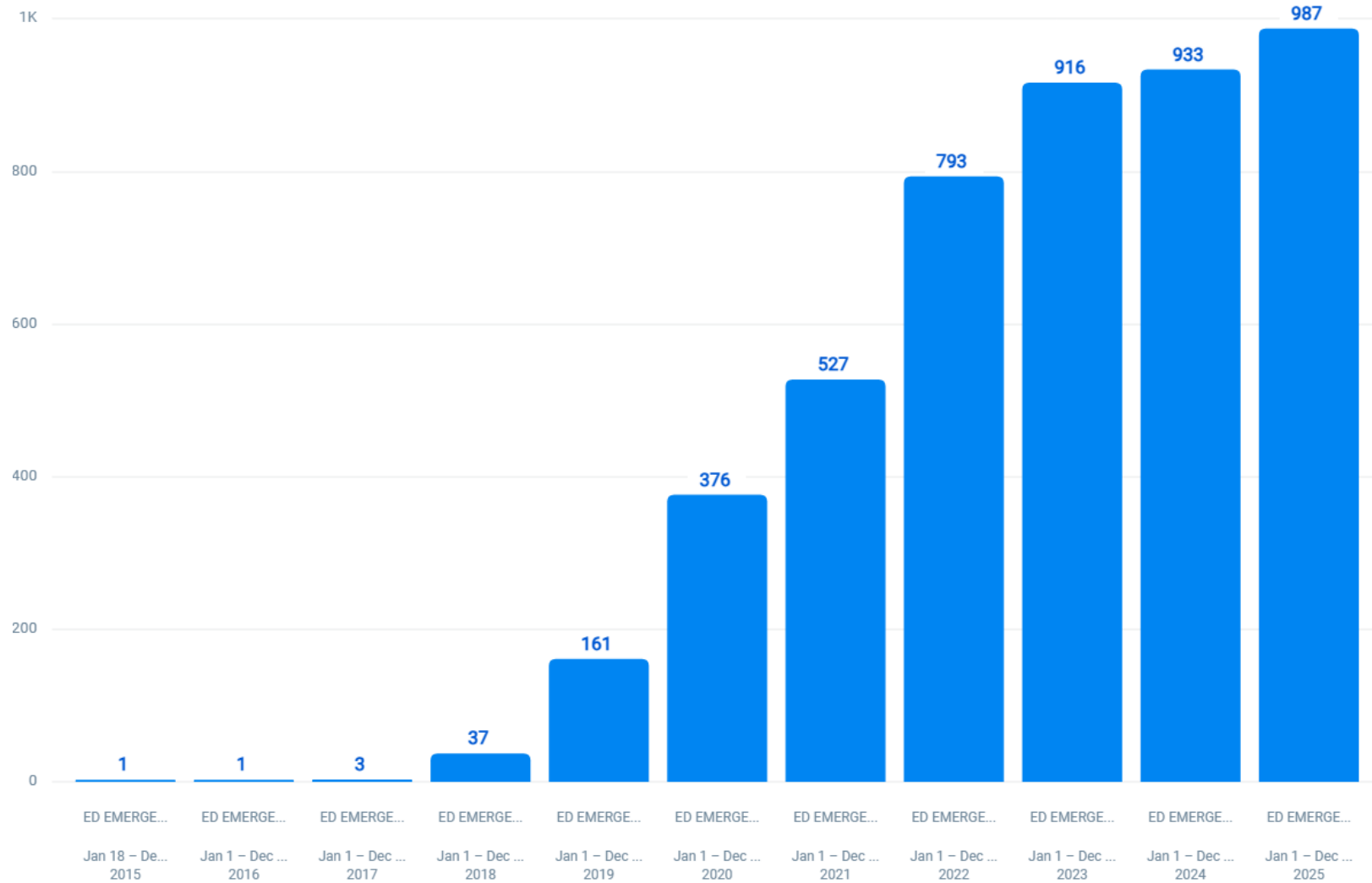


“You can’t start this in the ED”



*PLAY LIKE
A CHAMPION
TODAY*



Recent local MOUD work

- [Low Barrier MOUD Workgroup Final Report](#)
- [Medications for Opioid Use Disorder \(MOUD\) - MN Dept. of Health](#)
 - <https://youtu.be/8l7sXfC6xjw?si=ZHVx7MXRu3Cvsk9g>



If you focus on one thing

focus on being comfortable with macroinductions

Advocate for order sets

ED BUPRENORPHINE INITIATION [1529]

[Expand All](#) [Collapse All](#)

Buprenorphine Initiation [202969]

Select Location [202976]

- Emergency Department Initiation: For patients experiencing moderate opioid withdrawal and at least 24 hours from last opioid use. [202974] (Selection Required)
- Home Initiation: For patients who have recently used opioids and are not experiencing moderate withdrawal. [202975] (Selection Required)
- EMS Initiation: For patients who received their first dose of buprenorphine/naloxone (Suboxone) by EMS. [194102] (Selection Required)

Buprenorphine Initiation

Select Location

Emergency Department Initiation: For patients experiencing moderate opioid withdrawal and at least 24 hours from last opioid use.

ED Initiation

LORazepam (ATIVAN) tablet 1 mg
1 mg, Oral, ONE TIME, For 1 dose, today

buprenorphine-naloxone (SUBOXONE) 8-2 mg sublingual tablet 2 tablet
2 tablet, Sublingual, Once, For 1 dose, today, Maximum MME/Day: 480 MME/day for this order

buprenorphine-naloxone (SUBOXONE) 8-2 mg sublingual tablet 2 tablet
2 tablet, Sublingual, ONE TIME PRN, For 1 dose, Starting today, Until Discontinued, ongoing withdrawal symptoms or cravings, Maximum MME/Day: Unknown for this order

CONSULT TO CERTIFIED PEER RECOVERY SPECIALIST
Order details

Discharge Orders

REFERRAL TO ADDICTION MEDICINE
Internal referral, Addiction Medicine

buprenorphine-naloxone (SUBOXONE) 8-2 mg sublingual sublingual tablet
1 tablet, Sublingual, TID, Starting 5/4/2026, until 5/18/2026 or ending after 42 doses, Dissolve 1 tablet under tongue 3 times daily for 14 days, Disp-42 tablet, R-0, Normal, Prescription MME: 10,080 MME for entire prescription, Maximum MME/Day: 720 MME/day for this order

ⓘ This medication will not be e-prescribed. Invalid items: Pharmacy

naloxone (NARCAN) 4 mg/0.1 mL nasal spray
1 spray, Nasal, ONE TIME PRN, Starting 5/4/2026, Until Discontinued, For 1 dose, Disp-1 each, R-0, 1 spray by Nasal route one time as needed (opioid overdose).After removing nasal spray from box, gently insert the tip of the nozzle into either nostril. Press the plunger firmly to give dose; remove device from nose. If no reaction in 2-3 minutes, give a second dose. Pharmacy allowed to substitute per insurance., Normal
After removing nasal spray from box, gently insert the tip of the nozzle into either nostril. Press the plunger firmly to give dose; remove device from nose. If no reaction in 2-3 minutes, give a second dose. Pharmacy allowed to substitute per insurance.

ⓘ This medication will not be e-prescribed. Invalid items: Pharmacy

FENTANYL TEST STRIP
Routine

cloNIDine (CATAPRES) 0.1 mg oral TABS
0.1-0.2 mg, Oral, Q 8H PRN, Starting 5/4/2026, Until Discontinued, Disp-18 tablet, R-0, Take 1-2 tablets (0.1-0.2 mg) by mouth every 8 hours as needed (For anxiety), Normal
Do not order if patient's systolic blood pressure is persistently less than 90

ⓘ This medication will not be e-prescribed. Invalid items: Pharmacy

ondansetron (ZOFTRAN ODT) 4 mg oral disintegrating tablet
4-8 mg, Oral, TID PRN, Starting 5/4/2026, Until 5/11/2026, Disp-21 tablet, R-0, Take 1-2 tablets (4-8 mg) by mouth 3 times daily as needed for Nausea/Vomiting., Normal

ⓘ This medication will not be e-prescribed. Invalid items: Pharmacy

- Consider 7-14 day prescriptions at discharge
- Don't forget about naloxone
- Tips for success (in all situations)
 - Patients want to know you're on their team
 - Warn them that if withdrawal worsens, the answer will be more bupe
 - Confirm use timeline, no methadone use (3-7d)

A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin you want to feel very sick from your withdrawal symptoms

It should be at least . . .

- **12 hours** since you used heroin/fentanyl
- **12 hours** since snorted pain pills (Oxycontin)
- **16 hours** since you swallowed pain pills
- **48-72 hours** since you used methadone

You should feel at least three of these symptoms . . .

- Restlessness
- Heavy yawning
- Enlarged pupils
- Runny nose
- Body aches
- Tremors/twitching
- Chills or sweating
- Anxious or irritable
- Goose pimples
- Stomach cramps, nausea, vomiting or diarrhea

Once you are ready, follow these instructions to start the medication

DAY 1:

8-12mg of buprenorphine

Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

Step 1.

Take the first dose

4mg

Wait 45 minutes

45 minutes

- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

Step 2.

Still feel sick?
Take next dose

4mg

Wait 6 hours

6 hours

Most people feel better after two doses = 8mg

Step 3.

Still uncomfortable?
Take last dose

4mg

Stop

Stop

- Stop after this dose
- Do not exceed 12mg on Day 1

DAY 2:

16mg of buprenorphine

Take one 16mg dose

Most people feel better with a 16mg dose

16mg

Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

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- Do NOT swallow the medicine

4mg

4 hours

Most people feel better after two doses = 8mg

4mg

Stop

- Stop after this dose
- Do not exceed 12mg on Day 1

DAY 2:

16mg of buprenorphine

Take one 16mg dose

Most people feel better with a 16mg dose

16mg

Repeat this dose until your next follow-up appointment

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

Microdosing / Crosstapering



Keys to Success

- **Small doses**
Maximum 1 mg per dose
- **Avoid prolonged microdosing**
Complete transition in a timely manner
- **Clear patient instructions**
Ensure full understanding of the protocol



Avoid When

- Already in significant withdrawal
- Patient does not want to continue using full agonist opioids during transition
- Patient prefers rapid start
- Difficulty with health literacy
- Unable to self-administer doses at necessary frequency, including cutting/storing partial films or tablets

TABLE 1 Outpatient microdosing regimen

Day	Dose	Number of tablets per dose (buprenorphine-naloxone 2 mg-0.5 mg tablet)
1	Buprenorphine 0.5 mg-naloxone 0.125 mg SL BID	One-quarter tablet
2	Buprenorphine 1 mg-naloxone 0.25 mg SL BID	One-half tablet
3	Buprenorphine 2 mg-naloxone 0.5 mg SL BID	1 tablet
4	Buprenorphine 3 mg-naloxone 0.75 mg SL BID	One and a half tablet
5	Buprenorphine 4 mg-naloxone 1 mg SL BID	2 tablets
6	Buprenorphine 12 mg-naloxone 3 mg SL BID	6 tablets

BID, twice daily; SL, sublingual.

Does not require withdrawal
ahead of induction

Continue illicit opioid use

Transdermal to Sublingual Approach

1

Apply Patch (ED)

Buprenorphine (Butrans®)
10–20 mcg/hr transdermal
patch

2

Wait (Abstinence Period)

12–24 hours before
proceeding to induction

3

Macroinduction

16 mg SL buprenorphine
+ optional 16 mg re-dose

4

Maintenance Dosing

16–24 mg daily
thereafter

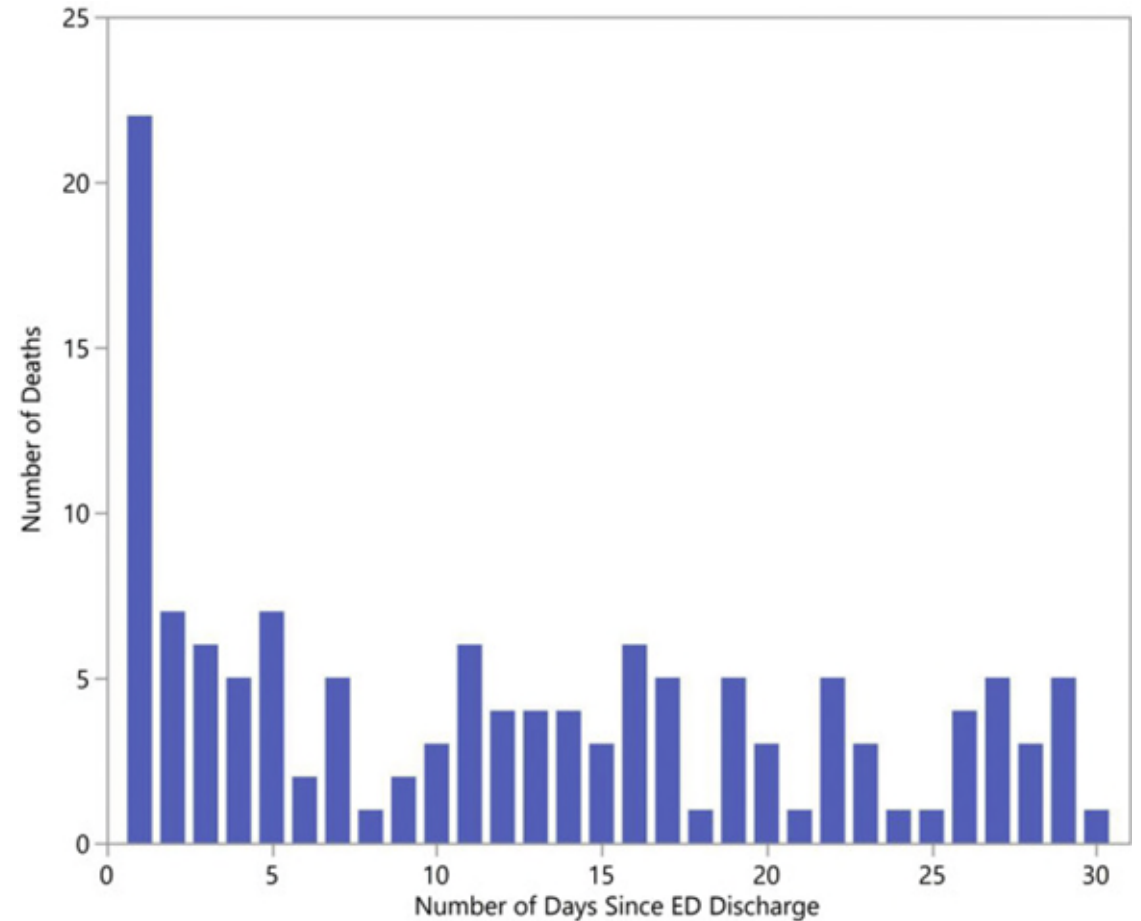
A note on insurance

If your patient is uninsured...

- SL tablets \$-\$\$
- SL films (brand \$\$\$ vs generic \$\$)
- Pharmacists cannot interchange formulations without a new rx (yet!)
- Filling on-site reduces barriers
- GoodRx

Even one dose is a win

- MOUD reduces mortality > 50%
- Post-overdose mortality risk highest in 1st 30 days (48h)
- A dose of buprenorphine after naloxone reversed opioid overdose may help reduce this risk

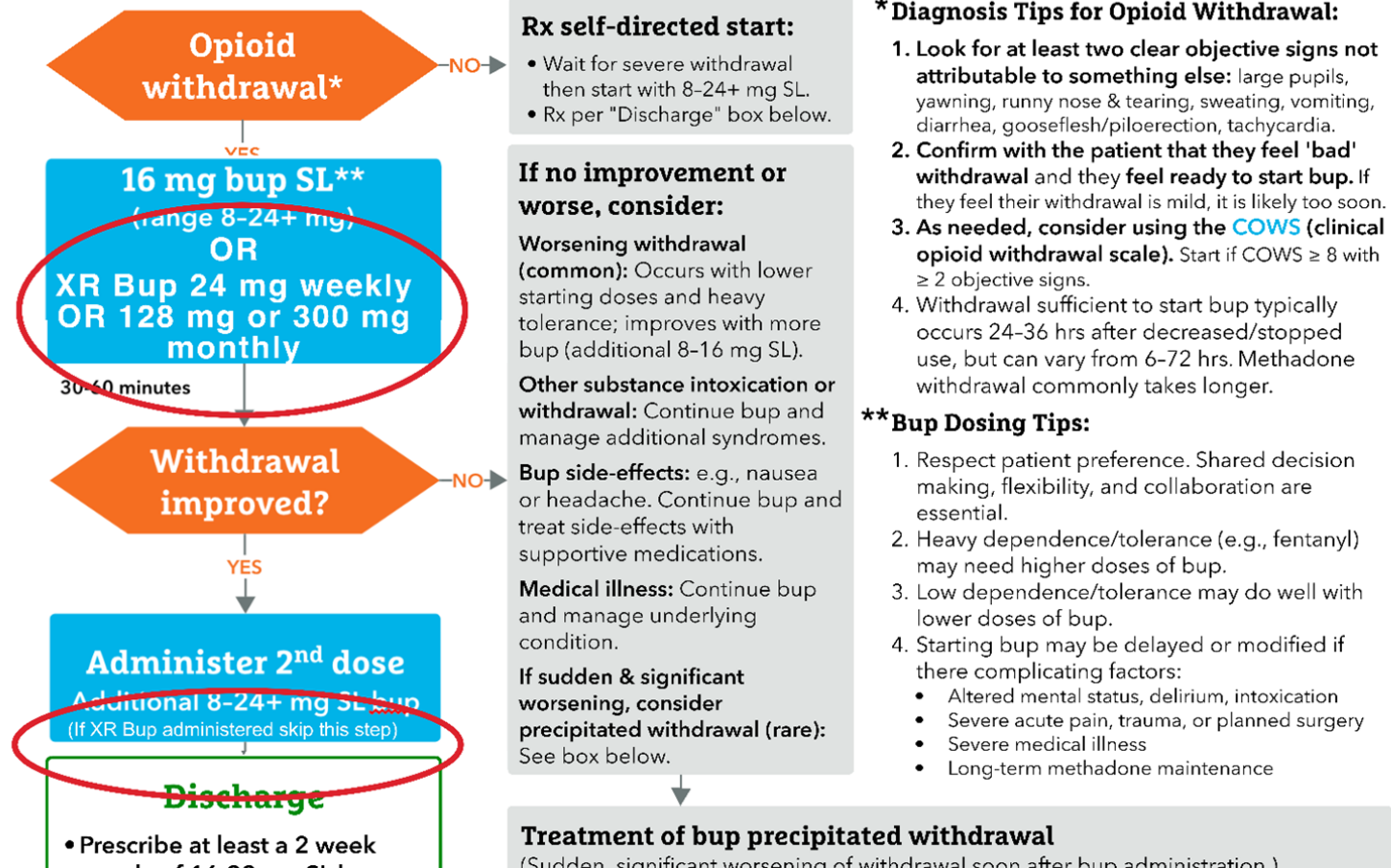


Direct To Inject (DTI) in the ED



Emergency Department Buprenorphine (Bup) Quick Start

Connect with your patient: Accurate diagnosis and treatment requires trust, collaboration, and shared decision making.



Direct To Inject (DTI) in the ED

- To be paid in the ED setting
 - Patient must discharge from the ED
 - Prior authorization retroactively submitted
 - If denied, potential for large patient bill and/or system cost