How to Manage and Taper Buprenorphine

Early Treatment

After you have initiated buprenorphine, see patients weekly at first to make sure the dose is right. Increase the dose if they are experiencing cravings—the maximum dose is typically 24 mg daily. Doses can be split if patients are having withdrawal symptoms between doses. Multiple doses per day can be helpful for patients with chronic pain. For most patients, the optimal dose will be 16–24 mg daily. Eventually you can see patients monthly.

Managing Side Effects

- Constipation is the most common side effect. All patients starting buprenorphine should be given docusate/senna, which can be increased up to three tabs BID. Polyethylene glycol, magnesium citrate, and suppositories can be used if docusate/senna is insufficient.
- Some patients have reactions to the naloxone in co-formulated buprenorphine/naloxone. Headache is the most common symptom, but GI distress and anxiety can also be seen. Try switching to buprenorphine monoproduct for these patients.
- Because it's a partial agonist, sedation from buprenorphine alone is uncommon. If patients are reporting sedation, look for other CNS depressants, either prescribed or illicit, such as benzos, muscle relaxants, or alcohol.

Buprenorphine Maintenance vs Tapering

- The best outcomes are with long-term treatment. Overdose risk skyrockets once the medication is stopped. Encourage patients to continue taking the medication.
- If the patient insists on stopping, buprenorphine should be tapered slowly (see "Opioid Withdrawal Management" fact sheet).
  - Proceed in 4 mg increments initially, but slow down toward the end to 1 mg at a time.
  - Decrease dose once every few days to few weeks as tolerated.
  - Films can be cut into small pieces; they are easier to use than tablets for small increments.
  - Adjunctive clonidine can be helpful toward the end of the taper.

If Buprenorphine Doesn't Work

- *Encourage social support.* In conjunction with buprenorphine, ongoing substance use treatment, peer support groups like Alcoholics Anonymous (AA), and sober friends and family can be invaluable in helping patients through the ups and downs of early recovery.
- *Consider methadone*. For some patients, the partial agonism of buprenorphine just isn't enough. Methadone is a good option for patients who continue to experience cravings on 24 mg of buprenorphine.
- *Assess for diversion*. Buprenorphine can be sold on the street. Patients may be insufficiently treated because they are selling rather than taking their medication. Early refills, incorrect pill counts, and urine drug screens negative for buprenorphine can suggest diversion.