Compass Opioid Stewardship in Practice Microlearning Series

COMPASS HEALTHCARE COLLABORATIVE
Sustainable Healthcare Transformation

Module 1: Standard Rotation to Buprenorphine from Chronic Full Agonist Opioid Therapy

Welcome to Compass Opioid Stewardship in Practice. Each week, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, this session is built for busy clinicians like you.

This week's session is brought to you by Dr. Susan Bradley, PharmD, JM; Director of Education and Clinical Coach in the Compass Opioid Stewardship Program.

Case Presentation

This week's case is about a patient, John, currently prescribed OxyContin 40 mg every 12 hours and hydrocodone/acetaminophen 10-325 mg, two tablets three times daily, totaling approximately 180 MMEs per day. The patient is being considered for a transition to buprenorphine for chronic pain management using a standard rotation approach. We'll walk through the clinical reasoning, dosing strategy, and the transition protocol.

Goal

Our clinical goal is to safely transition a high MME chronic pain patient from full opioid agonist to buprenorphine, a partial agonist, using a standard rotation method that minimizes withdrawal symptoms and supports effective pain control. Buprenorphine is safer than Oxycontin and hydrocodone because it has a sealing effect on respiratory depression, reducing overdose risk, and stabilizes opioid receptors without producing the same level of euphoria or sedation. To achieve our goal, we'll estimate a 30:1 conversion ratio where 1 mg of buprenorphine is roughly equivalent to 30 mg of morphine, meaning this patient would require approximately 6 milligrams of sublingual buprenorphine daily with their 180 MME current regimen. For pain management, multiple daily doses are essential. When treating opioid use disorder, one daily dose is sufficient to suppress cravings, but buprenorphine works best in frequent doses for pain control.

Clinical Steps

For this patient, we would recommend 2 mg of buprenorphine three times daily using Suboxone films. The patient could also use Subutex tablets if that was their preference, but the films tend to be a little bit easier when making dosing adjustments during the conversion period because you can easily cut them into one-half or one-quarter films. In this case, we are using Suboxone off-label as the patient's MME of 180 is higher than is what is recommended for starting Butrans or Belbuca, which are labeled for pain. We're going to use products that are labeled for addiction off-label for treating pain in situations where we have legacy patients with a high MME (usually anything over 90 MME).

With a standard rotation protocol, day zero is going to be our pre-transition day. We begin by discontinuing long acting opioids at least 24 hours prior to starting buprenorphine. The patient takes their final dose of OxyContin in the morning. Throughout the day, they continue short-acting hydrocodone/APAP to manage symptoms. Short-acting opioids are discontinued at least 12 hours prior to conversion. The last hydrocodone dose is therefore taken in the evening. This sets the stage for withdrawal to begin overnight, which is necessary for safe buprenorphine initiation when using a standard approach.

Day one is our initiation day. The key here is timing. We wait until the patient is in moderate to severe withdrawal, typically 12 or more hours after their last hydrocodone dose. And they can self-assess using the subjective opioid withdrawal scale or SOWS. Once withdrawal is confirmed, we start low, 1 mg of buprenorphine (half of a 2 mg film). If symptoms persist after an hour, they can take another 1 mg, repeating as needed up to a total of 4 mg for the day.

Day two is our stabilization day. Upon waking, the patient would take the total dose they needed on day one as one dose. If symptoms flare, they can add up to two more 1 mg doses with a maximum of 6 mg for the day. This helps fine tune symptom control while avoiding over medication.

Day three is structured dosing. Now we split the day two dose into three doses. Assuming the patient took 6 mg on day two, we would instruct them to take 2 mg three times a day to maintain steady coverage. The patient should call the office to report how they're feeling and how the dosing is working. Based on the feedback, the clinical team may adjust the plan and we have included the detailed transition plan for you within the summary of this session.

Lastly, we want to ensure we are providing supportive care. We should ask the patient what symptoms they usually experience when they miss a dose or are late taking it and anticipate those symptoms occurring. Prescribe ondansetron (Zofran) for nausea and vomiting and any other symptomatic treatments that may be indicated based on their patient's specific withdrawal symptoms.

The Compass OPSS program provides clinical protocols, dosing calculation support through our pharmacists and patient education tools to help guide transitions like this. For personalized technical assistance, please reach out to your clinical coach to schedule a coaching session.

Clinical Pearls

The clinical pearls we want you to remember are:

- Buprenorphine conversions can be estimated using a 30:1 conversion ratio
- You should anticipate withdrawal symptoms and get ahead of them when converting patients
- We want to hold long-acting opioids for at least 24 hours and short-acting opioids for at least 12 hours prior to starting buprenorphine when using a standard rotation approach.

Thank You

This education has been brought to you through the generous support of the Centers of Medicare and Medicaid Services. Thanks for reading this week's Compass Opioid Stewardship in Practice Microlearning Series. Thank you for being part of the Compass Opioid Stewardship Program. And thank you for all you do caring for your patients.

Resources

- Compass OPSS Buprenorphine for Pain: MME Based Product Decision Guide
- Subjective Opioid Withdrawal Scale

Full Standard Rotation Example

Day 0 (Pre-transition):

1. Take the last dose of OxyContin in the morning.
2. Continue hydrocodone/APAP throughout the day.
3. Take the last hydrocodone dose in the evening.

Day 1 (Initiation):

1. Wait until the patient is in moderate to severe withdrawal (at least 12 hours after last hydrocodone). This can be assessed by the patient using the Subjective Opioid Withdrawal Scale or SOWS
2. Begin with 2 mg buprenorphine film:
3. Start with 1 mg- or ½ film
4. If still in withdrawal after 1 hour, take another 1 mg.
5. Repeat up to 4 mg total (2 full films) on Day 1.

Day 2 (Stabilization):

1. Upon waking, take the total dose from Day 0.
2. May take up to 2 additional 1 mg doses as needed for symptoms.
3. Max dose: 6 mg (3 films).

Day 3 (Structured Dosing):

1. Take the total dose from Day 1, split into three doses (2 mg TID).
2. Call the office to report symptoms and dosing response.
3. Adjustments may be made based on clinical feedback.