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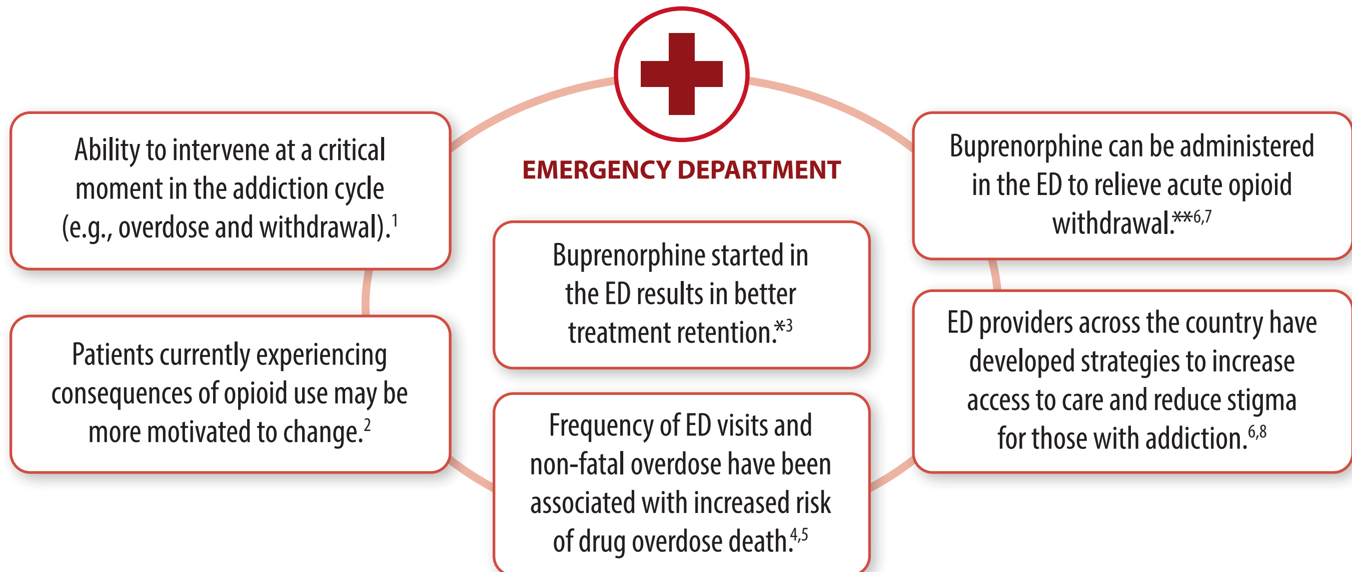
Emergency Department (ED): A Unique Opportunity to Save Lives Using Buprenorphine/Naloxone



*Compared to making a referral + a brief intervention. **See FAQ #2 for more information.

Stabilizing patients with ICD-10 opioid dependence or withdrawal[7]

ED presentation	Assess	Treat	Discharge & refer to treatment
• Seeking treatment for opioid dependence • Complication of opioid use (e.g., withdrawal, overdose, injection site abscess) • Clinical suspicion for opioid dependence identified during course of visit	**For moderate to severe opioid withdrawal** (Use clinical judgment or COWS* score ≥ 8) **OR** **Opioid dependence** (see back of handout for more information) If there are complicating factors such as acute liver failure, pregnancy ≥ 20 weeks, or intoxication with substances other than opioids, consider consultation with a specialist.	• Administer 4 to 8 mg buprenorphine¥ based on severity of withdrawal • Can re-dose every hour until withdrawal symptoms resolve (max total daily dose = 24 mg) • Buprenorphine can be administered in the ED to relieve acute withdrawal symptoms until outpatient care is available	• Provide opioid overdose education and prescribe naloxone • Provide patient with a written follow-up plan • Refer patient to outpatient provider for maintenance treatment • Prescribe buprenorphine upon discharge to last until patient has follow up with outpatient provider

*COWS = Clinical Opiate Withdrawal Scale (can be found in the electronic medical record); Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; > 36 = severe withdrawal. ¥Buprenorphine refers to buprenorphine/naloxone in this document.

Diagnosing ICD-10 opioid dependence

Buprenorphine/naloxone is FDA-approved for opioid dependence. ICD-10, the official VHA nomenclature, defines opioid dependence as the presence of **at least three of these features at any one time during the past year:**

1. A strong desire or sense of compulsion to take opioids (craving)
2. Difficulties in controlling opioid use (onset, termination, or levels of use)
3. A physiological withdrawal state
4. Tolerance
5. Progressive neglect of alternative interests because of opioid use
6. Persisting with opioid use despite evidence of harmful consequences

DID YOU KNOW

You don't have to ask the patient about all the opioid dependence criteria to make a diagnosis.

Use open-ended questions or your knowledge of the patient to determine if they meet the criteria for maintenance treatment.

Maintenance treatment needed

Diagnosis	Code	Guidance
Long-term current use of opiate analgesic	Z79.891	Patients may manifest opioid tolerance, withdrawal, and up to one symptom of "aberrant behavior" such as difficulty tapering
Opioid abuse	F11.1x	Opioid misuse, but not tolerance and withdrawal
Opioid dependence	F11.2x	Three or more features; correlates to moderate-severe opioid use disorder; treatment with buprenorphine should be offered

FAQs[9,10]

1. Will patients flock to the ED if we start offering buprenorphine?

No, EDs with buprenorphine protocols report that this has not happened. Patients with opioid dependence are already in your ED whether for overdose or for other reasons, such as asthma exacerbations or hyperglycemia. Buprenorphine treatment improves the likelihood that patients with opioid dependence will follow through with outpatient care, rather than repeatedly turning to the ED for "crisis" management.

2. Who can prescribe buprenorphine?

In January 2023, the Drug Enforcement Agency (DEA) removed the X-waiver requirement to prescribe buprenorphine. All providers with an active DEA registration can now prescribe buprenorphine to treat opioid use disorder. There are no limits on the number of patients a provider can prescribe buprenorphine. Existing state laws or regulations apply. For more information, see the DEA 2023 notification: **www.deadiversion.usdoj.gov/pubs/docs/A-23-0020-Dear-Registrant-Letter-Signed.pdf**

3. Does the patient need to be observed in the ED until all withdrawal symptoms subside?

No. Buprenorphine administration with adequate titration (cardiac monitoring not required) can alleviate withdrawal and reduce the risk of opioid use after ED discharge. Rapid referral is necessary for maintenance treatment. Work with your local SUD treatment program to develop a rapid referral process.

4. What is the worst thing that could happen after I administer buprenorphine?

If the patient has other opioids on board, buprenorphine can induce precipitated withdrawal. This risk can be minimized by assessing for last opioid use and conducting a COWS assessment. If precipitated withdrawal occurs, it can be mitigated with supportive medications for symptoms and/or higher doses of buprenorphine.

REFERENCES: 1. CSAM. *Use of Buprenorphine-Naloxone in the Emergency Department.* Jan 2018. **2.** SAMSHA. *TIP 63: Medications for Opioid Use Disorder.* www.samhsa.gov. **3.** D'Onofrio et al. *JAMA*. 2015;313(16):1636-1644. **4.** Brady et al. *Ann Epidemiol.* 2015 Aug;25(8):613-619.e2. **5.** Larochelle MR et.al. Touchpoints–Opportunities to predict and prevent opioid overdose: A cohort study. *Drug Alcohol Depend.* 2019;204:107537. **6.** NIDA. Initiating Buprenorphine Treatment in the Emergency Department. www.drugabuse.gov. **7.** Yale School of Medicine. ED-Initiated Buprenorphine. medicine.yale.edu/edbup/overview. **8.** SAMHSA. Use of Medication-Assisted Treatment in Emergency Departments. www.samhsa.gov. **9.** NIDA. Frequently Asked Questions about ED-Initiated Buprenorphine. www.drugabuse.gov. **10.** Herring et al. *Ann Emerg Med.* 2019; 73:481-487.

March 2023 V2 IB 10-1408 P96991