NHS Grampian

Guidance For The Use Of Oral Buprenorphine Products For The Treatment Of Opioid Dependence In NHS Grampian

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May 2022	August 2019	Updated hyperlinks to other sites/documents	Throughout document
July 2022	August 2019	Added references to MAT Standards	Throughout document
July 2022	August 2019	Removed statement regarding Espranor® being product of choice	Section 5. Page 4
July 2022	August 2019	Revised statement on baseline LFTs	Section 6.3. Page 5
July 2022	August 2019	Added bullet 3 in section 6.5. as another option for initiation	Section 6.5. Page 6.
July 2022	August 2019	Reworded 6.7.	Section 6.7. Page 8.
July 2022	August 2019	Simplified missed doses section	Table 6. Page 11.
July 2022	August 2019	Added injectable buprenorphine to DVLA information	Section 13. Page 12.
July 2022	August 2019	Added to pregnancy section (from NHS Borders guidance document)	Section 15. Page 13.
July 2022	August 2019	Removed section on concomitant use of CNS depressants. Duplication from other sections	Section 15. Page 14.
Nov 2022	August 2019	Added sentence re opt out BBV testing	Section 6.3. Page 6

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Feb 2023	August 2019	Supervision self-administration of medication section amended to bring in line with MAT standards document	Section 11.

* Changes marked should detail the section(s) of the document that have been amended, i.e. page number and section heading.

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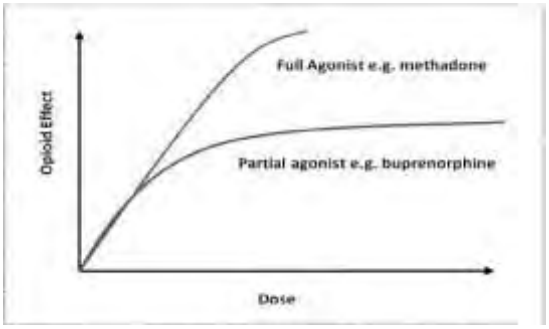
Guidance For The Use of Oral Buprenorphine Products For The Treatment Of Opioid Dependence In NHS Grampian

1. Introduction

This document is a guide to the prescribing and use of oral buprenorphine products when managing opioid dependence. It is for use by all health care professionals in Grampian involved in managing this treatment. Buprenorphine should be initiated by prescribers with sufficient knowledge in its use or in collaboration with drug and alcohol services.

2. Pharmacology



Buprenorphine:

- Only partially activates opioid receptors producing less euphoric or sedating effects than full opioid agonists such as heroin, morphine and methadone
- Has enough opioid activity to reduce cravings and prevent or alleviate opioid withdrawal in opioid dependent people despite only being a partial agonist
- Has a higher affinity (attraction) for opioid receptors than heroin, methadone and many other opioid drugs. This means that:
    - buprenorphine can cause precipitated withdrawal (see Section 3)
    - at higher doses it can reduce the effects of other opioid drugs
    - patients may be less likely to use additional opioids on top of their buprenorphine prescription as they may experience less effect
    - if opioid pain relief is required, the analgesic effect achieved can be less than expected.
- Has a ceiling effect. Continued dose increases will not result in a proportionate increase in opioid effect
- Has very little effect if swallowed. Oral buprenorphine products are therefore administered under (sublingual) or on the tongue (supralingual). Always check the administration guidance for the product prescribed in the Summary of Product Characteristics (SmPC)
- Has a lower risk of overdose than full opioid agonists if taken as prescribed. Overdose can still occur, particularly with poly drug use. The impact of prescribing other CNS depressant drugs alongside

buprenorphine should be considered. Adverse effects such as sedation and respiratory depression should be monitored for and information on opioid overdose and a supply of naloxone given.
- Drug Treatment Services (includes community pharmacy and GP surgeries) refer to Guidance For Services In Grampian To Supply Naloxone To People At Risk Of Opioid Overdose, Significant Others And Services In Contact With Those At Risk
- Other clinical services refer to the Patient Group Direction for the supply of Naloxone by Approved Healthcare Professionals Working within NHS Grampian

3. Precipitated Withdrawal

The high affinity of buprenorphine for opioid receptors means it can knock other opioids off opioid receptors. This leads to a drop in opioid effect which can cause symptoms of withdrawal in opioid-dependent patients starting on buprenorphine.

To avoid precipitating withdrawal, the first dose of buprenorphine should be taken when the patient is experiencing early signs of opioid withdrawal (see Section 7, Table 1). Use of a clinical opioid withdrawal scale can help assess for withdrawal (Appendix 1).

4. Choice Of Opioid Substitution Therapy (OST)

Methadone and buprenorphine are both effective medicines for managing opioid dependence, particularly when prescribed at optimal doses[1]. There is insufficient evidence to recommend one drug as more effective or safer than the other. The prescriber should provide the patient with a balanced view of each medicine to support informed decision making on treatment selection as outlined in the Medication Assisted Treatment (MAT) Standards for Scotland (Standard 2)[2].

A number of factors can help the patient and prescriber decide which medicine (methadone or buprenorphine) or formulation is most appropriate. These include:

- A patient's pre-existing preference for a particular medication
- Previous patient experience or outcomes from treatment with OST
- Patient age
- Duration and extent of drug use
- Risk of overdose. In patients with lower levels of dependence and older patients more sensitive to sedative effects of opioids, buprenorphine may be safer
- Specific safety concerns, e.g. diversion, poly drug and alcohol use, previous overdose, etc
- The potential value of rapid induction onto effective maintenance, which is more achievable with buprenorphine
- Acute pain management which may require strong opioids, in such cases methadone may be more suitable

- Relevant drug interactions or co-morbidities such as respiratory disease, history of cardiac abnormalities, advanced heart disease, ischaemic heart disease, cardiac conduction problems, Long QTc syndrome or those prescribed/taking drugs which prolong QTc, etc. Buprenorphine produces less respiratory depression and has less impact on QTc than methadone
- Current treatment is no longer effective e.g. at lower doses methadone might not provide cover for the full 24 hours. The longer half-life of buprenorphine may make dose reductions easier to tolerate
- Opioid analgesic dependence (prescribed or over the counter). Buprenorphine may be an option however patients need to be assessed on a case by case basis to take into account ongoing requirements for pain management. Resources are available from the "Opioids Aware | Faculty of Pain Medicine" website
- Time to dissolve. Faster dissolving products require less time to supervise. This can improve patient experience in the pharmacy and reduce opportunity for diversion where this is a concern
- Combination products. The addition of naloxone might reduce the risk of injection or snorting where there is evidence or concerns of this
- Cost-effectiveness of equivalent formulations and dosages.

Treatment is more likely to be successful when combined with psychological and/or social interventions tailored to the individual. Patients should be supported to access appropriate interventions however treatment should not be withdrawn if patients are not currently engaging with these.

5. Buprenorphine Products Available on Grampian Area Formulary

5.1. Buprenorphine Sublingual Tablets

Generic buprenorphine for the use as ORT is available as 0.4mg, 2mg and 8mg sublingual tablets.

Buprenorphine 200micrograms sublingual tablets are available however do not have a licensed indication for treatment of opioid dependence therefore any prescribing for this indication is classed "off-label".

Generic buprenorphine is available in lower doses which may be helpful at the end of treatment or during detoxification.

5.2. Buprenorphine Oral Lyophilisate (Wafer) (Espranor®)

Espranor® is a freeze-dried wafer formulation of buprenorphine available as 2mg and 8mg oral lyophilisate (wafers). Wafers should be dissolved **on top of the tongue.** Espranor® can dissolve in as little as 15 seconds however factors such as how dry or moist the mouth is and the number wafers administered at the same time will affect this.

Espranor® has a high bioavailability. The amount of drug reaching the blood stream may be higher than sublingual buprenorphine products (see Section 6). Patients should be monitored for signs of withdrawal or adverse effects when switching between different buprenorphine products and dose adjustments may be required.

Specific advice on administration of Espranor® oral lyophilisate can be found in Appendix 2.

5.3. Combined Buprenorphine and Naloxone Products

- Generic buprenorphine and naloxone is available as buprenorphine 2mg/ naloxone 0.5mg and buprenorphine 8mg/ naloxone 2mg sublingual tablets
- Suboxone® is available as
    - Sublingual Tablets 2mg/0.5mg, 8mg/2mg and 16mg/4mg strengths

These formulations contain the opioid antagonist naloxone. If taken as prescribed under the tongue the naloxone will have no effect as very little is absorbed from the mouth. If injected or snorted, naloxone can produce symptoms of opioid withdrawal in opioid dependent patients. This might deter some people IF there are concerns or evidence that this is happening.

6. Tips to Improve Absorption

For sublingual tablets the active ingredient will generally be absorbed after 3-5 minutes. A pulp may be present for 10-15 minutes after administration but will contain little buprenorphine. For oral lyophilisate this time is significantly reduced.

For all products, time to dissolve can vary depending on how moist or dry the mouth is and the number of tablets/wafers administered at the same time. Prescribing the lowest number or tablets/wafers needed to achieve the desired dose can help. Community pharmacies should offer water for the patient to moisten the mouth **before** administration of buprenorphine products if dry mouth is an issue.

Buprenorphine is inactive if swallowed therefore patients should be counselled against moving products around the mouth and minimising swallowing as much as possible during the administration process.

7. Initiation Of Therapy

Opioid dependence must be diagnosed prior to starting treatment. A comprehensive assessment should be undertaken and include drug screening which is positive for opioid drugs. Drug screens should be interpreted alongside clinical information and should not be treated as definitive themselves.

Patients must be assessed on an individual basis by a health care professional with sufficient knowledge in the use of buprenorphine products for management of opioid dependence to determine suitability of treatment. The patient's medical history and other prescribed medicines should be considered for contraindications, cautions and interactions when determining if treatment is suitable (see also Sections 15 and 16)

There are rare case reports of liver injury in patients prescribed buprenorphine. This led drug companies to recommend routine liver function tests (LFTs). Available evidence suggests the majority of reports occurred in patients with a diagnosis of hepatitis B or C or following injection of buprenorphine SL tablets. It suggests the risk is no greater for buprenorphine than for methadone 7-10.

Liver function tests (LFTs) are therefore not routinely recommended prior to initiating buprenorphine. Laboratory results, Trakcare and GP records (if accessible) should be checked. Clinicians should highlight the rare risk of liver injury with buprenorphine to patients to support an informed, shared decision on prescribing and necessity of LFTs. Regular review of blood borne virus (BBV) status and BBV testing is recommended for all patients and will help identify those who may be at higher risk. LFTs should therefore be considered for patients with a diagnosis of hepatitis or evidence of hepatic dysfunction.

All patients should be offered BBV testing and discussion regarding vaccination status in the early stages of treatment. Details on how to access vaccination in each HSCP area can be via: www.grampianvax.com/professional-referrals/

Lower initial doses and careful dose titration in patients with mild to moderate hepatic impairment are recommended. Buprenorphine products are contraindicated in patients with severe hepatic impairment. Both methadone and buprenorphine can accumulate in patients with hepatic impairment. Clinicians should weigh up the risk of continued illicit drug use versus the risks associated with the prescribed drug and monitor accordingly.

Precipitated withdrawal may occur when buprenorphine is first administered (see Section 3). If it happens, it typically begins within 1 to 3 hours after the first buprenorphine dose and peaks within 3 to 6 hours before improving. This should be discussed with all patients prior to commencing treatment with buprenorphine products and they should be reassured that, should they experience precipitated withdrawal, symptoms will improve.

7.1. Initial Dosing Schedules

To minimise the risk of precipitated withdrawal, and get the maximum benefit from buprenorphine, the patient should be displaying mild signs of opioid withdrawal before administering the first dose of buprenorphine (see Table 1). Use of a clinical opioid withdrawal scale can provide objective and subjective measures for assessing symptoms of withdrawal (Appendix 1).

During titration, daily supervision is recommended (see Section 11) to ensure proper placement of the product in the mouth and to observe patient response to treatment.

Clinicians should contact the community pharmacy to confirm they have stock or allow time to order it in. They should discuss initial dosing instructions and ask them to check that the patient is displaying mild symptoms of opioid withdrawal before they give the first self-administered dose.

If the clinician is not able to assess the patient in person prior to giving the first dose on day 1:

- There should be a clear plan agreed between the clinician and community pharmacist as to how the assessment of opioid withdrawal symptoms will take place. The clinical opioid withdrawal scale can be used to measure this.
- This could be a phone consultation between clinician and patient. Pharmacy staff would then confirm this with the patient in person.
- Another option is to prescribe day 1 doses as a take away dose for the patient to take when they are in withdrawal. This may support same day prescribing where it is clinically appropriate. Supervised administration can then begin on day 2. This is possible due to the relative safety of buprenorphine. Patient understanding of this plan, and how to take the product must be confirmed.

To reduce the severity and duration of precipitated withdrawal (should it occur) it is recommended that the dose for day 1 is split. The first dose should be supervised, the second dose dispensed away for administration 2-3 hours later. Following treatment induction on day 1, the patient should be stabilised to a maintenance dose during the next few days by adjusting the dose according to the clinical effect of the individual patient (Table 2).

Table 1 - Induction from full opioid agonists

Type of full agonist	Current dose of full agonist	Point of induction
Heroin	Any dose, any route of administration.	When objective and clear signs of withdrawal appear (at least 6 hours from the last use of heroin).
Methadone	Reduce to 30mg daily or lower prior to transfer. Higher doses may lead to precipitated withdrawal or treatment failure where the opioid effect experienced is not enough to cover withdrawal symptoms from cessation of full agonist opioids.	When objective and clear signs of withdrawal appear (at least 24 hours from the last use of methadone).
Opioid Analgesics	Any dose, any route of administration	When objective and clear signs of withdrawal appear (time will depend on opioid used).

Table 2 - Dosing during induction

	Buprenorphine and buprenorphine plus naloxone sublingual tablets	Espranor® Oral Lyophilisate
Day 1	4mg of buprenorphine followed later in the day by a further 4mg based on individual need. Maximum dose on Day 1 = 8mg in divided doses	2mg of buprenorphine followed by a further 2mg to 4mg later in the day based on individual need. Maximum dose on Day 1 = 6mg individed doses.
Day 2 on	The dose can be titrated up to a maximum of 16mg daily on day 2. From day 2 doses should be prescribed as a single daily dose. Titrate dose in steps of 2-8mg buprenorphine guided by assessment of the clinical and psychological status of the patient until the effective maintenance dose is achieved.	The dose can be titrated up to a maximum of 12mg daily on day 2.From day 2 doses should be prescribed as a single daily dose. Titrate dose in steps of 2-6mg buprenorphine guided by assessmentof the clinical and psychological status of the patient until the effective maintenance dose is achieved.

Table 3 - Maximum daily doses

	Buprenorphine and buprenorphine plus naloxone sublingual tablets	Espranor® Oral Lyophilisate
Maximum Daily Doses	Doses above 16mg are less commonly needed due to ceiling effect. First step is to check placement of tablet is correct as this can affect absorption. Maximum daily doses: • Buprenorphine plus naloxone products =24mg/6mg • Buprenorphine sublingual tablets = 32mg	Titrate to a maximum dose of 18mg daily according to patient need

Note: Higher doses of buprenorphine are associated with improved retention in treatment

7.2. Less Than Daily Dosing

Less than daily dosing is not commonly used in practice but may be of benefit to some patients, particularly in the later stages of dose reductions. If prescribing in this way, the dose given on any one day should not exceed the product's licensed maximum daily dose.

7.3. Transferring Patients between Sublingual Buprenorphine Products and Espranor®

The bioavailability of Espranor® oral lyophilisate (wafer) is higher than sublingual tablets. It has potential to result in an increase in adverse effects (during transfer to Espranor®) or symptoms of withdrawal (during transfer to a sublingual product) at the same dose. The following table can be used as a guide to equivalence. Dose can be adjusted according to response which may vary between patients.

Table 4 - Suggested Espranor® Conversions

Buprenorphine Sublingual products (with or without naloxone) dose	Approximate equivalent Espranor® dose
24 - 32mg	16 - 18mg
20 - 24mg	16 - 18mg
10 - 18mg	8 - 16mg
2 - 8mg	2 - 8mg

8. Maintenance

Patients should be reviewed more frequently (at least fortnightly) initially and when stable, less frequently, such as once a month. Depending on local service arrangements, patient risk assessment and other support available, prescribers may feel prescriptions can be reviewed as little as every three months during the maintenance phase where the dose remains appropriate and stable. NB: Controlled drug prescription writing requirements still apply. Patients should have the opportunity to discuss and amend treatment goals, including prescribing as needed.

Co-existing physical, emotional, social and legal problems as well as problematic drug and alcohol use should be addressed. Third sector agencies may be able to provide this additional support and patients should be signposted or referred accordingly. Access to treatment should not be dependent on engagement with wider support.

Drug testing can be used to monitor patient concordance with prescribed medication and detect ongoing drug use. Urine or oral fluid tests should be undertaken according to each individual patient's progress. Presence of substances should be used to guide treatment and risk assess. It should not be used to exclude patients from treatment. Regular drug testing when a patient in treatment openly discusses substance use is of less value. Note: In Grampian, current laboratory urine screening does not identify buprenorphine (Jan 2023). Where available, point of care testing may identify buprenorphine.

9. Dose Reduction and Stopping Treatment

The decision to begin dose reduction should be made jointly with the patient and clinician. Readiness will vary between patients, there is no set duration for the maintenance period. Patient response and ability to continue with dose reduction is key. If they struggle with the rate of reduction, stabilise the patient on a comfortable dose. Review treatment plan and support offered.

The daily dose of buprenorphine can be reduced initially by 2mg every two weeks or so,with final reductions in 400microgram increments. At daily doses below 2mg patients prescribed buprenorphine oral lyophilisate will require transfer to a sublingual format. At daily doses below 8mg buprenorphine daily differences in bioavailability are minimal and should not pose an issue. Reducing frequency of administration to alternate days is another option that might work for some patients.

Patients can experience withdrawal symptoms at the end of treatment irrespective of the speed of reduction and should be advised/supported accordingly.

For detoxification regimens, more rapid reductions are possible with buprenorphine however the patient's motivation, ability to cope and support structure should be carefully assessed. The risk of relapse and overdose due to loss of tolerance are increased. Rapid reductions are only recommended for use by specialist clinicians in substance use and are not generally recommended in community settings.

10. Injecting or Snorting Buprenorphine, "On Top" Use and Diversion

As with other opioid drugs, buprenorphine can be snorted or injected to enhance its effects or diverted e.g. exchanged for other substances. The inclusion of naloxone in combined buprenorphine/naloxone products is designed to deter intravenous or intranasal use as naloxone can precipitate withdrawal in opioid dependent patients. If taken under the tongue, naloxone is not absorbed and symptoms of withdrawal do not occur. Risk to the patient through bullying or theft of medication is also possible.

Prescribing sub-optimal doses of buprenorphine may result in use of medicines/ other substances by the patient. They may self-medicate with substances, e.g. opioids, alcohol or other sedative medication such as benzodiazepines. To minimise the risk, prescribers should take appropriate precautions when prescribing and dispensing buprenorphine, such as use of supervised administration, avoiding large quantities of medication when "take home". Review should assess whether the dose remains appropriate, avoids symptoms of withdrawal or craving and minimises on top use. If not, prescribers should consider whether buprenorphine remains the most appropriate treatment option in discussion with the patient.

11. Supervision Self-Administration of Medication

There is a delicate balance between offsetting risks of unsupervised dispensing and creating barriers to engagement with educational, occupational, social and vocational opportunities which are also important to a person's recovery. The reason for supervised dispensing should be clearly explained to the person (and family/named persons present) and regularly reviewed. Primary care colleagues can contact drug

and alcohol service for advice where needed. Any changes to dispensing arrangements and the reasons should be discussed with the person in advance wherever possible.

The rationale for supervised self-administration of OST dispensing includes:

- To support clinicians' continued assessment regarding engagement and response to the prescribed dose to mitigate risk of toxicity and overdose.
- To support initiation and titration.
- To support monitoring of presentation during periods of instability or increased risk where supervision is assessed as having potential to provide a protective factor.
- Risk factors that may indicate a need for supervised administration include but are not limited to:

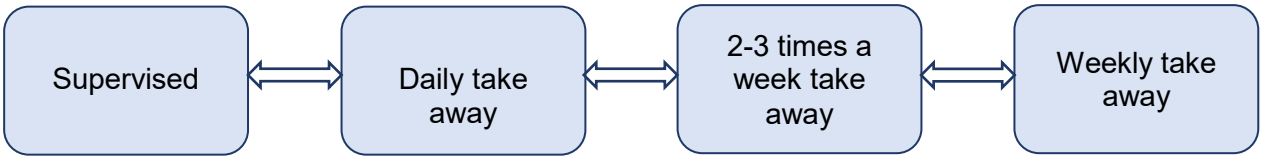
The patient has not reached a stable dose of OST	Continued and unstable pattern of drug or alcohol use including non-fatal overdose	Concerns regarding a deterioration in mental health presentation
Concern that prescribed medication is being used inappropriately, diverted (self or under pressure from others) or lost	Concerns about the safety of medicines stored in the home and possible risk to children or others	Regular missed "take home" collections – a period of supervision may improve stability

11.1. Changes to dispensing arrangements

There are a number of reasons why changes are made to supply arrangements. This may include a relaxation of dispensing or a return to supervised self-administration of OST. Ideally any changes to dispensing should be discussed with the person in advance but in some cases this is not always practically possible. Community pharmacies have regular contact with people and may have information which can support decision making.

11.2. Relaxation of Dispensing

The decision to relax dispensing arrangements is one example of an evidenced based psychological intervention (Contingency Management) and should always follow a collaborative review with the patient. Dispensing should be relaxed in a stepwise fashion and reviewed before each step.



Prior to relaxation of dispensing thought needs to be given to:

- Secure storage - how are medications being stored at home, particularly if children are present
- Whether the instalment instruction "If an instalment's collection day has been missed, please still dispense the amount for any remaining days of that instalment" is appropriate for this patient. Pharmacists may not alert prescribers to variable attendance as quickly as they may otherwise do. Adding "contact prescriber if 3 or more days missed" or similar to prescriptions can help
- Relaxation of dispensing should stay at the level that meets the patient's needs and level of risk. It can be stepped up again if risk emerges
- Weekly instalments are the lowest instalment frequency recommended for most. If less frequent instalments are prescribed the rationale should be documented and reviewed

11.3. Return to Supervised Self-Administration of OST

Recovery journeys are not always linear and people may move across different phases of treatment at different times. Where there are increased concerns about risk, and where a return to supervised dispensing is being considered, a review with the person to discuss dispensing arrangements should be offered. The therapeutic relationship in supporting discussions is key where providing a non-judgmental, validating and compassionate response to the person's views and concerns limits risk to the therapeutic relationship. A move to more frequent dispensing or supervision is generally recommended unless there are clear indications the impact on patient care, outcomes or engagement outweighs the identified risks.

With buprenorphine, a return to supervision risks precipitated withdrawal if other opioids have been taken. The most straightforward way to avoid this, and toxicity if there is uncertainty in tolerance, is by re-titration as per table 2. If there is any uncertainty in restarting medication, seek advice of colleagues within the drug and alcohol service, e.g. during hub/cluster meetings or medical or experienced clinical staff.

12. Missed Doses

The risk of overdose when restarting buprenorphine following missed doses is lower than with methadone. If the patient has been using full opioid agonists such as heroin or methadone in the period of missed buprenorphine doses, there may be a risk of precipitated withdrawal if buprenorphine is re-introduced. The patient's use of other opioids in the days since last buprenorphine dose should be considered by the pharmacist and prescriber alike when deciding which action to take. **Note:** If the patient does not return to the pharmacy and there are concerns for patient safety, the pharmacist should contact the prescriber to alert them.

Table 6 - Advice for Missed Doses of Buprenorphine

Number of days missed	Advice for community pharmacist	Advice for prescriber
Less than 3 days buprenorphine missed	If there are no additional concerns/patient rarely misses doses: • continue to dispense the prescription as stated • feedback any concerns to the prescriber	The pharmacist will not contact the prescriber if less than 3 days have been missed unless there are additional concerns. Document any concerns fed back in the patient's notes
3 or 4 days buprenorphine missed	• No significant concerns on patient's presentation • Risk of precipitating withdrawal assessed as low • continue to dispense prescription • contact the prescriber. Advise them of missed doses and action taken • record details in patient clinical care record	• Record details of pharmacist contact in the patient's clinical records. • Discuss missed doses with patient at next consultation.
	Pharmacist assesses that it may **not** be appropriate to continue at the current dose or is not confident in assessing • contact prescriber to discuss providing as much information as possible • record outcome of discussion in patient clinical care record	• Consider available information. • Consider whether it is necessary to review the patient in person • Consider need for re-titration versus continuation of dose • Advise pharmacist of action • Generate new prescription if re-titration is required.

Number of days missed	Advice for community pharmacist	Advice for prescriber
5 or more days buprenorphine missed	• Contact the prescriber to advise that 5 days have been missed to agree how to proceed.	• Consider the dose of buprenorphine currently prescribed and reason for missing doses. • For daily dose of 8mg or lower (any formulation) it may be possible to continue using existing prescription so long as this remains clinically appropriate. • For daily doses greater than 8mg re-titrate as described in Section 6.

13. Emergency/Planned Admission to Hospital

The high affinity of buprenorphine for opioid receptors may impact on the management of acute pain during hospital admissions. For planned admissions this can be minimised by:

- Ensuring that the patient is aware of this effect when starting buprenorphine.
- Contacting the hospital ward ahead of admission to alert them and where possibleagree a plan.

There are a number of strategies which can be used to manage pain which include but are not limited to:

- Prescribing non-opioid analgesia and/or use of local anaesthesia.
- Using higher doses of full opioid agonists.
- Splitting the dose of buprenorphine across the day.

Involving the specialist pain management team and anaesthetist can help optimise pain control where available.

Acute Pain Service: Bleep 2864 or ASCOM 52590
Woodend Acute Pain Service: Bleep 4379

On admission, ward staff should contact the community pharmacist and community prescriber to make them aware of the admission and ask them to put a hold on dispensing instalment prescriptions until otherwise informed.

The community prescriber should be contacted at an early stage for discharge planning. If the buprenorphine product has been temporarily reduced or stopped in hospital where clinically appropriate, this should be re-titrated before discharge.

Where ongoing treatment with an opioid analgesic is required following discharge a plan should be agreed including information on when and how to reduce and stop the opioid analgesic and re-titrate/reintroduce the agreed opioid substitute.

14. Driving

It is the responsibility of the patient to inform the DVLA of their current medical status. Doctors and other healthcare professionals should:

- Advise the individual on the impact of their medical condition for safe driving ability.
- Advise the individual on their legal requirement to notify the DVLA of any relevant condition.
- Treat, manage and monitor the individual's condition with ongoing consideration of their fitness to drive.
- Notify the DVLA when fitness to drive requires notification but an individual cannot or will not notify the DVLA themselves.

For buprenorphine DVLA guidance for health care professionals states that application for a Group 1 license (car and motorcycle) "may be considered when all of the following conditions can be met" See DVLA guidance for information on Group 2 licenses:

- Stable on the programme for a minimum of 1 year.
- The treatment programme is supervised by a consultant or specialist GP.
- The treatment is for management of opiate dependence.
- Oral/sublingual treatment only (not parenteral) but subcutaneous long-acting buprenorphine or naltrexone implants may be considered.
- There has been compliance with the programme (adherence to prescription and appointments, and toxicology testing with sustained stability).
- No non-prescribed psychoactive drug use during the programme or extra use of prescribed drugs such as methadone, buprenorphine, benzodiazepines.
- There is no toxicological evidence of problematic drug use.
- There is no adverse effect from treatment likely to affect safe driving.
- There is no evidence of problematic alcohol use or dependence.

15. Contraindications To Use Of Buprenorphine Containing Products

A full list of contraindications, cautions and adverse effects can be found in the Summary of product characteristics or the British National Formulary. https://www.medicines.org.uk/emc; www.medicinescomplete.com/mc/bnf/current/.

- Severe respiratory insufficiency.
- Severe hepatic insufficiency.
- Acute alcoholism or delirium tremens.
- Hypersensitivity to buprenorphine, naloxone or to any of the excipients.

16. Precautions for Buprenorphine Containing Products

16.1. Pregnancy

Specialist support should be sought when treating pregnant patients. UK clinical guidance states: “Research evidence demonstrates no difference in adverse effects between methadone and buprenorphine with both having no adverse effects on the pregnancy or neonatal outcomes, with incidence of Neonatal Abstinence Syndrome (NAS) similar to methadone exposure (Blandthorn, Forster & Love 2011, Jones et al 2010). However, there is some evidence that buprenorphine use results in NAS of lower severity.”

Therefore, in a pregnant woman who is informed of the risks it is reasonable to allow her to remain on methadone or buprenorphine. It is necessary for women and their clinicians to weigh up the risks and benefits to both mother and baby of not taking a specific treatment against those of initiating or continuing the treatment. This will vary from person to person and depend on the severity of the mother’s condition and the complications that could arise if her treatment is altered. Transfer to buprenorphine during pregnancy is not generally recommended due to the potential risk of precipitated withdrawal during initiation of treatment and the risk of inducing withdrawal in the foetus. Current advice and information leaflets to support discussion can be found on the BUMPs (Best Use of Medicines in Pregnancy) website.

The impact of buprenorphine on pain management plans during labour should be considered (See Section 12).

16.2. Breastfeeding

For women stabilised on a buprenorphine product who wish to breastfeed, an individual risk-benefit analysis to inform decision making should be undertaken. Due to the lack of evidence of the effects of these drugs on breastfed infants, manufacturers’ advice is to avoid, although expert consensus opinion states that the effects of these medications on the breastfed infants is likely to be minimal and that breastfeeding is not contraindicated. See also bumps - best use of medicine in pregnancy (medicinesinpregnancy.org)

UK Guidance states “Breastfeeding should be encouraged, even if the mother continues to use drugs, except where she uses cocaine or crack cocaine, or a very high dose of benzodiazepines. Specialist advice should be sought if she is HIV positive. Hepatitis C is not a contraindication to breast feeding (HIS 2013).

Methadone or buprenorphine treatment is not a contraindication to breastfeeding and breastfeeding may reduce the intensity and length of neonatal abstinence syndrome and has been shown to improve outcomes (Mayet et al 2008)”.

16.3. Liver function (See Section 6.3).

16.4. Overdose

Buprenorphine is reported to be safer in overdose than full agonists, such as methadone [3], causing less respiratory depression. This being said, drug related deaths involving buprenorphine have been reported particularly when taken in combination with other sedative drugs such as alcohol or benzodiazepines.

In the event of overdose, medical advice should be sought. Standard procedures for reversing opioid-induced respiratory depression should be followed. **Note:** It may be necessary to use more than the normal amount of naloxone.

17. Adverse Effects

A full list of side effects and cautions can be found in the Summary of product characteristics or the British National Formulary. https://www.medicines.org.uk/emc https://www.medicinescomplete.com/mc/bnf/current/

The most common side effects of buprenorphine products include: constipation, headaches, sleepiness, insomnia, sickness and sweating. It should be noted that patients often report a "clear head" with buprenorphine containing products as opposed to the "clouding" effect often experienced with methadone or heroin.

18. Consultation

The document was sent to the following individuals/groups for consultation:

Tiamika Chidothe	Lead Nurse, Aberdeenshire Drug and Alcohol Service
Ruth Hills	Specialist Pharmacist, Gastroenterology, ARI
Lynsey Murray	CMHN, Team Lead, Moray Integrated Drug and Alcohol Service
Richard Legg	GP with Special Interest
Angela MacManus	Principal Pharmacist, Royal Cornhill Hospital
Bethany Potter	Advanced Pharmacist, Aberdeen City Drug and Alcohol Service
Laura Rothney	Senior Nurse Practitioner, Aberdeen Integrated Drug & Alcohol Service
Naomi Scott	Consultant Anaesthetist, Chronic Pain Service, ARI
Michael Turner	Consultant Psychiatrist and Clinical Lead, NHSG Drug and Alcohol Services

19. References

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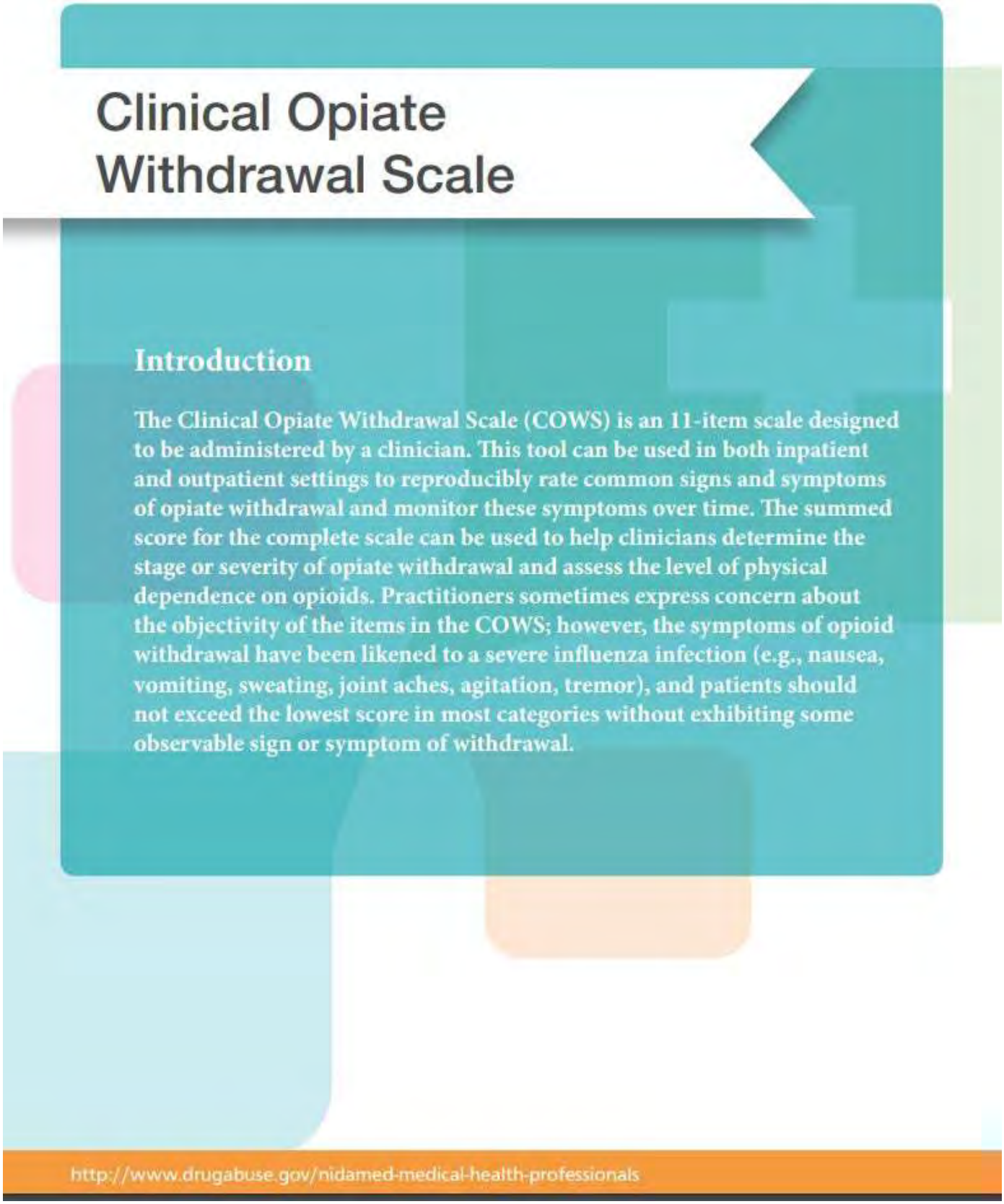
Appendix 1 – Clinical Opiate Withdrawal Scale



APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. 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 increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/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	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 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	**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
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	**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
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	**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
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates 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	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
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	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

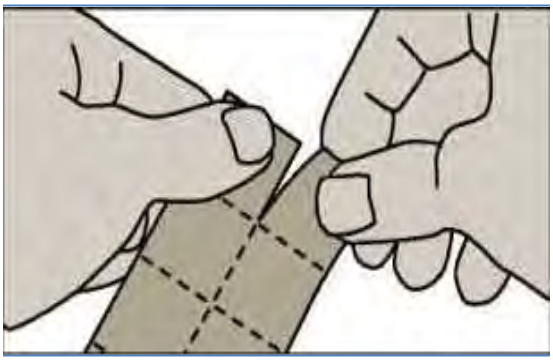
Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253-9.

Appendix 2 – How To Administer Espranor®

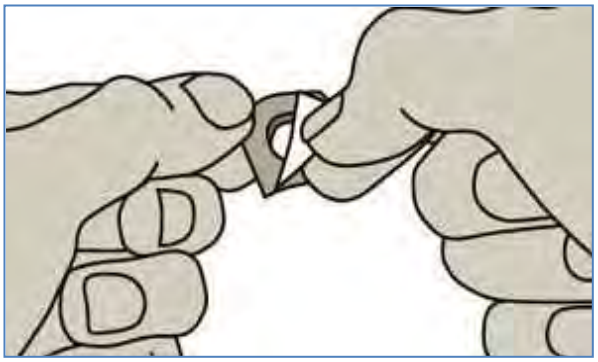
How to Administer Espranor®

Espranor® is sensitive to moisture.

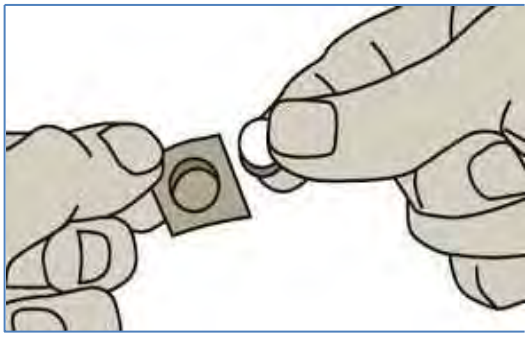
Make sure your hands are dry before handling the wafer.



1) Tear a square off the blister pack along the perforated lines.



3) Remove the wafer carefully from the foil and take out from the packaging immediately.



2) The foil is easily peelable.

   Do not force the wafer through the foil as it is fragile and can easily break.

   Instead, fold back the foil and then peel it off.

4) Place the wafer on the tongue and close your mouth. Allow it to remain there for a few seconds until it has dissolved.

   Try to avoid swallowing during the first 2 minutes.

   Do not eat or drink for at least 5 minutes

Risk materials and patient information leaflet can be accessed here.