CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Buprenorphine (*Suboxone®*) in the Emergency Department

Buprenorphine (BUP) is a unique schedule III opioid used for the treatment of acute and chronic pain, opioid withdrawal, and maintenance treatment of opioid addiction. The most common formulations are sublingual (alone or in combination with naloxone: Suboxone), transdermal (10mcg/hr = about 0.5mg/day), and intravenous (Buprenex). ***Administration*** of BUP in any form in the emergency department (ED) for any reason can be done by any DEA-licensed prescriber—no X waiver is required. If you would like to prescribe BUP for the treatment of opioid addiction you must obtain a DEA X waiver. BUP can be prescribed for the treatment of acute or chronic pain without a waiver.

Choosing the right patient

Starting a patient on BUP lowers mortality from opioid addiction 7-fold. **We strongly recommend starting BUP in ED after overdose (OD),** due to 10% risk of fatal OD within 12 months in these patients**.** Have a low threshold to give BUP for patients in opioid withdrawal or who desire to stop using opioid pills or heroin. *Warning:* BUP can potentiate the effects of sedatives like alcohol and benzodiazepines (but less than other opioids). Assess risk and benefit with these high-risk patients. Some patients with significant liver disease (ALT>5x normal) may not be able to take buprenorphine long-term; however, no screening labs are needed to start BUP in the ED.

When do you administer BUP in the ED?

BUP will displace other drugs from opioid receptors, replacing the high-intensity stimulation from drugs like heroin or oxycodone with stable drug levels over 2-3 days, eliminating craving and withdrawal symptoms. Starting BUP when patients have moderate withdrawal symptoms provides immediate relief and stops withdrawal discomfort without causing euphoria or sleepiness. Do **not** start BUP on opioid-dependent patients who are **not** in withdrawal. For these patients, BUP causes withdrawal, and decreases patients' desire to stay on BUP or to try BUP again.

How do you know if a patient is in opioid withdrawal?

Significant opioid withdrawal is present if a patient has at least 3 of these symptoms:

- Joint and body aches
- Chills and sweats
- Goose pimples
- Anxious and irritable
- Shaking, tremors, twitch

Simple ED Protocol

Clinical Opiate Withdrawal Scale (COWS) of 8 or greater. Use this interactive COWS calculator or see reverse of this page for scoring tool.

- Heroin, short-acting morphine/hydrocodone/oxycodone: normally wait 12 hours before BUP administration
- Long-acting opioids (Oxy, MSContin): normally wait 16-24 hours
- Methadone is unpredictable: normally wait at least 48 hours & COWS of 10 or greater

How to give BUP in the ED?

At least 8 mg tablet (Suboxone or Subutex) under the tongue, not swallowed; if the tablets are swallowed, very little BUP gets absorbed. In patients unable to tolerate sublingual tablets, IV BUP (0.3mg) can be used. (Avoid transdermal buprenorphine. It is generally too weak to prevent withdrawal symptoms and is best used for patients with chronic pain.)
No observation is required. OK to discharge after administration. OK to administer in low-acuity, "fast-track" type areas of the ED. A single 8 mg dose will have peak effect by about 1 hour and control withdrawal symptoms 6-12 hours.

How to discharge a patient

Always offer a naloxone prescription or kit.
No DEA X waiver – Prescribe comfort meds (e.g. clonidine, loperamide, ondansetron, NSAIDS) and recommend follow-up at treatment center. It is legal in all states to offer return ED visits for BUP administration for 3 days in a row if needed.
DEA X waiver—give bridge script to last until outpatient visit: e.g., 8mg Suboxone, SL tabs. Take 1 tab under the tongue twice a day for withdrawal symptoms. Dispense #6-7.

Follow up in outpatient setting. (Develop referral protocols and agreements.)

MORE INFORMATION IS AVAILABLE AT: https://www.erpainaddiction.org/addiction-treatment
Suboxone® is the trade name for buprenorphine + naloxone. Naloxone component is only released if the tablet is injected.

PATIENT NAME:	DATE OF ASSESSMENT:
PATIENT DATE OF BIRTH:	MEDICAL RECORD NUMBER:

Clinical Opioid Withdrawal Score (COWS)

For each item, write in the number that best describes the patient's signs or symptom. Rate only 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.*

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	*Time:*	*Time:*	*Time:*	*Time:*
Resting Pulse Rate: Record beats per minute *after patient is sitting or lying down 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 activity* • 0 - no chills or flushing • 1 - subjective 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 movement of legs/arms • 5 - unable to sit still for more than a few seconds				
Pupil size • 0 - pupils pinned or normal size for light • 1 - pupils possibly larger than normal for light • 2 - pupils moderately dilated • 5 - pupils dilated that only 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 scored* • 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 allergy* • 0 - none 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 or anxious • 4 - patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin • 0 - skin is smooth • 3 - piloerrection of skin can be felt or hairs standing up on arms • 5 - prominent piloerrection				
5—12 = *mild*; 13—24 = *moderate*; 25—36 = *moderately severe*; > 36 = *severe withdrawal* **TOTAL**				
OBSERVER INITIALS				

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs,* 35(2), 253–9.