Alaska Emergency Department Buprenorphine Guide

This guide provides an overview of the key steps to consider when a patient presents to the emergency department with evidence of opioid use disorder (OUD). This is intended to be an aid and not an exhaustive manual of all available management options. Providers should always use their own clinical judgment and are responsible for assessing the unique needs and circumstances of each patient.

1. Identify OUD patients appropriate for buprenorphine

- Consider OUD in patients with opioid use and concerning circumstances.
  - Confirm patient has moderate (4-5 points) or severe (6 or more) OUD by DSM-5. *See other side for DSM-5 criteria for OUD.*
- Many ED patients with OUD will be appropriate candidates for buprenorphine.
- Consider whether abstinence is a realistic alternative. Relapse rates are very high.
- Talk with patient about starting buprenorphine.

2. Identify and consider complicating factors

- Use of long-acting opioid (methadone, OxyContin).
- Heavy use of sedatives, including alcohol, benzodiazepines, Soma, Lyrica, gabapentin, etc.
- Pregnancy. Buprenorphine can be used if in withdrawal, but **do not** precipitate withdrawal.
- Liver failure.

3. Determine COWS score for timing of buprenorphine

ED Induction - *See other side for COWS scoring.*

- COWS ≥8: Patient should be in adequate withdrawal and ready for buprenorphine. **Many patients have used buprenorphine before and know when they are in sufficient withdrawal to begin, as well as a dose that has previously worked for them. Consider asking your patient.** The more severe the withdrawal, the more likely induction will be effective.
- COWS <8: Patient is not ready for buprenorphine yet. Have patient return to ED when withdrawal is more severe (12-24 hours after last opioid dose).

Home Induction

- Requires prescriber with an X waiver.

See also: the "Alaska Patient Guide for Beginning Buprenorphine" and the ACEP POC "Buprenorphine Use in the ED Tool"

4. Follow-up

Follow up with an office-based opioid treatment (OBOT) clinic or methadone clinic as soon as possible within 24-72 hours.

If a patient requires additional buprenorphine prior to follow-up:

- A provider with an X wavier can prescribe buprenorphine, or
- The patient can return to the emergency department once per day for a maximum of three days for buprenorphine administration.*

Other considerations

Supportive medications

Generally not needed if prescribing buprenorphine

- Clonidine 0.1-0.3mg, TID PRN
- Phenergan 25mg, TID PRN, nausea and vomiting
- Zofran 8mg, TID PRN, nausea and vomiting
- Bentyl 20mg, QID PRN, cramps
- Imodium, PRN, diarrhea
- Trazodone 50mg at HS, PRN, sleep
- Benadryl 50mg, TID PRN, anxiety or insomnia
- Acetaminophen/ibuprofen, PRN, pain

Obtain additional data

- Review PDMP
- Urine drug screen
- HCG
- Method of use (injection)
- Quantity of use/day
- Establish timing of last opioid use

*72-hour Rule

Per title 21, §1306.07(c), a non-waivered prescriber can administer buprenorphine or methadone in the ED and the patient can return for three consecutive days to get buprenorphine or methadone as they wait for an appointment.

Developed by the Alaska Department of Health and Social Services with assistance from Dr. Mark Simon *11/18/2019*

Clinical Opiate Withdrawal Scale (COWS)

For each item, write in the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____

Date: _____

Buprenorphine Induction: _____

Resting pulse rate: Record beats per minute; measured after patient is sitting or lying for one minute

0 = pulse rate 80 or below
1 = pulse rate 81-100
2 = pulse rate 101-120
4 = pulse rate greater than 120

Sweating: Over past ½ hour not accounted for by room temperature or patient activity

0 = no report of chills or flushing
1 = subjective report of chills or flushing
2 = flushed or observable moistness on face
3 = beads of sweat on brow or face
4 = sweat streaming off face

Restlessness: Observation during assessment

0 = able to sit still
1 = reports difficulty sitting still, but is able to do so
3 = frequent shifting or extraneous movements of legs/arms
5 = unable to sit still for more than a few seconds

Pupil size

0 = pupils pinned or normal size for room light
1 = pupils possibly larger than normal for room light
2 = pupils moderately dilated
5 = pupils so dilated that only the rim of the iris is visible

Bone or joint aches: If patient was having pain previously, only the additional component attributed to opiate withdrawal is score

0 = not present
1 = mild diffuse discomfort
2 = patient reports severe diffuse aching of joints/muscles
4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny nose or tearing: Not accounted for by cold symptoms or allergies

0 = not present
1 = nasal stuffiness or unusually moist eyes
2 = nose running or tearing
4 = nose constantly running or tears streaming down cheeks

GI Upset: Over last ½ hour

0 = no GI symptoms
1 = stomach cramps
2 = nausea or loose stool
3 = vomiting or diarrhea
5 = multiple episodes of diarrhea or vomiting

Tremor: Observation of outstretched hands

0 = no tremor
1 = tremor can be felt, but not observed
2 = slight tremor observable
4 = gross tremor or muscle twitching

Yawning: Observation during assessment

0 = no yawning
1 = yawning once or twice during assessment
2 = yawning three or more times during assessment
4 = yawning several times/minute

Anxiety or Irritability

0 = none
1 = patient reports increasing irritability or anxiousness
2 = patient obviously irritable/anxious
4 = patient so irritable or anxious that participation in assessment is difficult

Gooseflesh skin

0 = skin is smooth
3 = piloerection of skin can be felt or hairs standing up on arms
5 = prominent piloerection

≥8 needed to qualify for buprenorphine in ED

Score: 5-12 = Mild | 13-24 = Moderate | 25-36 = Moderately severe
More than 36 = Severe withdrawal

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Check all that apply.

- ☐ Opioids are often taken in larger amounts or over a longer period of time than intended.
- ☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ☐ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ☐ Craving, or a strong desire to use opioids.
- ☐ Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
- ☐ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ☐ Important social, occupational or recreational activities are given up or reduced because of opioid use.
- ☐ Recurrent opioid use in situations in which it is physically hazardous.
- ☐ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.

The tolerance and withdrawal criteria do not apply to individuals taking opioids solely under appropriate medical supervision:

- ☐ Tolerance, as defined by either of the following:
  - ○ A need for markedly increased amounts of opioids to achieve intoxication or desired effect, OR
  - ○ Markedly diminished effect with continued use of the same amount of an opioid.
- ☐ Withdrawal, as manifested by either of the following:
  - ○ The characteristic opioid withdrawal syndrome, OR
  - ○ The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

_____**Total number of boxes checked**

Moderate or severe level of OUD needed to qualify for buprenorphine in ED

Score: 4-5 boxes = Moderate | 6 or more boxes = Severe

COWS source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.
DSM-5 Criteria based on American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Washington DC, page 541.