Michigan Opioid Collaborative

Transition from Full Agonist Prescription Opioids to Sublingual Buprenorphine for Pain or Opioid Use Disorder (off-label indication)

Pre-treatment information

1. Have a clear diagnosis and plan
2. Agree on treatment goals and plan for off ramp if not working (functional improvement, safer medication regimen, improved pain control, etc)
3. Identify complexity that may require subspecialty care: uncontrolled major psychiatric disorder, other active SUD, pregnancy
4. Check PDMP (MAPS in Michigan)
5. Perform urine drug screen (Drug 10) with confirmatory testing if results are unexpected
6. Offer counseling services
7. Start Talking form (in MI)
8. Instruct on proper use of sublingual medication
9. Prescribe the abuse deterrent formulations (buprenorphine/naloxone) – Dosing below is for generic or Suboxone

Morphine Mg Equivalent Dosing (MME) -- (MS = oral morphine mg)

Opioid	Relative potency	Opioid	Relative potency	Opioid	Relative potency
Tapentadol mg	= MS x 0.4 *	Oxycodone	= MS x 1.5 **	Hydromorphone	= MS x 4-5
Hydrocodone	= MS	Heroin	= MS x 2.5	Fentanyl →	1 mcg/hr approx. 2 mg/day MS
Butorphanol	= MS	Oxymorphone	= MS x 3-4	Methadone	= 4-20 x MS potency

* Example: Tapentadol 100 mg = 40 mg morphine equivalent

** Example: Oxycodone 20 mg = 30 mg morphine

Prescribing Principles

1. Films may be cut in half, or even smaller. Tablets can be cut in half.
2. Films or tablets should be held under the tongue for 5 minutes without eating, drinking, talking
3. With a good plan, transition to buprenorphine can be done at home
4. Avoid weekend calls for refills – write prescriptions in 1-4 wk (7, 14,21,28 day) amounts, not 30 days
5. Write "for pain" on the buprenorphine rx when appropriate and prescribe off-label with "regular" DEA (do not need to use X-license)
6. Medicaid will not pay for bupe/naloxone for pain and an X-DEA and indication OUD must be used
7. If applicable, delay benzo taper until stable after conversion to buprenorphine
8. See UM guide for peri-procedure buprenorphine management
9. Contact the Michigan Opioid Collaborative for needed assistance
10. Dose TID or even QID for pain, BID for OUD

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Choice of buprenorphine transition protocol is based on opioid(s) currently being used (short-intermediate-long acting)

1. Short-acting opioids (codeine, tapentadol, hydrocodone, morphine IR, oxycodone IR, oxymorphone IR, hydromorphone)				
Preparation	Opioid-free interval	Transition dosing	Initial target dose in (mg/day)	Comments
If prior pill dose is > 180 MMED, taper to ≤ 180 by 10% of total every 4 days.	12 hours	1 mg SL Q30 min x 4 doses (OK to combine the third and fourth doses if there is regression of pain or withdrawal symptoms at 1 hr). After 4 hr, continue that day with target dose.	• < 50 MMED → 0.5-3 (divide into 3 doses for pain patients) • 50-150 MMED → 3-6 • > 150 MMED → 6-8	• For OUD patients, divide total into 1-2 doses/day, use higher end of range. • For patients with pain > OUD, divide into 3-4 doses/day at lower end of range
2. Intermediate-acting opioids (morphine ER, oxycodone ER)				
Preparation	Opioid-free interval	Transition dosing	Initial target dose (mg/day)	Comments
• If on Kadian, convert to equal amount of morphine ER *** divided into 3 doses • If prior dose is > 180 MMED, taper to ≤ 180 by 10% of total every 4-7 days	12 hours	1 mg SL Q30 min x 4 doses (OK to combine the third and fourth doses if there is regression of pain or withdrawal symptoms at 1 hr). After 4 hr, continue that day with target dose.	• < 50 MMED → 0.5-3 (divide into 3 doses for pain patients) • 50-150 MMED → 3-6 • > 150 MMED → 6-8	• For OUD patients, divide total into 1-2 doses/day, use higher end of range. • For patients with pain > OUD, divide into 3-4 doses/day at lower end of range
3. Long-acting opioids (fentanyl patches, methadone) – "Bridging" with short-acting opioid permits symptom control during clearance				
Preparation (get help if not able to taper)	"Bridging" treatment	Transition dosing	Initial bup target dose (mg/day)	Comments
Fentanyl prior dose • > 75 mcg/h – taper by 12 mcg every 6-9 days • ≤ 75 mcg/h, proceed to "bridging" *Methadone prior dose* • ≤ 80 mg/day – taper by 5 mg each week • > 80 mg/day – taper by 10 mg each week	1. Stop fentanyl or methadone on the morning of day 1. Begin morphine IR 30 mg 4-5 times per day for 5 days (7 days, if obese) 2. On the 5th night, stop morphine IR 3. Start induction on the 6th morning after no opioid x 12 h	After 12 hrs off "bridge," 1 mg SL Q30 min x 4 doses (OK to combine the third and fourth doses if there is regression of pain or withdrawal symptoms at 1 hr). After 4 hr, continue that day with target dose.	• < 50 MMED → 0.5-3 (divide into 3 doses for pain patients) • 50-150 MMED → 3-6 • > 150 MMED → 6-8	• For OUD patients, divide total into 1-2 doses/day, use higher end of range. • For patients with pain > OUD, divide into 3-4 doses/day at lower end of range **WARNING: Transition from long-acting opioids can be more challenging than from shorter acting agonists**

*** **Example:** MS Contin or its generic