Optimizing care for chronic pain and opioid use disorder

Buprenorphine quick reference guide

Overview

Buprenorphine is a high-affinity partial mu-opioid receptor agonist with a ceiling effect on respiratory depression and superior safety compared to traditional full agonist opioids. It offers evidence-based efficacy for both chronic pain and OUD. With expanded prescribing access (no longer requiring the DATA X-waiver), buprenorphine is now a vital option in primary and specialty care settings.

Buprenorphine is a flexible, effective and safer opioid option for managing chronic pain and opioid use disorder (OUD). With proper patient selection and initiation strategies, it enables you to help improve function, reduce risk and support recovery. This quick reference guide gives an overview of the advantages of buprenorphine and how to implement it within patient care.

Questions? We're here to help.

For chat options and contact information, visit **UHCprovider.com/contactus**.

Clinical advantages

- Comparable or superior to morphine, oxycodone and hydrocodone
- Reduces risk of overdose, ceiling effect for respiratory depression
- Reduces opioid-induced hyperalgesia, anxiety and depression
- Partial mu-agonist, kappa/delta antagonist – supports pain relief and mood stabilization

Indications and use

Chronic pain with or without opioid use disorder (OUD): Buprenorphine is endorsed by DHHS, VA/DoD guidelines as a first-line alternative to Schedule II opioids.

OUD treatment: Proven to reduce all-cause mortality by 50% and is appropriate for both induction and maintenance therapy.

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Initiation strategies

1. Opioid-naive or low-dose patients
   Direct initiation with low-dose buprenorphine (e.g., 0.5 mg BID). Titrate gradually based on analgesic response and tolerability.
2. Opioid-tolerant patients
   Option A: Taper first, then initiate
   Gradual weaning off full agonist opioids. Initiate buprenorphine once daily opioid dose is low.

   Option B: Concurrent initiation
   Start buprenorphine 0.5–1 mg BID while continuing full agonist. Taper full agonist as buprenorphine is up-titrated. The following chart outlines a concurrent initiation process.
   Example: Transitioning from oxycodone ER 30 mg BID + IR 5 mg QID

Day	Buprenorphine dose	Oxycodone plan
Day 1	0.5 mg BID	Stop PRN oxycodone IR
Day 2	1 mg BID	Continue oxycodone ER BID
Day 3	2 mg BID	Continue ER
Day 4	3 mg BID	Reduce oxycodone ER to PM only
Day 5	4 mg BID	
Day 6	5 mg BID	Discontinue all oxycodone
Day 7	Adjust as needed	

Individualization of microdose initiation regimens is common based on prior dosing and patient tolerability

Acute pain and perioperative considerations

- Continue baseline buprenorphine (split dose q6-8h if needed)
- Supplement with full agonists (short-acting opioids) for breakthrough pain
- Prioritize multimodal analgesia (NSAIDs, acetaminophen, regional blocks)
- Coordinate care with outpatient MOUD/pain providers

Prescribing essentials

No X-waiver required (2023 policy change). DEA-registered providers can prescribe for pain or OUD.

Formulations include:

- Sublingual (Suboxone, Subutex, Zubsolv)
- Buccal film (Belbuca)
- Transdermal (Butrans)
- Injectable (Sublocade, Brixadi)

[1] RHMP may include additional data sources or update data sources as appropriate

Cautions and monitoring

- Dental injury risk (especially with SL/buccal forms)
- Liver enzyme monitoring recommended
- Avoid concurrent sedatives (e.g., benzodiazepines, alcohol)
- Use naloxone for overdose reversal (may require higher doses)

References

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