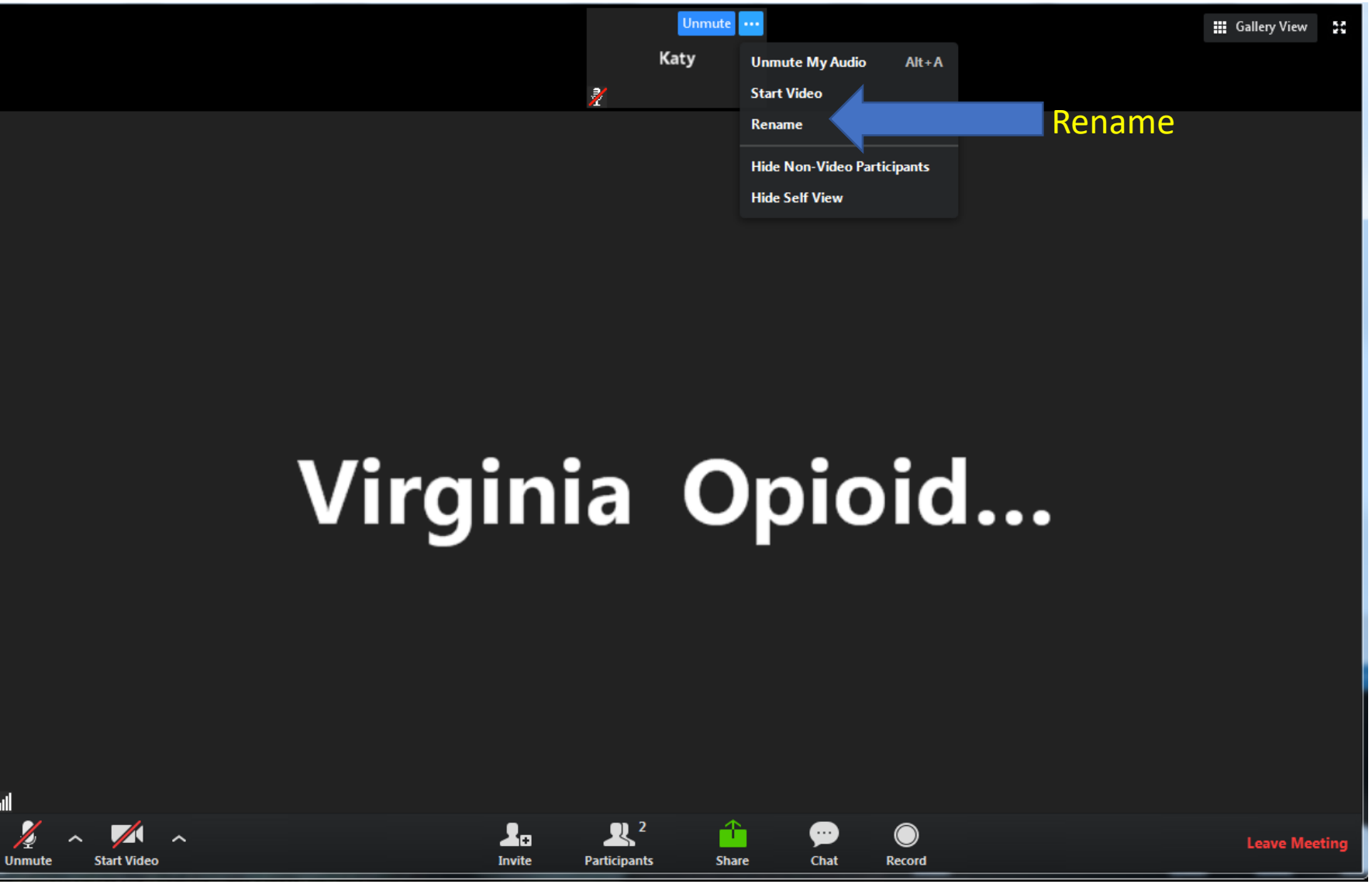
Virginia Opioid Addiction ECHO* Clinic

October 4, 2019

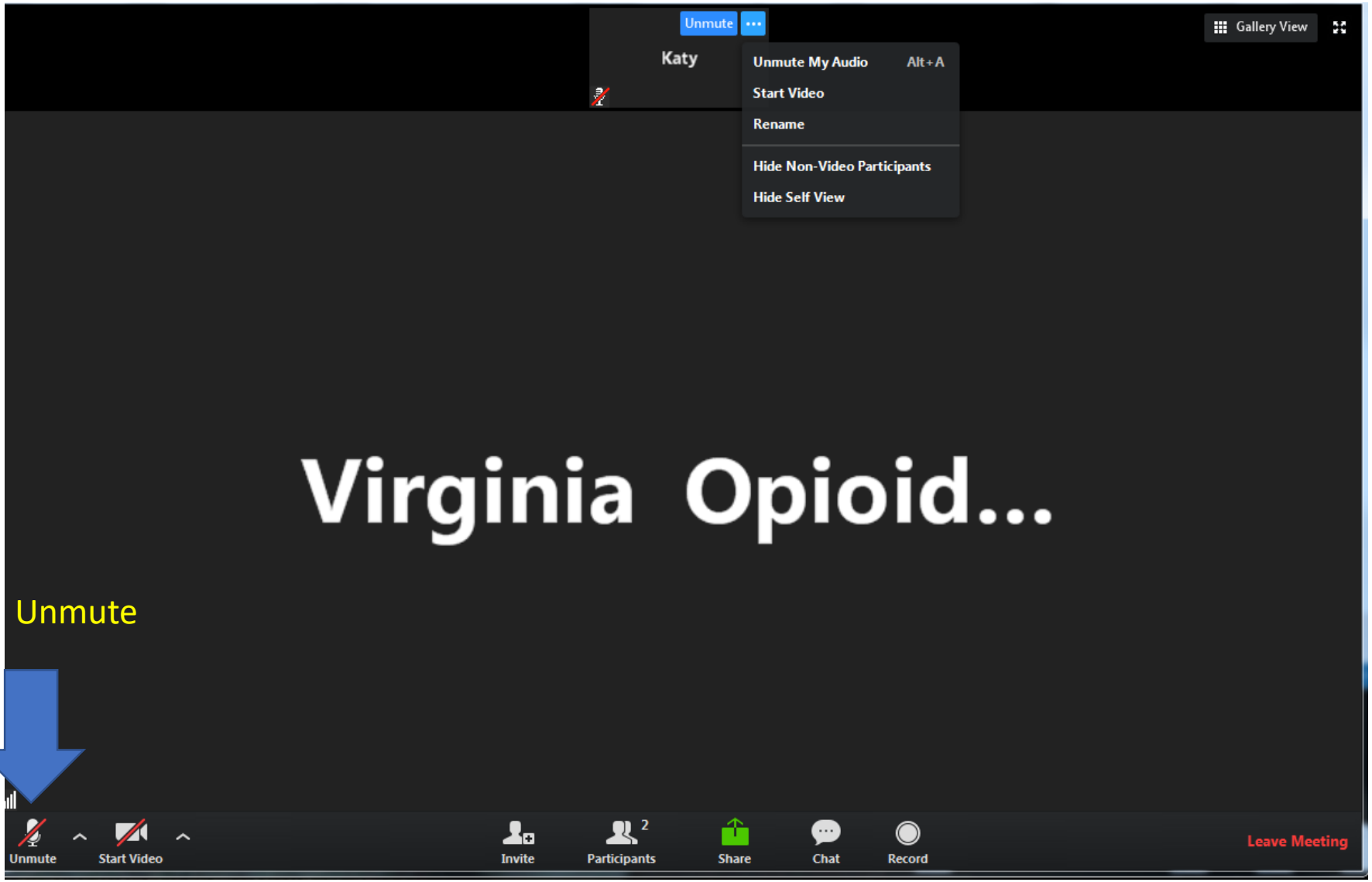
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



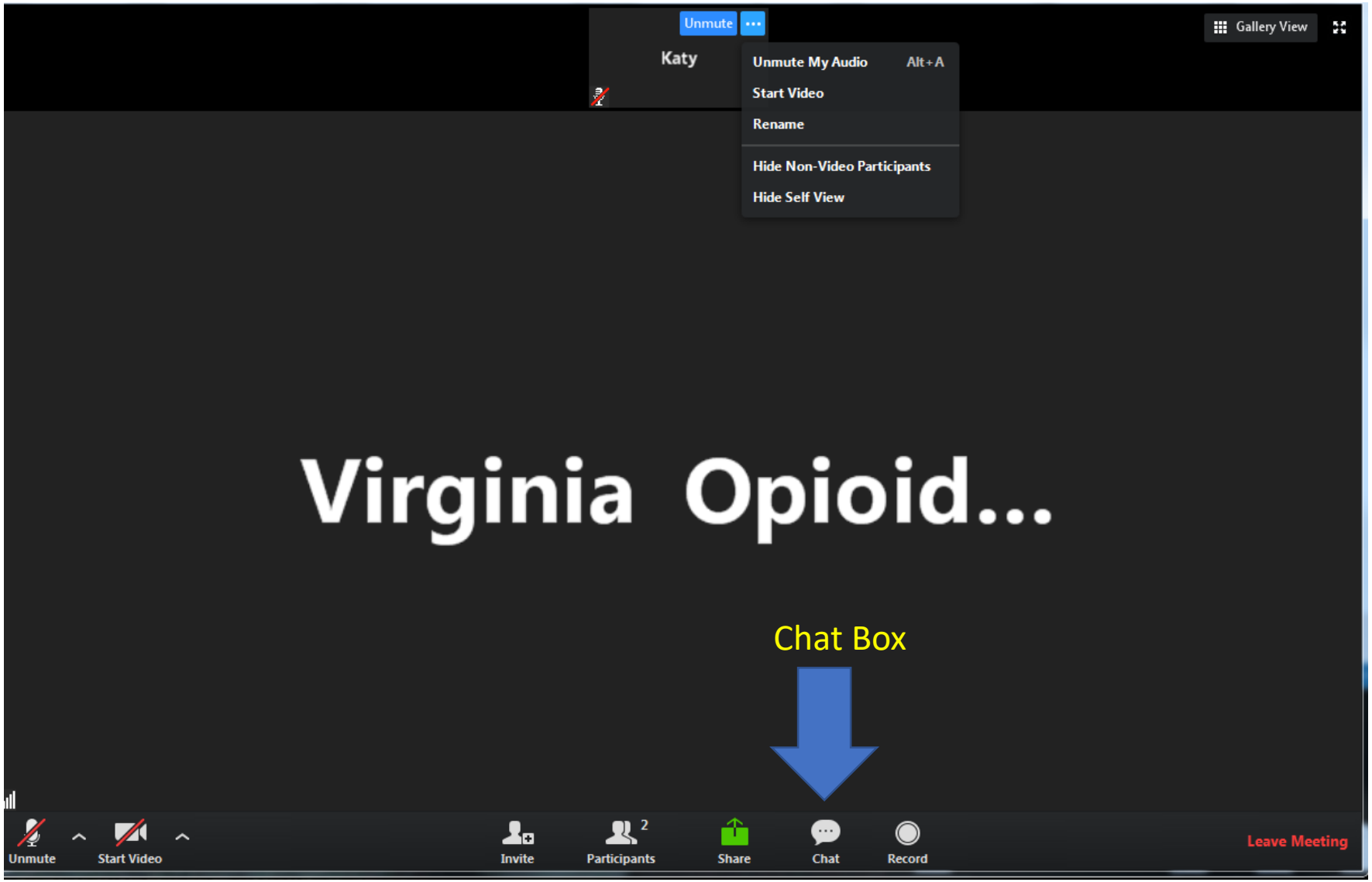
- Rename your Zoom screen, with your name and organization

Helpful Reminders



- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by inter-professional experts
- Website Link: www.vcuhealth.org/echo

Hub Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub and Principal Investigator	Vimal Mishra, MD, MMCi
Clinical Expert	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Kanwar Sidhu, MD
Didactic Presentation	Albert Arias, MD Sunny Kim, PMHNP- BC
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

Introductions:

- Name
- Organization

Reminder: Mute and Unmute to talk

*6 for phone audio

Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Injectable Buprenorphine/ Naloxone XR- Experiences in the Field**
   II. **Albert Arias, MD**
   Sunny Kim, PMHNP-BC

II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

INJECTABLE BUPRENORPHINE/ NALOXONE XR - EXPERIENCES IN THE FIELD

ALBERT ARIAS MD
SUNG CHEOL "SUNNY" KIM PMHNP-BC
VCU HEALTH
MOTIVATE CLINIC

DISCLOSURE

- Albert Arias MD
  - None
- Sung Cheol "Sunny" Kim PMHNP-BC
  - None
- All data and studies used in this presentation are from Indivior funded research

LEARNING OBJECTIVES

- Participants will be able to identify FDA guideline for Sublocade
- Participants will be able to identify the mechanism of Sublocade
- Participants will be able to identify efficacy and safety of Sublocade
- Participants will be able to identify common side effects of Sublocade
- Participants will be able to discuss patient cases for Sublocade

WHAT IS SUBLOCADE?

Formulation	**Subcutaneous monthly long acting injection of buprenorphine using ATRIGEL®**
Strength	**300 mg & 100 mg** **300mg x first 2 months** **100 mg maintenance (300mg off label maintenance acceptable)**
Frequency	**Every 28 days (most PBMs allow as early as 26 days)**
FDA approval	**Moderate to severe opioid use disorder** **Minimum of 7 days of SL buprenorphine before administration** **Dose between 8 mg – 24 mg of sublingual buprenorphine** **Abdominal subcutaneous injection** **Continue w/ behavioral health support** **Supplemental sublingual buprenorphine not approved by FDA**
REMS	**Risk Evaluation and Mitigation Strategy (REMS) Program** **All healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified**
Cost	**$1580 (both 300 &100)**

DOSE IT WORK?

- Successful case studies
  - E. R.
  - A.A.

CASE OF E. R.

Background

- 36 yo AA male with OUD severe with multiple complicate orthopedic surgeries in the past

OUD history and course of MAT

- First opioid after knee injury at 20 yo. No miss use occasional opioid prescription use
- Spinal fusion age of 30. +Tolerance/Withdrawal. Started running out early, using diverted opioids
- Only used prescription opioid. Chewing/PO only never used IV/IN
- Initiation of MAT Oct 2018. stable on 8 mg SL BUP

What prompted transition to Sublocade

- Dec 2018 started working. With increased physical demand pt started running out of BUP early
- Trigger for use is pain. Pt also felt ashamed taking BUP at work

Course of sublocade

- Transition to Sublocade Jan 2019
- Constipation after 2nd 300 mg. Resolved with increase fiber intake and transition to 100 mg
- 10th Sublocade injection in Oct 2019. Sustained remission. Pt fully satisfied with the pain/OUD control

CASE OF A. A.

Background

- 26 yo Caucasian female with opioid use disorder severe, history of benzo abuse, MDD, GAD and cluster B PD traits

OUD history and course of MAT

- First opioid use 14 yo. Occasional IN use only. Worsen after abortion on age 16. started IN use, transitioned to IV heroin use within 2 yrs. Daily use, multiple rehab/inpt tx in the past
- Initiated MAT Feb 2018 stable on 16 mg of SL BUP
- Multiple relapses in the early stages but stabilized on OUD. Started abusing benzodiazepines instead of opioids in Mar 2018
- Initiation out pt benzo taper May 2018, completed Dec 2018

What prompted transition to Sublocade

- Pt "hate" taste of BUP and she complained of somnolence right after BUP intake

Course of sublocade

- Transition to Sublocade Jun 2019
- Currently on 100 mg, 4th injection Sept. In sustained remission
- No SE. Pt Fully satisfied

PHYSIOLOGICAL TARGET
(SUBLOCADE LABEL ON FILE)

- Average buprenorphine plasma concentrations of 2-3 ng/mL were associated with mu-opioid receptor occupancy ≥70% and the reduction of illicit opioid use
- Observed plateau for maximal response was reached at buprenorphine plasma concentrations of approximately 2-3 ng/mL for illicit opioid use and 4 ng/mL for opioid withdrawal symptoms

Pharmacokinetic parameters[1]	SL buprenorphine daily stabilization[1]		SUBLOCADE[1]		
Mean	12 mg (steady-state)	24 mg (steady-state)	300 mg (1st injection)	100 mg (steady-state)	300 mg (steady-state)
$C_{avg,ss}$ (ng/mL)	1.71	2.91	2.19	3.21	6.54
$C_{max,ss}$ (ng/mL)	5.35	8.27	5.37	4.88	10.12
$C_{min,ss}$ (ng/mL)	0.81	1.54	1.25	2.48	5.01

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PBR-6000 HYDROMORPHONE CHALLENGE STUDY: SAFE GUARD FOR OD (NASSER ET AL., 2016)

- Subjects were first stabilized on sublingual buprenorphine (8–24 mg daily), then received two subcutaneous injections of RBP-6000 (300 mg) on Day 1 and Day 29
- SUBLOCADE 300 mg blocked 6 mg and 18 mg doses of hydromorphone
- Blockage effect persisted for 6 weeks
- Stabilization doses of sublingual buprenorphine (8-24 mg daily) failed to provide full blockade of 18 mg hydromorphone

- A grain of salt
  - "Non-opioid rescue medications (eg, clonidine, hydroxyzine, loperamide, ibuprofen, methocarbamol, and acetaminophen) were permitted to help alleviate signs and symptoms of opioid withdrawal and for prophylaxis of opioid withdrawal throughout the trial as determined by the investigator." (Nasser et al., 2016)

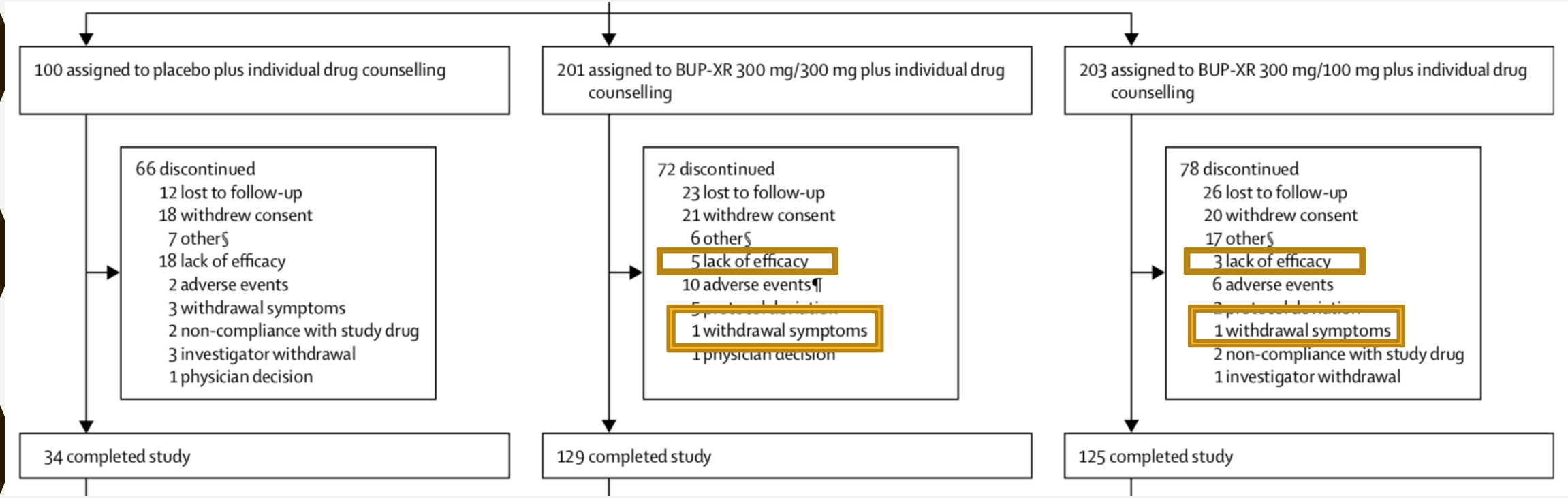
EFFICACY AND SAFETY, PHASE 3 TRIAL

- Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: a multicenter, randomized, double-blind, placebo-controlled, phase 3 trial (Haight et al., 2019)

	BUP-XR 300 mg/300 mg plus individual drug counselling (n=196)	BUP-XR 300 mg/100 mg plus individual drug counselling (n=194)	Placebo plus individual drug counselling (n=99)
Primary outcome*			
Mean participants' percentage abstinence	41·3% (39·66%)	42·7% (38·50%)	5·0% (16·98%)
p value *vs* placebo plus individual drug counselling	p<0·0001	p<0·0001	NA
Key secondary outcome			
Number of participants who were ≥80% abstinent	57 (29%)	55 (28%)	2 (2%)

EFFICACY AND SAFETY, PHASE 3 TRIAL

- A grain of salt
  - "Participants could receive loperamide and **non-opioid medications to alleviate opioid withdrawal symptoms** as judged by the investigator or medically qualified sub-investigator, and were **discontinued from the study if they required supplemental buprenorphine for any reason**" (Haight et al., 2019)



	BUP-XR 300/300 mg plus individual drug counselling (n=201) (n=201)	BUP-XR 300/100 mg plus individual drug counselling (n=203) (n=203)	Placebo plus individual drug counselling (n=100)
Any treatment-emergent adverse event	134 (67%)	155 (76%)	56 (56%)
Any serious treatment-emergent adverse event	7 (3%)	4 (2%)	5 (5%)
Any severe treatment-emergent adverse event	13 (6%)	15 (7%)	4 (4%)
Any treatment-emergent adverse event leading to discontinuation	10 (5%)	7 (3%)	2 (2%)
Any treatment-emergent adverse event leading to death	1 (<1%)	0	0
Treatment-emergent adverse events, by preferred term*			
Headache	17 (8%)	19 (9%)	6 (6%)
Constipation	16 (8%)	19 (9%)	0
Nausea	16 (8%)	18 (9%)	5 (5%)
Injection-site pruritus	19 (9%)	13 (6%)	4 (4%)
Vomiting	11 (5%)	19 (9%)	4 (4%)
Insomnia	17 (8%)	13 (6%)	11 (11%)
Upper respiratory tract infection	12 (6%)	15 (7%)	1 (1%)
Injection-site pain	12 (6%)	10 (5%)	3 (3%)
Nasopharyngitis	10 (5%)	11 (5%)	1 (1%)
Fatigue	12 (6%)	8 (4%)	3 (3%)
Anxiety	8 (4%)	10 (5%)	5 (5%)
Drug withdrawal syndrome	7 (3%)	9 (4%)	6 (6%)
Blood creatine phosphokinase increase	5 (2%)	11 (5%)	1 (1%)
Diarrhoea	5 (2%)	5 (2%)	5 (5%)

EFFICACY AND SAFETY, PHASE 3 TRIAL

Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial (Haight et al., 2019)

CASE STUDIES

CASE OF M. A.

Background

- 48 yo AA female with opioid use disorder severe

OUD history and course of MAT

- First opioid use 23 yo. Mostly IN use rarely used IV. Multiple legal complications due to drug use. Was in recovery for 2 yrs due to court requirements. Relapsed right after completion of drug court
- MAT initiated Jan 2018
- Appeared stabilized on 24 mg SL BUP but use of BUP metabolite quantitative study revealed pt is tempering with her urine samples

What prompted transition to Sublocade

- After pt learned that she cannot get away with tempering urine samples pt continuously +COC/OPI. Minimally engaged with behavioral health requirements
- Despite multiple warning pt's quantitative BUP study does not show improvement

Lab Results	06/17/2019 16:17	06/17/2019 16:00	05/22/2019 16:45
UDS Interpretation			
☐ Buprenorphine, Urine	>2000 ng/mL		>2000 ng/mL
☑ Norbuprenorphine, Urine	8 ng/mL		7 ng/mL

CASE OF M. A.

- Course of Sublocade
  - Informed pt that we will transition her to sublocade 6/20/2019
  - Pt appeared intentionally stalling the transition by showing up late to appt, not taking BUP, come after use of opioids
  - Pt admitted to front desk staff that she's been diverting most of her BUP, she plans to stall the transition as long as she can and if she transition she plans to claim sublocade does not work so she can transition back to SL BUP
  - 8/5/2019 Pt claimed that her SL BUP were stolen. UDS positive for COC/OPI. No SL BUP prescription given. Asked pt to return 8/6/2019
  - 8/6/2019 pt returned. Pt complains of severe wd due to no BUP for 24 hrs. SL BUP 8 mg given at the clinic to ensure that pt won't go into wd. Sublocade 300 mg given
  - 8/9/2019 pt walked in complaining of withdrawal symptoms. Symptomatic management meds given. Asked pt to return in 1 wk and informed pt if no improvement on her symptoms we will refer her out to BUP dispensary program
  - 8/16/2019 pt no show'd
  - 9/2/2019 pt returned for 2nd sublocade. No more wd s/s UDS OPI/COC. Wishes to continue with sublocade

CASE OF L. L.

- Background
  - 55 yo Caucasian male patient with opioid use disorder severe, long history of alcohol use disorder, cannabis use disorder, MDD, schizotypal PD
- OUD history and course of MAT
  - Started using cannabis and alcohol daily when he was 25-35. Pt was drinking "anything" with alcohol in it. Claims that he had total of 40-60 inpt detox in the past
  - Age 35-45 started opioids. Started with cough syrups with opioids. Transitioned OXY and fentanyl patches
  - Maintained sobriety 1991-1996 after a detox then relapsed to opioids again
  - Maintained sobriety 2001-2012 after a detox then relapsed again to opioids due to back pain
  - Been active with AA/NA since the 80s. Relapsed on alcohol as well 2015
  - Started using Kratom in an attempt to control his opioid withdrawal in 2016

CASE OF L. L.

Course of MAT

- Initiation of BUP 05/2017. good response stable on 16 mg for nearly 3 months
- Pt started overusing 09/2017. showing manipulative behaviors, splitting between providers
- Pt abused indigent care program offered by VCC to accumulate more BUP (obtained nearly 7 wks of BUP within 5 wks period).
- Set a clear boundary with pt then pt stopped seeing this provider 12/2017
- Pattern of overuse continued

What prompted transition to Sublocade

- Pt continued his SL BUP use beyond >24 mg

CASE OF L. L.

- Course of sublocade
  - **2/11 first sublocade 300 mg**. Pt walked out with #7 8/2 SL films instruction to use only if needed
  - 2/18 pt reports he used all #7 films
  - 2/25 pt reports use of 8-16 mg SL BUP daily
  - 3/4 pt now using 16 mg SL BUP daily
  - **3/11 second sublocade 300 mg given**
  - 3/18 not been using any SL BUP
  - 3/25 complains of craving but not been using any SL BUP
  - 4/1 complains of worsening cravings but did not provided any SL BUP
  - 4/5 SL BUP prescribed (8 mg daily) for 3 days over the phone
  - **4/8 third sublocade 300 mg given**
  - After 3rd injection, pt started to claim that sublocade "leaked out" and that is why he needs more SL BUP

CASE OF L. L.

Average # of supplemental films (8/2)
• 2/11-3/11 (28 days): avg 3 films daily • **3/11-4/8 (28 days): avg 0.35 films daily** • 4/8-5/6 (28 days): avg 1.25 films daily • 5/6-5/31 (25 days): avg 1.68 films daily • 5/31-6/26 (26 days): avg 1.35 films daily • 6/26-7/22 (26 days): avg 1.12 films daily • 7/22-8/16 (25 days): avg 1.04 films daily

Date of sublocade administration (all 300)
• 2/11 • 3/11 • 4/8 • 5/6 • 5/31 • 6/26 • 7/22 • 8/16 • Total #8 300 mg injections

CASE OF L. L.

- Course of sublocade con't

- Initial plan was to slowly taper off SL BUP but pt not been compliant with the instructions
- 8/16 Insurance denied to renew his PA. Gave last (8^{th}) 300 mg injection along with SL BUP 8 mg daily for 28 days
- 9/5 pt returned 8 days early (20^{th} day from last Sublocade). Pt wishes to be back on 24 mg of SL BUP
- Per blockage study Sublocade can block hydromorphone up to 6 wks and the last depot is active up until 9/27 but pt put on 24 mg of SL BUP on 9/5 due to withdrawal/cravings

CASE OF L. L. ANALYSIS

- Is pt diverting SL BUP?
  - No hard evidence of diversion. All staff believe pt is using all SL BUP
- Is pt ultra-hypermetabolizer?
  - BUP/NBUP quantitative study from June shows showing >1000 ng NBUP from his urine
  - Pharmacogenomic test shows pt is a hypermetabolizer of CYP3A4/5 and CYP2C8 but not an ultra-hypermetabolizer
  - Assessment shows no clear pattern of withdrawal or craving. It appears pt is responding to random cravings and symptoms that he believes withdrawal
- Is it behavioral?
  - Actively involved with groups and counseling at the clinic at least biweekly
  - Actively involved with AA/NA groups in the community

CASE OF L. L. CURRENT PLAN

- Continue with 24 mg of SL BUP daily
- Due to his past pattern of SL BUP use we plan to transition him back to Sublocade
- Appeal sublocade PA. informed pt that we will not provide any SL BUP if he transition back to Subloccade

IMPRESSION (PURELY BASED ON THE CLINICAL EXPERIENCES)

For providers

- Pros
  - Diversion control
  - Protection from OD
  - Revenue (buy and bill provides +5% reimbursement)
- Cons
  - Efficacy of withdrawal and craving control questionable
  - Cannot increase pt's engagement
  - Managing logistics

For pts

- Pros
  - Remove the choice of skipping BUP
  - Protection from OD
  - No more pharmacy visit
  - No more daily dosing
  - Good insurance coverage and PAP (max $5)
- Cons
  - Efficacy of withdrawal and craving control questionable
  - Painful

REFERENCES

- Haight BR et al. (2019). Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial. Lancet. 393(10173):778-790.
- Nasser AF et al. (2016). Sustained-Release Buprenorphine (RBP-6000) Blocks the Effects of Opioid Challenge with Hydromorphone in Subjects with Opioid Use Disorder. J Clin Psychopharmacol. 36(1):18-26.
- SUBLOCADETM label on file.

Questions?

Case Presentation #1
Jennifer Phelps, BS, LPN

- 12:35-12:55 [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Case Presentation #1

Please state your main question(s) or what feedback/suggestions you would like from the group today?

Have a client in the maintenance phase of treatment, that has been stable for awhile off opioids, not consistence with her MAT treatment, misses appointments, week or two at a a time, also with her psych meds. Can be unstable psych sxs at times, manic and depressive phases, but has maintained a job on and off, housing, and school overall. At what point do you consider transitioning to Sublocade or Vivitrol?

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

26 year old white female. Currently not enrolled in college was taking full time course load, did well for 2 semester's, had to pull weekends in jail to complete her sentencing, and started to become overwhelmed. While working a full time job, she lost her job. Went for a period of not working, for about 2 months, started working again in the last 3 weeks, recently increased her hours, but has struggled to keep any sense of normalcy in scheduled appointments. She has a boyfriend, that also has mental health problems, she lives with her grandmother, and has a supportive father that does not live with her.

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Case Presentation #1

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

She reports that she has experienced domestic violence as an adult. She reports there was emotional abuse as well as neglect in childhood. She is currently on probation. She has court on June 24th and has two pending charges for tempering with her interlock device. She started VASAP classes and will have to start VASAP groups soon. DX:
Bipolar 1 Disorder, Opioid dependence, Cocaine dependence;
MEDS: Suboxone 8mg-2 mg SL films 1 po qd
Abilify 10 mg, q am, bupropion HCL SR 100 mg 1 po q pm; Resulti 3 mg 1 po qd; trazodone 100 mg, 2 tabs po q hs PRN; levothyrozine qd) PCP) less constipation---we discussed nutrition and fiber.
sleep is "probably too much now".
Appetite is still not good--still some vomiting---has heard from GI office---going September 24.
Still has leukocytosis---going to hematology August 13.

all Metabolite testing has been negative for everything only positive for BUP last time was negative for BUP had been taken meds in over 2 weeks. staff did patient education on this, discussed possible need for med change at this point. Client missed her last 2 appointments, due to her work schedule and just "chaotic life". (come in leave before being seen running late for her appointment and running out for work).

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Case Presentation #1

What interventions have you tried up to this point ?
Additional case history (e.g. treatments, medications, referrals, etc.)

She has completed a 90 in patient residential treatment program prior to coming to us for services, she started OBOT with 90 days clean time coming from treatment on MAT. She has been highly motivated, but reluctant to attend AA or NA, groups, "they just make me want to use, I don't feel I am strong enough to be around people talking about actively using". Being in jail, was hard for her she would report how she struggled with hearing of people actively using, but that probation helped her "stay clean". MHSS has been offered, Recovery House for Women, Individual therapy, Anger Management, (she has not followed through with these stated Recovery House or Crisis Stabilization was "too much like being in jail".) She was decompensate in the office emotionally meltdown, we talk about compliance with her psych med management. Discussion about getting her family to attend the SFAMI Supporting Families of Addiction and Mental Illness group for extra support as she identified lack of family support as a barrier.

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Case Presentation #1

What is your plan for future treatment? What are the patient's goals for treatment?

Referred for Women's Trauma group, Will keep in MAT, plan to discussed possible changing over to Naloxone or tapering off Suboxone, as client seems to go for periods of time without using Suboxone, has been opioids free for awhile now, however psych needs and cravings are still not controlled. Clients level of engagement and motivation cont. to reassess and reengage. Wrap services around as needed,

Other relevant information

Client is active linked to Substance Abuse Case Management, Psych Med management, Out Patient for therapy services, primary care, has been referred for Recovery House program but declined, offered Crisis Stabilization several times declined, discussed MHSS, but is not open to this at this time.

End of Case Study

Reminder: Mute and Unmute to talk
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Use chat function for questions

Case Presentation #2
Sunny Kim, NP

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
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Case Presentation #2

Please state your main question(s) or what feedback/suggestions you would like from the group today?

What comes first? Pt's autonomy or harm reduction?

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

Mr. G is a 40 yo AA American male with 9th grade education. He was 6'3" 300lb since he was a teenager. Unfortunately because he was a statue he was involved with violence in his area. Mr. G often acted as a muscle for his friends and never had a stable job in his life. Multiple incarceration related violence and possession of illicit substance and spent most of his 20s in the prison system. In his early 30s, pt suffered TBI related to violence and is on disability. Mr. G used to live his mother and sisters time to time but due to his poor impulse control he destroyed his relationship with his family and rarely gets any support from them. Sometimes pt's family assisted him with paying rent for an apartment but due to his poor impulse control he often become homeless. Pt is working with his case manager but he often ignores or does not follow through with her suggestions.

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Case Presentation #2

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

PMH of TBI, HTN, hyperlipidemia, opioid use disorder severe

Initiated MAT December of 2017. Quickly stabilized on 24 mg of BUP. Initially very focused on longer prescription duration because he had difficulty with transportation. This greatly motivated pt. There were multiple relapses but he managed to earn 4 wks prescription privilege at one point by maintaining his sobriety but he could not keep up with it very long. Over 2018 pt had 2 ODs and his been on weekly/biweekly prescription for nearly a year now

Behaviorally challenging to work with Mr. G because of his poor impulse control. There were a few times that Mr. G became very loud and argumentative at the clinic that required police to be called in but he recognized this later and always came back to apologize his action at the clinic. Housing was very challenging for the same reasons. He was removed from multiple shelter options and when his case worker manage to get a housing for him he could not keep up with rent or removed because of his inappropriate behaviors

Pt was never fully engaged with the counseling or therapy at the clinic. Most of times, pt was inappropriate for group therapy sessions. We encouraged pt but he often became argumentative with the counselor or did not showed up to his therapy appointment.

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Use chat function for questions

Case Presentation #2

What interventions have you tried up to this point ?
Additional case history (e.g. treatments, medications, referrals, etc.)

Pt could not keep his sobriety with SL BUP. Often pt came early for his appointment because of misused or losing the medication. When he had all his BUP with him he still showed poor adherence at times.

We wanted to transition him to SQ BUP but pt was very resistant. After last OD he agreed to transition. First SQ BUP given in June. Pt did not returned to clinic for 6 wks. When he showed up he told the clinic that "I would never do the shots again" because of constipation. Informed pt that this is a manageable symptom with other medications but he did not wanted to do it because "a grown man should never dig things out of his behind."

We started SL BUP and convinced pt to transition back to SQ BUP if we can provide him with medications for opioid induced constipation. There were some complications obtaining these medications with his PBM but managed to get a PA approve for him.

Pt disappeared for a month after we reinitiated SL BUP. When he returned we told pt that we are ready to put him back on SQ BUP but he declined because he knew that he will be returning to jail "for a long time" and he did not wanted to "dig it out" when he was incarcerated.

Informed pt that he will likely to have milder opioid withdrawal with SQ BUP when he is incarcerated. Also shared the concern that he may OD before he return to jail because he was continuously tested positive for opioid and cocaine. Pt was concerned that he will be constipated while he is incarcerated. Informed pt that he can be treated while he is in jail but he was reluctant to try SQ BUP again.

What is your plan for future treatment? What are the patient's goals for treatment?

I suggested SQ BUP or daily prescription for SL BUP but pt stated that his opinion matter in this matter and wanted SL BUP prescription for a week. I yield on this and gave 1 wk prescription with a condition of maintaining sobriety. I anticipate pt will fail to maintain his sobriety and I plan on using this as a leverage to transition him to SQ BUP

End of Case Study

Reminder: Mute and Unmute to talk
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Use chat function for questions

Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts

Telehealth

About Telehealth at VCU Health +

For Patients +

For Providers +

Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- **Michael Bohan, MD** from Meridian Psychotherapy
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Michael Fox, DO** from VCU Health
- **Shannon Garrett, FNP** from West Grace Health Center
- **Sharon Hardy, BSW, CSAC** from Hampton-Newport News CSB
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- **Caitlin Martin, MD** from VCU Health
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- **Crystal Phillips, PharmD** from Appalachian College of Pharmacy
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- **Daniel Spencer, MD** from Children's Hospital of the King's Daughters
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- **Barbara Trandel, MD** from Colonial Behavioral Health
- **Bill Trost, MD** from Danville-Pittsylvania Community Service
- **Art Van Zee, MD** from Stone Mountain Health Services
- **Ashley Wilson, MD** from VCU Health
- **Sarah Woodhouse, MD** from Chesterfield Mental Health

Claim Your CME and Provide Feedback

- www.vcuhealth.org/echo

- To claim CME credit for today's session
- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

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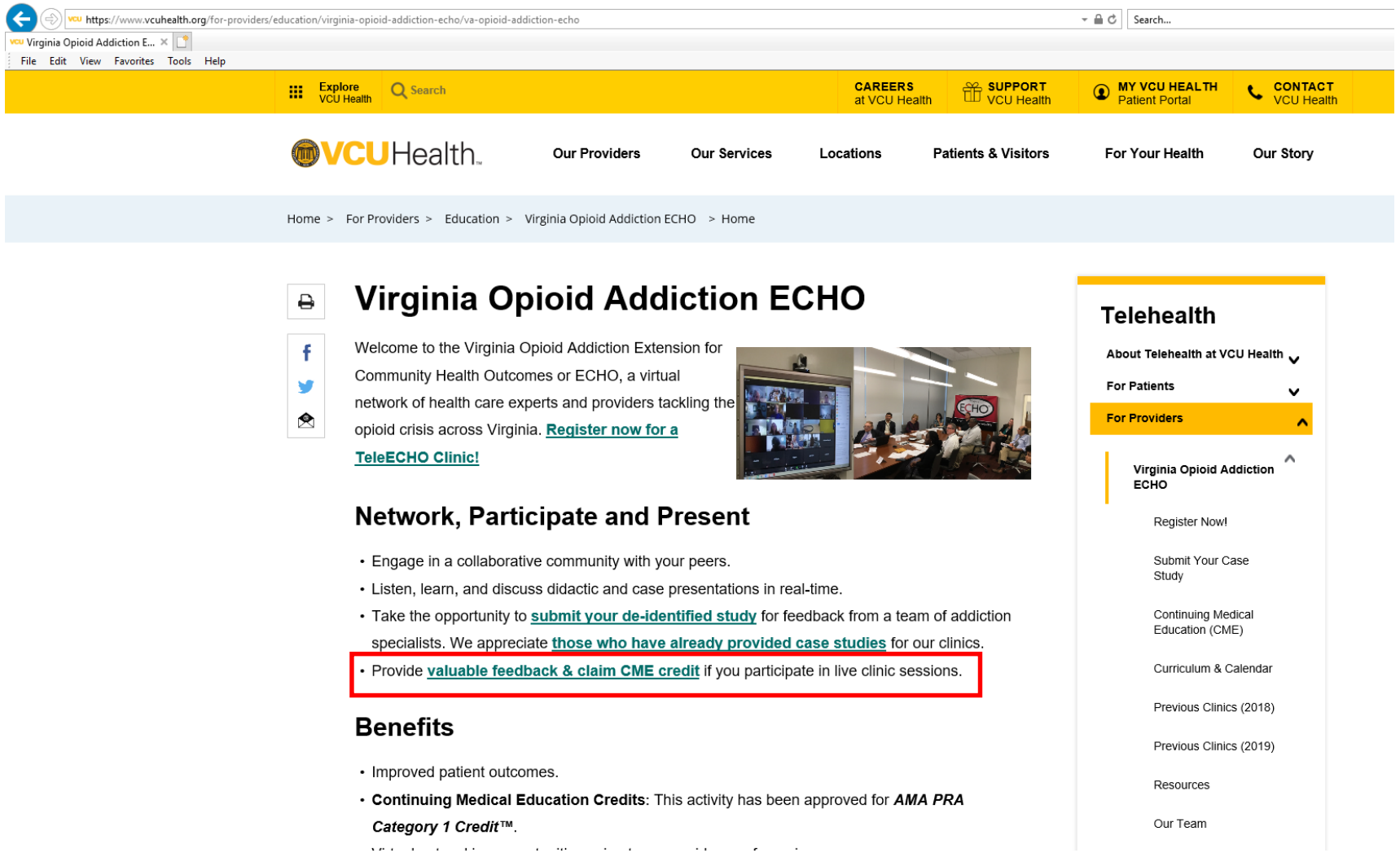

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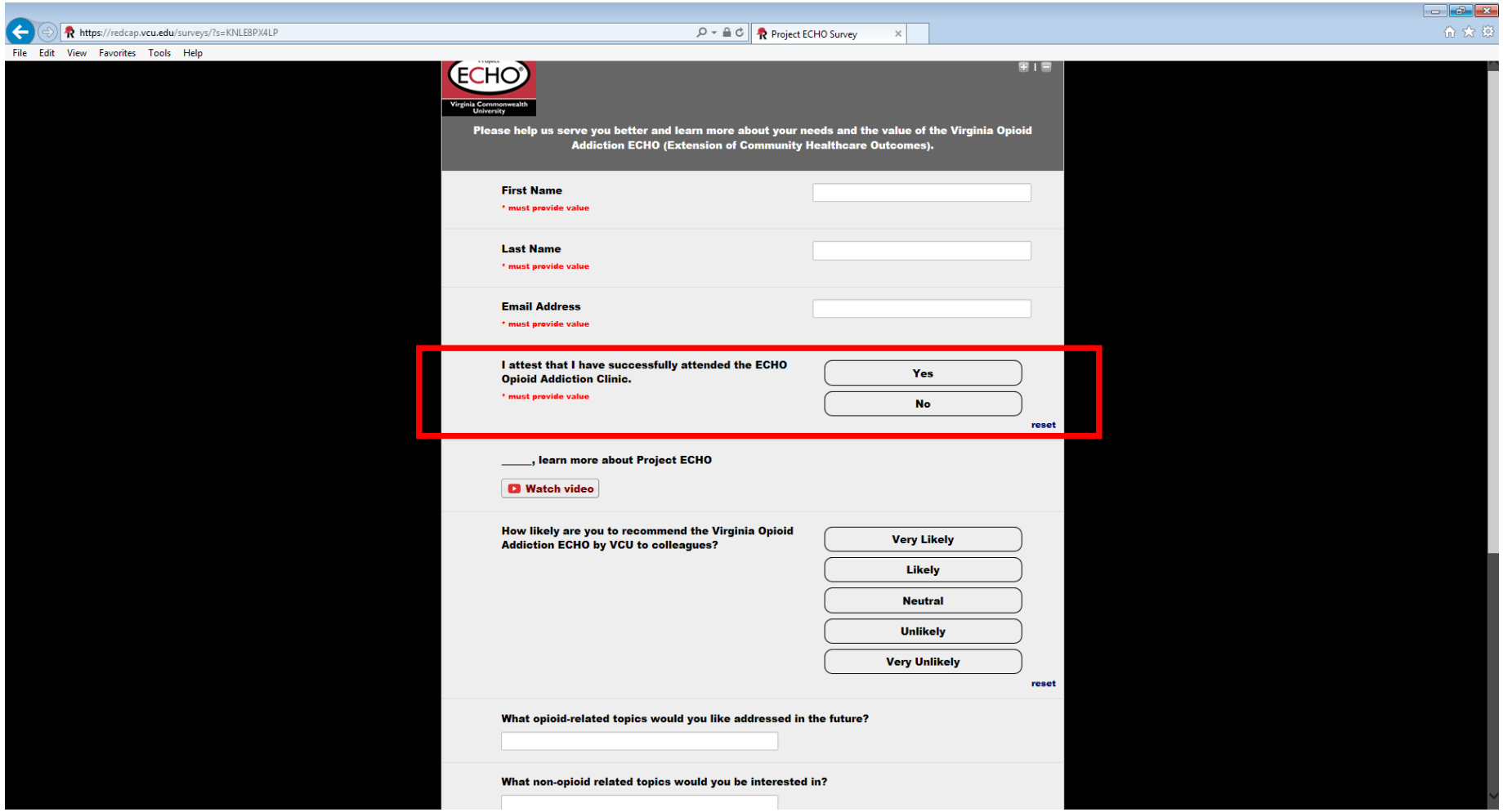

Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/va-opioid-addiction-echo

Virginia Opioid Addiction E...

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Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. **Register now for a TeleECHO Clinic!**

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to **submit your de-identified study** for feedback from a team of addiction specialists. We appreciate **those who have already provided case studies** for our clinics.
- Provide **valuable feedback & claim CME credit** if you participate in live clinic sessions.

Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits**: This activity has been approved for ***AMA PRA Category 1 Credit™***.

Telehealth

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- For Providers
  - Virginia Opioid Addiction ECHO
    - Register Now!
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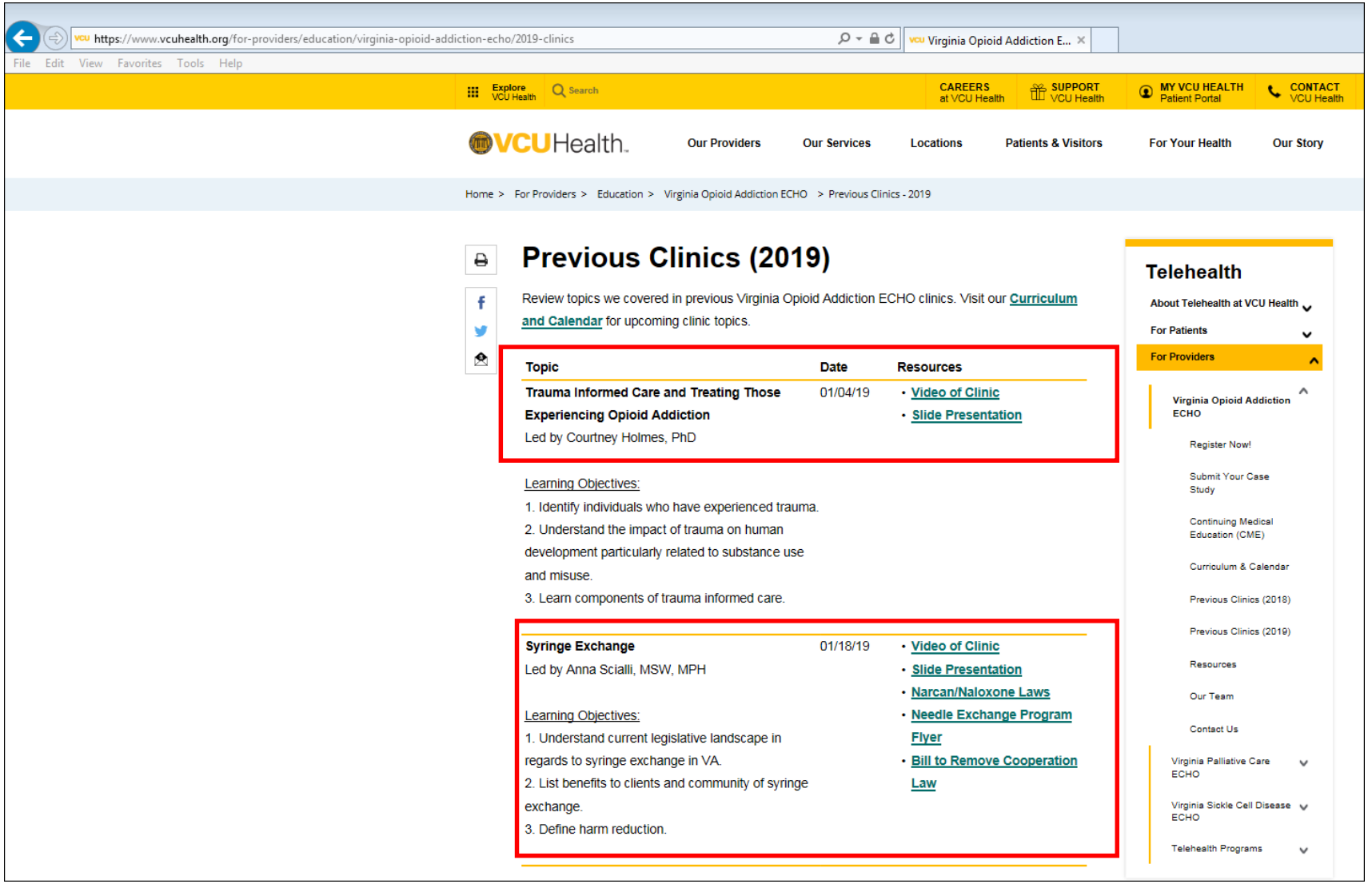
    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Resources
    - Our Team

Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Oct 18:	Proud (Prevention and Recovery from Opioid Use Disorder) Program: Using the "Yale Model" for MAT Treatment	Ben Fickenscher, MD
Nov 1:	Alcohol Use Disorder	Albert Arias, MD
Nov 15:	Detecting Diversion: USDOJ Guidelines	Oliva Norman
Dec 6:	Helping Manage Patient Trauma	Anika Alvanzo, MD

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

VCU

Resources

- Haight BR et al. (2019). Efficacy and safety of a monthly buprenorphine depot injection for opioid use disorder: a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial. Lancet. 393(10173):778-790.

- Nasser AF et al. (2016). Sustained-Release Buprenorphine (RBP-6000) Blocks the Effects of Opioid Challenge with Hydromorphone in Subjects with Opioid Use Disorder. J Clin Psychopharmacol. 36(1):18-26.

- SUBLOCADETM label on file.