EMS-Administered Buprenorphine

December 2025

ScalaNW

Purpose and Scope

This document provides information to support medical program directors (MPDs) and emergency medical services (EMS) providers who are developing or participating in an MPD approved buprenorphine administration program in Washington state. The first section is sample guidance and is recommended for use as a quick field-reference guide. The second section expands on the first and is recommended as training material. Training for EMS providers must be approved by the EMS MPD.

This document does not take the place of department approved MPD protocols. EMS providers must follow approved protocols regarding medication administration and patient transportation and practice within their scope as outlined by the Washington State Department of Health and under the medical oversight and direction of an MPD.

Additional information can be found in **Washington State DOH EMS Guideline Paramedic Buprenorphine Administration**

Table of Contents

Sample Policy and Procedure

Buprenorphine Administration for Opioid Withdrawal

Opioid use disorder (OUD) is a treatable medical condition with high mortality rates. Treating opioid withdrawal with buprenorphine can be a lifesaving intervention—it prevents overdose by blocking other opioids for at least 24 hours after a single dose and can facilitate connection to addiction recovery services.

Inclusion Criteria

- In opioid withdrawal:
  - Post overdose reversal with naloxone: COWS ≥4, OR
  - Without naloxone: COWS ≥8
- Age: ≥13
  - Consult medical control for ages 13-16

Exclusion Criteria

- Age <13
- Benzodiazepine or other (non-opioid) sedative intoxication suspected
- Unable to consent
- Altered mental status
- Signs of respiratory distress or hypoxia
- Acute trauma or severe medical illness such as sepsis, respiratory distress, suspected organ failure
- Report of methadone use within the last 48 hours

Assessment

Symptoms of opioid withdrawal include:

- Tachycardia
- Restlessness, agitation, anxiety
- Sweating
- Feeling hot and cold
- Yawning
- Stomach cramps, diarrhea
- Body aches
- Dilated pupils
- Watery eyes, runny nose
- Nausea/vomiting (may also occur from BVM)
- Piloerection (gooseflesh/goosebumps)

Calculate the Clinical Opioid Withdrawal Scale (COWS) to determine whether buprenorphine is indicated. COWS score should be:

- **≥4 for patients who received naloxone**
- **≥8 for patients who did NOT receive naloxone**

Counseling and Consent

Offer buprenorphine and explain benefits, e.g.:

> Would you like some medicine to help you feel better?

> Buprenorphine is a medicine that treats withdrawal. It can also prevent overdose.

Explain risk of precipitated withdrawal, e.g.:

> This medicine should help you feel much better. Sometimes people need more than one dose.

> There is a small risk that the first dose can make you feel sicker; if that happens, another dose will help.

Address questions about continuing buprenorphine, e.g.:

> Buprenorphine also treats opioid use disorder (addiction). You can take buprenorphine to feel better right now, and decide later if you want to keep taking it.

Address questions about safety in pregnancy, e.g.:

> Buprenorphine is recommended treatment for withdrawal in pregnancy.

> Buprenorphine is a safe treatment for opioid use disorder (addiction) in pregnancy. You can talk to a provider about continuing the medication, and they can provide more information.

Confirm patient agrees to take buprenorphine

Medication Administration

Sample process

1. Offer water to wet the mouth or a sour hard candy to promote salivation.

Do not chew or swallow the candy when taking the medication—remove if necessary. Another candy can help with the medication's bad taste.

2. Explain how to take buprenorphine.

- Put under your tongue until dissolved; do not swallow it.
- Avoid talking, eating, drinking, or smoking while it's dissolving.
- Avoid eating or drinking for 15 minutes after.
- Rinse out your mouth 15-30 minutes after to prevent tooth decay.

3. Administer buprenorphine at appropriate dose.

Age 16+: 16 mg (2 strips) under the tongue

8 mg 8 mg

Age 13-16: 8 mg (1 strip) under the tongue

8 mg

Additional medications may be offered.

With medical director's approval, additional medications may be given for symptom control. For example:

- **Generalized opioid withdrawal:** tizanidine 2 mg OR clonidine 0.1 mg
- **Nausea/vomiting:** ondansetron 4-8 mg (dissolvable preferred)
- **Diarrhea:** loperamide 4 mg
- **Pain:** acetaminophen 325-650 mg OR ibuprofen 600-800 mg
- **Anxiety/agitation:** hydroxyzine 25-50 mg OR olanzapine 5 mg (dissolvable preferred)

5. Reassess COWS in 10-15 minutes.

6. Additional buprenorphine dose may be indicated.

For continued withdrawal symptoms:

- Age 16+: 8 mg (total dose 24 mg)
- Age 13-16: 8 mg (total dose 16 mg)

For buprenorphine-induced precipitated withdrawal (worsening of COWS by approximately 5+ points within 15 minutes after initial dose):

- Age 16+: 16 mg (max dose 32 mg)
- Age 13-16: 16 mg (max dose 24 mg)

Transport

Sample process

- The patient does not have to accept transport to be treated.
- Encourage transport to the hospital or appropriate alternative destination.
- **Provide:**
  - Leave-behind naloxone
  - OUD resources, e.g.:
    - University of Washington's **statewide telehealth buprenorphine service**, (206) 289-0287
    - **Washington Recovery Helpline**, (866) 789-1511
    - Syringe service programs (DOH)
    - **Never Use Alone Hotline**, 800-484-3731
  - Fentanyl test strips, if patient does not intentionally use fentanyl
- Document patient contact information for Mobile Integrated Health, or other EMS follow up program, if available.
- EMS programs enrolled in ScalaNW can call the scheduling line to make a follow-up appointment.

Alternative Transport Destinations

- Alternative destinations may be the best option for medically stable patients, as they are better equipped to support patients with substance use disorders and linkage to care.
- Destinations may include withdrawal management facilities, crisis stabilization or crisis relief centers, addiction treatment clinics, and sobering centers.
- Establish relationships with potential alternative destinations to determine whether and how they can accept patients.
- Alternative transport may not be available in all areas. If unavailable, offer transport to the emergency department.
- Ages <16 should be encouraged to go to the hospital for closer monitoring.
- See **Ambulance Transportation Billing Guide** for information on *Alternative Destination Transports for People with Mental Health or Substance Use Disorders*, including applicable regulations and reimbursement guidance.

Leave-behind naloxone

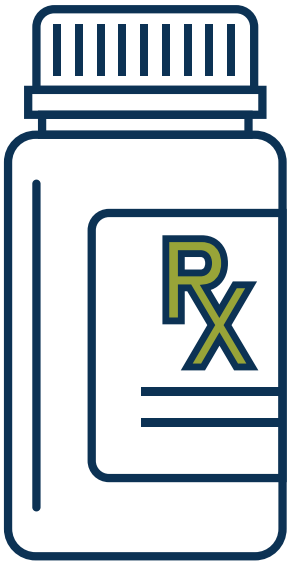
At the end of the response, provide naloxone for the patient to take with them.

See DOH **EMS Naloxone Leave Behind Program Guidance** for implementation support.

Training

This section provides more information that can be incorporated into a training curriculum.

Why Provide Buprenorphine?



- Buprenorphine is a potentially life-saving medication. It significantly decreases morbidity and mortality in patients with OUD.
- Naloxone can precipitate severe opioid withdrawal in opioid-dependent patients; buprenorphine can alleviate that withdrawal.
- Buprenorphine reduces the risk of opioid overdose by blocking the effects of other opioids.
- Buprenorphine protects against repeat overdose after reversal.
  - A single dose of buprenorphine helps prevent opioid overdose by blocking other opioids for at least 24 hours, during the highest risk time for repeat overdose.
  - Naloxone can wear off before other opioids do, putting the patient at risk for repeat overdose.
  - People with OUD will have an intense urge to use again after reversal to alleviate withdrawal, further increasing their risk for repeat overdose.
- Relieving the patient's distress from withdrawal provides better care and can facilitate willingness to transport and engage in treatment.
  - Overdose patients treated with buprenorphine are six times more likely to engage in addiction treatment within one month after the overdose.[1]
  - Administering buprenorphine is a compassionate and potentially life-saving intervention that is recommended regardless of whether a patient is interested in long-term OUD treatment.

[1]Carroll G, Solomon KT, Heil J, Saloner B, Stuart EA, Patel EY, et al. Impact of Administering Buprenorphine to Overdose Survivors Using Emergency Medical Services. Ann Emerg Med. 2023;81:165–75. https://doi.org/10.1016/j.annemergmed.2022.07.006

Pharmacology

Buprenorphine is a partial opioid agonist that both activates and blocks opioid receptors; by comparison:

- Fentanyl (an opioid agonist) activates opioid receptors.
- Naloxone (an antagonist) blocks opioid receptors, thus removing opioids that are present.
- Buprenorphine (partial agonist) provides moderate activation and blocks other opioids from opioid receptors.

Buprenorphine has a very strong affinity for opioid receptors, so it out-competes other opioids and naloxone.

Because of these properties, buprenorphine can both treat and cause withdrawal depending on what is already in the person's system.

- It causes withdrawal when displacing full agonist opioids like fentanyl.
- It treats withdrawal when given to someone already in withdrawal by partially activating the receptors.

Risks and Safety

Buprenorphine is a safe and potentially life-saving medication.

Respiratory depression/overdose

- Buprenorphine has a very low risk of respiratory depression and significantly reduces the risk of respiratory depression when other opioids are used.
- Overdoses involving buprenorphine are rare and typically also involve other CNS depressants, like alcohol and benzodiazepines.

Precipitated withdrawal

- Precipitated withdrawal is a sudden, significant worsening of withdrawal symptoms after an opioid antagonist (like naloxone and naltrexone) or partial agonist (like buprenorphine) is given to an opioid-dependent person.
- Because of its strong affinity for opioid receptors, buprenorphine replaces other opioids that are present. Because buprenorphine is a weaker opioid, this can precipitate withdrawal in people who are opioid-dependent.
- Opioid-dependent patients should be in withdrawal before starting buprenorphine to prevent the more severe symptoms of precipitated withdrawal.
- Patients who regularly take methadone are at higher risk for precipitated withdrawal if they've had methadone within the 48 hours preceding buprenorphine administration. This is because methadone is a more potent, longer-acting opioid.
- The treatment for precipitated withdrawal is more buprenorphine. Additional buprenorphine will occupy more opioid receptors, which will reduce withdrawal severity.

How to Take Buprenorphine

Buprenorphine is a sublingual medication that must be placed under the tongue to absorb. Instruct patients to follow these steps for proper administration.

Before taking the medication

- Wet the mouth to help the medication absorb better.
  - Sucking on a sour hard candy increases saliva production, which helps the medication absorb better; alternatively,
  - Take a sip of water.
- Do not chew or swallow the candy when taking the medication. Remove the candy if necessary.
- Another candy can be given after administration to get rid of the bad taste of the medication.

Administering the medication

- Place the film(s) or tablet(s) under the tongue.
- Allow the medication to completely dissolve (typically about 10 minutes).
- Do not swallow the medication – it must be absorbed under the tongue to work.
- Patients should avoid talking, eating, drinking, or smoking while the medication is dissolving.

After taking the medication

- Wait at least 15 minutes after it has dissolved before eating or drinking.
- If the flavor is unpleasant, a candy or mint can help.
- Rinse out the mouth to prevent tooth decay, which can occur with long term use of buprenorphine.

Additional Medications

Symptom management

If the prescriber approves, additional medications can be offered for symptom control. For example:

- Generalized opioid withdrawal: tizanidine 2 mg OR clonidine 0.1 mg
- Nausea/vomiting: ondansetron 4-8 mg
- Anxiety/agitation: hydroxyzine 25-50 mg OR olanzapine 5 mg
- Diarrhea: loperamide 4 mg
- Pain: acetaminophen 325-650 mg OR ibuprofen 600-800 mg

When available, dissolvable medications are preferred due to nausea/vomiting associated with opioid withdrawal.

Patient resources

Washington Recovery Helpline – 24/7 support for substance use disorder and help finding treatment options.

1-866-789-1511

warecoveryhelpline.org

Washington Telebuprenorphine Hotline – provides low-barrier access to buprenorphine for opioid use disorder daily from 9 am – 9 pm.

206-289-0287

Never Use Alone Hotline – a trained volunteer will stay on the line and call for help if you become unresponsive while using.

1-800-484-3731

Washington Syringe Service Programs – drug user health programs providing naloxone, safer use supplies, and other harm reduction resources.

doh.wa.gov/SSPlist

Using the Clinical Opioid Withdrawal Scale (COWS)

The **Clinical Opioid Withdrawal Scale (COWS)** is one measure of severity of opioid withdrawal and is widely used.

Buprenorphine should only be given in the field if the patient is in withdrawal.

- Remember that buprenorphine is a partial opioid agonist with strong affinity for the opioid receptor – it can precipitate severe withdrawal if a patient is not in adequate withdrawal or does not have a high enough COWS score.

Pros of the COWS

- Best validated test available
- While subjective, it does eliminate some bias
- Allows for monitoring progression of symptoms and medication response

Cons of the COWS

- Not validated in the pre-hospital setting
- Subjective
- Not specific
  - Symptoms may be from conditions other than opioid withdrawal (e.g., stimulant intoxication, sepsis). It is a useful tool, but not a replacement for clinical judgment.

In addition to the COWS:

- Ask the patient if they are in opioid withdrawal, and how bad the withdrawal is. If they use opioids frequently, most will have experience with withdrawal and will be aware of the symptoms and severity.
- Asking about other substances used can help inform whether the score could be inflated due to stimulant use.
- Buprenorphine may be indicated if the COWS score is:
  - ≥4 for patients who received naloxone
  - ≥8 for patients who did NOT receive naloxone
- The COWS score can be quickly calculated using an electronic or paper form.
- **MDCalc** has a phone app and a website with the COWS tool that is commonly used. Download the app for quick use in the field.
- A paper form can be found **here**, from the American Society of Addiction Medicine, for printing.

COWS score interpretation:

<5: no active withdrawal

5-12: mild withdrawal

13-24: moderate withdrawal

25-36: moderately severe withdrawal

>36: severe withdrawal

Who is Eligible?

Buprenorphine is a safe medication for use in opioid withdrawal. It is safe for patients with OUD, including in patients who are:

- Youth (≥13)
- Pregnant
- Are also using other drugs like methamphetamine

Patients who are in opioid withdrawal and meet the following criteria should be considered for buprenorphine:

- Age: ≥13
  - Consult medical control for ages 13-16 prior to administration.
  - Rationale: Buprenorphine is a lifesaving medication and should not be withheld for younger patients that otherwise qualify. Age of consent for SUD treatment in WA is 13.

COWS

- Post overdose reversal with naloxone: COWS >4, OR
- Without naloxone: COWS >8
- Rationale: see Using the Clinical Opioid Withdrawal Scale (COWS) above

Who is Not Eligible?

Age <13

Benzodiazepine or other sedative intoxication suspected.

- Buprenorphine only works on opioid receptors; it will not benefit other sedative-related health concerns.
- When combined with other sedatives (e.g., alcohol, benzodiazepines), buprenorphine can contribute to CNS depression (e.g., low respiratory drive, depressed consciousness).

Report of methadone use within the last 48 hours and COWS <8.

- People who are dependent on methadone and have taken a dose within the 48 hours preceding buprenorphine administration are at higher risk of precipitated withdrawal.

Patients otherwise too ill to be treated in the field and should be transported to the hospital, including those who:

- Are unable to consent or have altered mental status.
- Are poorly oxygenated (Sp02 <92).
- Have other acute injuries or medical illness (e.g., sepsis, respiratory distress, suspected organ failure).

Consider additional crew discussion or consult medical control to determine appropriateness for buprenorphine in patients who:

- Received chest compressions or lengthy BVM resuscitation.
- Are experiencing signs of respiratory distress despite appropriate 02 sat, OR
- May have aspirated.

Case Examples

The following case examples can be presented for discussion as part of training.

Case 1: Severe withdrawal

Subjective:

- 31-year-old patient, reported opioid overdose.
- Received 2 doses of intranasal naloxone just prior to arrival.
- Bystanders say that when he got naloxone, he looked dusky and blue and was not breathing well. He is now breathing on his own. He can say his name and is awake and making purposeful movements.

Objective:

- Vitals: BP 148/98, P 98, RR 12, 96% on room air
- Patient lying supine on ground, writhing around; stands up and attempts to gather his things to leave the scene, visibly agitated
- Skin – normal coloration, warm, sweating on face
- HEENT – no abnormalities, pupils dilated
- Chest – equal breath sound, normal respirations
- Extremities – no abnormalities

TRAINING NOTE - Patient Engagement:

- Check in and offer help
- Redirect to ambulance with water, snacks, space to talk away from scene

Patient History:

- Reports he smoked some “blues,” denies alcohol or other drugs

Case 1: Severe withdrawal

Re-assessment:

- Vitals re-assessed in ambulance, tachycardic to 140s
- Pupils 5+ bilaterally, equal
- Intermittent dry heaving
- A little agitated, but apologizes, says he just feels sick
- Shaking, tremor
- Tearing from both eyes (wipes eyes)
- Sniffling a lot
- Yawning twice
- Difficulty sitting still
- Asks if you have any Tylenol for muscle aches, rubbing muscles
- Hair on arm standing up

COWS

- HR 140s (+4)
- Sweating – sweat on brow (+3)
- Restlessness – can't sit still (+5)
- Pupils – 5 bilateral, moderately dilated (2+)
- Bone or aches – rubbing muscles (+4)
- Runny nose/tearing – tear (+2)
- GI upset – vomiting actively (+3)
- Tremor – shaking (+4)
- Yawning – yawning once or twice (+1)
- Anxiety – obviously irritable (+2)
- Gooseflesh – hair standing up (+3)
- = 33, severe withdrawal

Training Note: Discussion

Is this just opioid withdrawal? What else could be going on?

Likely just opioid withdrawal.

Is buprenorphine indicated?

Yes, severe withdrawal.

Is buprenorphine contraindicated?

No.

Plan?

- Buprenorphine 16 mg now with option for 8 mg more in 15 minutes if symptoms persist.
- Encourage transport to ED or alternative destination for continued buprenorphine and other services.
- Provide resources, including leave-behind naloxone and treatment information.

Outcome

Upon arrival at ED, appeared to be resting comfortably and stopped vomiting. A little sleepy but wakes to verbal stimuli with minimal effort.

Case 2: Mild withdrawal

Subjective:

- 23-year-old patient, reported opioid overdose.
- Received 2 doses bystander naloxone and woke up.

Objective:

- HR 90, BP 130/90, RR 12, SPO2 95 room air
- First responder assessment: Awake. Some speech that was incomprehensible, but able to communicate. Oriented
- Skin – no gooseflesh, warm, dry
- Pupils 3+
- Patient agitated, one of the first responders says, "stay still while I'm retaking your blood pressure," and patient says, "I can't!" and moves their arm away
- Patient yawning twice
- When asked, +mild body aches, + nausea (no vomiting)

TRAINING NOTE - Assessment:

- Ask patient how they're feeling; are they in withdrawal?

COWS

- HR 90 (+1)
- Sweating (0)
- Restlessness (+1)
- Pupils (0)
- Bone or aches (+1)
- Runny nose/tearing (0)
- GI upset – reports nausea (+2)
- Tremor (0)
- Yawning – 2 times (+1)
- Anxiety – obviously irritable (+2)
- Gooseflesh (0)
- = 8, mild withdrawal

Training Note: Discussion

Did you ask the patient how they're feeling?

Just withdrawal? What else could be going on?

- Stimulant use, mental health problem, low blood sugar.

Buprenorphine indicated?

- Yes.

When talking about buprenorphine, patient says, "I'm pregnant, is that an issue?"

Buprenorphine contraindicated?

No.

Recall that pregnancy is not a contraindication

- Buprenorphine is a first-line recommended treatment for withdrawal and opioid use disorder in both pregnant and non-pregnant patients.
- There is a risk of neonatal opioid withdrawal at birth if the medication is taken long term.
- Withdrawal, overdose, and ongoing use are known to have greater risks to the pregnancy and fetus than buprenorphine.

Plan?

- Buprenorphine 16 mg now with option for 8 mg more in 15 minutes if symptoms persist.
- Encourage transport to ED or alternative destination for continued buprenorphine and other services.
- Provide resources, including naloxone and treatment information.

Outcome

Transported to alternative destination (overdose receiving center) where they prescribed buprenorphine and connected to an ongoing care provider.

Case 3: Primary stimulant use

Subjective:

- 37-year-old patient, first responders on scene.
- Found unconscious/unresponsive in the alleyway by passerby. A person called 911 while another passerby administered 4mg nasal Narcan 2 times. No CPR performed. Unknown drug usage, unknown medical Hx, Rx or allergies.

Objective:

- Patient now awake, talking to you, sitting on ground, speaking in short sentences, says they want to go to hospital
- BP: 176/104, HR:112, O2: 100%, RR 16, end tidal CO2: 71mmHg, blood glucose: 117
- Skin – warm, face flushed, no gooseflesh
- HEENT – atraumatic, pupils dilated, equal, round, and reactive to light, sniffling
- Lungs clear bilaterally
- Yawns once during exam

If asked, patient reports:

- Mild discomfort in muscles
- Mild nausea (no vomiting)
- No tremor
- Feels anxious

Patient History:

- Says, "I usually only use "clear" (methamphetamine), I don't really use opioids."
- Record shows patient had another opioid overdose last month

COWS

- HR 112 (+2)
- Sweating – flushed (+2)
- Restlessness – frequent shifting (+3)
- Pupils – 5+ b/l (+2)
- Bone or aches – diffuse discomfort (+1)
- Runny nose/tearing – nasal stuffiness (+1)
- GI upset – subjective nausea (+2)
- Tremor (0)
- Yawning – yawns x1 (+1)
- Anxiety – subjective anxiety (+1)
- Gooseflesh (0)
- = 15, moderate withdrawal

Training Note: Discussion

Just opioid withdrawal? What else could be going on?

Symptoms may be attributable to meth intoxication (e.g., tachycardia, sweating, restlessness, anxiety).

Buprenorphine indicated?

- No. Although COWS is positive, stimulant use (methamphetamine) is more likely to be causing the symptoms.
- Patient may have little to no opioid tolerance/only intermittent fentanyl use.

Buprenorphine contraindicated?

No, but additional consideration is warranted.

Plan?

- Medical consultation and transport to ED/alternative destination for assessment.
- Provide resources, including leave-behind naloxone, fentanyl test strips, and treatment information.

Outcome

Patient denied transportation but accepted leave-behind naloxone and fentanyl test strips.

Case 4: Moderate withdrawal, on 4L NC

Subjective:

- 19-year-old patient with a reported overdose. Concern for opioid overdose, got 8 mg bystander naloxone from roommates.
- On arrival, the patient is sitting up with assistance from first responders, breathing spontaneously.
- Shirtless, sweating, shaking uncontrollably, and not very verbal.
- Roommates on scene reported that patient uses many different drugs, but were unsure what he used PTA.
- Roommates also reported that everyone in the apartment has been sick over the last couple weeks with a URI.
- The patient became more responsive when in the back of the ambulance and acknowledged snorting fentanyl earlier in the morning.
- Shifting in stretcher.
- Denies any medical history, meds, or allergies.
- If asked – no aching/pain.

Objective:

- HR 120s, BP 140/80
- RR 24, SPO2 80% via NRB @ 15 lpm, now 92% with O2 via NC 4L
- Skin diaphoretic and pale, no gooseflesh
- GCS 14, blood glucose 406
- HEENT – PERRL, 4+, no signs of trauma, snorting/stuffy nose during conversation
- Chest – rhonchorous lung sounds, bilateral
- Extremities – no abnormalities, but shaking uncontrollably
- No yawning
- Says anxious if asked

COWS

- HR 120 (+2)
- Sweating – diaphoretic (+4)
- Restlessness – shifting (+3)
- Pupils – 4+, possibly larger than normal (+1)
- Bone or aches (0)
- Runny nose/tearing – stuff nose (+1)
- GI upset – nausea if asked (+2)
- Tremor (+4)
- Yawning (0)
- Anxiety (+1)
- Gooseflesh (0)
- = 18, moderate withdrawal

Training Note: Discussion

Just withdrawal? What else could be going on?

URI, pneumonia, aspiration, pneumonitis, pulmonary edema, cardiac event from hypoxia or drug use.

Buprenorphine indicated?

Probably, but likely has an illness that requires hospitalization.

Buprenorphine contraindicated?

Yes, contraindicated because of respiratory distress. SPO2 needs to be >92% on room air.

Plan?

Transport to ED.

Outcome

Admitted to MICU with aspiration pneumonitis. Given buprenorphine while inpatient.

Case 5: On methadone

Subjective:

- 39-year-old patient with reported opioid overdose. Received 8mg bystander naloxone from passerby.
- On arrival, the patient is awake, anxious, fidgety, trying to stand up and gather things.
- Sweating, shaking uncontrollably, and not very verbal, speech is soft and a little slurred.
- People on scene reported patient was unarousable and didn't seem to be breathing well.
- The patient became more responsive when in the back of the ambulance and acknowledged methamphetamine and Xanax use earlier in the morning after dosing at methadone clinic.
- Still shaking, shifting around, sniffling a lot, very achy everywhere, occasional yawning.
- Denies any medical history, only medication is methadone 180 mg daily, no allergies.
- Says anxious if asked.

Objective:

- HR 120s, BP 150/85
- RR 22, SPO2 96%
- Skin – diaphoretic and pale, gooseflesh
- GCS 14, blood glucose 165
- HEENT – PERRL, 4+, no signs of trauma, snorting/stuffy nose during conversation
- Chest – clear lung sounds bilat
- Extremities – no abnormalities, but shaking uncontrollably
- No yawning

COWS

- HR 120 (+2)
- Sweating – diaphoretic (+4)
- Restlessness – shifting (+3)
- Pupils – 4+, possibly larger than normal (+1)
- Bone or aches (+2)
- Runny nose/tearing – stuffy nose (+2)
- GI upset – nausea if asked (+2)
- Tremor (+4)
- Yawning (+1)
- Anxiety (+1)
- Gooseflesh (+2)
- = 24, moderate withdrawal

Training Note: Discussion

Just withdrawal? What else could be going on?

Not much else.

Buprenorphine indicated?

Indicated for withdrawal symptoms.

Buprenorphine contraindicated?

Contraindicated because of methadone dose < 48 hours ago.

Plan?

- Treat with adjunctive meds if available for opioid withdrawal (tizanidine, clonidine), nausea (ondansetron), pain (acetaminophen, ibuprofen), anxiety (hydroxyzine).
- Encourage transport for better symptom management and monitoring. Can get methadone at ED and some alternative destinations (e.g., overdose receiving center, withdrawal management facility).
- May be more comfortable in an ED or recovery center than on the streets.
- Reassure that naloxone will wear off in approximately 45-60 min. Caution against using again to feel better, which could lead to another overdose.
- Patient should be monitored for at least 2 hours in case of repeat overdose.

Additional Resources

1. WA Department of Health **Overdose Resources for EMS**

2. King County EMS-initiated buprenorphine **training video** (13 minutes)

3. Grayken Center Clinical Opioid Withdrawal Scale **training video** (3.5 minutes)

EMS Scope of Practice Guidance

In general EMS scope of practice includes environment of practice, EMS service affiliation; training, skills and procedures; and medical oversight and direction by a DOH certified EMS physician medical program director (MPD). The Washington State Department of Health provides guidance on approved skills, procedures, and patient care environments: **EMS scope of practice**

Certified EMS providers are authorized to provide patient care under department approved county MPD protocols. (RCW 18.73, 18.71, 70.168, WAC 246-976). Other regulations may apply. MPDs are required to develop or adopt a patient care protocol (protocol) as defined in WAC 246-976-010.