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Buprenorphine 101

Evidence-Informed Prescribing in the Fentanyl Era

An Outpatient Dual Diagnosis Perspective

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Disclosures

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"Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose."

Learning Objectives

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- After completing this activity, participants will be able to:
  - Explain buprenorphine pharmacology and its clinical implications
  - Optimize induction and dosing in the fentanyl era
  - Prevent early disengagement using harm-reduction and language-informed care
  - Apply an ADPIE framework to improve retention and safety

Why This Matters

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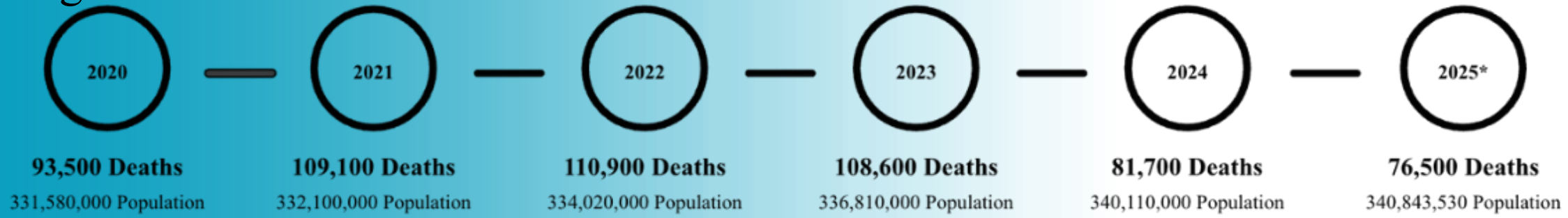
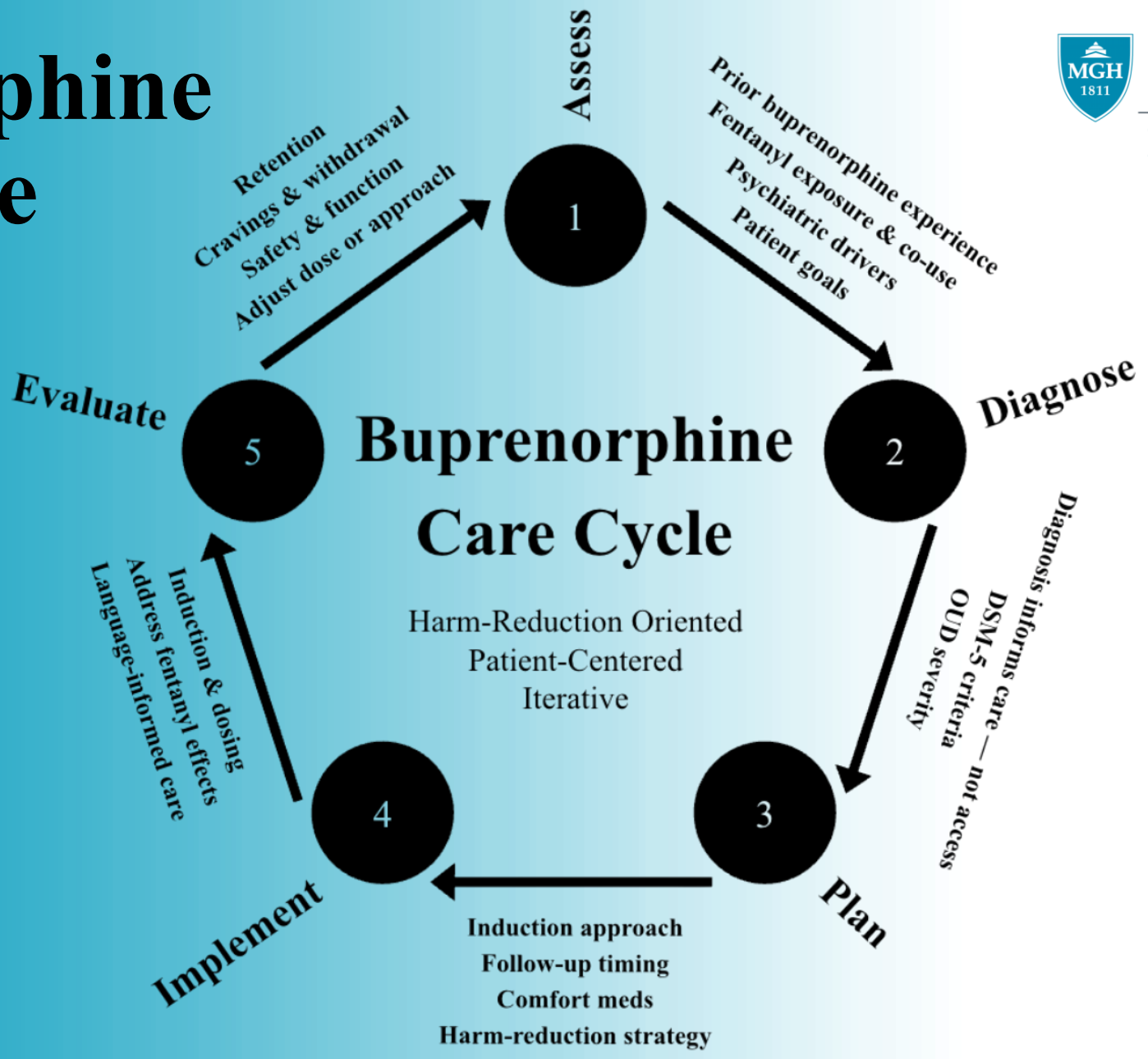
- Drug overdose deaths in the U.S.



  - In 2024, we saw the largest one-year decline ever recorded at 27%
  - Preliminary Data for 2025 is estimating around 76,500 OD deaths
- Key context
  - Opioids remain involved in ~76% of overdose deaths
  - Buprenorphine is first-line, evidence-based, and scalable
  - MAT Act: any DEA-registered provider may prescribe buprenorphine for OUD
  - Sustained progress depends on access, retention, and evidence-based care

Sources: Centers for Disease Control and Prevention, provisional data 2025; SAMHSA, MAT Act (2023)

Buprenorphine Care Cycle



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Assessment

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- Prior Buprenorphine Experience: Dose, timing, setting, precipitated withdrawal, follow-up
- Current Opioid Exposure: Route, frequency, last use, (fentanyl exposure likely)
- Psychiatric Symptom Drivers: Anxiety, trauma, mood instability, insomnia, pain
- Co-use & Overdose Risks: Benzodiazepines, alcohol, gabapentinoids
- Medical Screens: Pregnancy potential, hepatic disease, respiratory risk, toxicology screens (not required to start or continue treatment)
- Structural Factors: Housing, transportation, pharmacy access
- Patient-Defined Goals: Abstinence, stability, overdose prevention

Assessment predicts *how* we treat — not *whether* we treat

Clinical observation supported by PCSS guidance

Diagnose: Opioid Use Disorder

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1	Opioids are often taken in larger amounts or over a longer period than was intended	The presence of at least 2 of these symptoms indicates an Opioid Use Disorder (OUD) The severity of the OUD is defined as: MILD: The presence of 2 to 3 symptoms MODERATE: The presence of 4 to 5 symptoms SEVERE: The presence of 6 or more symptoms
2	There is a persistent desire or unsuccessful efforts to cut down or control opioid use	
3	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects	
4	Craving or a strong desire to use opioids	
5	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home	
6	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	
7	Important social, occupational, or recreational activities are given up or reduced because of opioid use	
8	Recurrent opioid use in situations in which it is physically hazardous	
9	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.	
10	Tolerance,* as defined by either of the following: a) Need for markedly increased amounts of opioids to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of opioid	
11	Withdrawal,* as manifested by either of the following: a) Characteristic opioid withdrawal syndrome b) Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	

- Pattern of opioid use leading to clinically significant impairment or distress
- Severity: mild, moderate, severe
- Guides treatment intensity
- Informs monitoring and follow-up
- Helps anticipate risk and support needs

Diagnosis informs care — not access

Severity and risk fluctuate over time so be sure to reassess periodically

Source: DSM5

Plan: Set Patients Up for Success

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- Select an Induction Strategy
- Check PDMP
- Send Prescriptions to the Pharmacy for both buprenorphine and naloxone!
- Anticipate Early Barriers
- Plan for Retention
- Address Co-Occurring Needs
- Match Treatment to Real Life

Planning is anticipatory problem-solving — not just medication selection

Good planning reduces early disengagement and improves retention

Clinical observation supported by PCSS guidance

Implement & Evaluate

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- Start Buprenorphine in Adequate Withdrawal
- Expect Fentanyl-related Variability
- Follow-Up Early
- Adjust Dose and Supports Promptly
- Use Data to Guide — Not Penalize

Early adjustment improves retention and safety

Implementation and evaluation are iterative — reassess and adapt

Clinical observation supported by PCSS guidance

Major Features of Buprenorphine

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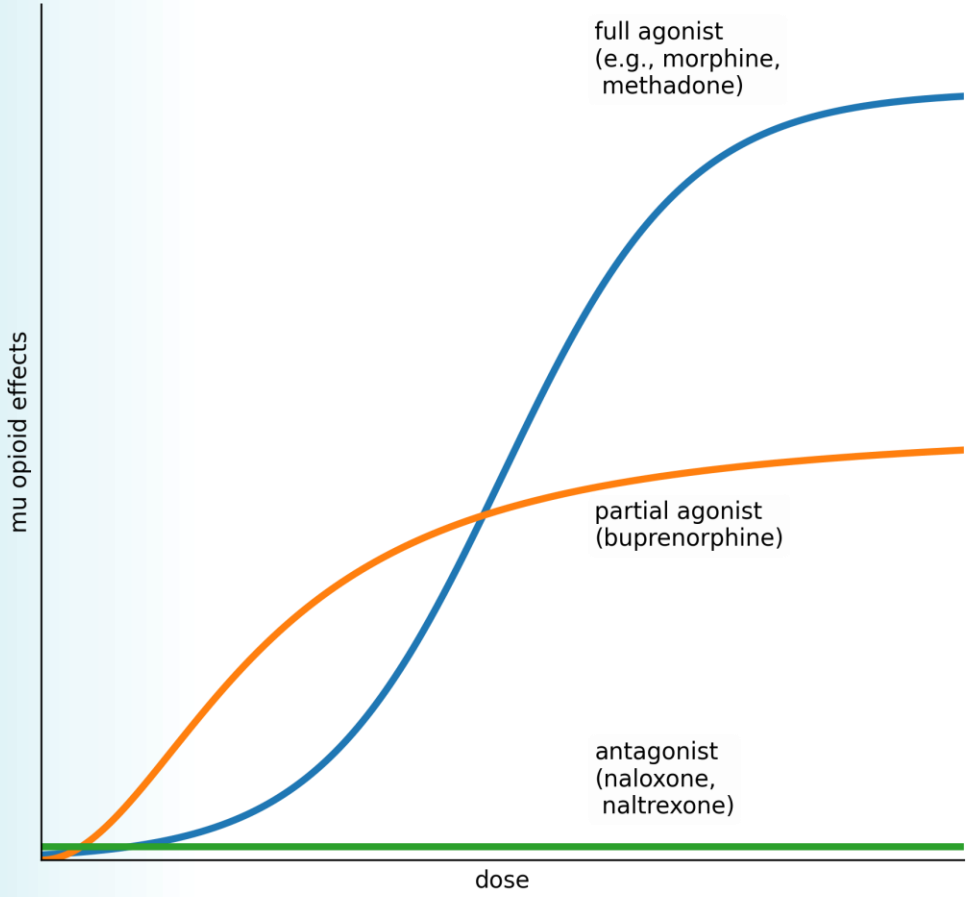
Buprenorphine's pharmacology explains both its safety and its challenges

- **Partial μ-opioid receptor agonist**
  - Suppresses withdrawal and cravings
  - Lower risk of respiratory depression compared to full agonists
- **High μ-opioid receptor affinity**
  - Displaces other opioids from the receptor
  - Blocks effects of full agonists
  - Can precipitate withdrawal if given too early
    - Naloxone is *not* the cause of precipitated withdrawal
- **Slow dissociation from the μ-opioid receptor**
  - Long Half-Life ~24 to 36 Hours
  - Remains bound for prolonged periods
  - Contributes to clinical stability and overdose protection



Source: Orman & Keating, 2009

Induction in the Fentanyl Era

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- What's Changed:
  - Fentanyl Delays and Complicates Withdrawal Onset; can Vary!
  - Higher Opioid Receptor Occupancy → Higher Precipitated Withdrawal Risk
  - Increased Patient Fear and Disengagement
- What Helps:
  - Individualized Strategy
  - Home Induction when Appropriate
  - Clear Physiologic Education
  - Comfort Medications
  - Plan Early Follow-Up (48–72h check-in)

Source: Krawczyk et al., 2023; MCSTAP, 2022

Dosing: Considerations/ Update

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- Do Not Interpret Cravings as Non-Adherence
- Dose to Effect and be sure to Reassess Frequently
  - Dose to Effect = Suppression of Withdrawal and Cravings, Improved Safety and Function
- Monitor sedation and co-use (alcohol, benzodiazepines) when Escalating Doses

Source: Krawczyk et al., 2023; Nataraj et al., 2024; SAMHSA, 2025

Dosing: What the Data Now Supports

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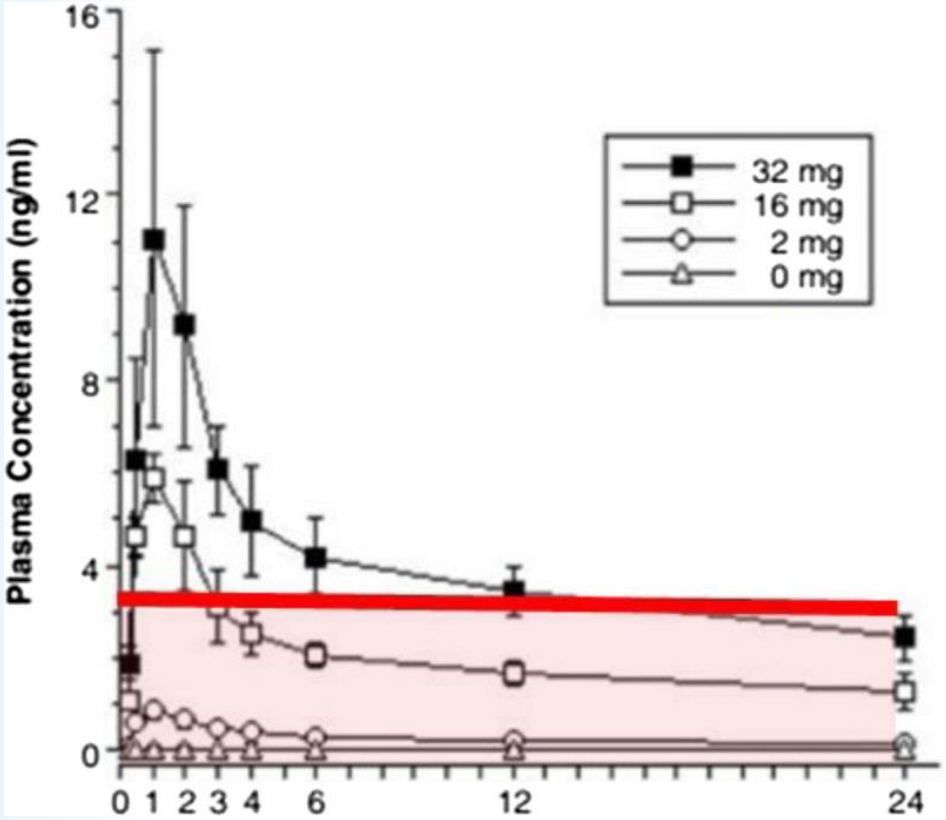
- Higher Doses are Associated with Improved Retention; Dose needs Vary Widely; No Single Dose fits all Patients
  - Doses **16–24 mg/day**: common stabilization range however, fentanyl exposed patients often require >16mg
  - Doses **24–32 mg/day** associated with: ↑ retention, ↓ illicit opioid use and No significant increase in adverse events



The concept of a rigid 'ceiling dose' is not supported by current retention and safety data.
Dose decisions should be individualized and made in the context of patient response, safety monitoring, and shared decision-making.

Source: Grande et al., 2023; Krawczyk et al., 2023; Nataraj et al., 2024; SAMHSA, 2025

Buprenorphine Induction Options

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- **Standard Induction: Initiating Buprenorphine** aft

❑ Shared decision making: 2 experts in the room
❑ Choose location for induction (in-office or home)
❑ STOP full agonist
❑ Time from last opioid depends on agonist properties
❑ Feel sufficient WITHDRAWAL - utilize Clinical Opiate Withdrawal Scale (COWS)
❑ Use adjunctive medications to manage symptoms
❑ Initiate sublingual buprenorphine
❑ Repeat dosing until withdrawal symptoms improve

Resting Pulse Rate: beats / minute
Measured after patient is sitting or lying for one minute
(0) pulse rate 80 or below
(1) pulse 81 to 100
(2) pulse 101 to 120
(4) pulse rate greate than 120

GI Upset:
over last 1/2 hour
(0) no GI symptoms
(1) stomach cramps
(2) nausea or loose stool
(3) vomiting or diarrhea
(5) multiple episodes of diarrhea or vomiting

Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.*
(0) no report of chills or flushing
(1) subjective report of chills or flushing
(2) flushed or observable moistness on face
(3) beads of sweat on brow or face
(4) sweat streaming off face

Tremor:
Observation of outstretched hands
(0) no tremor
(1) tremor can be felt, but not observed
(2) slight tremor observable
(4) gross tremor or muscle twitching

Restlessness:
Observation during assessment
(0) able to sit still
(1) reports difficulty sitting still, but is able to do so
(3) frequent shifting or extraneous movements of legs/arms
(5) unable to sit still for more than a few seconds

Yawning:
Observation during assessment
(0) no yawning
(1) yawning once or twice during assessment
(2) yawning three or more times during assessment
(4) yawning several times/minute

Pupil size:
(0) pupils pinned or normal size for room light
(1) pupils possibly larger than normal for room light
(2) pupils moderately dilated
(5) pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability:
Measured after patient is sitting or lying for one minute
(0) none
(1) patient reports increasing irritability or anxiousness
(2) patient obviously irritable or anxious
(4) patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches:
If the patien was having pain previously, only the additinal component attributed to opiates withdrawal is scored
(0) not present
(1) mild diffuse discomfort
(2) patient reports severe diffuse aching of joints/muscles
(4) patient is rubbing joints or muscles and is unable to sit still because of discomfort

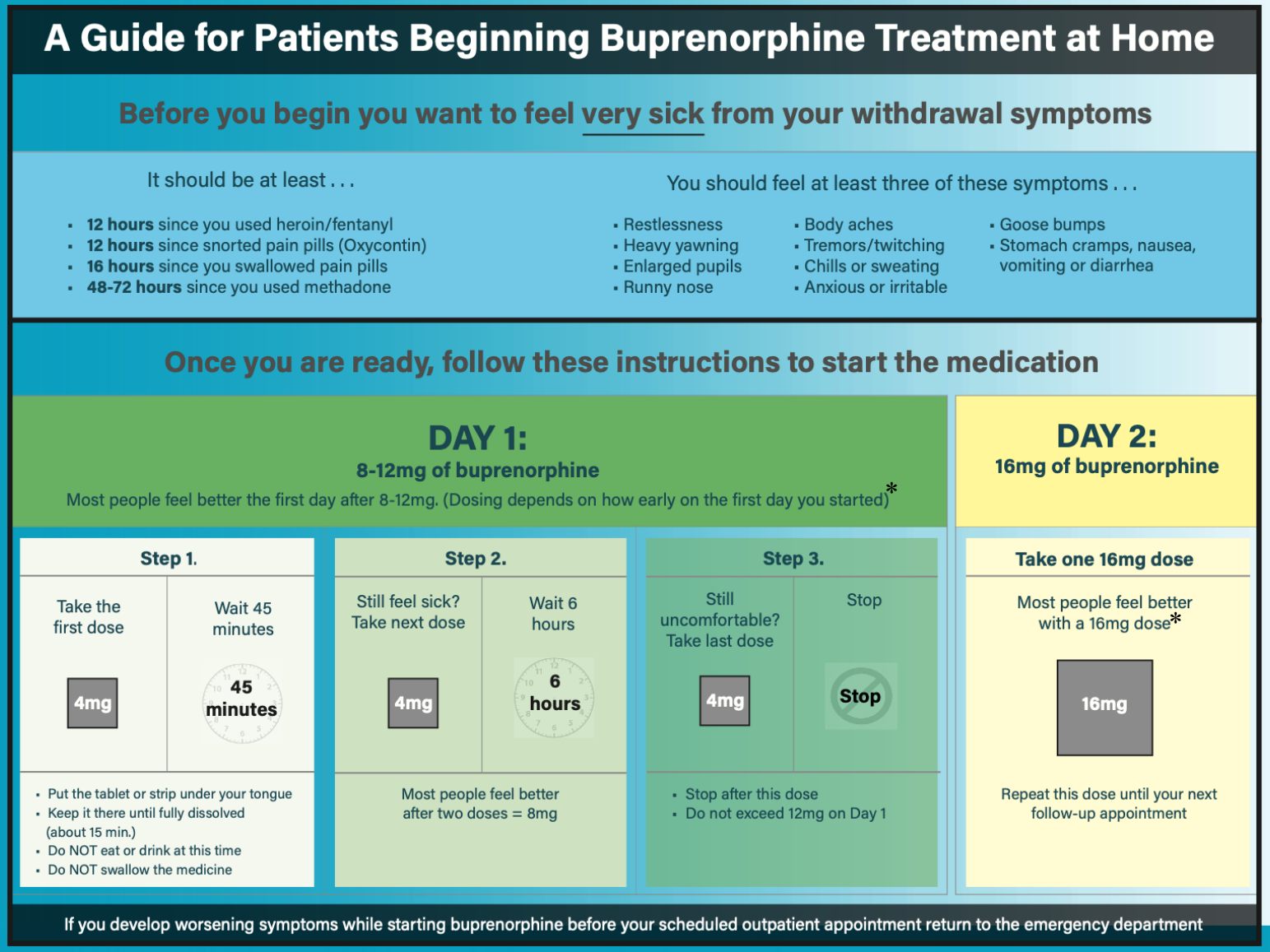
Gooseflesh skin:
(0) skin is smooth
(3) piloerrection of skin can be felt or hairs standing up on arms
(5) prominent piloerrection

Runny nose or tearing:
Not acounted for by cold symptoms or allergies
(0) not present
(1) nasal stuffiness or unusually moist eyes
(2) nose running or tearing
(4) nose constantly running or tears streaming down cheeks

Total Score:
The total score is the sum of all 11 items
Initials of person completing assessment:
Score: 5- 12 = ***mild;*** 13-24 = ***moderate;***
25-36 = ***moderately severe;***
more than 36 = ***severe withdrawal***

Sources: Lee, Journal Addiction Med, 2014, SAMHSA, 2023

Standard Induction Example



A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin you want to feel very sick from your withdrawal symptoms

It should be at least . . .

- **12 hours** since you used heroin/fentanyl
- **12 hours** since snorted pain pills (Oxycontin)
- **16 hours** since you swallowed pain pills
- **48-72 hours** since you used methadone

You should feel at least three of these symptoms . . .

- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose
- Body aches
- Tremors/twitching
- Chills or sweating
- Anxious or irritable
- Goose bumps
- Stomach cramps, nausea, vomiting or diarrhea

Once you are ready, follow these instructions to start the medication

DAY 1:
8-12mg of buprenorphine
Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)*

Step 1.
Take the first dose — 4mg
Wait 45 minutes — 45 minutes

- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

Step 2.
Still feel sick? Take next dose — 4mg
Wait 6 hours — 6 hours

Most people feel better after two doses = 8mg

Step 3.
Still uncomfortable? Take last dose — 4mg
Stop — Stop

- Stop after this dose
- Do not exceed 12mg on Day 1

DAY 2:
16mg of buprenorphine

Take one 16mg dose
Most people feel better with a 16mg dose*
16mg

Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

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- Start once in objective moderate–severe withdrawal (≥3 physical signs of opioid withdrawal)
- Dosing: Take ½–1 strip or tablet, reassess after 45–60 minutes, and repeat until withdrawal improves
- May titrate up to 32 mg/day if needed

Buprenorphine Induction Options

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- **Low-Dose Buprenorphine Initiation (LDBI)**
  - Evidence base is evolving: LDBI is supported mainly by observational studies and case series; randomized comparative effectiveness data are limited and ongoing.
  - LDBI is a novel approach that leverages buprenorphine's pharmacology to reduce precipitated withdrawal risk and may avoid prolonged opioid tapers.
  - Best suited for patients with prior precipitated withdrawal, high fentanyl exposure, or inability to tolerate abstinence
  - LDBI is not yet standardized and protocols vary by setting and patient characteristics.
  - Unlike traditional induction:
    - Patients may continue full opioid agonists (e.g., fentanyl, methadone) during buprenorphine titration
    - Once a therapeutic buprenorphine dose is achieved, the full agonist is discontinued without a slow taper
  - Typical duration: **3–10 days**
    - Longer protocols (up to ~1 month) have been reported in select cases
  - Multiple LDBI strategies exist (ie: Bernese, Thakrar, Howard Street, etc)

Sources: Hämmig et al., 2016; Hayes et al., 2023; Weimer et al., 2023; Koenigs et al., 2024; Suen et al., 2025

LDBI: Bernese Method

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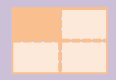
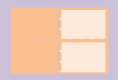
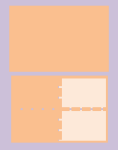
A Guide for Patients Beginning Buprenorphine Treatment With the Bernese Method at Home (Days 1 – 5)

- Main goal is to ease you into buprenorphine treatment slowly while trying to prevent precipitated withdrawal.
- Use of full agonist opioids (oxycodone, heroin, fentanyl, etc.) can continue until day 6 of induction.
- You can continue using the same amount (you are NOT required to decrease drug use but you can if tolerated).
- Continue with the buprenorphine even if drug use is stopped/restarted before day 6.
- The idea is to slowly increase buprenorphine levels up to the desired dose of 12 mg per day (day 7).
- This method should cause minimal withdrawal symptoms.
- Call the MGH Bridge Clinic if you experience withdrawal symptoms or if you have any other questions/concerns.

Once you are ready, follow these instructions to start the medication:

	Day 1	Day 2	Day 3	Day 4	Day 5
Total Daily Dose	**0.5mg daily**	**0.5mg twice daily**	**1 mg twice daily**	**2 mg twice daily**	**3 mg twice daily**
# of 2mg films	1/4 Film	1/4 Film x 2	1/2 Film x 2	1 Film x 2	**Return to Clinic** 1 + 1/2 Film x 2
Morning					
Evening					

Days 1-5: Total of 6.75 films (2mg strength) will be used. Your first prescription will include 7 films.
Days 6-7: Back to clinic on Day 5 for appointment. Your second prescription will include 8mg films for easier dosing.

A Guide for Patients Beginning Buprenorphine Treatment With the Bernese Method at Home (Days 6 & 7)

- Main goal is to ease you into buprenorphine treatment slowly while also trying to prevent precipitated withdrawal.
- The idea is to slowly increase buprenorphine levels up to the desired dose of 12 mg per day (day 7).
- Use of full agonist opioids (oxycodone, heroin, fentanyl, etc.) should stop on day 6
- This method should cause minimal withdrawal symptoms.
- Call the MGH Bridge Clinic if you experience withdrawal symptoms or if you have any other questions/concerns.

After returning to clinic, finish the regimen using 8 mg films:

	Day 6	Day 7
Total Daily Dose	**4 mg twice daily**	**8 mg in the AM, 4 mg in the PM**
# of 8mg films	**STOP other opioid use** 1/2 Film x 2	1 Film AM 1/2 Film PM
Morning		
Evening		

Days 1-5: Total of 6.75 films (2mg strength) will be used. Your first prescription will include 7 films.
Days 6-7: Back to clinic on Day 5 for appointment. Your second prescription will include 8mg films for easier dosing.

Source: Hämmig et al., 2016

Buprenorphine Oral Formulations

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Medication	Subutex® (Buprenorphine)	Suboxone® (Buprenorphine/ Naloxone)	Zubsolv® (Buprenorphine/ Naloxone)
Dosing Options (mg)	2mg 8mg	2mg/0.5mg 4mg/1mg 8mg/2mg 12mg/3mg	0.7mg/0.18mg 1.4mg/0.36mg 2.9mg/0.71mg 5.7mg/1.4mg 8.6mg/2.1mg 11.4mg/2.9mg
Formulation	Tablet	Film (Brand and Generic) or Tablet (Generic)	Tablet (Brand or Generic) or Film (Generic)
FDA Approval in Pregnancy	Yes	No (not specifically approved for pregnancy; commonly used when benefits outweigh risks)	
Schedule	All three options are listed as Schedule III Medications		
Storage	Store between 68-77°F	Store between 59-86°F	
Initiation	Start when objective, clear signs of withdrawal are evident to avoid precipitated withdrawal.		
Time to Peak Dose	~1-2 Hours	~60-90 Minutes	~75-110 Minutes
Administration	Place under tongue and allow to dissolve completely. Do not chew, cut, swallow; and avoid eating, drinking, or talking until dissolved.	Place under tongue and allow to dissolve completely. Do not chew, cut, swallow; and avoid eating, drinking, or talking until dissolved.	Place under tongue and allow to dissolve completely. Do not chew, cut, swallow; and avoid eating, drinking, or talking until dissolved.
Other Information	Most often used when naloxone-containing products are not appropriate (ie: pregnancy or naloxone intolerance)	Most commonly prescribed transmucosal buprenorphine product	Lower milligram numbers ≠ lower potency (higher bioavailability)

Sources: NAABT, 2010 and Indivior Inc., 2023 and Orexo US Inc., 2023

Suboxone/ Zubsolv Equivalents

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SUBOXONE sublingual tablets, including generic equivalents	Corresponding dosage strength of ZUBSOLV sublingual tablets
One 2 mg/0.5 mg buprenorphine/naloxone sublingual tablet	One 1.4 mg/0.36 mg ZUBSOLV sublingual tablet
One 8 mg/2 mg buprenorphine/naloxone sublingual tablet	One 5.7 mg/1.4 mg ZUBSOLV sublingual tablet
12 mg/3 mg buprenorphine/naloxone taken as: • One 8 mg/2 mg sublingual buprenorphine/naloxone tablet AND • Two 2 mg/0.5 mg sublingual buprenorphine/naloxone tablets	One 8.6 mg/2.1 mg ZUBSOLV sublingual tablet
16 mg/4 mg buprenorphine/naloxone taken as: • Two 8 mg/2 mg sublingual buprenorphine/naloxone tablets	One 11.4 mg/2.9 mg ZUBSOLV sublingual tablet

Source: SAMHSA, 2023

Buprenorphine LAI Formulations

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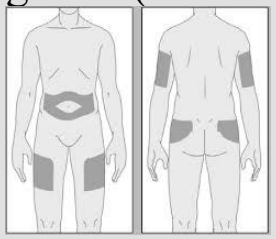
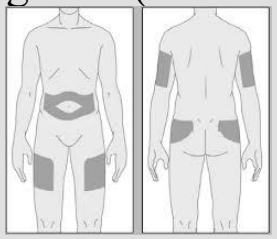
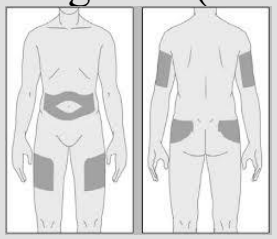
Medication	Brixadi® (Weekly)	Brixadi® (Monthly)	Sublocade® (Monthly)
Dosing Options (mg)	8mg, 16mg, 24mg and 32mg	64mg, 96mg and 128mg	100mg and 300mg
FDA Approval in Pregnancy	Yes	Treating OUD in pregnancy improves maternal and neonatal outcomes. No buprenorphine formulation is FDA-approved specifically for pregnancy. Neonatal opioid withdrawal syndrome (NOWS) is expected and treatable	
Schedule	All three options are listed as Schedule III Medications		
Storage	No refrigeration needed		Once removed from refrigeration, can remain at room temperature for up to 12 weeks (since 2025)
Initation	Can be administered after single 4mg SL BUP dose	Patients currently on SL BUP or weekly injectable	Can be administered after single 4mg SL BUP dose
Time to Peak Dose	~6-8 Hours Post Injection	~24 Hours Post Injection	~24 Hours Post Injection
Administration: Clinic Administered	Flexible dosing sites (after 4 doses/ steady state) 	Flexible dosing sites (after 4 doses/ steady state) 	Flexible dosing sites (since 2025) 

Sources: Braeburn Inc., 2023 and Indivior Inc., 2025

Extended Release Buprenorphine

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Key Benefits

- Higher and more consistent serum levels than current SL dosing (8-24mg)
- Alternative for patients struggling with SL formulations (dosage, formulation, stability)
- Now used in inductions and rapid starts

Pharmacokinetics and Clinical Considerations

- Steady state: requires 4-6 injections. SL supplementation may be needed in early treatment
- Withdrawal symptoms may occur during first few months
- Consider extending loading doses beyond 2-3 months and supplemental SL
- Recent FDA Approval (2023) of second formulation (Brixadi): Increases dosing flexibility and faster treatment initiation
- Patient expectations should be set regarding delayed steady state and possible early withdrawal symptoms.

Comfort Medications

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Symptom	Drug	Dose
Anxiety/ Agitation	Hydroxyzine	25-100mg orally every 6-8 hours as needed (max 400mg/ day)
Anxiety	Lorazepam	1mg every 4-6 hours as needed (max 6mg/ day); short-term only; caution with co-use
Hypertension and Tachycardia	Clonidine	0.1-0.2mg every 6-8 hours, taper if given for >7 days
Diarrhea	Loperamide	4mg initial dose followed by 2mg after each loose stool (max 16mg/ day)
Myalgias, Arthralgias	Acetaminophen	1,000mg every 6-8 hours
Myalgias, Arthralgias	Ibuprofen	600mg every 6 hours for up to 7 days (max 2,400mg/ day)
Nausea, vomiting	Ondansetron	4mg every 6 hours as needed (max 16mg/ day)
Insomnia/ Agitation	Trazodone	25-100mg nightly (max 300mg)
Muscle Cramps	Cyclobenzaprine	5-10mg every 8 hours as needed (max 30mg/ day)
Gastrointestinal cramps	Dicyclomine	10-20mg every 6-8 hours as needed (max 160mg/ day)

Source: León-Barriera et al., 2023

Patient Education

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- What Buprenorphine Does — and Doesn't Do
- What to Expect during Induction
- How to Take it Safely
- When to Call for Help
- Harm Reduction Saves Lives

Buprenorphine works best when patients know what to expect and feel supported

Education improves safety, retention, and trust

Clinical observation supported by PCSS guidance

Patient Handouts

Example of commonly used patient handouts — local protocols vary

A Guide for Patients Beginning Buprenorph

Before you begin you want to feel very sick from yo

It should be at least . . .

- **12 hours** since you used heroin/fentanyl
- **12 hours** since snorted pain pills (Oxycontin)
- **16 hours** since you swallowed pain pills
- **48-72 hours** since you used methadone

You should feel

- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose

Once you are ready, follow these instructions to

DAY 1:

8-12mg of buprenorphine

Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

Step 1.

Take the first dose: 4mg

Wait 45 minutes: 45 minutes

...r tongue ...d

Step 2.

Still feel sick? Take next dose: 4mg

Wait 6 hours: 6 hours

Most people feel better after two doses = 8mg

Step 3.

Still uncomfortable? Take last dose: 4mg

Stop: Stop

- Stop after this dose
- Do not exceed 12mg on Day 1

Take one 16mg dose

Most people feel better with a 16mg dose: 16mg

Repeat this dose until your next follow-up appointment

...g symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

Before taking your first dose, stop taking all opioids for 12-36 hours. You should feel pretty lousy, like having the flu. These symptoms are normal. You will feel better soon.

- ❑ Before your first dose of medication, you should feel **at least three** of the following:
  - ○ Very restless, can't sit still
  - ○ Twitching, tremors, or shaking
  - ○ Enlarged pupils
  - ○ Bad chills or sweating
  - ○ Heavy yawning
  - ○ Joint and bone aches
  - ○ Runny nose, tears in your eyes
  - ○ Goose flesh (or goose bumps)
  - ○ Cramps, nausea, vomiting or diarrhea
  - ○ Anxious or irritable
- ❑ Complete the SOWS. You need your SOWS score to be ≥17 before taking your first dose of buprenorphine.

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Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

If you have started bup before:

- If it went well, that's great! Just do that again.
- If it was difficult, talk with your care team to figure out what happened and find ways to make it better this time. You may need a different dosing plan than what is listed here.

If you have never started bup before:

- Gather your support team and if possible take a "day off."
- You are going to want space to rest. Don't drive.
- Using cocaine, meth, alcohol or pills makes starting bup harder, and mixing in alcohol or benzos can be dangerous.

Place dose under your tongue (sublingual).

If you have a light habit: *(For example, 5 "Norco 10's" a day)*

- Consider a low dose: start with 4mg and stop at 8mg total.
- **WARNING:** Withdrawal will continue if you don't take enough bup.

If you have a heavy habit: *(For example, injecting 2g heroin ... day or smoking 1g fentanyl a day)*

- Consider a high dose: start with a first dose of 16mg.
- For most people, the effects of bup max out at around 24-32mg.
- **WARNING:** Too much bup can make you feel sick and sleepy.

Not going well? Have questions? Contact your N...

WWW.MGHCME.ORG

Other Resources to Know About

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Street Check is an innovative community-partnered project to develop and standardize sample collection, analysis, and reporting for community drug checking programs.

Addiction and Mental Health Recovery Peer Support Resource Guide

findhelp

Ask Bertha is a local Resource Finder for Food, Health, Housing, and more

Check out Massachusetts Drug Supply Data Stream (MADDS) to learn more about the local illicit drug supply to better inform public health, public safety and policy responses

Safe Spot is a free, 24/7, national hotline that is staffed by a dedicated team of people with lived and living experience with overdose and drug use.

Language Shapes Care

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- Evidence shows:
  - Stigmatizing Language ↓ Engagement
  - Neutral Language ↑ Honesty & Retention

DO	DON'T
"Positive" / "Negative"	"Dirty" / "Clean"
"Return to Use" / "Ongoing Use"	"Relapse" / "Using"
"Substance Use Disorder"	"Substance Abuse Disorder"

We should use language that is precise, non-punitive, and patient-centered

Source: Wakeman, 2024 and Devi et al., 2025

Preventing Drop-Out

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- Interventions:
  - Validate Prior Harm/ Poor Experiences and Outcomes
  - Slow the Process when needed
  - Provide Clear, Written Home-Start Instructions
  - Symptom-targeted Comfort Meds to Reduce return-to-use during waiting period
  - Follow-Up in 48–72 hours
  - Set Expectations about Discomfort and Timing
- Precipitated Withdrawal (PW) Facts that Reduce Fear:
  - Occurs in a minority of inductions
  - Caused by timing, not naloxone
  - Prior PW ≠ Contraindication to future Buprenorphine
  - Risk Reduction: wait for clear, objective withdrawal

Clinical observation supported by PCSS guidance

Key Take-Home Messages

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- Buprenorphine saves lives
- Pharmacology matters
- The fentanyl era has changed induction and dosing
- Cravings are not non-adherence
- Higher doses are often appropriate and safe
- Precipitated withdrawal is uncommon
- Comfort medications, education, and early follow-up prevent drop-out
- Urine toxicology is a clinical tool, not a gatekeeper
- Language is part of treatment
- Individualized, harm-reduction–informed care improves outcomes
- Psychiatric care and MOUD are synergistic
- MOUD saves lives — even when imperfect

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Case 1: "Suboxone Didn't Work For Me"

Alex is a 32-year-old man with opioid use disorder who presents requesting buprenorphine. He reports daily fentanyl use by inhalation and says, "Suboxone didn't work for me — it made me violently sick." He previously attempted a home induction using 8 mg after 12 hours of abstinence and experienced severe worsening of symptoms. He has not tried buprenorphine since.

Key Assessment Findings:

- Daily fentanyl exposure, uncertain purity
- Prior precipitated withdrawal
- High anxiety and fear about induction
- No current benzodiazepine or alcohol use

Questions: How would you validate Alex's prior experience without reinforcing fear? What induction strategy would you consider, and why?

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Case 2: "Still Craving at 16mg"

Maria is a 41-year-old woman with severe OUD, stabilized on buprenorphine/naloxone 16 mg daily for three weeks. She reports improved withdrawal but ongoing cravings in the late afternoon and has had two episodes of return-to-use. She worries this means "the medication isn't working."

Key Assessment Findings:

- Partial response at 16 mg
- Ongoing fentanyl exposure prior to treatment
- No significant sedation or adverse effects
- Motivated to stay in care

Questions: How would you respond to Maria's concern without framing this as failure? What data supports increasing the dose rather than switching medications?

Case 3: "The Missed Appointments"

James is a 55-year-old man with OUD, PTSD, and chronic pain who has missed two follow-up appointments after starting buprenorphine. A urine toxicology screen shows fentanyl and prescribed buprenorphine. The care team debates whether he is "noncompliant."

Key Assessment Findings:

- Unstable housing
- Limited phone access
- Transportation challenges
- Ongoing pain and trauma symptoms

Questions: How might labeling this as "noncompliance" change the care trajectory? What interventions would improve retention in this case?

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Case 4: "I'm Afraid to Stop Using"

Helen is a 39-year-old woman with opioid use disorder who presents requesting treatment but expresses fear of stopping fentanyl due to prior severe withdrawal. She states, "I want to get on buprenorphine, but I can't go through that withdrawal again.

Key Assessment Findings:

- Daily intranasal fentanyl use, multiple times per day
- Prior severe precipitated withdrawal during two previous buprenorphine inductions
- High anxiety and fear related to induction
- PTSD and chronic insomnia
- Stable housing and reliable phone access
- Motivated to engage in treatment but reluctant to stop opioids abruptly

Questions: How does Helen's prior experience shape your induction strategy? What approach could reduce precipitated withdrawal risk while supporting retention? What factors would make LDBI inappropriate in this case?

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