

Adolescent Buprenorphine Initiation at Home (13+)

Additional Clinical Guidance

- Opioid use disorder (OUD) is a treatable health condition. It is best treated with methadone or buprenorphine.
- Buprenorphine and methadone are life-saving medications for OUD that reduce the risk of all-cause mortality and overdose death by over 50%.
- Recovery often requires multiple treatment attempts. A repeat encounter is not a treatment failure, but an opportunity to reinstate potentially life-saving medication.
- If patients continue to use other opioids while on methadone or buprenorphine, a higher dose may be needed to manage their symptoms. Therapeutic dosing should be guided by adequate management of withdrawal and cravings.
- Opioid withdrawal is excruciating. Without swift and adequate intervention, patients may self-direct discharge and be at risk for overdose.
- Patients with OUD are highly stigmatized. Stigma prevents people from seeking care and worsens health outcomes. Providers should challenge biases to provide compassionate, evidence-based care.
- Adolescents may have better outcomes if a guardian is involved in their care. If the patient consents, a dependable adult can help manage medications and symptoms.

Assessment

- Consider screening for abuse, assault, mental health comorbidities, HIV, HCV, and STIs.

Labs

- Drug testing is not necessary to initiate treatment for OUD.
- If drug testing is performed for clinical reasons, obtain informed consent.

Pharmacotherapy

- Buprenorphine is a partial opioid agonist that helps to minimize withdrawal and lessen opioid cravings.
- Buprenorphine has minimal effect on respiratory drive, making respiratory depression unlikely even at higher doses.
- Buprenorphine has high receptor affinity, allowing it to out-compete other opioids. This competitive binding can precipitate withdrawal because it will rapidly replace the more potent opioid that is present. This is why patients should be in withdrawal before starting buprenorphine with this method.

- Competitive binding also reduces overdose risk by blocking other opioids. Even a single dose provides protection for at least 24 hours, during the high-risk period after discharge.
- Doses should be adjusted based on symptoms— if the patient has ongoing withdrawal symptoms or cravings to use, a dose increase should be considered.

Special populations

Consider expert consultation for pregnant adolescents.

Polysubstance use

- Stimulant intoxication can falsely elevate the COWS score.
- Buprenorphine administration may unmask symptoms of stimulant intoxication.
- Polysubstance use is never a contraindication for initiating buprenorphine.

Discharge planning

- Help the patient schedule a follow-up appointment. Hospitals enrolled in ScalaNW can call the 24/7 appointment scheduling line and receive a confirmed date, time, and location for MOUD follow up appointment during the 10-minute phone call.
 - For hospitals not enrolled in ScalaNW, the Washington Recovery Helpline MOUD Locator (online or at 1-866-789-1511) is a useful resource for finding OUD treatment in Washington.
- Ensure the patient is provided with a buprenorphine prescription to last until their scheduled appointment. If an appointment is not scheduled, provide at least 7-14 days to allow time to secure an appointment.
 - Patients can call the Washington Telebuprenorphine line (206-289-0287) if they run out of medication prior to their follow up appointment.
- Patients commonly need adjunct medications to control withdrawal symptoms until they stabilize on the medication. Provide scripts to last at least 7 days.
- Write down the earliest time they can take their first buprenorphine dose (12-24 hours after their last use).
- In Washington, emergency departments are required to dispense naloxone to patients with OUD or others who are at risk of opioid overdose, in compliance with SB5195. Ensure patient is discharged with naloxone in hand.
- If possible, connect patient with supports such as social workers, care navigators, or peers to improve patient experience and linkage to care.

Patient Education

- Recommend that an adult or other supportive, responsible person help the patient with dosing at home, if possible.
- Discuss the risk of precipitated withdrawal.
 - Because buprenorphine is a partial agonist with high receptor affinity, it can cause sudden, severe withdrawal if it is taken (at typical doses) before the patient is in moderate withdrawal.
 - If this happens, additional doses of buprenorphine can alleviate withdrawal by providing more activation of the opioid receptors. Adjunct medications should also be taken.
- Instruct the patient to assess their symptoms before starting buprenorphine. The worse they feel when they start the medication, the lower the risk of precipitated withdrawal. They should have **at least 3 symptoms** of withdrawal prior to starting the medication. At least one of these should be an objective sign (i.e., measurable or visible to someone other than the patient).

■ Restlessness	■ No appetite	■ Sweats
■ Yawning	■ Stomach cramps	■ Chills
■ Runny nose	■ Body aches	■ Goosebumps
■ Big pupils	■ Shaking	■ Nausea or vomiting
■ Watery eyes	■ Twitching	■ Diarrhea
- Explain the use of each adjunct medication, and that they can be used throughout the initiation process.
- Advise the patient on proper administration:
 - Buprenorphine must be administered under the tongue, or it will not absorb properly.
 - Drinking water prior to administration can help it dissolve faster.
 - It can take 5-10 minutes for the medication to fully absorb. Avoid eating, drinking, smoking, or talking during this time, and for 15 minutes after.
 - After 15 minutes has passed, a strong mint can help with the aftertaste, which many find unpleasant.
 - To prevent oral decay, rinse mouth with water 30 minutes after administration.
- Recommend taking their dose around the same time each day.

- Warn that respiratory depression can occur if buprenorphine is taken with other CNS depressants. Patients should avoid using other drugs, drinking more than their usual amount of alcohol, or taking higher doses of CNS-depressing medications.
- Advise the patient to continue buprenorphine even if they return to using other opioids.
- Educate on overdose prevention strategies. Ensure the patient and their support system understand when and how to use naloxone.
- The risks of change in use patterns, which can alter tolerance and increase risk of opioid overdose.