daily (75 mcg film + 150 mcg film)</td>
<td>4 mg SL BID</td>
<td>Full dose</td>
</tr>
<tr>
<td>3</td>
<td>450 mcg PO twice daily</td>
<td>4 mg SL TID</td>
<td>Full dose</td>
</tr>
<tr>
<td>4</td>
<td>450 mcg PO twice daily</td>
<td>2 mg SL TID – 8 mg SL BID</td>
<td>Stop</td>
</tr>
</tbody>
</table>

BID, twice daily; PO, per oral; SL, sublingual; TID, 3 times daily.

Transdermal Bup Considerations

- Designed as a 7 day patch for chronic pain
- 20 mcg/hour patch $\rightarrow$ 480 mcg/day $\rightarrow$ roughly 0.5 mg bup daily
- Patch reaches peak plasma concentrations at 48 hours, might allow for even more gradual introduction of bup
- Butrans patch only FDA-approved for chronic pain so limited outpatient use for microdosing

Ghosh, Klaire, Tanguagey, Manek, Azar, 2019
Raheemullah and Lembke, 2019
Transdermal Bup Sample Method

- Day 1: 20mcg patch x1, continue baseline methadone
- Day 3: apply a second 20mcg patch; decrease methadone dose by 1/3
- Day 5: apply a third 20mcg patch; decrease methadone dose 1/3
- Day 7: Stop methadone, start SL Bup 2mg and increase as tolerated

Ghosh, Klaire, Tanguagey, Manek, Azar, 2019
Transdermal Bup for Chronic Pain

<table>
<thead>
<tr>
<th>Before Induction</th>
<th>Day 1</th>
<th>Day 2\textsuperscript{a}</th>
<th>Day 3</th>
<th>After Full Agonist Opioid Discontinuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slowly taper full agonist opioids as tolerated until discontinued</td>
<td>Administer transdermal buprenorphine 20 μg/hr microdosing 48 hr bridge</td>
<td>Administer previous day's total SL buprenorphine dose. If tolerated,\textsuperscript{b} administer 2 to 4 mg every 2 to 4 h as needed.\textsuperscript{c} Limit second day SL buprenorphine dose to 16 mg.\textsuperscript{d}</td>
<td>Discontinue full agonist opioids not yet tapered. Continue established SL buprenorphine daily dose.\textsuperscript{e}</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{a}Day 2 starts the transdermal buprenorphine microdosing.

Raheemullah and Lembke, 2019
“Rapid” Microinduction

- Bernese type protocols dose Bup Q12H
- “Rapid” protocols dose Bup at Q1-4H
- SL Bup’s time to peak plasma concentration is 60 to 90 minutes, making more frequent dosing feasible

Ghosh, Klaire, Tanguagey, Manek, Azar, 2019
Chiang, and Hawks, 2003
# Rapid Microdosing Protocols

**TABLE 1. Titration schedule for Case 1**

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine/Naloxone*</th>
<th>Hydromorphone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dosing</td>
<td>Total Daily Dose</td>
</tr>
<tr>
<td>Day 0</td>
<td>N/A</td>
<td>1 mg</td>
</tr>
<tr>
<td>Day 1</td>
<td>0.25g SL q4h</td>
<td>2.5 mg</td>
</tr>
<tr>
<td>Day 2</td>
<td>0.5 mg SL q4h</td>
<td>5 mg</td>
</tr>
<tr>
<td>Day 3</td>
<td>1 mg SL q4h</td>
<td>8 mg</td>
</tr>
<tr>
<td>Day 4</td>
<td>2 mg SL q4h</td>
<td>16 mg</td>
</tr>
<tr>
<td>Day 5</td>
<td>16 mg SL daily</td>
<td>Discontinued</td>
</tr>
</tbody>
</table>

**TABLE 2. Titration schedule for Case 2**

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine/Naloxone*</th>
<th>Hydromorphone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dosing</td>
<td>Total Daily Dose</td>
</tr>
<tr>
<td>Day 0</td>
<td>N/A</td>
<td>3 mg</td>
</tr>
<tr>
<td>Day 1</td>
<td>0.5 mg SL q3h</td>
<td>2.5 mg</td>
</tr>
<tr>
<td>Day 2</td>
<td>1 mg SL q3h</td>
<td>8 mg</td>
</tr>
<tr>
<td>Day 3</td>
<td>12 mg SL daily</td>
<td>12 mg</td>
</tr>
</tbody>
</table>

Klaire, Zivanovic, Barbic, Sandhu, Mathew, Azar, 2019
Other methods not covered here

- “Azar method” using transdermal fentanyl patch
- Slow-release oral morphine (SROM) methods
- Both involved converting daily opioid requirement/use to equipotent dose of a more predictable a short acting full agonist like fentanyl patch or SROM, then maintaining on this opioid to achieve washout of previous opioids, then using a traditional SL Bup induction
- IV Bup microdosing has also been reported
CAUTION with Microdosing

• **Data is limited** to case reports and case series
• There are **no randomized trials published yet** directly comparing ANY microdosing protocol to traditional Bup induction (or to other microdosing protocols) for tolerability, treatment retention, etc.
• Off label use of medications is limited in outpatient OUD treatment
• Collaborating with methadone clinics on microdosing in outpatient setting is important, can be challenging
• **HOWEVER**: Benefits likely outweigh the massive risk of patient with OUD going without standard of care and lifesaving treatment with Bup maintenance

Terasaki, Smith, and Calcaterra, 2019
Final Recommendations for Microdosing

- Any microdosing protocol can be considered so long as it adheres to basic principles of small doses increased stepwise while patient is maintained on full agonist opioids.
- Ok to be flexible if patient skips or delays a dose.
- Use comfort medications aggressively:
  - clonidine, acetaminophen/ibuprofen, dicyclomine, consider short benzodiazepine rx
- A strong therapeutic alliance with patient (esp. with OUD patients) is key, as many are traumatized by previous precipitated withdrawal.
- Daily phone call check-ins if outpatient.
- Education and direct involvement of hospital/community pharmacists and of bedside nursing.
- Create order sets to simplify protocols.
Long Acting Buprenorphine - Why?

- SL Bup is new standard of care, but it has drawbacks:
  - **potential for withdrawal** if missed/forgotten dose/loss of access due to insurance or pharmacy issue
  - patients must remember to take regularly
  - **stigma** of being seen with SL Bup
  - illegal to carry doses without the entire Rx bottle
  - misuse/diversion/unintended use/accidental poisoning
  - concern for diversion in correctional settings limits access
  - patients with **housing instability** may have issues storing Bup safely and securing it from theft
  - **SL Bup can have inter-dose fluctuation in plasma concentration, which could cause daily swings in receptor occupancy, leading to instability/cravings/use**
  - Goal: provide sustained buprenorphine exposure throughout an extended dosing interval, at concentrations sufficient to control all aspects of the disease (craving, withdrawal symptoms, and **blockade** of other opioids)

Ling, Shoptaw, and Goodman-Meza, 2019
Bup implant: Sixmo®/Probuphine®

- Six-month-long implant (4 implants) to upper arm, max of two successive doses
- Originally approved in US in 2016, discontinued by manufacturer in October 2020 with no plans to re-introduce, likely due to success of injectable ER bup
Injectable Extended Release Bup: Sublocade®

- One-month long depot injection, immediately turns into a solid, no special training required, RN can administer
- Two dosages: 300 mg (1.5 mL) and 100 mg (0.5 mL)
  - Usual dosing 300 mg loading dose for first two months, followed by 100 mg maintenance dose monthly
  - Select patients with most severe OUD are maintained at 300 mg monthly
- Patient must be maintained on SL Bup > 8mg, for > 7 days prior to injection
- Sub-cutaneous injection to abdomen only, can be painful, pre-medication with local lidocaine (1-3 cc) is MGH standard. Ice pack also helpful.
- Must be stored refrigerated and highly secure as diversion and IV use could result in thromboembolic events
- Initial studies did not compare it directly to SL Bup
- Some retrospective data to support treatment retention is greater with Sublocade vs SL Bup

Chappuy, Trojak, Nubukpo, Bachellier, Bendimerad, Brousse, and Rolland, 2020
Jones, Ngaimisi, Gopalakrishnan, Young, Laffont, 2020
Rioux, Cuellar, Oliver, Hsu, and Szapkiw, 2020
Brief Sublocade® Pharmacokinetics

- Sublocade was designed to deliver a level of plasma buprenorphine that translates into at least a 70% sustained mu-opioid receptor occupancy in the brain over 1 month:
  - after second injection, could block “drug-liking” effects of hydromorphone at 6 and 18 mg IM
- Half life is 43 to 60 days, takes 4-6 months to steady state
- Predicted that 2-week occasional delay in dosing would not impact efficacy
- May test positive for Bup months after last injection
- Recent case series showing potential to “auto-taper” patients wishing to discontinue Bup with sublocade

Ling, Shoptaw, and Goodman-Meza, 2019
AD Ritvo, Calcaterra, and J Ritvo, 2020
Injectable Extended Release Bup: Brixadi®

- Still awaiting FDA approval as of January 2022
- Week-long or month-long subcutaneous depot injection
  - **Weekly** dosages 8, 16, 24, or 32 mg (volume between 0.16 and 0.64 mL)
  - **Monthly** dosages 64, 96, 128, or 160 mg (volume between 0.18 and 0.36 mL)
  - dose does not correspond linearly to SL Bup doses, need to use chart
- Stored at ambient temperature, no special training required, administered to buttock, leg, arm, or abdomen, immediately turns into a liquid-crystalline gel
- Can start for people not currently maintained on SL Bup
- Safety profile similar to SL Bup with exception of injection site reactions (in greater than 5%)
- Double-blind RCT found it comparable to SL Bup for people not treated with SL Bup in the past 60 days
- Higher weekly doses shown to block hydromorphone IM

Chappuy, Trojak, Nubukpo, Bachellier, Bendimerad, Brousse, and Rolland, 2020
Ling, Shoptaw, and Goodman-Meza, 2019
Soyka, 2020
Long Acting Bup - Final Thoughts

• Not a panacea, but another helpful tool
• Although efficacy in clinical trials has been proven, there is no demonstrated superiority of long-acting Bup over daily SL Bup
• Safety data are reassuring, adverse effects are mild (similar to SL Bup)
• Reduce number of required clinic visits, eliminate need for take home meds, reduce stigma associated with frequent SUDs clinic vis and having mOUD at home or on person, allow patients to travel freely
• Reduce pre-occupation with meds that many SUDs patients suffer

Ling, Shoptaw, and Goodman-Meza, 2019


Thank you!

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