Buprenorphine–naloxone

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1 Buprenorphine–naloxone is first-line therapy for opioid use disorder in Canada

Buprenorphine–naloxone is effective in reducing illicit opioid use, but has a lower overdose risk and fewer adverse effects than methadone.[1] Both buprenorphine–naloxone and methadone treatments are associated with reduced all-cause mortality, and both are more effective than abstinence-based treatments.[2] Buprenorphine–naloxone is also safe to prescribe and initiate in pregnancy;[1,3] however, clinicians treating pregnant patients with opioid use disorder should consider consulting a specialist.[1,3]

2 Buprenorphine–naloxone should be offered in all care settings, including primary care, emergency departments and correctional facilities

Treatment started in the emergency department with continuation in primary care is associated with increased engagement in treatment.[4] Buprenorphine–naloxone allows for safe home induction for patients not yet in withdrawal.[5] Alcohol misuse is not a contraindication.[3] Although buprenorphine–naloxone is simple to prescribe, physicians and nurse practitioners should become familiar with their provincial educational recommendations before prescribing. Numerous online and in-person education courses and telemedicine services are available (Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.180776/-/DC1).

3 To initiate buprenorphine–naloxone, patients should ideally be in moderate opioid withdrawal

The first dose should not be given until at least 12–24 hours since the last opioid dose, and the patient has a score of greater than 12 on the Clinical Opiate Withdrawal Scale.[3] The dose on day 1 is 2–4 mg sublingually every 2 hours until withdrawal has resolved, to a maximum of 12 mg.[3]

4 Optimal buprenorphine–naloxone maintenance doses should prevent withdrawal symptoms for 24 hours

The dose can be increased by 2–4 mg per visit to control withdrawal symptoms (maximum 24 mg/d).[3] Patients may require daily visits for 3 days but, once stable, can be assessed every 1–2 weeks.[3] For patients on the maximum dose with ongoing withdrawal symptoms, methadone should be considered.[1] Stable patients wishing to taper require gradual small-dose reductions (2 mg every 2 weeks).

5 All patients with opioid use disorder should have access to the full spectrum of treatments

Psychosocial interventions, peer support, take-home naloxone and harm-reduction services should be offered.[1]

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