Compass Opioid Stewardship in Practice Microlearning Series

Module 17: Managing Opioid Risk and Transitioning to Buprenorphine (Part 3)

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. Rachael Duncan, PharmD, BCPS, BCCCP; Clinical Coach in the Compass Opioid Stewardship Program.

Case Presentation

Mary is a 67-year-old woman with chronic pain, diabetic neuropathy, and depression, anxiety, and insomnia. She uses opioids, benzodiazepines, and other medications, and occasionally drinks alcohol to help with sleep.

Goal

Focus in on how we would rotate Mary from her current opioid therapy to buprenorphine.

Achieving our Goal

Switching from high-dose full opioid agonists to buprenorphine can reduce overdose risk while potentially improving neuropathic pain, sleep quality, and mood. Buprenorphine's ceiling effect on respiratory depression and flexible dosing for pain make it a safer long-term option when carefully implemented.

Estimated Dose Conversion

- A commonly used approximate conversion is 30:1 (morphine to buprenorphine).
- For a total daily dose of 225 MME, the estimated starting range is ~7–8 mg/day of sublingual buprenorphine.
- Because buprenorphine dosing for pain requires shorter dosing intervals, divide the total daily dose into multiple doses (e.g., 2 mg four times daily).

Note: Dose conversions are approximate and should always be individualized based on withdrawal symptoms and clinical response.

Product Selection

- Sublingual buprenorphine/naloxone films or tablets may be used off-label for pain when higher opioid equivalents make transdermal or buccal pain formulations less practical.
- Films are often helpful during transition because they can be split for dose adjustments.

Standard Rotation Protocol (Short-Acting Opioid → Buprenorphine)

Day 0 – Pre-Transition

- Discontinue short-acting opioid in the evening.
- Ensure at least 12 hours before buprenorphine initiation.
- Mild-to-moderate withdrawal should begin overnight.

Day 1 – Initiation

- Begin buprenorphine when the patient is in moderate withdrawal (typically ≥12 hours after last opioid dose).
- Use a withdrawal tool (e.g., SOWS or COWS if observed).
- Start 2 mg.
- If withdrawal persists after 60–90 minutes, give 1–2 mg additional doses as needed.
- Typical Day 1 maximum: ~6 mg.

Day 1 – Initiation

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Day 3 – Structured Pain Dosing

- Divide the stabilized daily dose into 3–4 doses per day for improved analgesia.
- Follow up (phone or visit) to assess:
  - Pain control
  - Withdrawal symptoms
  - Sleep and function
- Adjust dosing as needed.

Supportive Withdrawal Care

Anticipate symptoms based on patient history and prescribe supportive medications when appropriate, such as:

- Nausea/vomiting: ondansetron
- Autonomic symptoms: clonidine (if appropriate)
- Sleep disturbance or anxiety: short-term non–respiratory depressant options

Educate patients that mild withdrawal symptoms during transition are common and temporary.

Patient Education Points

- Buprenorphine may:
  - Improve neuropathic pain control
  - Reduce opioid-related sleep disruption
  - Improve mood in some patients
  - Lower overdose risk compared to high-dose full agonist opioids
- Pain control typically improves once dosing is stabilized and divided throughout the day.
- Encourage ongoing communication during the transition period.

Clinical Pearls

The clinical pearls we want you to remember are:

- Bupe conversion estimate is 30:1.
- Anticipate withdrawal symptoms and get ahead of them using non-opioid medications.
- Hold short-acting opioids for at least 12 hours prior to starting buprenorphine when doing a standard rotation.
- Provide education and handouts for the patient to follow closely during the transition.
- Use your motivational interviewing skills to prep patients for future changes in therapy.

The Compass OPSS program provides clinical protocols, dosing calculation support through our pharmacists, and patient education tools to help guide transitions. For more personalized technical assistance on this topic, we encourage you to reach out to your Clinical Coach to schedule a coaching session.

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

- Opioid Risks and Side Effects
- Risk Management: Putting it All Together
- Recommended Screening Tools for Pain and Opioid Risk Management