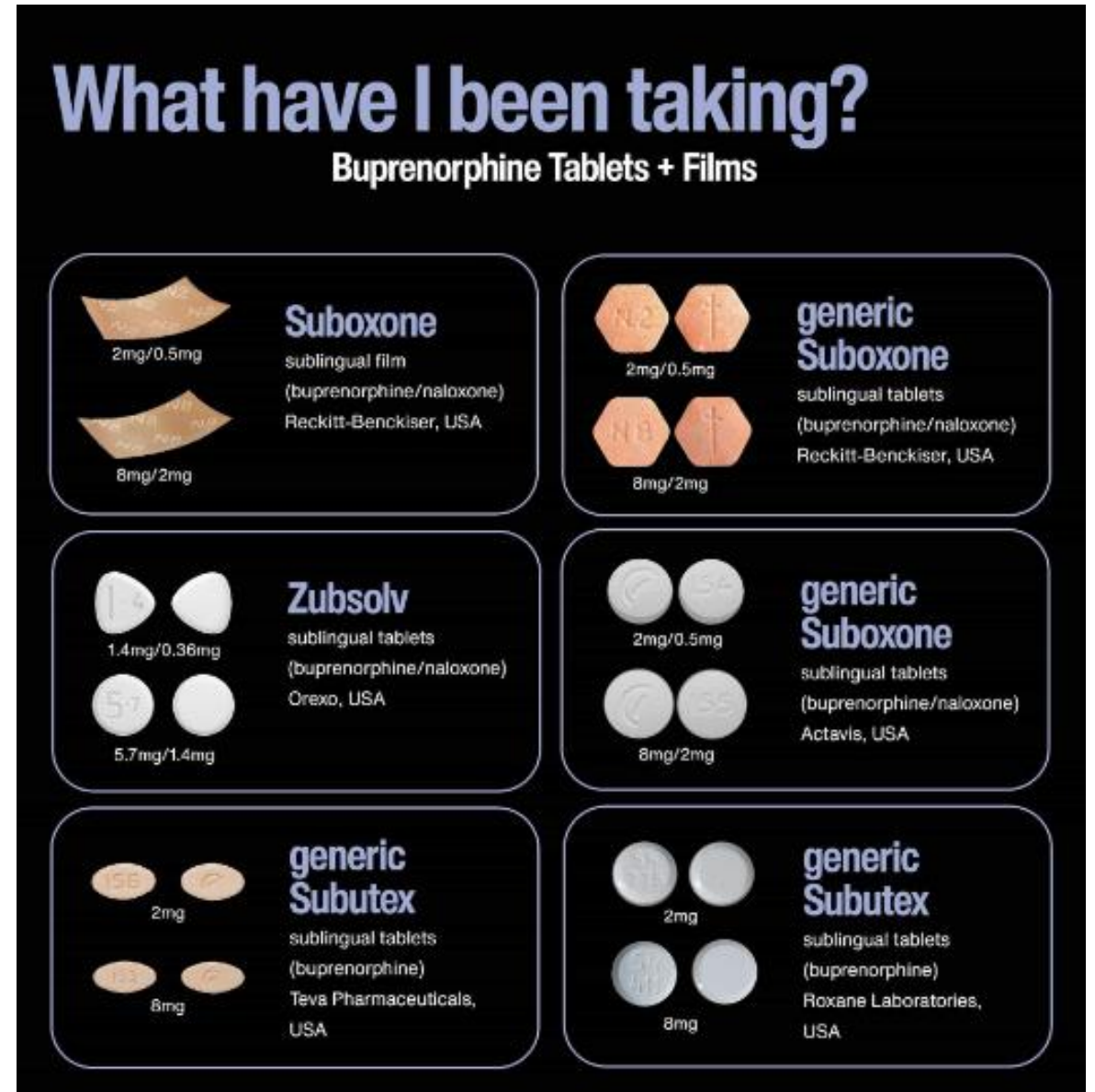


Rethinking pain relief: buprenorphine's role in PALTC

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Conflicts of interest

- I have no conflicts of interest to disclose

Learning objectives

- Understand the role for buprenorphine as an effective analgesic, aside from its use for opioid use disorder (OUD), and highlight opportunities for lower risk profile compared with full agonist opiates
- Explain why older adults may be particularly good candidates for buprenorphine for pain management
- Review different formulations of buprenorphine, and consider which might be most feasible in the PALTC setting.

Case #1

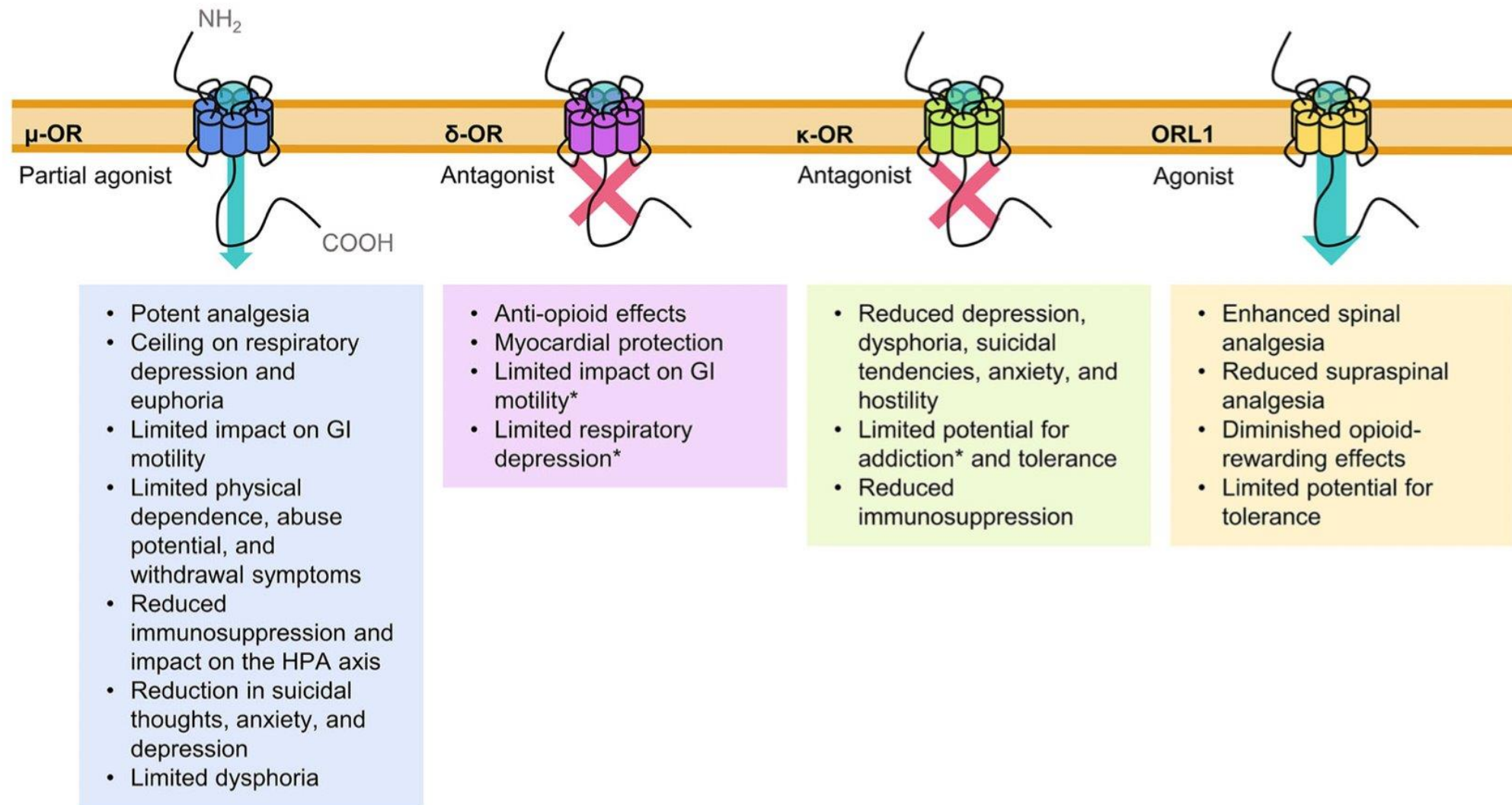
- A 75 year old woman is a resident of a local skilled nursing facility, where she has lived after a stroke 2 year previously. She is now dependent on a wheelchair for ambulation and requires assistance with transfers and ADLs.
- She frequently complains of bilateral knee pain which limits her ability to spend time in the chair.
- X-rays have noted joint space narrowing bilaterally, and she has failed two attempts at corticosteroid injections.
- Her family is requesting opiates for pain management for her suspected knee OA.

Buprenorphine for analgesia?

- Some clinicians still associate buprenorphine (bup) with OUD, but it has been FDA approved for chronic pain in transdermal and buccal forms
- Analgesia is roughly the same as full agonist opiates

How does it work?

- Both quantitatively and qualitatively different receptor effects vs other opioids
- **Partial agonism $\neq$ partial analgesia!** - No demonstrated ceiling effect
- Partial MOR agonist -> comparable analgesia, but $\downarrow \downarrow$ β -arrestin signalling
- β -arrestin -> bad opioid effects
 - Tolerance, physical dependence, respiratory depression, constipation
- KOR antagonist -> may $\downarrow$ anxiety, depression, SI, OUD potential
- DOR antagonist, full ORL1 agonist -> limited tolerance, $\downarrow$ reward (thought)



More about the PK/PD

- Partial agonism – less strong activation of the receptor
- Higher affinity – will chase out other opiates that currently occupy the receptor (can precipitate withdrawal)

Table 2. MOR receptor affinity of buprenorphine compared to select opioids, adapted [23]

Hydromorphone	1.7 times
Morphine	5.4 times
Fentanyl	6.2 times
Oxycodone	120 times

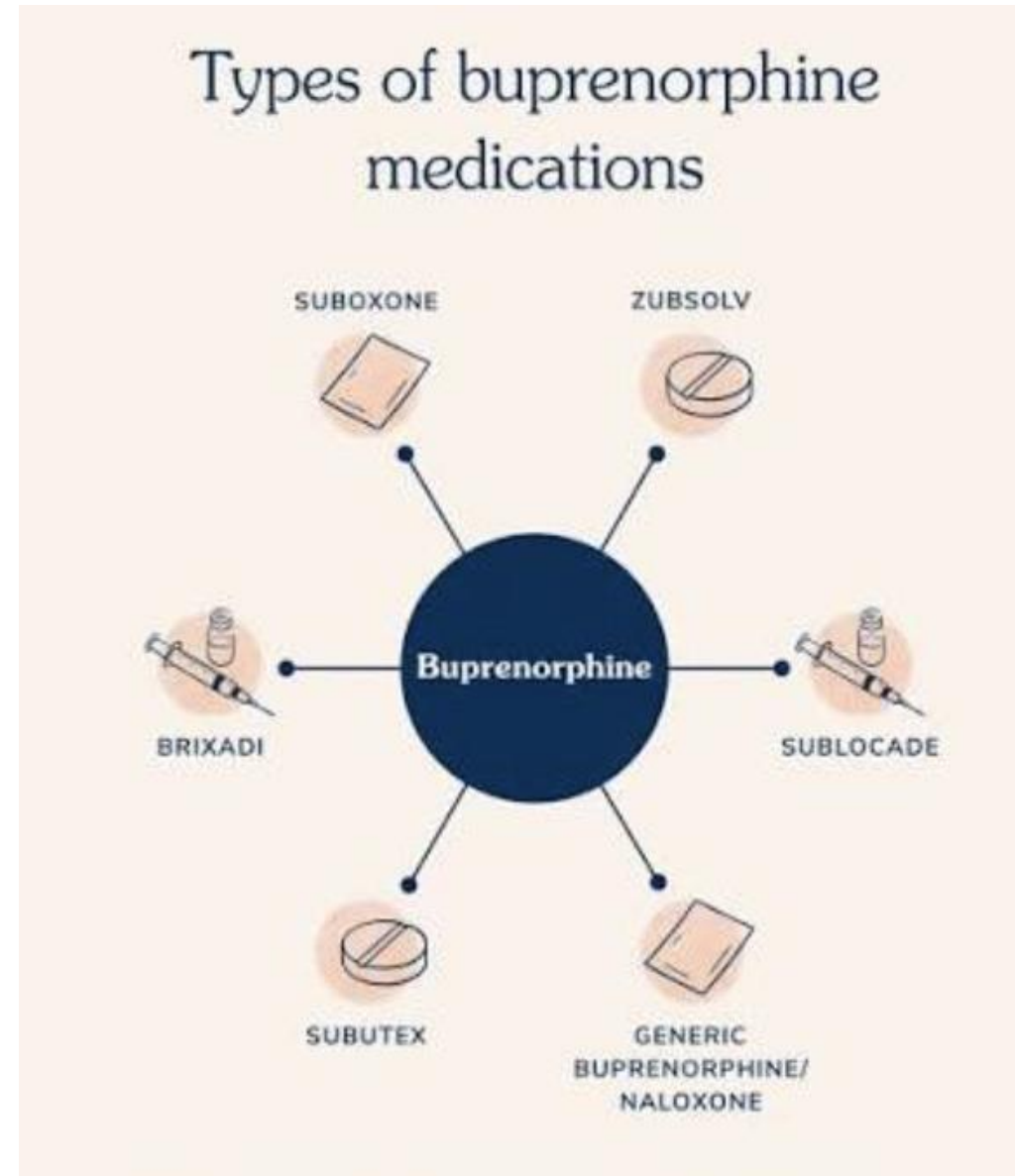
Pharmacologic takeaways

- Less respiratory depression = decreased overdose risk
 - Safer for residents with COPD, OSA, frailty, polypharmacy, concurrent benzodiazepine use
- High analgesic potential
- Less activation of dangerous side effects (constipation, neuropsychiatric effects of reward signalling)

Safer in older adults?

- Less likely to cause side effects in the setting of multimorbidity:
 - Safe in **renal dysfunction** (not renally metabolized)
 - Less drug-drug interactions
 - Less likely to cause **cognitive adverse effects**/falls
 - Less overdose potential (respiratory depression)

Formulations



How to initiate (opiate naïve)

- Easiest method – buprenorphine patch (Butrans)
 - 5, 7.5, 10, 15, 20 mcg/hr
 - Start at 5mcg/hr and increase weekly until effective analgesia
- Alternative option: increasing SL films
 - Belbuca – 75, 150, 300
 - Suboxone (buprenorphine-naloxone) 2-0.5mg, 8-2mg --> **would need to cut**
 - Start at lowest dose BID PRN, increase every 2-3 days until effective analgesia



What if they're already on opiates?

Original:

Day	Buprenorphine	Schedule II opioid
Day 1	0.5 mg SL daily*	Full dose
Day 2	0.5 mg SL BID*	Full dose
Day 3	1 mg SL BID	Full dose
Day 4	2 mg BID	Full dose
Day 5	4 mg BID	Full dose
Day 6	8 mg qam, 4 mg qpm	Full dose
Day 7	12 mg	Stop

*Note both examples require access to 2mg SL strips and ability to cut them, which can be hard in SNF

Rapid:

Day	Buprenorphine dose	Potent opioid
Day 1	SL 0.25 mg q 4 h*	Continue or stop
Day 2	SL 0.5 mg q4h*	Continue or stop
Day 3	SL 1 mg q4h	Continue or stop
Day 4	SL 2 mg q4h	Stop
Day 5	SL 16 mg/d (can be in divided doses)	Stop

Equianalgesic conversion (multiple options)

Equianalgesic Conversion Table

Buprenorphine	Oral Morphine Equivalent/24hrs (OME)							
	12	24	48	60	80	100	150	300
Transdermal (TD) patch	5mcg/hr q7days	10mcg/hr q7days	20mcg/hr q7days					
Buccal patch	75mcg daily	75mcg q12hrs	150mcg q12hrs		300mcg q12hrs		450mcg q12hrs	
Sublingual (SL) tabs					1mg BID (split 2mg tabs)		1mg TID	2mg TID

Equianalgesic conversion (multiple options)

TABLE 1 – Approximate dose conversion strategies from existing Long-Term Opioid Therapy		
<50 MEDD RECOMMEND: FDA approved formulations for pain (e.g. mcg dose transdermal or buccal products)	50 – 90 MEDD RECOMMEND: All buprenorphine formulations (mcg or mg) available based on patient response	>90 MEDD RECOMMEND: Buprenorphine milligram formulations should be considered
<30 MEDD – Treat as opioid naïve • Patch is preferred • 5mcg recommended starting dose 30-50 MEDD – • Consider 10mcg/hr patch as initial dose • Onset may be delayed 24 hours • Overlapping dosing of full agonist opioid for first 24 hours is reasonable FDA conversions to buprenorphine are highly conservative – • Manufacturer listed conversions already account for cross-tolerance • Be responsive during titration phase	Patients who are stable on existing LTOT • Appropriate for mcg formulations as initial dose • Buccal film preferred • Overlapping strategies may be helpful Patients with poor function and symptom control despite existing LTOT (or with concern for behavioral risks but without OUD) • Appropriate for consideration of mg formulations with a focus on early stabilization of withdrawal symptoms • Gradual titration to support functional goals after initial stabilization • May stabilize on lower doses than required for OUD.	Early Emphasis on mitigating withdrawal and discomfort during the transition from full-agonist LTOT Veterans with pain may stabilize on lower doses than DSM-V OUD Veteran preference should guide method of transition • STOP- START • Low Dose Buprenorphine initiation (LDBI) †

Low risk is not NO risk

- Lower risk of falls, constipation, respiratory depression, and misuse does not mean this is impossible.
- Still worth remembering for older adults:
 - Risk of falls, sedation, constipation, and drug-drug interactions can be there (even if less than full agonist)
 - Would not recommend starting if patient is otherwise NOT a candidate for full agonist!

Pain management success should be measured by function

- Goal in post-acute care: getting the patient walking, talking, and participating in rehab -> more than reducing the pain score.
- Things to be attentive toward (with help from staff input):
 - Mobility
 - Rehab participation
 - Sleep
 - ADLs
 - Quality of life (patient or family reported) - ie: spending more time in the wheelchair in the activity room now that knee pain is improved

What about cost?

- Butrans patch (generic buprenorphine TD): ~ \$60–180/month cash; typically covered by Medicare Part D, many Medicaid plans, and commercial insurers, often with prior authorization.
- Belbuca buccal film: ~ \$450–600/month; highest cost formulation, coverage variable and prior authorization common.
- Buprenorphine/naloxone SL films: ~ \$50–150/month generic; generally widest formulary coverage.
- Older adult payment pearls:
 - Generic transdermal patch often offers the best balance of adherence + coverage.
 - Medicaid: usually lowest out-of-pocket cost (but small formulary in GA)
 - Medicare Part D: frequently covered, but copays and PA requirements vary by plan.
 - Commercial insurance: commonly covered; manufacturer assistance may be available.

Case #1, continued

- You decide to initiate butrans patch 5 mcg/hr, which you uptitrate weekly based on patient's family's report of perceived pain + staff reports of crying out less with transfers and able to tolerate peri care.
- At 15mcg/hr, patient exhibits no distress in ADLs and is not sleepy midday, family is satisfied with improved pain control.



Thank you!

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