Emergency Department Buprenorphine (Bup) Quick Start

Connect with your patient: Accurate diagnosis and treatment requires trust, collaboration, and shared decision making.

Opioid withdrawal* — NO → **Rx self-directed start:**
- Wait for severe withdrawal then start with 8–24+ mg SL.
- Rx per "Discharge" box below.

YES ↓

16 mg bup SL**
(range 8–24+ mg)

30-60 minutes ↓

Withdrawal improved? — NO → **If no improvement or worse, consider:**

Worsening withdrawal (common): Occurs with lower starting doses and heavy tolerance; improves with more bup (additional 8–16 mg SL).

Other substance intoxication or withdrawal: Continue bup and manage additional syndromes.

Bup side-effects: e.g., nausea or headache. Continue bup and treat side-effects with supportive medications.

Medical illness: Continue bup and manage underlying condition.

If sudden & significant worsening, consider precipitated withdrawal (rare): See box below.

30-60 minutes ↓ YES

Administer 2nd dose
Additional 8–24+ mg SL bup

Discharge

- **Prescribe at least a 2 week supply of 16-32 mg SL bup per day.**
- **Example 2 week order:** buprenorphine/ naloxone 8/2 mg film 1 film SL TID #42,1 refill. Notes to pharmacy: OK to substitute tablets or monoproduct. Bill Medicaid FFS, ICD 10 F11.20.
- **Dispense/distribute naloxone** in-hand from the ED.

Bup Rx Notes

- The X-waiver program has ended. Only a DEA license is needed to prescribe (schedule III).
- Either bup or bup/nx SL films or tab are OK.
- Bup monoproduct or bup/nx OK in pregnancy.

For pregnancy: Bup in Pregnancy
For post-overdose: Bup Opioid Overdose

For minors: Caring for Youth
For self-directed starts: Bup Self-Start

*Diagnosis Tips for Opioid Withdrawal:

1. **Look for at least two clear objective signs not attributable to something else:** large pupils, yawning, runny nose & tearing, sweating, vomiting, diarrhea, gooseflesh/piloerection, tachycardia.
2. **Confirm with the patient that they feel 'bad' withdrawal** and they **feel ready to start bup.** If they feel their withdrawal is mild, it is likely too soon.
3. **As needed, consider using the COWS (clinical opioid withdrawal scale).** Start if COWS ≥ 8 with ≥ 2 objective signs.
4. Withdrawal sufficient to start bup typically occurs 24–36 hrs after decreased/stopped use, but can vary from 6–72 hrs. Methadone withdrawal commonly takes longer.

**Bup Dosing Tips:

1. Respect patient preference. Shared decision making, flexibility, and collaboration are essential.
2. Heavy dependence/tolerance (e.g., fentanyl) may need higher doses of bup.
3. Low dependence/tolerance may do well with lower doses of bup.
4. Starting bup may be delayed or modified if there complicating factors:
   - Altered mental status, delirium, intoxication
   - Severe acute pain, trauma, or planned surgery
   - Severe medical illness
   - Long-term methadone maintenance

Treatment of bup precipitated withdrawal

(Sudden, significant worsening of withdrawal soon after bup administration.)

Act quickly

16 mg bup SL AND **2 mg lorazepam PO**

30 minutes ↓

Symptoms improved?

NO → **16 mg bup SL**

YES → **Observe & DC**

30 minutes ↓

Continued severe withdrawal?

YES ↓

Escalate level of care to manage potential moderate to deep sedation including cardiac, pulse oximetry, and end tidal CO2 monitoring:

1. Ketamine (0.3 mg/kg IV slow push q 15 minutes and/or infusion).
2. Fentanyl 200 mcg IV q10 minutes. Total dose of > 2000 mcg has been reported.

After clinical resolution, observe and discharge with bup Rx and/or XR-bup

Adjuvants:

OK but should not delay or replace bup. Use sparingly with appropriate caution.

Benzodiazepines:
- Lorazepam 2 mg PO/IV

Antipsychotics:
- Olanzapine 5 mg PO/IM

Alpha-agonists:
- Clonidine 0.1-0.3 mg PO

D2/D3 agonists:
- Pramipexole 0.25 mg PO

Gabapentinoids:
- Pregabalin 150 mg PO

California Substance Use Line
(844) 326-2626

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