BUPRENORPHINE (Sublocade) Fact Sheet [G]

BOTTOM LINE:
Buprenorphine alone was previously preferred for initial (induction) phase of treatment, with buprenorphine/naloxone combination preferred for maintenance treatment (unsupervised administration). Currently, combination is favored for both induction and maintenance as this decreases misuse or diversion potential. Studied and approved for ages ≥16.

PEDIATRIC FDA INDICATIONS:
Pain (2+ years).

ADULT FDA INDICATIONS (16+ YEARS):
Opioid dependence, induction; opioid dependence, maintenance (Sublocade); moderate-severe pain (Belbuca, Buprenex, Butrans).

OFF-LABEL USES:
None.

DOSAGE FORMS:
- **SL tablets (G):** 2 mg, 8 mg (scored).
- **Extended-release injection (Sublocade):** 100 mg/0.5 mL, 300 mg/1.5 mL prefilled syringes.
- **Buccal film (Belbuca, [G]):** 0.075 mg, 0.15 mg, 0.3 mg, 0.45 mg, 0.6 mg, 0.75 mg, 0.9 mg (used for pain).
- **Injection (Buprenex, [G]):** 0.3 mg/mL (used for pain).
- **Transdermal patch (Butrans):** 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr (used for pain).

DOSAGE GUIDANCE (16+ YEARS):
- Begin at least four hours after last use of heroin or other short-acting opioids and when first signs of withdrawal appear. If an opioid-dependent patient is not in sufficient withdrawal, introduction of buprenorphine may precipitate withdrawal due to its partial agonist effect.
- Start 2–8 mg SL day 1; then 8–16 mg SL QD (usual induction dose range is 12–16 mg/day and accomplished over three to four days).
- Other than extended-release injection, not for maintenance treatment; patients should be switched to the buprenorphine/naloxone combination for maintenance and unsupervised therapy.
- Patients with moderate to severe opioid use disorder and stabilized with SL or buccal buprenorphine for >7 days may convert to monthly subcutaneous injections. Start 300 mg monthly for two months, then 100 mg monthly maintenance. Some patients may require higher doses.

MONITORING: LFTs.

COST: SL: $$; monthly injection: $$$$$

SIDE EFFECTS:
- Most common: Headache, pain, insomnia, nausea, anxiety.
- Serious but rare: Hepatitis reported rarely, ranging from transient, asymptomatic transaminase elevations to hepatic failure; in many cases, patients had preexisting hepatic dysfunction. QT prolongation with higher doses of transdermal.

MECHANISM, PHARMACOKINETICS, AND DRUG INTERACTIONS:
- Opioid agonist (delta and mu receptors) and antagonist (kappa receptors).
- Metabolized primarily through CYP3A4; t ½: 24–48 hours.
- Avoid concomitant use with opiate analgesics: diminished pain control. Additive effects with CNS depressants. CYP3A4 inhibitors and inducers may affect levels of buprenorphine.

EVIDENCE AND CLINICAL PEARLS:
- C-III controlled substance. Prescribing of SL tablets for opioid dependence will no longer be limited to prescribers with a DEA X-waiver. Moving forward, all prescribers renewing or applying for their DEA number will be required to take an eight-hour substance use treatment course and will be able to prescribe buprenorphine.
- Previously, there were limits to the number of patients an X-waivered provider could treat with buprenophine. As of this book's publishing date, such limits are no longer expected.
- Binds to various opioid receptors, producing agonism at delta receptors, partial agonism at mu receptors, and antagonism at kappa receptors (opioid agonist-antagonist).
- Although only studied in adults thus far, monthly injection offers alternative that may be convenient for some patients.

FUN FACT:
The subcutaneous implant formulation of buprenorphine (Probuphine) was discontinued. Its use was severely limited as it was invasive, expensive, and an option only for patients stable on ≤8 mg/day. Other implants currently in development include medications that will treat schizophrenia, breast cancer, photosensitivity, and Parkinson's disease.