Dear Healthcare Partner,

My patient has encountered an obstacle to buprenorphine treatment. The problem at hand is an arbitrary buprenorphine dosage threshold which is below the effective dose required for management of this patient. This has resulted in serious risk of harm to this patient.

The goal of buprenorphine treatment for Opioid Use Disorder (OUD) is to reduce the harms associated with ongoing substance use, it is not to use the lowest dose for the shortest duration possible. These are often misunderstood concepts. Tragically, it is all too often misunderstood and acted upon with practices, policies and frank stigmatization based on the idea that a lower dose or a shorter time spent on buprenorphine is somehow what is best. The opposite is in fact true. The clinical research on buprenorphine treatment for OUD shows that the longer and more adequate the dose of buprenorphine, the better the outcome for addiction treatment.

For instance, higher dose buprenorphine therapy defined as 16-32mg has been shown to result in statistically better treatment outcomes then doses below 16mg.[[1]](#footnote-1) Although methadone shows the strongest benefits for treatment outcomes, buprenorphine at doses of 16mg or higher is similarly effective.[[2]](#footnote-2)

In contrast, many in the medical field continue to operate under the false notion that 16mg of buprenorphine is the ceiling dose for effective buprenorphine treatment. This fallacy is not based on clinically significant research but is rather based on published studies of PET scan results after buprenorphine administration on the brains of a small hand full of subjects in 2000 and 2003.[[3]](#footnote-3)[[4]](#footnote-4) Modern medicine unequivocally designates clinically and statistically significant research-based outcomes as normative and it would be quite the opposite to hold in vivo research results above evidence-based medicine.

The lack of adherence to effective dosage of buprenorphine therapy is not uncommon. For instance, the 2020 JAMA Article mentions explicitly that, "[e]ven when available, pharmacotherapy [medication assisted treatment with buprenorphine] is often unreasonably restricted through low dosages and limited duration."[[5]](#footnote-5)

Denial of effective buprenorphine dosage contradicts evidence-based medicine and perpetuates an error message to the medical community that is frankly dangerous. It suggests lower dosing is more appropriate when it is clearly not and further stigmatizes this life-saving treatment. This is discriminatory, biased and results in substandard care. I am requesting immediate corrective action.

Thank you for your time and careful consideration.

Sincerely,

1. Fareed A, Vayalapalli S, Casarella J, Drexler K. Effect of Buprenorphine Dose on Treatment Outcome. *J Addict Dis.* 2012;31(1):8-18. doi: 10.1080/10550887.2011.642758. [↑](#footnote-ref-1)
2. Wakeman S. Diagnosis and Treatment of Opioid Use Disorder in 2020. *JAMA*. 2020;323(2):2082-2083. doi:10.1001/jama.2020.4104.  Hereinafter referred to as the “2020 JAMA Article”. [↑](#footnote-ref-2)
3. Zubieta J, Greenwald M, Lombardi U, *et al*. Buprenorphine-induced Changes in Mu-Opioid Receptor Availability in Male Heroin-Dependent Volunteers: A Preliminary Study. *Neuropsychopharmacology*. 2000;23(3):326–334. doi:10.1016/S0893-133X(00)00110-X. [↑](#footnote-ref-3)
4. Greenwald, M, Johanson, C, Moody, D, *et al.* Effects of Buprenorphine Maintenance Dose on Mu-Opioid Receptor Availability, Plasma Concentrations, and Antagonist Blockade in Heroin-Dependent Volunteers. *Neuropsychopharmacology*. 2003;28(11):2000–9. doi:10.1038/sj.npp.1300251. [↑](#footnote-ref-4)
5. 2020 JAMA Article at 3. [↑](#footnote-ref-5)