Order Set For Opioid Withdrawal

MONITORING

☐ Temp, HR, RR, BP, O2 saturation, and COWS on initial assessment

Repeat q1h when COWS ≥ 8

Repeat q2h when COWS < 8

☐ Notify the most responsible provider (MRP) for any of the following (transfer to ED if MRP not available):

- COWS ≥ 13
- Severe or worsening tremor
- Increasing agitation
- Profuse sweating
- Repeated vomiting or diarrhea
- Hallucinations or delirium
- Systolic BP > 180
- Diastolic BP > 110
- HR > 120
- RR < 10
- SpO2 < 92%
- T > 37.7°C

LABORATORY TESTS

☐ Urine toxicology (point of care drug screen if available)

☐ Urine HCG

☐ Serum HCG

☐ Serum CBC, creatinine, glucose, TSH, AST, ALT, ALP, GGT, bilirubin, albumin, INR

As required based on history:

☐ HIV serology

☐ Syphilis serology

☐ Gonorrhea & chlamydia urine

☐ Anti-HAV, HBsAg, HBsAb, HBcAb, Anti-HCV

☐ HCV RNA viral load if history of infection

☐ ECG

Note: Do not delay treatment while waiting for investigation results.

MEDICATIONS

Note: All doses should be observed by a staff member or local pharmacist.

BUPRENORPHINE/NALOXONE

1. **Standard induction:** For COWS ≥ 13 AND appropriate timing from last opioid use:
    - At least 12h since last short acting opioid (heroin, IR oxycodone, hydromorphone, morphine)
    - At least 18h since last controlled-release opioid (e.g. CR oxycodone, hydromorphone, morphine)
    - At least 48h since last street fentanyl use
    - At least 72h since last methadone use

Day 1:

☐ Buprenorphine 4mg (2 x buprenorphine/naloxone 2mg/0.5mg tablets) SL q1h, maximum 16mg as long as client is not drowsy and COWS > 8 **OR**

☐ Buprenorphine 2mg (1 x buprenorphine/naloxone 2mg/0.5mg tablet) SL q1h if elderly (maximum 8mg), on benzodiazepines, or unsure of time of last opioid (maximum 16mg)

☐ Notify prescriber if COWS score **increases** by 2+ after first dose

Day 2:

☐ Provide Day 1 total daily dose plus 2–4mg (1–2x buprenorphine/naloxone 2mg/0.5mg tablets) SL for withdrawal relief not lasting 24h

Day 3:

☐ Provide Day 2 total daily dose plus 2–4mg (1–2x buprenorphine/naloxone 2mg/0.5mg tablets) SL for withdrawal relief not lasting 24h

Note: Clients in naloxone-induced withdrawal after reversal of overdose still need to meet criteria for time from last opioid use to avoid precipitated withdrawal. For clients not meeting the criteria for a standard induction, offer a home start or microdosing protocol.

2. **Microdosing induction:** For clients that are not in the timeframe from last opioid use for standard induction and MRP is available to provide medical support

☐ Buprenorphine 0.5mg (quarter of buprenorphine/naloxone 2mg/0.5mg tablet) SL once daily x 1 day
THEN buprenorphine 0.5mg (quarter of buprenorphine/naloxone 2mg/0.5mg tablet) SL BID x 1 day
THEN buprenorphine 1mg (half of buprenorphine/naloxone 2mg/0.5mg tablet) SL BID x 1 day

Note: Switch to standard induction once enough time has passed since last opioid use. Support patients with symptomatic care as needed during microdosing.

3. **Home start (client-led induction):** For clients that are not in the timeframe from last opioid use for standard induction and MRP is not available, COWS < 12, or client declines microdosing
(refer to **http://www.metaphi.ca/wp-content/uploads/ED_OUD_RxHome.pdf** and **http://www.metaphi.ca/wp-content/uploads/ED_OUD_HomeStartInfo.pdf** for protocol and client instructions)

Note: Switch to standard induction once MRP is available.

METHADONE

☐ Methadone 30mg PO once daily x 3 days
THEN methadone 40–45mg PO once daily x 3 days

☐ Methadone 20mg PO once daily x 3 days if at high risk of toxicity
THEN methadone 30–35mg PO once daily x 3 days

☐ Methadone 10mg PO once daily x 5 days if unknown tolerance or recent abstinence from opioids
THEN methadone 15mg PO once daily x 5 days

Note: Symptomatic management of ongoing withdrawal should be offered during methadone titration. This can include the addition of SROM for clients with known high opioid tolerance and/or daily fentanyl use.

SLOW-RELEASE ORAL MORPHINE (SROM)

☐ SROM 60–120mg PO once daily x 2 days (open capsules and sprinkle beads onto yogurt or applesauce for witnessed ingestion
THEN titrate dose by 30–60mg every 48h as needed, with consideration of opioid tolerance

Note: Average daily dose of 200–800mg PO once daily, maximum recommended dose 1200mg PO once daily

MEDICAL COMPLICATIONS

☐ Contact MRP (or transfer to ED if MRP is not available) for any of the following:

- Tachycardia (HR > 120bpm)
- Hypertension (elevation of systolic or diastolic BP 20–30mmHG above baseline)
- Repeated vomiting or profuse sweating
- Seizures, confusion, hallucinations, delusions, or agitation

SYMPTOMATIC MANAGEMENT

☐ Acetaminophen 1000mg PO q6h PRN for pain, maximum 4g in 24h

☐ Ibuprofen 400mg PO q6h PRN for pain, maximum 3.2g in 24h

☐ Dimenhydrinate 25–50mg PO/IM q4h PRN, maximum 200mg in 24h

☐ Ondansetron 4–8mg PO/IM q4–6h PRN for nausea, maximum 32mg in 24h

☐ Clonidine 0.1–0.3mg q6–8h PO PRN for sweats/goosebumps/restlessness, maximum 1.2mg in 24h

☐ Loperamide 4mg PO, followed by 2mg after each loose stool, maximum 16mg in 24h

DISCHARGE ORDERS

- ☐ Confirm follow-up plans, including outpatient referral
- ☐ Ensure client has a prescription with daily observed dosing lasting at least until their confirmed follow-up
- ☐ Provide naloxone kit (document on naloxone dispensing record)
- ☐ Fax client summary to the appropriate clinic(s) and community providers

Name _____ **Signature** _____

Prescriber _____

Date _____ **Time** _____