Rhode Island Department of Health Academic Center Public Health Grand Rounds

Practical Implications of Prescribing Buprenorphine for Chronic Pain

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Program Release: January 4 2019
Expiration Date: January 4, 2021
Estimated time to complete: 60 minutes
There are no prerequisites for participation.

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Disclaimer

This educational program is designed to present scientific information and opinion to health professionals, to stimulate thought, and further investigation.

Learning Objectives

At the conclusion of this session, attendees should be able to:

1. Be aware of the on and off label use of buprenorphine-containing products in the outpatient setting
2. Recognize the advantages and disadvantages of buprenorphine for pain management
3. Describe the practical implications for using buprenorphine off label, including documentation and insurance reimbursement

Target Audience

Primary Care Physicians, Physician Assistants, Advanced Practice Registered Nurse, Nurses, Medical Students, Residents & Fellows.

CME Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Warren Alpert Medical School of Brown University and the Rhode Island Department of Health Academic Center. The Warren Alpert Medical School is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation

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RI Specific: This activity qualifies for 1.0 hours CME Credit in Opioid Pain Management/Chronic Pain Management, one of the required areas of section 6.0; 6.2.1 RI CME re-licensure requirements.

This training also meets the requirements set forth in RI Regulation 3.14 Prescriber Training Requirement for Best Practices Regarding Opioid Prescribing. This specific training requirement is required only once and must be completed before renewal of controlled substance registration or two (2) years (whichever is longer).

Other Health Professionals: Participants will receive a Certificate of Attendance stating this activity is designated for 1.0 hours *AMA PRA Category 1 Credits™*. This credit is accepted by the AANP, AAPA, and RI Pharmacy re-licensure.

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This activity may include discussion of off-label or investigative drugs uses. Speakers are aware that it is their responsibility to disclose to the audience this information. Individual Faculty Disclosure information may be found in the conference handouts.

Faculty Disclosure/Conflict of Interest

The following Speaker and Planning Committee* have indicated that they have no relevant financial relationships to disclose:

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Catherine DeGood D.O.

Care New England Medical Group | Butler Behavioral Health
Meadows Edge Recovery Center | 580 Ten Rod Road | North Kingstown, RI 02852

Objectives

1. Be aware of the on and off label use of buprenorphine-containing products in the outpatient setting
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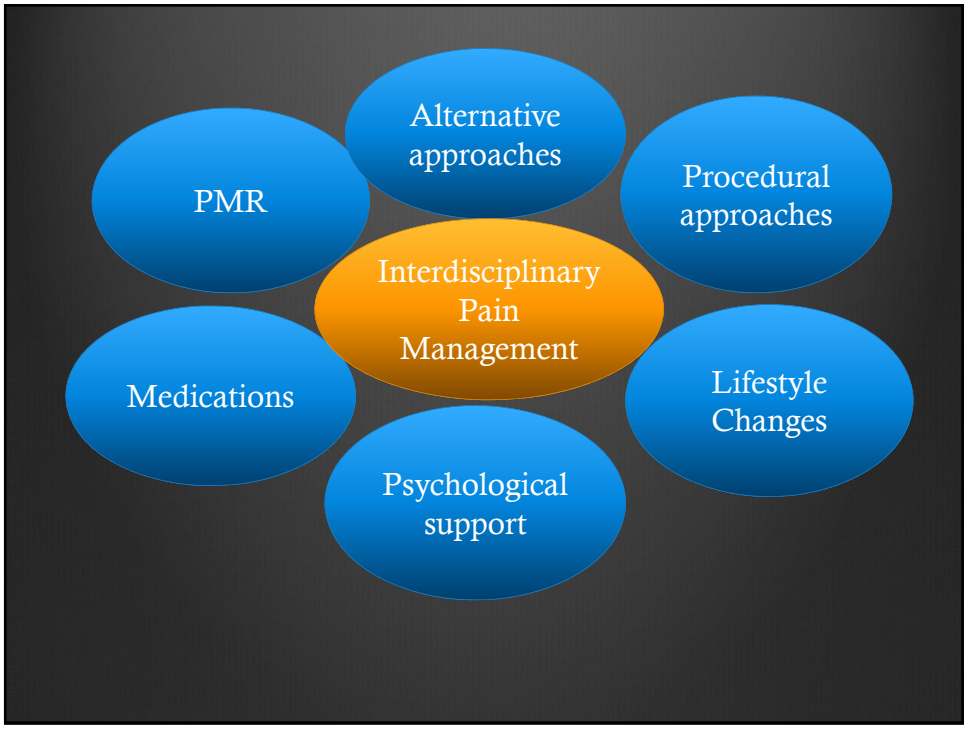
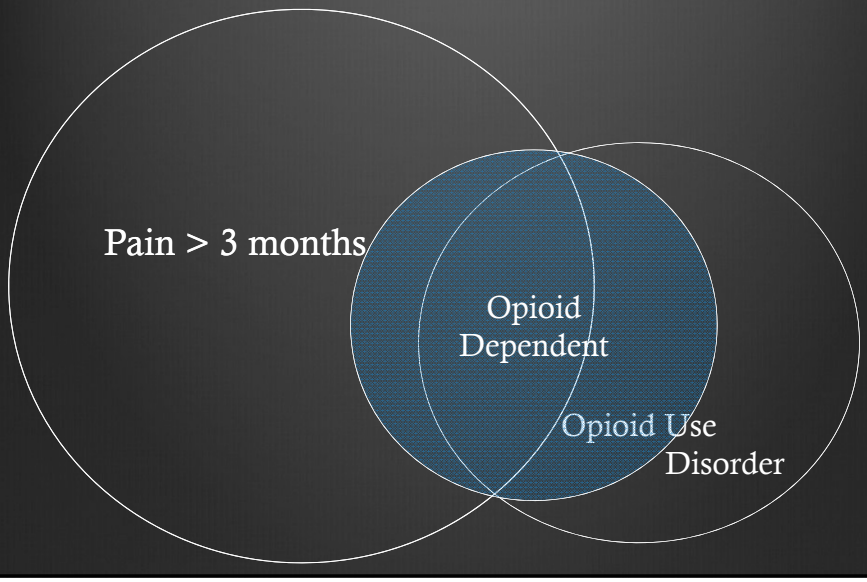


Pain

- Pain is an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage
- Chronic pain – pain that persists or recurs for more than three months

International Association for the Study of Chronic Pain. Classification of Chronic Pain, Second Edition (Revised)
www.iasp-pain.org. Accessed on October 1, 2018

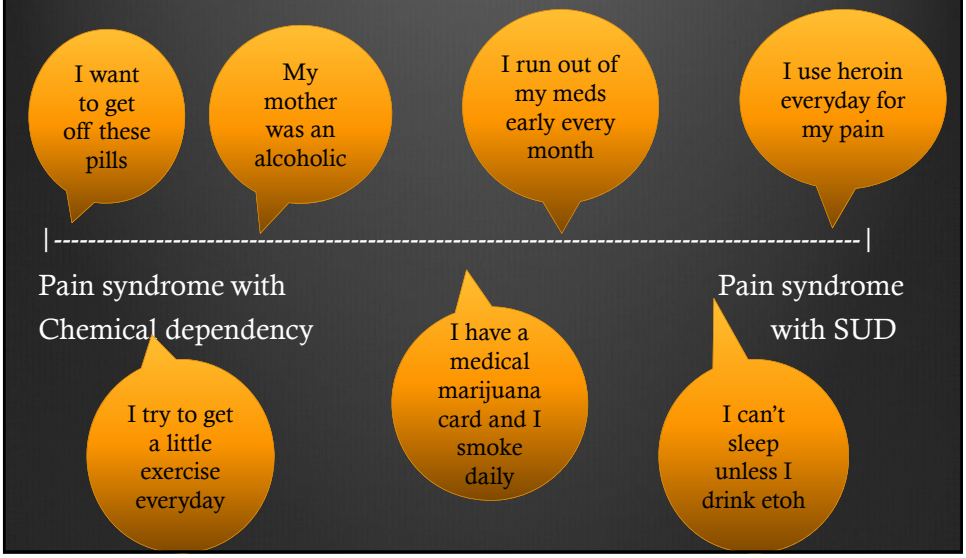
Disorder vs Dependence



Screening tools

- Opioid Risk Tool (ORT), Screener and Opioid Assessment for Pts with Pain (SOAPP)
- Personal history of substance abuse
- Family history of substance abuse
- Age
- Comorbid psychiatric or psychological issues
- H/o abuse, especially preadolescent sexual abuse
- Legal problems

Is it pain or is it addiction?



Buprenorphine

- Originally released in the UK in 1978 for pain
- Approved in the US in 1981 as Buprenex
- SL formulations released in 1982
- Drug Addiction Treatment Act of 2000 passed
- 2002 FDA approved for opioid use disorder treatment

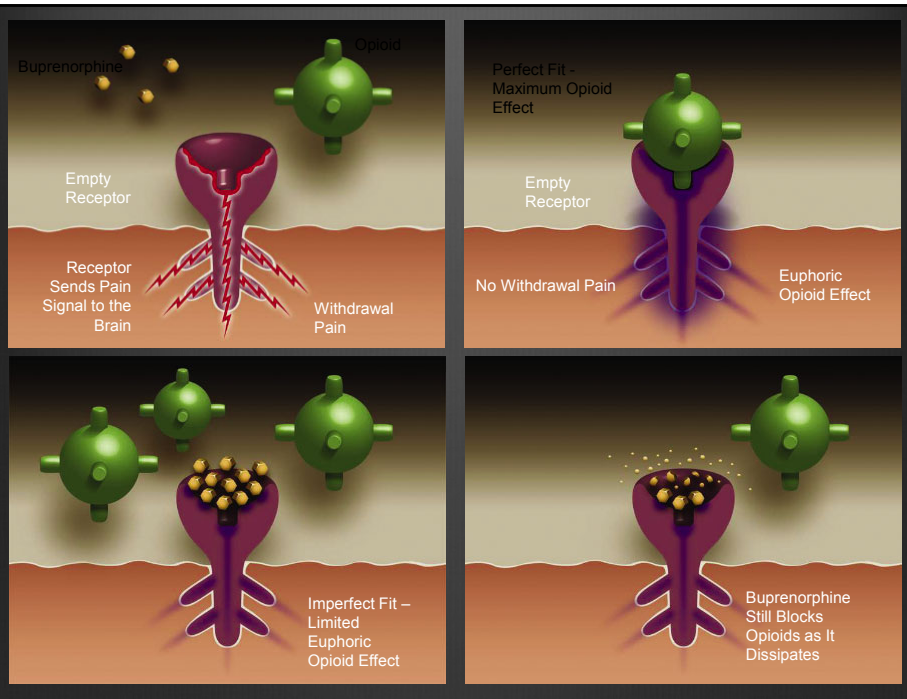
https://www.deadiversion.usdoj.gov/fed_regs/rules/2002/fr1007.htm

Mechanism of Action

- Partial agonist of mu opioid receptor
  - Both activates receptor and blocks other opioids from binding
  - High receptor site affinity
  - Slowly detaches
- Antagonist at kappa receptor
  - slows receptor activity which modulates withdrawal symptoms
  - Anti depressant and anti-anxiety properties

Buprenorphine – an attractive opioid with underutilized potential in treatment of chronic **pain**
Ish K Khanna, Sivaram Pillarisetti
J **Pain** Res. 2015; 8: 859–870. Published online 2015 Dec 4. doi: 10.2147/JPR.S85951
PMCID: PMC4675640

Practical Considerations for the Clinical Use of Buprenorphine Hendrée E. Jones, Ph.D. Sci Pract Perspect. 2004 Aug; 2(2): 4–20.



Courtesy of NAABT, Inc. (naabt.org)

Benefits vs. full agonist opioids

- Improved safety profile
  - Ceiling effect on respiratory depression
  - Causes less cognitive impairment
- Does not significantly prolong the QTc interval
- Effective for multiple pain types, including nocioceptive, neuropathic, and cancer
- Less analgesic tolerance
- Lower abuse potential

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Benefits continued

- Safe and effective in the elderly
- Safe in renal failure and for those on HD
- Less constipation, no effect sphincter of Oddi
- Not immunosuppressive
- Does not adversely effect the hypothalamic-pituitary-adrenal axis or cause hypogonadism

Pain Pract. 2008 Jul-Aug;8(4):287-313. doi: 10.1111/j.1533-2500.2008.00204.x. Epub 2008 May 23.
Opioids and the management of chronic severe pain in the elderly: consensus statement of an International Expert Panel with focus on the six clinically most often used World Health Organization Step III opioids (buprenorphine, fentanyl, hydromorphone, methadone, morphine, oxycodone).
Pergolizzi J[1], Böger RH, Budd K, Dahan A, Erdine S, Hans G, Kress HG, Langford R, Likar R, Raffa RB, Sacerdote P.

Medical considerations

- Additive effects with other sedating medications
- Risk of precipitated withdrawal
- Can lower seizure threshold
- Slightly lowers BP when starting
- Hepatic function-if severe consider monoproduct
- GI effects-nausea, constipation

Pain Formulations

Generic	Brand	Dose
Buprenorphine IV/IM	Buprenex	0.3mg /1ml
Transdermal	Butrans	5mcg, 10mcg, 15mcg, 20mcg
	Generic patch	5mcg, 10mcg, 15mcg, 20mcg
Buccal	Belbuca	75mcg, 150mcg, 300mcg, 450mcg, 600mcg, 750mcg, 900mcg

Substance Use Disorder Formulations

Generic	Brand	Dose
buprenorphine/naloxone transmucousal	Suboxone film	12mg, 8mg, 2mg, 4mg
	Zubzolv	0.7mg, 1.4mg, 2.9mg, 5.7mg, 8.6mg, 11.4mg
	Bunavail	2.1mg, 4.2mg, 6.3mg
	Generic tabs and films	2mg, 8mg
Buprenorphine	Subutex	8mg, 2mg
	Generic	8mg, 2mg
6 month implant	Probuphine	
Subcutaneous Injection	Sublocade	300mg, 150mg
	More coming in fall	

Opioid Use Disorder Diagnostic Criteria

1. Opioids are often taken in larger amounts or over a longer pe
intended.
2. There is a persistent desire or unsuccessful efforts to cut dow
3. A great deal of time is spent in activities necessary to obtain
recover from its effects.
4. Cra ge to use opioids.
5. Rec a failure to fulfill major role obligations at work, school
or h
6. Continued opioid use despite having persistent or recurren
problems caused by or exacerbated by the effects of opioid
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 ha
use despite knowledge of having a persistent or recurrent phy
problem that is likely to have been caused by or exacerbated
9. Tolerance
10. Withdrawal

Someone wants them off of it

Inactive, isolated

On a benzodiazepine

Continued or worsening pain

Initiating Therapy for Pain

- Non-opioid dependent: 5mcg patch
- Opioid dependent:
  - Benefit from in office induction due in unfamiliarity with buprenorphine
  - Low dose- 2mg
- Need to be in mild-moderate opiate withdrawal
  - long acting opioid 24-96 hours
  - short acting opioid 6 hours

Initiating Therapy for Pain

- Start ¼-½ tab SL in office. Recheck at 30, 60 and 120 min
- If no worsening symptoms and continued significant withdrawal at 60min administer another ½ tab
- When symptoms improved, discuss they can take another ½ tab in the evening if needed and call me for check in tomorrow

DEA-things to know

- SUD formulations CAN be used off label for pain
- Pain formulations CAN NOT be used off label for SUD
- X DEA number needed on prescriptions for SUD
- X number not needed when prescribed off label for pain
- If X number on prescription, counts towards DATA 2000 provider pt limit
- "Three day rule"

https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07

Coding

- Require a ICD 10 code
- BCBS and NHP do not have "required diagnosis" stipulations
- Many medicare supplementals will cover monoproduct for pain
- Tufts, Cigna and United usually require SUD diagnosis
- Primary diagnosis in record can be pain diagnosis and secondary F11.1 on RX

Perioperative Management

3 protocols

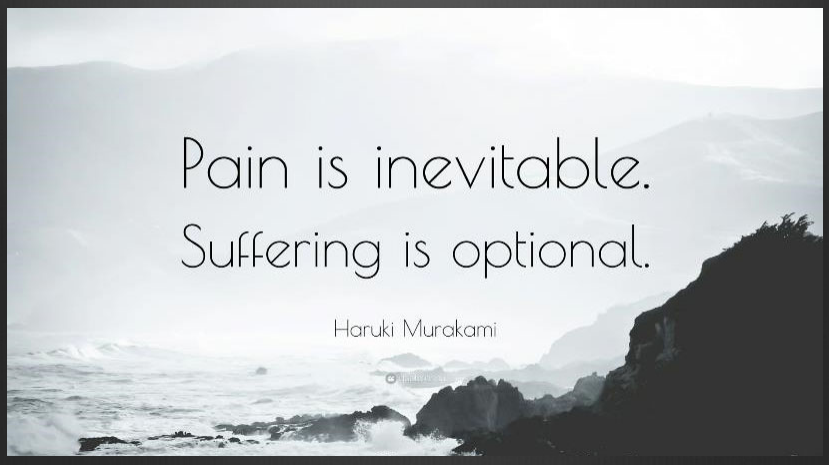
1. Hold buprenorphine 5 days before surgery-Michigan Protocol
2. Hold buprenorphine day of surgery-Boston Medical Center
3. Continue buprenorphine through surgery

http://pcssnow.org/wp-content/uploads/2015/12/Alford-Acute-Chronic-Pain-MAT-FINAL3-12-22-15.pdf

Ongoing Questions

- Analgesic effect vs treating opioid hyperalgesia?
- Analgesic ceiling?
- Acute pain management with:
  - Full agonist opioids
  - Other partial agonists
- Withdrawal symptoms-psychological vs physical elements

Thank you



Resources

1) Chen, Kelly Yan, et al. “Buprenorphine–Naloxone Therapy in Pain Management.” Anesthesiology:
The Journal of the American Society of Anesthesiologists, The American Society of Anesthesiologists, 1 May 2014, anesthesiology.pubs.asahq.org/article.aspx?articleid=1917779

2) Rolley E. Johnson, PharmD , Paul J. Fudala, PhD, Richard Payne, MD, Buprenorphine: Considerations for
Pain Management, Journal of Pain and Symptom Management, March 2005 Volume 29, Issue 3, Pages 297–326

3) Alford, Dan. “Managing Acute and Chronic Pain with Patients on MAT.” PCCS, pcssnow.org/wp-content/uploads/2015/12/Alford-Acute-Chronic-Pain-MAT-FINAL3-12-22-15.pdf

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