**Identify BUP Candidate**

- **ED-BUP Candidates** have opioid use disorder (OUD) with active, regular opioid use. No methadone use. Consider complicating factors to right.

**Assess Opioid Withdrawal**

- Assess opioid type and last use

- **COWS < 8**
  - X-Waivered Provider?
    - No: No BUP given or Rx. Consider ED hold or return ± clonidine or other ancillary meds
    - Yes: Rx: Home induction ± dispense 1st dose (4 mg QID or 8 mg BID) Provide printed induction instructions

- **COWS > 8**
  - Administer 1st dose BUP 4-8 mg Reassess in ≥ 30 min

  - X-Waivered Provider?
    - No: Admin more BUP; total dose 12-32 mg. No Rx. Consider high dose or ED hold/return if delay to referral/next dose
    - Yes: Admin more BUP; total dose 8-16 mg Rx: 16 mg/day until appointment.

**Why Reassess BUP Patients?**

- If worsening withdrawal or sedation, consider alternative diagnoses (e.g., sepsis) or other complicating factors

**Worsening or Precipitated Withdrawal**

- BUP can cause worsening withdrawal if too large a dose is given too soon after the last opioid use. Precipitated withdrawal is when this is very severe and sudden — and may warrant expert consultation.
- Reassure patient. Reassess situation (e.g., if had methadone).
- Treatment may be to stop BUP and give ancillary medications for symptomatic treatment (particularly if had methadone). Alternative may be to give large dose of BUP to flood remaining receptors.
- BUP itself can cause nausea and other symptoms of withdrawal

**Medication and Dose Considerations:**

- **Initial Dose**: Typically 4-8 mg
  - Consider lower initial dose (2-4 mg) in higher risk patients or if withdrawal signs/symptoms are inconsistent or less clear
  - Start higher dose in more severe withdrawal (COWS > 12)

- **Total Dose**: Typically 8-16 mg, then 16 mg/day
  - 8 mg will treat withdrawal in most cases
  - Recommend higher dose when delayed access to next dose

- **Higher “Loading” Dose Option (Total: 24-32 mg)**: Then, 16 mg/day
  - May extend the duration of BUP action on withdrawal, craving, and opioid blockade for 2 or more days.
  - For experienced providers/experts and appropriate patients only

- **Prescribe BUP/Naloxone formulation!**
  - Combination is for abuse deterrence. Naloxone absorption is negligible when taken sublingually as directed.
  - Typically 16 mg/day. Divide doses for unobserved/home induction.

**Ancillary Medications**

- Not usually necessary with BUP
  - e.g., NSAIDs, clonidine, anti-emetics, dicyclomine, acetaminophen, gabapentin, benzos, etc.

**DEA 72 Hour Rule**: Patients may return to ED for up to 3 days in a row for repeat doses. At each visit administer 16 mg SL BUP

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***IMPORTANT***

All patients receive:

- Warm Referral for ongoing treatment.
  - Document cell # (___) ___ - ___
  - Uses Peers, SW, other supports
- The BUP-specific discharge instructions
- Naloxone kit with harm reduction and overdose education
- Respect, encouragement, motivational brief intervention

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1 Consider ED return, hold, or observation if waivered provider will become available and/or for patient to receive dose.