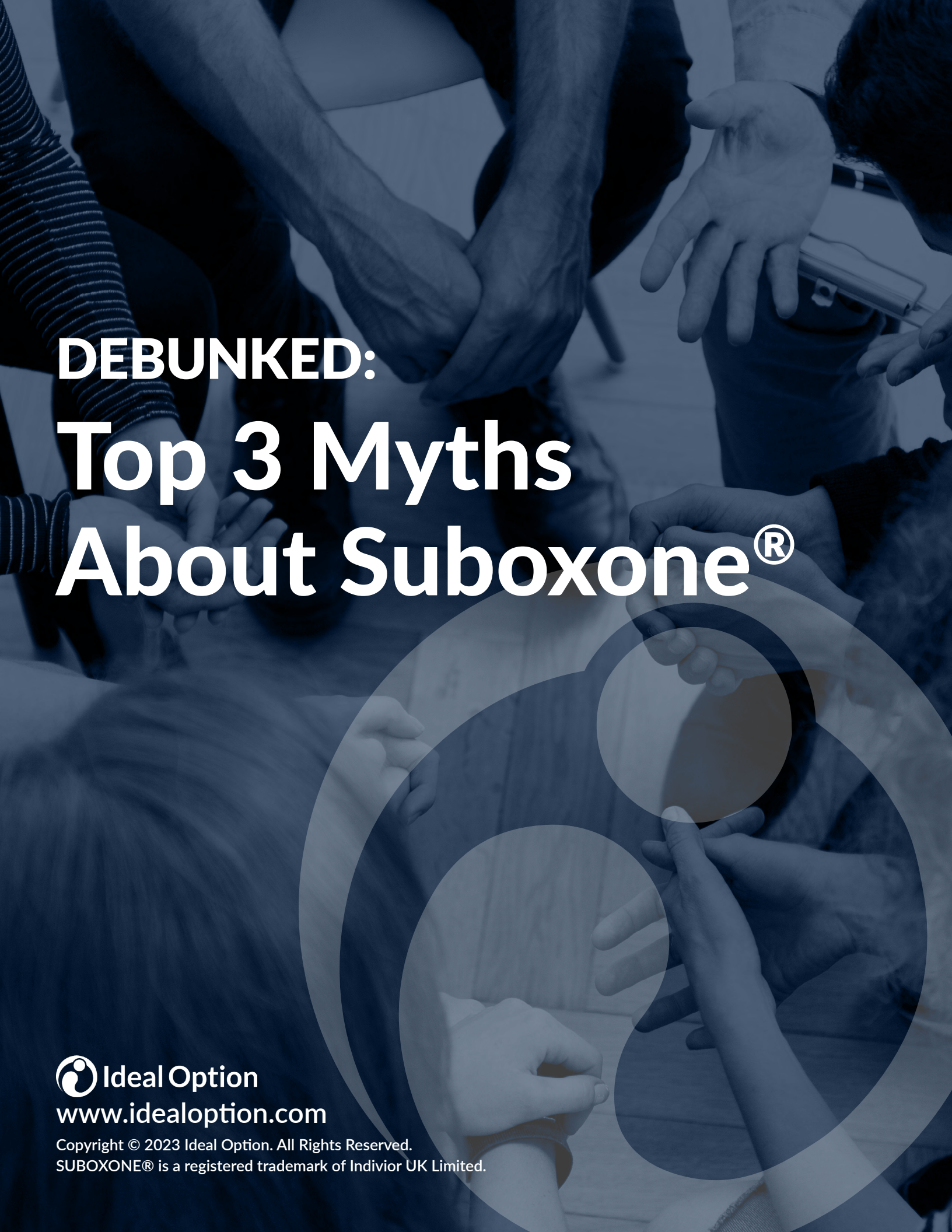


DEBUNKED:
Top 3 Myths About Suboxone®

Ideal Option
www.idealoption.com

Struggling with opioid addiction? Don't let misinformation keep you from medication that can give you your life back.

Here's a remarkable set of facts:

In study after study, for over two decades, buprenorphine (commonly prescribed as Suboxone®) has been proven to save the lives of folks addicted to opioids like heroin, fentanyl, and oxycodone.

We know that without Suboxone, some **90%** of patients with opioid use disorder (OUD) will relapse.

We know Suboxone cuts the relapse risk by **50%** and has an excellent safety profile.

We know Suboxone suppresses the misery of withdrawal — the nausea, the diarrhea, the muscle aches — and the urge to use. As one Ideal Option patient put it, "*On Suboxone, you just don't have the cravings that make you spend your rent money and destroy your life and relationships.*"

And yet, most people who need Suboxone — about **64%** of them — don't receive it.

Why not?

The reasons are complex, but among the obstacles are three pervasive myths.

3 Myths

1 **Suboxone is just another addictive drug.**

2 **Suboxone doesn't work for fentanyl.**

3 **Suboxone isn't as effective as methadone.**

Sometimes, these misconceptions scare off potential patients. Sometimes, they're even perpetuated by medical professionals.

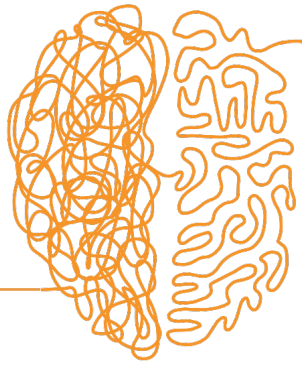
Ok, let's separate myth from reality.

"At Ideal Option, we see every day how buprenorphine is the key to long-lasting recovery from opioid addiction."

— Brian Dawson, MD, FASAM, Chief Medical Officer

MYTH 1

“Suboxone is just another addictive drug”



First, let's unpack the various sub-myths within this common misconception. Generally, when folks call Suboxone "just another addictive drug," they mean Suboxone is merely another substance people with OUD will abuse, perhaps even overdose on, and require for life. These assumptions are faulty. Taking Suboxone is not "replacing one drug with another."

Suboxone, a film that slowly melts under the tongue, combines two drugs: buprenorphine and naloxone (commonly known as Narcan®). Buprenorphine, the dominant component, suppresses withdrawal and cravings, while the small dose of naloxone deters patients from abusing the medication.

What's critical to understand: buprenorphine, though classified as an opioid, works on brain chemistry in a very different way from addictive opioids such as oxycodone, heroin, and fentanyl. Nerve cells in our brain are outfitted with opioid receptors — think of them as microscopic docking stations. These receptors attract all types of opioids, including the endorphins naturally released during exercise or sex, as well as manufactured opioids. When opioids bind to these receptors, this triggers a surge of dopamine, the "feel good" chemical involved in the brain's pleasure and reward system.

The problem is, when you shoot heroin or pop oxy, the surge becomes a flood. And when your brain is flooded with dopamine day after day, year after year, circuits go awry. The brain demands ever more opioids, sprouting extra receptors to accommodate the deluge. If you disregard your brain's demands — because your supply runs out or because you quit cold turkey — well, your opioid receptors are left in the lurch, wide open and screaming. That's withdrawal. You feel so sick that you'll do virtually anything to get more opioids.

Suboxone disrupts this destructive cycle because it's a different kind of opioid: a less potent one.

Buprenorphine molecules fill those screaming opioid receptors without triggering a high. You feel stable, even-keeled, normal — not euphoric.

Q. What if you try to get high by taking extra buprenorphine?

A. Buprenorphine causes much less euphoria than oxycodone, heroin, or fentanyl. That's because it's only a partial "opioid agonist" — there's a limit to how much it can activate the opioid receptors. Most patients report feeling normal or possibly more energized when taking Suboxone, but they don't feel that "pleasure" sensation and don't feel the need to take more than prescribed.

Even if you did take extra, the risk of overdose is low. Naloxone is included in Suboxone to stop you from abusing it. If Suboxone is crushed and snorted or melted onto a spoon and injected, the naloxone portion can hurl you into precipitated withdrawal, an extremely miserable form of withdrawal.

Typically, Suboxone overdose only happens when the medication is taken with sedatives like benzodiazepines.

Suboxone restores normal brain chemistry.

Q. What if you take heroin or fentanyl on top of buprenorphine?

A. That won't work either, because your opioid receptors are already filled. Any additional opioid, no matter how potent, will get pushed aside. A Suboxone dose lasts 24 hours, so when you take the medication daily, as instructed, your opioid receptors are continually occupied. You won't get high, and you won't get sick.

Something else makes Suboxone different from "just another addictive drug": The medication allows the brain to heal. While other opioids prompt the brain to sprout new opioid receptors, pushing you deeper into addiction; Suboxone does the opposite. As you live life without addictive opioids, your extra receptors are reabsorbed by brain tissue. Over time, your brain is restored to its normal state.

So where does the "replacing one drug with another" idea come from?

From a stigma deeply ingrained in our culture, among some politicians and law enforcement and even among less-informed physicians and 12-step groups. This crowd believes that taking medication to overcome addiction shows weakness.

It's a belief tied to the misconception that addiction is a moral failing rather than a disease.

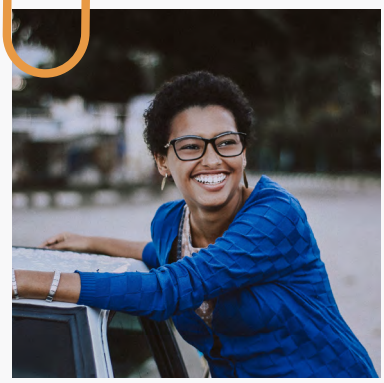
This kind of moralizing can prevent people with OUD from taking life-saving medication such as Suboxone. If you're told enough times that you're a bad person and addiction is your fault, eventually you'll come to believe that. So, people feel undeserving of treatment.

Suboxone is not a "crutch."

No one belittles a smoker for using nicotine gum to quit tobacco. Yet many people perceive Suboxone as a "crutch," and look down on anyone who can't quit opioids cold turkey.

In reality, the cold turkey approach is almost certain to fail. Without medication, fewer than 10% of people with OUD recover, and virtually all patients relapse within 30 days of leaving inpatient treatment or jail. Many start using on their first day out. Some, having lost tolerance, overdose and die.

So, while emotional support and counseling play an important role in recovery, the brain circuitry of an OUD patient requires medication, first and foremost.



Shante's Story

"Suboxone is 1,000 times better than going cold turkey."

Six times in six years, Shante checked into inpatient treatment for heroin addiction, but she was never offered medication. Each time, she relapsed, usually on her first day out.

"The disease of addiction is so cunning it would always bring me back," recalls Shante, an Ideal Option patient. *"The cravings would be so intense. I could be in my old environment or just smell something and I would start sweating."*

It wasn't until Shante enrolled in Suboxone-based outpatient treatment that she was able to maintain recovery.

"Suboxone helped so much with the cravings and anxiety," she says. *"It makes it easier for you to get up in the morning, take a shower, and get on with your day."* Shante says the medication gave her the stability and focus to maintain a job, pursue her studies, and take good care of her daughter.

"It's been amazing — I'm back to being myself," she says. In recovery, Shante has earned her associate's degree and become a licensed addiction counselor, and she's now studying for her bachelor's degree. *"Before,"* she says, *"I wouldn't have believed any of this could be possible."*

Can you ever quit Suboxone?

Central to the myth that taking Suboxone amounts to "replacing one drug with another" is the assumption that OUD patients need to take Suboxone forever. In truth, some people do. Some don't. But either way, there's a big difference between being dependent on a medication to live and being clinically addicted.

Patients with a long history of opioid addiction may well need to remain on Suboxone indefinitely. But this is no different from other patients with chronic diseases who rely on medication to stay alive and thrive.

Certainly, no one accuses people with diabetes of being "addicted" to insulin, yet our culture commonly passes judgment on those who rely similarly on Suboxone. At the same time, patients with a relatively short history of opioid addiction — perhaps a patient who fell into addiction following surgery and quickly spiraled downward — may be able to wean off the medication after a few years.

Most patients can eventually taper to a very low dose, following a gradual tapering strategy. Many patients are able to feel just as stable on 2 mg of buprenorphine per day as they did on a 24 mg dose. However, tapering quickly is a recipe for relapse.

The fact is, OUD has a profound effect on brain chemistry, and until the brain has been restored to its normal state, the urge to use can strike at any time. The mere sight of a needle or vibe of the old neighborhood can trigger intense cravings and quick relapse in a person who has been opioid-free for a decade, overriding all the good intentions, determination, and gains made in recovery. But if that same person's opioid receptors are continually filled by buprenorphine, the person will be better equipped to walk away.

"I struggled with the idea that Suboxone is a crutch."

Joe's Story

After a decade of opioid addiction, multiple stints in inpatient treatment, and countless relapses, Joe was able to maintain recovery with the help of Suboxone. Still, he couldn't shake the feeling that he was "trading one drug for another."

So, he stopped taking his medication.

"I wanted to try living without any assistance at all, and I stayed sober for 6 or 8 months without Suboxone," recalls Joe, 34, an Ideal Option patient. *"I didn't drink or use or smoke weed."*

But then one night, at a restaurant where he worked, Joe overheard a guy talking about Percocet.

"I butted in and asked, 'Hey, could I get one of those?' It started all over again."

Eventually, maintaining his supply became too exhausting and expensive. Then, a cousin died of an overdose.

"I went back to Suboxone," Joe says. *"This time I understood how it works. I wanted to do things the right way this time. I might be a lifer, but so what?"*

It's important for patients not to fixate on when, or if, they might taper off Suboxone. "If you have to take a pill to feel normal for the rest of your life, versus using drugs and committing crimes," says Joe, an Ideal Option patient who relapsed when he stopped taking his medication, "that's what you do."

Overdosing on Suboxone is exceptionally rare.

Some folks avoid Suboxone because they believe it's a gateway to abuse, even overdose.

In reality, Suboxone generally only has the potential to be harmful if also taken with alcohol or sedatives, and its common side effects — constipation and sleep difficulties, for example — are minor. What's more, naloxone (Narcan), the secondary component of Suboxone, deters patients from injecting the medication.

You probably know Narcan as the drug administered by emergency responders to reverse opioid overdoses. Taken alone, Narcan instantly boots opioids off the receptors, restoring breathing while sending the person who overdosed into severe withdrawal.

But when a low Narcan dose is combined with buprenorphine to form Suboxone, very little naloxone is absorbed into the bloodstream, so it doesn't trigger withdrawal. However, melting Suboxone onto a spoon and injecting it can trigger severe withdrawal, a deterrent for anyone looking to get high.

Without Suboxone, up to

90%

of patients with opioid use disorder (OUD) will relapse.

Suboxone cuts this relapse risk *in half.*

And since buprenorphine blocks stronger opioids from binding to the brain's opioid receptors, there's no reward to be had. Trying to get high on Suboxone is a waste of money.

If you do succumb to temptation, Suboxone buys you time to evaluate your actions.

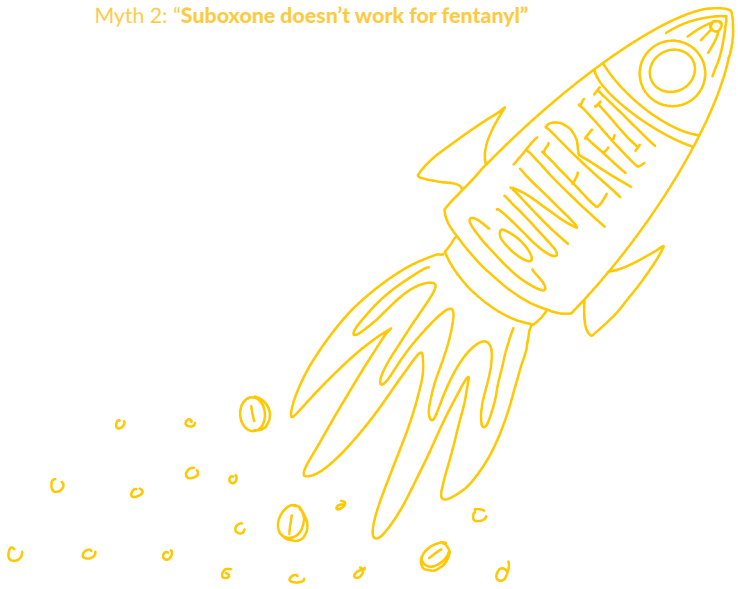
What you do with this time — perhaps you keep working to rebuild your life, with counseling or group support — determines long-term success.

"Suboxone brings patients back to a state before they were addicted, and no other type of treatment — no amount of counseling or therapy — can do that."

-Penny Bell, SUDP, Director at Ideal Balance

MYTH 2

“Suboxone doesn’t work for fentanyl”



The fentanyl crisis is a 5-alarm fire. Cheap to produce and 50 to 100 times more potent than heroin, fentanyl has flooded the illegal drug supply, and the number of counterfeit pills containing fentanyl has skyrocketed.

Lab testing shows 2 out of every 5 pills with fentanyl contain a potentially lethal dose. So, it's no wonder U.S. drug overdoses have skyrocketed, too.

Yet nationwide, most people addicted to fentanyl aren't getting help, in part because Suboxone is perceived as ineffective against this particular opioid, when in fact, Suboxone works exceptionally well for fentanyl addiction.

When taken at the right time in the right dose, Suboxone suppresses the nausea, muscle aches, and anxiety that make fentanyl withdrawal unbearable and dramatically reduces the intense urge to use this highly addictive opioid.

"Suboxone took away my cravings," says Randy, 35, a father of three who lost his delivery job and his car to fentanyl addiction. *"I was surprised — instead of feeling high, you just feel sober."* On fentanyl, Randy ignored his kids and fought with his wife; when his supply ran short, he says, *"I felt like I needed it RIGHT NOW. Like, if I don't get it, I'm going to start throwing up."*

Thanks to Suboxone, Randy says, he has a new job and has mended his relationship with his family. *"Every day, I'm showing them I'm on the right path."*

At Ideal Option, we've helped plenty of patients like Randy overcome fentanyl addiction. So, why does the "Suboxone doesn't work for fentanyl" myth persist?

Because traditionally, the first few days of Suboxone treatment have been difficult for many fentanyl patients, and most folks are not aware of new, far more bearable approaches.

In the past, fentanyl patients faced a formidable barrier to Suboxone treatment: a prolonged period of withdrawal before initiating the medication.

Whereas patients dependent on heroin or prescription painkillers need to abstain from opioids for 24 hours before starting Suboxone to avoid becoming ill, fentanyl patients must remain opioid-free for 36 hours. Otherwise, Suboxone may hurl them into "precipitated withdrawal," a particularly intense form of withdrawal.

Specifically, buprenorphine kicks fentanyl off the brain's opioid receptors, but because the medication is far less potent than fentanyl, *"this creates a net deficit of opioid activity, which the body experiences as severe withdrawal,"* explains Dan Goulette, PA-C, VP of Provider Operations at Ideal Option.

However, the path to avoiding precipitated withdrawal — abstaining from fentanyl for 36 hours — can be miserable, too. The headaches, diarrhea, and other symptoms can be so severe that many patients give up within 8 hours and, understandably, never want to try again.

Fortunately, there's a workaround: two new, more tolerable paths to Suboxone called low dose and high dose initiation.

"These approaches have been much more comfortable and successful for our patients," **says Dan Goulette, PA-C, VP of Provider Operations at Ideal Option.** ***"I've had so many fentanyl-dependent patients tell me, 'There's no way I could have done this any other way.'"***

At Ideal Option, fentanyl patients can follow the low dose initiation method by beginning with a tiny dose of Suboxone and, over a 5-day period, gradually increase the dose while maintaining their baseline fentanyl intake. At that point, they are able to stop using fentanyl and shift fully to a conventional starting dose of Suboxone, a critical first step to recovery.

Meanwhile, they've bypassed 36 hours of suffering.

Low dose initiation, also known as micro-initiation or micro-dosing, reflects an improved understanding among addiction medicine specialists of how the body processes fentanyl.

"Fentanyl builds up in the fatty tissue, and it takes a much longer time to clear out of the body than heroin or oxycodone," Dan explains.

When Suboxone is introduced gradually, it doesn't abruptly displace the fentanyl on the brain's opioid receptors.

On the other hand, patients following the high dose initiation method, also known as macro-initiation, will discontinue fentanyl use completely and take a higher total dose of Suboxone on day one before dropping to a conventional dose on day two. While this method increases the risk of precipitated withdrawal, the risk is lessened by taking additional doses of Suboxone.

High dose initiation is ideal for patients who want to stop using fentanyl immediately but cannot abstain for the required 36-hour period. In this case, they are willing to tolerate a brief period of discomfort to transition to Suboxone more rapidly.

During both initiation methods, some patients take withdrawal medications to reduce any restlessness, anxiety, or nausea they may be feeling. Throughout the process, patients are in daily contact with Ideal Option providers.

"In the course of a 4- to 5-day period, the patient's anxiety level is dramatically decreased because they're not worrying about precipitated withdrawal or cravings," says Dan.

Emily's Story

"If I can do it, anyone can."

When her prescription pain pills ran out, Emily turned to the street. *"I thought I was buying Percocet, but I was buying fentanyl,"* she says. *"I got so high off one pill I couldn't move. I was a zombie."*

After work, she'd drive to a gas station, crush the pills and snort until her nose would bleed. Whenever she'd try to cut back, she'd feel too sick to get out of bed. *"I was sweating, shaking, and puking,"* Emily says. She missed so much work that she lost her job in medical billing. To maintain her supply, she started selling fentanyl.

Finally, exhausted from chasing pills and lying to her boyfriend, Emily called Ideal Option. *"I was nervous about Suboxone, but I decided to give it a shot."* On her first go-around, Emily didn't take the medication consistently, and she relapsed for a few weeks. *"Then I realized I was tired of having the drug control me."* She went back on Suboxone and has not relapsed again.

"I don't even think about drugs anymore," says Emily, now a certified nursing assistant. *"People tell me: 'You're a completely different person. Before, you were negative and withdrawn. Now you're always smiling.'"*

MYTH 3

“Suboxone isn’t as effective as methadone”

Another reason some people addicted to opioids avoid Suboxone is they've heard methadone works better — and yet, for a variety of reasons, they don't want to try methadone, either.

So, they go untreated, sinking deeper into addiction.

Is methadone actually a better choice for opioid addiction?

Actually, Suboxone has many advantages.

While both medications have good track records when taken properly and both suppress withdrawal symptoms and cravings, methadone has a greater potential for abuse and overdose.

Though methadone can be a lifesaver for some people, it can be dangerous for others. That's because it doesn't bind to opioid receptors as tightly as buprenorphine does.

"You can stack other opiates on top of it, so if you take methadone and then heroin, you will get an additive effect," explains Dan Goulette.

Taking too much methadone can cause respiratory depression and heart problems.

Most methadone overdoses stem from methadone purchased off the street, not dispensed through treatment centers. However, some people with OUD who are not enrolled in treatment do seek out methadone to get high or to avoid the misery of withdrawal.

Jenna, now an Ideal Option patient, previously enrolled in a methadone clinic to sustain her addiction. *"At the time, I had no plans of recovery—I was just trying to get high,"* recalls Jenna, 34.

When she decided to seek treatment, after living on the street and then landing in jail, she chose Suboxone.

"It's a safeguard, a defense," she says. "It doesn't get you high and it takes away the cravings."

Suboxone treatment is also more convenient than methadone. Stable Suboxone patients can see a provider every 3 or 4 weeks and take the medication daily at home, whereas many methadone patients must come to a clinic every day and be observed taking the medication.

For patients who lack childcare or transportation or who have jobs or busy lives, visiting a methadone clinic every day can be cumbersome.

"I didn't have the money to get to the methadone clinic every day," says Patricia, an Ideal Option patient who underwent methadone treatment for three months before switching to Suboxone. While Patricia credits methadone with helping her get off opioids, she says she feels better taking Suboxone. *"On methadone, I found myself dozing off a lot,"* says Patricia.

Switching from methadone to Suboxone does require 72 hours of abstinence from methadone, an uphill battle for many patients.

However, the same micro-initiation protocol that eases the fentanyl to Suboxone transition also works quite well for shifting from methadone to Suboxone. So, that barrier can be overcome without the misery so many expect.

Even the standard 24-hour abstinence period required for patients addicted to heroin or prescription painkillers is more bearable than it's reputed to be — and definitely not a reason to avoid treatment.

Yes, the transition period before the first Suboxone can be distressing and uncomfortable.

But 24 hours is not an eternity.

"My first reaction was: No way, I'm not going to be sick for 24 hours," says Amber, 37, an Ideal Option patient who struggled with heroin addiction for a decade, including stints in jail and years sleeping on the street.

For a while, Amber's fear of withdrawal stopped her from calling Ideal Option. But with support from her husband and her mom, and motivated by memories of her brother, who died of a heroin overdose, Amber picked up the phone.

"What's 24 hours of misery to get your whole life back?" Amber says. "That's what I had to put in my head: It's only 24 hours."

To be sure, that abstinence period was no fun — *"like the flu times a million,"* with leg cramps, cold sweats, and diarrhea, Amber recalls. *"I was like: Get me to the pharmacy NOW."*

When Amber finally did arrive at the pharmacy, her symptoms vanished almost immediately — just minutes after she placed the Suboxone film under her tongue.

"By the time I got home, I was back to feeling like myself," Amber says. *"I didn't even want to use. I was shocked. Suboxone is like a miracle drug."*

Putting the Myths to Bed, Once and For All

The myths surrounding Suboxone cause a lot of confusion. Worse, these misconceptions deter OUD patients from receiving highly effective treatment.

Research and experience prove that taking Suboxone is not "trading one drug for another." The medication is not a crutch. It's not exceptionally risky or a gateway to abuse. It doesn't require abject misery to get started on.

It's what Ideal Option patients call "amazing," "a godsend," and "armor against cravings."

If you are struggling with addiction to any opioid, Suboxone is, in short, a very realistic shot at getting your life back.

Ideal Option
www.idealoption.com