ASSESSING PATIENTS FOR BUPRENORPHINE TREATMENT (CASES ONLY)

**Goal**
To train providers to assess whether patients having opioid use disorder meet criteria for receiving office-based buprenorphine treatment and select patients who are suitable.

**After completing this module (didactic + cases), participants will be able to:**

- Assess whether patients having opioid use disorder are appropriate for office-based buprenorphine treatment
- Identify patients who are not good candidates for office-based buprenorphine treatment
- Anticipate common medical and psychiatric problems in patients with opioid use disorder that may complicate its treatment
- Adjust assessment to meet needs of patient groups having specific additional requirements, including adolescents, pregnant women, and geriatric patients
- Develop an individualized buprenorphine treatment plan for patients
- Determine what referral is appropriate for the treatment of opioid use disorder when patients are not good candidates for office-based treatment

**Practice Gap**
Providers need to be able to assess patients with opioid use disorder for appropriateness for office-based opioid treatment. TIP 40, Chapter 3, is on Patient Assessment, focuses on patient assessment in the treatment of opioid use disorder\(^1-3\). The FSMB Model policy also describes 6 critical aspects of patient assessment\(^4\).
Name: Mr. Reyes
Age: 30 years old
Reason For Visit: Mr. Reyes, a schoolteacher, is having difficulty with work because he has been calling in sick too much.

Patient History: Mr. Reyes injects heroin at least once daily and also regularly takes large quantities of codeine pills. He has been injecting heroin on and off since he was 16 years old. A few years ago, he was in an automobile accident that resulted in a back injury. Following the accident, he experienced back pain for which he needed codeine. The back pain has since resolved, but he still takes large quantities of codeine pills, from several providers, to stave off heroin withdrawal.

Treatment History: Mr. Reyes has a history of several outpatient detoxifications and three residential drug treatment stays without opioid pharmacotherapy. He remained heroin-free and codeine-free for about 6 months following the last treatment, which was about a year ago. He also has been alcohol abstinent for the past two years. His only current medical problem is that he is hepatitis C positive, and he has been so for at least 10 years. His liver function tests are currently in the acceptable range for buprenorphine treatment.

With What You Now Know, Is Mr. Reyes A Good Candidate For Office-based Buprenorphine Treatment At This Time? (Choose The Best Answer)

1. Yes, he may be a good candidate for office-based buprenorphine treatment at this time
2. No, intensive outpatient counseling and groups are his best option at this time
3. No, medically supervised withdrawal only is his best option at this time
CASE – MR. REYES QUIZ FEEDBACK

(1) Yes, He May Be A Good Candidate For Office-based Buprenorphine Treatment At This Time
Correct. Mr. Reyes may be a candidate for office-based buprenorphine treatment. Even though he failed very intensive treatment before, opioid maintenance therapy was not offered in those treatments and could be tried. Intensive outpatient treatment is likely to interfere with work obligations, and privacy is especially important in his profession. Due to several unsuccessful attempts at detoxification in the past, maintenance as part of his treatment plan will be particularly important. He will also need supportive counseling as part of his plan, which could be offered at evening or weekend appointments. Having maintenance continue for now does not preclude the possibility of attempting to taper the buprenorphine at some point in the future.

(2) No, Intensive Outpatient Counseling And Groups Are His Best Option At This Time
Saying "No" to office-based buprenorphine treatment is not the best answer. Intensive outpatient treatment is likely to interfere with work obligations, and privacy is especially important in his profession.

(3) No, Medically Supervised Withdrawal Only Is His Best Option At This Time
This is not the best answer at this time, because Mr. Reyes has had several unsuccessful attempts at detoxification in the past. Even though he failed very intensive treatment before, opioid maintenance was not offered in those programs and could be tried. Maintenance therapy is particularly important for him as part of his treatment plan because of the past failed attempts at detoxification.
CASE STUDY – MR. HARRIS

Meet Your Patient

Name: Mr. Harris
Age: 28 years old
Reason For Visit: He wants "to try bup".

Patient History: Mr. Harris says he has been seeing physicians at the VA, but they are "upset with me because I crushed my pain pills and snorted them, but I didn't use any more in a day than they told me I could. They don't like it, but it's the only way to stop the pain. Even then it's only for about 3 hours."

Mr. Harris has undergone seven reconstructive surgeries. He has a history of shrapnel injuries to legs, arms, and face during military service 9 years ago. He says that he has a prescription for 80 mg oxycodone tablets, eight per day, for pain control. He reports drinking no more than three drinks per day, but he does drink at least five times a week at that rate.

Mr. Harris – Conversation

Determining If Mr. Harris Is An Appropriate Candidate For Buprenorphine Treatment

Mr. Harris is a patient with legitimate pain who also may have opioid use disorder. He has some concerning symptoms that suggest the diagnosis, but it is not yet clear if he is appropriate for buprenorphine treatment. For instance, he admitted to crushing and snorting his pain medication. Inappropriate administration of chronic pain medication (crushing/inhaling, or dissolving/injecting) does not in itself mean he has opioid use disorder, but it is a red flag. Patients with chronic pain may inappropriately change the method of administering a drug in order to achieve better pain control. Rather than addiction, his snorting misuse could also be to experience euphoria from opioids. Usually snorting crushed tablets would result in faster effect and shorter duration of action, making the medication more "abusable" and increasing the likelihood of addiction.

Some questions you should ask to determine whether Mr. Harris is an appropriate candidate for buprenorphine treatment include whether his opioid use is affecting his psychosocial circumstances and why he wants to try buprenorphine now.

Provider: I see from your chart that you are taking oxycodone. Who is prescribing it for you?

Mr. Harris: The doctor down at the VA gives it to me. He knows how much I hurt and that it helps ease my pain.

Provider: What happens when you don't take your prescription?

Mr. Harris: I hurt too much. Start getting the shakes and headaches.

Provider: How about lessening your dosage? Have you ever tried that?

Mr. Harris: Not if I can help it. Sometimes I have to stretch it before I can get back and get a refill, but I can't sleep well when I do that.

Provider: Have you ever tried other medications for your pain?

Mr. Harris: They don't do any good. The oxycodone seems to work the best for me.

Provider: But now you want to try buprenorphine treatment? Tell me, what's making you consider buprenorphine?
**Mr. Harris:** I know I'm not getting any better. And I'm relying on the oxycodone too much. I need to try something else.
QUIZ: MR. HARRIS – DIAGNOSIS AND PLAN

Preliminary Diagnosis
• History of pain syndrome, r/o chronic pain
• Misuse of prescription opioids, r/o opioid use disorder
• Alcohol use, r/o alcohol use disorder

Based On What You Know And His Preliminary Diagnoses, Is Mr. Harris A Good Candidate For Buprenorphine Treatment? (Choose One)
1. Yes, he fits the criteria for being a good candidate for treatment now.
2. No, he is not a good candidate for treatment and further evaluation is not needed.
3. Further evaluation is needed to determine whether office-based opioid treatment with buprenorphine is a good choice for him.
MR. HARRIS – DIAGNOSIS AND PLAN QUIZ FEEDBACK

(1) Yes, He Fits The Criteria For Being A Good Candidate For Treatment Now, (2) No, He Is Not A Good Candidate For Treatment And Further Evaluation Is Not Needed.
It appears that Mr. Harris is not a good candidate for buprenorphine maintenance at this time; he requires further evaluation. A complete evaluation for opioid use disorder and more about his history and current drug use is warranted in order to determine his candidacy. Recommended next steps are as follows:

- Determine the basis of his behavior in crushing his medication
- Provide appropriate pain management and dose control for indicated pain medications
- Give information about opioid use disorder, and risk of misusing and borrowing medications to "get high"
- Coordinate care with all prescribers and other providers to better monitor this patient
- Conduct ongoing evaluation to aid in full diagnosis

(3) Further Evaluation Is Needed To Determine Whether Office-based Opioid Treatment With Buprenorphine Is A Good Choice For Him.
Correct. It appears that Mr. Harris is not a good candidate for buprenorphine maintenance at this time; he requires further evaluation. To determine his candidacy, complete an evaluation for opioid use disorder and learn more about his history and current drug use. Recommended next steps are as follows:

- Determine the basis of his behavior in crushing his medication
- Provide appropriate pain management and dose control for indicated pain medications
- Give information about opioid use disorder, and risk of misusing and borrowing medications to "get high"
- Coordinate care with all prescribers and other providers to better monitor this patient
- Conduct ongoing evaluation to aid in full diagnosis

Poll: Among your patients who are opioid-addicted and use tobacco, would you recommend tobacco cessation?
- Yes, I would treat both the tobacco addiction and the opioid addiction
- Yes, but I would focus on the opioid addiction first
- No, tobacco use isn't necessary in this situation

What do you think? Take the poll yourself!
https://bup.clinicalencounters.com/assessing-patients-poll/

Poll: How comfortable are you with providing office-based opioid treatment to patients who report other substance use?
- Very comfortable
- Somewhat comfortable
- Somewhat uncomfortable
- Very uncomfortable
Let us know what you think!

https://bup.clinicalencounters.com/methadone-poll/
QUIZ: CASE STUDY – MR. SANTOS

Name: Mr. Santos
Age: 58 years old
Reason For Visit: Mr. Santos came to your office with his wife to request buprenorphine treatment.

Patient History: He recently started using heroin again at present, he uses about "three to four grams a day." He is also being treated for HIV. He says that his “inpatient detox worked with buprenorphine, but now I started using heroin again, and I'm afraid it will mess up my HIV treatment." Mr. Santos has been using heroin since age 25. He was diagnosed as having PTSD after witnessing the death of his parents as a young adult but received extensive treatment for this. His wife, Linda, says he still has occasional nightmares. She keeps track of his HIV medications and makes him take them every day, but now that he has relapsed she is threatening to leave. She says, "I just can't be around him when he's using drugs every day."

Treatment History: Mr. Santos mentions that he has previously used buprenorphine during an inpatient detox.

With What You Now Know, Is Mr. Santos A Good Candidate For Buprenorphine Treatment In Primary Care? (Choose One)

1. Yes, because it is likely he has opioid use disorder and seems to be interested in treatment.
2. Yes, because he has had success in the past with detoxification using buprenorphine.
3. No, because his HIV will complicate treatment too much.
4. No, because PTSD complicates treatment too much.
CASE STUDY – MR. SANTOS QUIZ FEEDBACK

(1) Yes, Because It Is Likely He Has Opioid Use Disorder And Seems To Be Interested In Treatment.
Possibly. With the facts that you have so far, Mr. Santos seems like he may be an appropriate candidate for buprenorphine treatment. You will have to explore his history of use and treatment attempts further and learn more about his medical and psychiatric problems before proceeding, however. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.

(2) Yes, Because He Has Had Success In The Past With Detoxification Using Buprenorphine.
That is not the best answer. Taking buprenorphine in the past for detoxification should not factor into your current evaluation. You will have to explore further his history of use and treatment attempts and learn more about his medical and psychiatric problems before proceeding. If there are no major problems, Mr. Santos would be an appropriate candidate for buprenorphine treatment. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.

(3) No, Because His HIV Will Complicate Treatment Too Much.
That is not the best answer. His HIV is well-controlled and can be treated concurrently with opioid dependence. You will have to explore his history of use and treatment attempts further and learn more about his medical and psychiatric problems before proceeding, however. If there are no major problems, Mr. Santos would be an appropriate candidate for buprenorphine treatment. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.

(4) No, Because PTSD Complicates Treatment Too Much.
Possibly incorrect. Severe psychiatric problems are a contraindication to buprenorphine treatment in the office. However, it is not clear that his PTSD is currently a severe problem. Evaluating this will be important. His HIV is well-controlled and can be treated concurrently with opioid dependence. You will have to explore his history of use and treatment attempts further and learn more about his medical and psychiatric problems before proceeding. Mr. Santos may be an appropriate candidate for buprenorphine treatment. Given the known history regarding past PTSD and current relationship problems, concurrent counseling is indicated.
QUIZ: PAIN INQUIRY – MRS. DAVIS

Name: Mrs. Davis
Age: 46 years old
Reason For Visit: Followup for a shoulder injury
Patient History: Mrs. Davis has abused prescription opioids sporadically for several years. She recently injured her shoulder and had been using opioids more frequently to manage her pain.

Review the following dialogue and determine whether it is a complete pain history:

**Provider:** How long have you had this pain?
  **Mrs. Davis:** Around a week. It seems to be getting worse instead of better.

**Provider:** I’m sorry to hear that. Is it limiting what you can do or affecting your sleep?
  **Mrs. Davis:** Getting dressed is difficult. Sometimes I roll on it in my sleep, and it wakes me up.

**Provider:** Can you use your other arm and show me where the pain is located?
  **Mrs. Davis:** Here. [Points to the back of her right shoulder].

**Provider:** I see. What seems to trigger the pain or make it worse?
  **Mrs. Davis:** Reaching behind me is the worst.

**Provider:** What is the pain intensity on a scale of 0-10?
  **Mrs. Davis:** It’s a 10 for a second and lingers at an 8 for a while. I take an opioid and it settles down.

Of Course, The Provider Would Follow-up On Mrs. Davis’ Self-medication With Opioids. But Focusing On Just The Pain History, Try Using The Acronym PQRSTU To Help You Remember All The Questions To Ask In A Complete Pain History, Answer The Following Question: Of The Choices Below, Which Question Category Has NOT Yet Been Asked Of Mrs. Davis? (Choose One)

1. "Where is the pain located?"
2. "Does it hurt?"
3. "Is the pain dull, sharp, or throbbing?"
4. "How badly does it hurt?"
Case Pain Inquiry Quiz Feedback

(1) "Where Is The Pain Located?"
This exact question was asked already.

(2) "Does It Hurt?"
The answer to this question is already clearly yes.

(3) "Is The Pain Dull, Sharp, Or Throbbing?"
Correct. This question assesses the Q of the PQRSTU acronym and stands for pain quality, which is a question that has not been asked yet.

(4) "How Badly Does It Hurt?"
This question assesses the severity of the pain which was already asked by asking about pain intensity.
QUIZ: MRS. DAVIS TREATMENT SELECTION

Name: Mrs. Davis
Age: 46 years old
Reason For Visit: Followup for a shoulder injury
Review History: Mrs. Davis has been assessed to have opioid use disorder. She has been using opioids more frequently to manage her pain and takes paroxetine (Paxil®) for depression and anxiety.

With What You Now Know, Is Mrs. Davis A Good Candidate For Office-based Buprenorphine Treatment At This Time? (Choose The Best Answer)

1. No, she has been abusing prescription opioids off and on for several years and seems to have some control of her use; therefore, she does not need maintenance treatment.
2. No, because she has a psychiatric disorder.
3. Yes, because you can safely taper her off of the paroxetine and then start buprenorphine treatment.
4. Yes, because stabilized patients can typically take selective serotonin reuptake inhibitors (SSRIs) and buprenorphine simultaneously.
Quick Case – Mrs. Davis Quiz Feedback

(1) No, She Has Been Abusing Prescription Opioids Off And On For Several Years And Seems To Have Some Control Of Her Use; Therefore, She Does Not Need Maintenance Treatment.

Although her history of use is also significant, you should not assume that she has control over her use and can stop abusing prescription opioids if she chooses to do so. Because she meets the DSM criteria for opioid use disorder, she may be an appropriate candidate for buprenorphine treatment. However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.

(2) No, Because She Has A Psychiatric Disorder.

Mrs. Davis' psychiatric disorders (depression and generalized anxiety disorder) appear to be well controlled. She appears to be psychiatrically stable.

(3) Yes, Because You Can Safely Taper Her Off Of The Paroxetine And Then Start Buprenorphine Treatment.

There is no need to taper Mrs. Davis off of paroxetine before starting buprenorphine. Patients who are psychiatrically stable can take SSRIs and buprenorphine simultaneously, monitoring for possible additive sedative effects, especially at first. However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.

(4) Yes, Because Stabilized Patients Can Typically Take Selective Serotonin Reuptake Inhibitors (SSRIs) And Buprenorphine Simultaneously.

Possibly. Patients who are psychiatrically stable can take SSRIs and buprenorphine simultaneously, monitoring for possible additive sedative effects, especially at first. However, you will need to further evaluate her suitability as a candidate and explore all options before making a final decision.

Poll: Studies show that almost 70% of patients will use the internet to gain further insight into conditions if told to by their provider. Will you suggest websites about buprenorphine to your patients?

- Yes, I will recommend that my patients look for patient websites on buprenorphine.
- Yes, I will recommend specific patient website(s) on buprenorphine to my patients.
- No, I plan to provide all the information the patient needs via my own website.
- No, I plan to use only paper to provide patient education on buprenorphine.
- Does not apply to me or none of the above

How about you? If you haven't taken the polls yet, follow the link below:

https://bup.clinicalencounters.com/assessing-patients-poll/
CASE STUDY – MS. TAYLOR

Name: Ms. Taylor
Age: 29 years old
Reason For Visit: She heard, "There is a drug to take if you are addicted to heroin."
Present History: She has been without treatment for three months, using heroin daily during this time.

Treatment History: A year ago, Ms. Taylor spent a month in jail after being arrested on drug possession charges. She was arrested when she was 6 months pregnant.

Ms. Taylor was started on methadone in jail and was maintained on a dose of 40 mg when she transferred to a residential facility affiliated with a local methadone clinic. She requested to come off of methadone because she "didn't want the baby to be born addicted." The taper was unsuccessful, and so she continued maintenance therapy, taking 40 mg throughout her pregnancy.

Quiz: Ms. Taylor – History

Medical: She requested a methadone dose reduction for her baby. She stated that methadone was harming her and made her feel sick, that she "did not really need it anyway." She claimed that she was constantly exhausted, although staff observed that she was quite active.

Psychosocial: She seemed well-adjusted and was compliant when she left the facility for other appointments, however, she did not tolerate the structure of residential treatment well. She had some interpersonal problems, was very dramatic, and was disruptive within the treatment facility:

- She often complained to the other patients and staff.
- She told others that the providers were putting her baby at risk.
- She interrupted groups with these issues and avoided participation in-house activities.

Follow-up: Ms. Taylor had a baby girl while in treatment and elected to have her tubes tied to avoid the potential of putting another baby through withdrawal. After her baby was born, Ms. Taylor left the program and dropped out of both methadone and residential treatment. Soon after that, she relapsed back to heroin injection. Ms. Taylor stopped breastfeeding, and her mother took over care of the baby. That was three months ago. Ms. Taylor now has come to your practice seeking treatment. She says she is highly motivated to get her baby back.

Given Her History, Should You Consider Ms. Taylor As A Potential Patient For Buprenorphine Treatment In Your Practice? (Choose One)

1. Yes, only if she agrees to psychosocial counseling.
2. Yes, only if she agrees to residential treatment.
3. No, she should be put back on methadone first since that somewhat worked in the past.
4. No, her history makes her a poor candidate for buprenorphine treatment.
Ms. Taylor – History Quiz Feedback

(1) Yes, Only If She Agrees To Psychosocial Counseling.
Correct. Office-based buprenorphine treatment may be effective because it may provide her with the comfort and support she needs to be successful and she seems motivated by her baby. Ms. Taylor may be appropriate for buprenorphine treatment, but only if she agrees to participate in psychosocial counseling. You should be aware that Ms. Taylor may be a problematic patient and plan accordingly. For instance, recall that Ms. Taylor was disruptive in a residential setting and did not like being on methadone while she was pregnant. She may be at a different 'readiness to change' phase at this point because she comes in seeking treatment and seems motivated by her baby.

Some patients who don't tolerate methadone well feel 'normal' when taking buprenorphine and are entirely compliant. However, doing poorly at a higher level of care (e.g., residential) is often a red flag for potential problems.

(2) Yes, Only If She Agrees To Residential Treatment.
Residential treatment is not the best option. Ms. Taylor is a potential candidate for buprenorphine treatment, but residential treatment may not be the best approach, because she did not tolerate the structure of residential treatment and disturbed her fellow residents at her previous treatment facility.

(3) No, She Should Be Put Back On Methadone First Since That Worked Somewhat In The Past.
Methadone is not the best option. Though methadone may have worked somewhat in the past, Ms. Taylor did not receive or react to methadone treatment well while in residential treatment, because she did not tolerate the structure of residential treatment and disturbed her fellow residents at her previous treatment facility.

(4) No, Her History Makes Her A Poor Candidate For Buprenorphine Treatment.
Buprenorphine should be considered. It is true that doing poorly at a higher level of care should be a red flag for potential problems. However, Ms. Taylor may be at a different point now regarding her willingness to change and to participate in structured treatment, because she did not tolerate the structure of residential treatment and disturbed her fellow residents at her previous treatment facility.
Ms. Taylor – Treatment Plan

The Importance Of A Structured Plan
A very structured treatment plan needs to be in place before Ms. Taylor begins buprenorphine treatment. Working together with Ms. Taylor on patient agreements and practice rules and guidelines is a must. If Ms. Taylor had not had a tubal ligation, it would also be essential to determine if Ms. Taylor plans to get pregnant again in the near future – buprenorphine is not the treatment of choice during pregnancy, as is discussed in the module on special populations.

Questions to ask Ms. Taylor include what she thinks she can handle right now regarding treatment, and if she would participate in groups, 12-step programs, or individual counseling. Because patients who have attended methadone clinics have experienced daily observed doses, she may be able to comply with structure up to a point.

Discussing Treatment With Ms. Taylor

**Provider:** Ms. Taylor, I think buprenorphine treatment would help you, but I am concerned because you had trouble with other treatment programs. Our program includes some components that you had trouble with before. I need you to go to counseling every week, see me every week, and attend at least one Narcotics Anonymous meeting each week. If you cannot stick to these parts of the program, then we cannot prescribe the buprenorphine treatment.

**Ms. Taylor:** Cool, I can do that. Hey, it's still easier than going to the methadone clinic every day.

**Provider:** Yes, one of the advantages of buprenorphine is that you can take it at home, instead of going to the clinic every day to get it from a nurse. It is still a big commitment, however. You still have to participate in urine drug tests and go to counseling and keep all of your appointments. Agreed?

**Ms. Taylor:** Yup, I can do that, doc. (signs the patient-provider treatment agreement).

Ms. Taylor – Follow Up

Following Up With Ms. Taylor

Six weeks ago, Ms. Taylor went through buprenorphine induction with no problems. The dose of generic buprenorphine/naloxone at which she was stable was 16 mg. Since then, she has attended her weekly counseling sessions and clinic visits. You have since done two urine tests, both of which were clean. She has also actively participated in Narcotics Anonymous (NA), carrying the Basic Text around with her, which is a guidebook for NA. She reports she is working on the fifth step and wants to be a better person for her daughter.
MR. SANTOS – FURTHER EVALUATION

Asking More Questions

You must ask some more questions of Mr. Santos before you can decide about office-based opioid treatment.

**Provider:** Do you use any other drugs or alcohol?

**Mr. Santos:** Alcohol isn't a problem now, but in the past, I drank heavily. And...well, I do smoke crack sometimes, but it's not my main problem. I can take it or leave it. If I control my heroin problem, I'll be fine. [He also denies use of sedatives or benzodiazepines.]

**Provider:** I'd like to talk about your history of addiction treatment, including your most recent detoxification experience.

**Mr. Santos:** I was in methadone maintenance treatment for five years, but I tapered off and was drug-free for three years before I relapsed. I was in an in-patient detox program two months ago. [He brought his records with him to show the use of monotherapy buprenorphine in treatment and a two-week taper from 32 mg down to 0 mg. He was discharged on citalopram (Celexa®) for depression.]

**Provider:** You said you had PTSD. Do those symptoms ever come back?

**Mr. Santos:** Well, I used to have a lot of nightmares about my parents' deaths. It was hard on me, but it got better with lots of therapy and with time and finding Linda.

**Provider:** How is your mood? Do you have depression or suicidal thoughts?

**Mr. Santos:** I did get down about having HIV, and that's when I started using. I'm not suicidal or anything. Plus, Linda and I have a lot to live for. The doctors say that my HIV can be controlled. If I can just stop using heroin, I'll be OK.

**Provider:** Yes, that is important. What kind of treatment have you had for your HIV? Do you know your t-cell count or viral load?

**Mr. Santos:** I've been on the HAART regimen for four months. I got checked out about six weeks ago, and I think the doctor said I was doing good. He said he couldn't detect the virus, but I can't remember what my t-cell count looked like. [His records show that his CD4 count was 375] I'm really glad my viral load isn't an issue, and I want to keep it that way. That's why I went to the detox program, and that's why I'm here today.

Considering Mr. Santos' Case

There are pros and cons associated with starting induction now. Considerations FOR Starting Induction Now

- He is familiar with the medication and has recently been as high as 32 mg buprenorphine. Linda could monitor his first dose at home if you chose a home induction.
- He is HIV positive and using heroin with needles, which puts him at risk for other diseases contracted from shared needles, making treatment urgent.
- He has home support and is agreeable to rekindle his group attendance.
- He has agreed to all your office structure conditions for buprenorphine treatment.

Considerations AGAINST Starting Induction Now

- You may want to talk to the previous group therapist to see what happened when he was discharged.
• You may want to observe his first dose yourself. You could give him a prescription for two, 8 mg generic combination buprenorphine/naloxone tablets for induction purposes to bring back to the office tomorrow or use at some future date.

It is important to weigh all of these options before starting Mr. Santos on buprenorphine.

**Poll: Based on the information provided, are you inclined to prescribe buprenorphine to Mr. Santos?**

- Yes
- No

How about you? If you haven't taken the polls yet, follow the link below:

https://bup.clinicalencounters.com/assessing-patients-poll/

**Mr. Santos – Treatment Plan**

**Deciding Mr. Santos If Is Appropriate For Office-based Opioid Treatment (OBOT)**

You are satisfied with Mr. Santos' responses and feel he is a good candidate for OBOT. You recommend that he participate in therapy to support his treatment and he agrees to this stipulation. He is pleased and ready to begin right away.

*In fact, Mr. Santos MAY be ready for induction right now. You examine him and find that he has dilated pupils, a slight tremor, elevated blood pressure, and a pulse of 96, with some piloerection. He has been sniffling throughout the interview. He has some swelling on his left arm at injection sites, but no cellulitis or abscess. He has new and old ‘tracks’ on both arms and both legs. His liver is not enlarged or tender. His on-site dipstick urine test is positive for morphine and cocaine.*