

# Buprenorphine/naloxone for opioid dependence

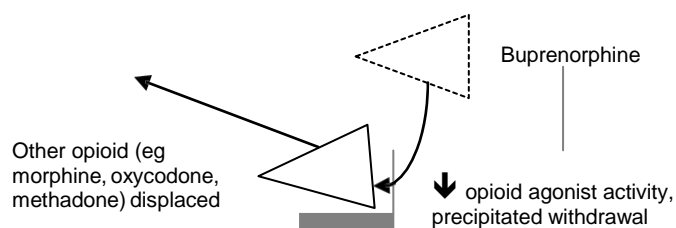
## Important points to know about buprenorphine/naloxone (Suboxone<sup>®</sup>)

### Background

Buprenorphine is an established maintenance treatment for people with opioid dependence that has been available in Australia for more than 10 years. It has similar effectiveness as methadone in reducing heroin or illicit morphine use, keeping people in treatment, improving health and social wellbeing, and reducing blood-borne virus transmission as well as criminal activity.

- > Suboxone<sup>®</sup> is a combination of buprenorphine and naloxone, which has been available over the last few years. The naloxone is inactive orally but if the preparation is injected, the naloxone attenuates the effect of the buprenorphine and can precipitate withdrawal if the person is opioid dependent. It is taken sublingually.  
The 'film' formulation is the only formulation of buprenorphine/naloxone generally authorised in South Australia.
- > Buprenorphine is a S8 or S100 drug. However buprenorphine is only a partial opioid agonist, which means that there is a ceiling to the cardio-respiratory and CNS depressant effects of buprenorphine so it is inherently safer than other S8 opioids.
- > Despite this ceiling effect, buprenorphine is an opioid agonist so people on buprenorphine will experience tolerance to opioids and will experience withdrawal if it is stopped. It is also an effective analgesic.
- > Risk of precipitated withdrawal! The major risk associated with commencing buprenorphine is precipitated withdrawal. This happens if the patient still has a significant amount of opioid in his or her system that is occupying the mu-opioid receptors. If a patient is given buprenorphine in this situation, the buprenorphine, which has higher receptor affinity but lower intrinsic activity, displaces the other opioid from the receptors resulting in lower opioid agonist activity and precipitating withdrawal.

### Understanding precipitated withdrawal



- > The typical dosage range for opioid dependence is 12-16mg daily. Most patients become stable on 12-24mg per day but some need a higher dose. Maximum daily dose is 32mg per day. Occasionally people might become stable on 8mg per day.
- > The drug is taken sublingually at the pharmacy as a supervised daily dose. Once the patient is stable, the dose can be doubled and they can then change to second daily dosing. (eg 16mg daily would be 32mg every second day).
- > Effect onset at 30 to 60 minutes. Its peak effect is at one to four hours. Effect duration is short at low dose (eg 4mg) but the effects of doses of more than 16mg can last from 24 to 72 hours, which allows for alternate day dosing.

### Criteria for opioid dependence

#### *Presence of three or more in last 12 months*

- > Tolerance (marked increase in amount; marked decrease in effect).
- > Characteristic withdrawal symptoms; substance taken to relieve withdrawal.
- > Opioids taken in larger amount and for longer period than intended.
- > Persistent desire or repeated unsuccessful attempt to quit.
- > Much time/activity to obtain, use, recover.
- > Important social, occupational, or recreational activities given up or reduced.
- > Use continues despite knowledge of adverse consequences (eg failure to fulfil role obligation, use when physically hazardous).





If drug use continues, or resumes, then talk through the reasons with the patient. Often there are ongoing stressors such as relationships, legal matters, Family Court, finances and accommodation that trigger resumption or continuation of drug use, despite treatment. Sometimes an increase in dose can be effective, but in addition work with the patient to seek other help with these other issues.

### Features to determine whether patient is stable/dose is adequate:

- > No longer constantly thinking about using opioids (heroin, morphine). These intrusive thoughts about substance use are called cravings.
- > No longer actually using opioids other than the Suboxone®/buprenorphine-naloxone. This can be established through:
  - Patient's history
  - Presence of fresh track marks
  - Urine drug screens (you can do up to 22 tests per year under Medicare for monitoring a patient in treatment). Request a urine screen for drugs of dependence/abuse. Write that the patient is on Suboxone®. If they are not using any additional opioids the result will come back buprenorphine only.
- > Whether they are working, engaged in education, active parenting.
- > Whether they are attending for dosing every day. The pharmacist will ring you if your patient misses more than three doses in a row. You should see the patient and talk about why they missed their doses.
- > How they present to the pharmacist (eg always tidy, courteous, payments are on time, not intoxicated).

## Ceasing treatment

When patients have been stable for an extended period of time and wish to come off treatment, planning can for this can start. Patients do best when they have had an extended period of time with little or no drug use.

They also do best when treatment cessation is planned and the patient is in control of the rate of dosage reduction. If there are crises along the way, then slow or stop the reduction (or even increase the dose) and then, once stable, talk through future plans with the patient.

It is important to consider:

- the patient's environment, whether they now operate in a drug free social environment
- what relationships they are in that give them resilience
- whether they have ongoing legal, financial, accommodation or family issues that are stressful
- whether there are ongoing unresolved or untreated mental health problems..

Consider reductions of 2mg every three-to-four weeks and monitor withdrawal effects with the patient. Often patients can cease from 2mg but at times they can experience significant withdrawal. If this is the case either use symptomatic medications or contact the Drug and Alcohol Clinical Advisory Service for further advice (see below).

**Ceasing from doses higher than 2mg is not recommended. Withdrawal is significant and relapse into using illicit opioids is likely.**

## Unsupervised doses

Unsupervised doses or 'take-aways' increase flexibility for the patient and reward them for progress. Indicators of progress are listed above in the section 'Features to determine whether patient is stable/dose is adequate'.

Refer to the SA Health Drugs of Dependence Unit policy [Policy for Non-Supervised Dosing of Methadone and Buprenorphine in Drug Treatment Programs](http://www.sahealth.sa.gov.au/drugsofdependence) at <http://www.sahealth.sa.gov.au/drugsofdependence> under Forms and Resources.

In summary:

- Patients can start to have unsupervised doses after the first two months of treatment, as long as opiate use and injecting has ceased (check urine drug screens and injecting sites) If drug screens are positive for amphetamines or opiates, then unsupervised doses should not be allowed.
- The maximum number of unsupervised doses per week is five for **Suboxone**<sup>®</sup>. Patients should gradually build up to this level after 18 months of treatment. Generally up to six/month up to first nine months, then three/week to 18 months.

## Interpreting urine drug screens

For details on the use of urine drug screens in the context of monitoring opioid dependence, please refer to the fact sheet called '[Urine drug screening: its use in determining patient progress](#)'.

## Missed doses

Missed doses may indicate that the patient is experiencing problems and may be becoming unstable. Pharmacists will let you know if the patient misses more than three consecutive doses, or more than 10 in one month. This may indicate reduced stability, plus there is the risk of reduced tolerance when the **Suboxone**<sup>®</sup> has not been taken for a few days. This increases the risk of toxicity when the patient resumes dosing. Therefore when there have been missed doses:

- Talk with the patient about the circumstances and if there are other stressors that need to be addressed, then assist the patient with these.
- Assess their current substance use (self-report, urine drug screen, examination for sedation, track marks, talk with pharmacist about how the patient has been presenting).
- If up to three doses missed, resume normal dosing.
- If four or five days missed, halve the dose. Resume previous dose over two-to-three days after daily assessment. (increases by up to 8mg per day to previous dose).
- If more than five days missed, resume stabilisation as if the patient were starting afresh (see above).

## Other considerations

- > Depression and anxiety. It is best to stabilise the opioid dependence with maintenance treatment before treating the patient's mental health problems. In many cases the mental health problems can improve just by being on maintenance treatment. If mental health problems are ongoing, targeted psychological therapies or pharmacological approaches may be indicated.
- > Hepatitis C if the patient has been injecting. Hepatitis C can be treated with Direct Acting Antiviral agents. Treatment can in most situations be provided through general practice. Information can be obtained from the South Australian Hepatitis SA website. <http://hepatitissa.asn.au/about-hepatitis/hepatitis-c/treatment-hcv>. Further information can be obtained at <https://www.nps.org.au/australian-prescriber/articles/managing-hepatitis-c-in-general-practice>
- > If pregnancy occurs during treatment, seek advice from the Drug and Alcohol Clinical Advisory Service (DACAS) on 7087 1742.

It is best for patients to stay on their maintenance treatment while pregnant.

Concurrent alcohol or benzodiazepine dependence problems. Problems with alcohol or benzodiazepine dependence can become more evident once the patient is being maintained on Suboxone<sup>®</sup>/buprenorphine-naloxone. There is an increased risk of opioid toxicity if these other substances are used as well. Information on referrals in these situations can be made via the Alcohol and Drug Information Service (1300 13 1340), the duty doctor at DASSA Central on 7425 5000 during work hours or from the 24-hour Drug and Alcohol Clinical Advisory Service on 7087 1742.

- > There are only a few clinically important drug interactions with Suboxone®/buprenorphine-naloxone. Sedative effects with alcohol, benzodiazepines and other sedatives are cumulative. Suboxone® at maintenance doses will block most opioids at normal doses. Taking additional opioids when on maintenance will NOT cause a precipitated withdrawal; they just won't work very well because the  $\mu$ -receptors are tightly occupied by the buprenorphine. If you have concerns about a patient's ongoing use of opioids advice can be sought from the duty doctor at DASSA Central Clinic on 8130 7500 during work hours or the 24-hour Drug and Alcohol Clinical Advisory Service (7087 1742 or 1300 13 1340).
- > Pain problems. Suboxone®/buprenorphine-naloxone acts as a medium potency opioid. It is an effective analgesic and will often help with pre-existing pain. NSAIDs and paracetamol can be used in addition. In circumstances where additional acute pain relief is required, contact the Drug and Alcohol Clinical Advisory Service for advice on 7087 1742 or 1300 13 1340.

## Other resources for advice/assistance

### Drug and Alcohol Clinical Advisory Service

Tel: 7087 1742

For clinical advice from senior DASSA clinicians  
24 hours a day, seven days a week.

### Drugs of Dependence Unit (DDU)

Tel: 1300 652 584

Fax: 1300 658 447

(The DDU [Policy for Non-Supervised Dosing of Methadone and Buprenorphine in Drug Treatment Programs](#) at <http://www.sahealth.sa.gov.au/drugsofdependence> Under forms and resources)

### DASSA Central Services

Tel: 7425 5000 (ask for Duty Doctor or Nurse),  
9:00am – 5:00pm, Monday – Friday.

### DASSA Northern Service

Tel: 08 7485 4600 (ask for Duty Doctor or Nurse),  
9:00am – 5:00pm, Monday – Friday.

### DASSA Southern Service

Tel: 8325 8111 (ask for Duty Doctor or Nurse),  
9:00am – 5:00pm, Monday – Friday.

### DASSA Buprenorphine/Naloxone (Suboxone®) Information

Information on understanding Suboxone® prescribing is available from the [GP Program – Medication assisted treatment for opioid dependence](#) page of the [SA Health](#) website

(To access this go to the home page of the SA Health website

→Clinical Resources

→Clinical Programs

→Drug and alcohol programs

→GP Program (Medication Assisted Treatment for Opioid Dependence).

The [National Guidelines for Medication Assisted Treatment for Opioid Dependence](#) are available on the home page of the [National Drug Strategy](#) website.

### Alcohol and Drug Information Service

Tel: 1300 13 1340

8.30am to 10pm every day. Confidential telephone counselling and information.

### Hepatitis SA

Tel: 8362 8443 or 1300 437 222 (regional callers)

[www.hepatitissa.asn.au/](http://www.hepatitissa.asn.au/)

[www.sahealth.sa.gov.au/dassa](http://www.sahealth.sa.gov.au/dassa)

© Department for Health and Wellbeing, Government of South Australia. All rights reserved. February 2019

