Suboxone vs Buprenorphine: Organized Ignorance?

By J.T. Junig, MD, PhD

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I have written in the past about my feelings about 'Suboxone Film'– that it is a product that serves only one purpose, and that is to block generic competition from the Suboxone market. Today, a *Bloomberg* article discussed the current nature of the buprenorphine/naloxone business, and the efforts by RB to prevent generic competition from making roads that would lead to significant price reductions for healthcare consumers.

The point missed by the writers of the *Bloomberg* article, though, is the same point that is missed by many physicians– even by many addictionologists. The dirty secret that RB does not want anyone to realize is that the equivalent of generic Suboxone is already available, in the form of orally-dissolving tablets of buprenorphine.

Suboxone consists of buprenorphine plus naloxone. Naloxone is an opioid antagonist that is added to the compound to reduce diversion of Suboxone– in the form of intravenous injection of a dissolved tablet. Naloxone is not active unless injected. The molecule is poorly absorbed through the oral mucosa because of the molecule's size and poor lipid-solubility. Instead, during typical dosing of Suboxone, naloxone is swallowed, absorbed from the small intestine, and totally destroyed at the liver before reaching the systemic circulation through a process called 'first pass metabolism.'

All of the beneficial aspects of Suboxone come from the partial agonist buprenorphine. The ceiling effect of buprenorphine causes a reduction in cravings through a process that I've described in earlier posts. Naloxone does absolutely nothing to reduce cravings, increase safety, or reduce euphoria, provided that the medication is not injected.

Confusion comes from several sources, all which are forms of intellectual laziness or intellectual dishonesty by the physicians who prescribe the medication and the pharmacists who dispense it.

I am particularly disappointed that the large organizations that supposedly oversee the science of addiction have dropped the ball on this issue.

A few examples of intellectual laziness:

- Some physicians who prescribe Suboxone say that one shouldn't use buprenorphine 'because it doesn't have the opioid blocker and therefore…' (add whatever here– it causes euphoria, it is addictive, it isn't safe– I've heard all of the remarks, and all or incorrect). The confusing part is that the statement is partially correct; generic buprenorphine does not have the opioid blocker naloxone. BUT, naloxone is irrelevant to the actions of Suboxone. The 'opioid blocker' in generic buprenorphine? Buprenorphine! As a partial agonist, buprenorphine has antagonist properties that are responsible for ALL of the effective clinical properties of Suboxone. I suspect that some docs get confused between naloxone and naltrexone, the latter being an orally-active opioid antagonist that is NOT part of Suboxone.

- Letting the fear of diversion be the only factor that determines the type of buprenorphine prescribed. My discussions with hundreds of opioid addicts, over the past six years, have taught me that buprenorphine is rarely a favored drug of choice. Rather, it is taken by addicts who are sick and tired of using who want a break from using without withdrawal, who have no money for an agonist, or when no agonists are available. In such cases, buprenorphine or Suboxone are equally effective– and equally diverted. When I ask addicts new to treatment about their injecting habits, I always ask whether they injected buprenorphine or Suboxone; the typical response is either 'can you do that?' or 'why would I do that, since heroin is cheaper?'

There is even some question whether the naloxone in Suboxone does anything to block diversion. Discussions with buprenorphine patients on my forum suggest that those who have injected Suboxone in the past did not experience withdrawal, consistent with what I would expect from combining a low-affinity antagonist with a high-affinity partial agonist.

In my part of the country, an 8 mg tab of buprenorphine costs as little as $2.33. This low cost should be part of the equation for choice of medication, just as it is for other medications. Does anyone doubt that there are some people kept from treatment by a price differential of 300%? Is it ethical to fear diversion so greatly that treatment is effectively withheld– for a condition with the fatality rate of opioid dependence? I'm sure readers know my own opinion, especially when there are effective ways to reduce diversion, such as close monitoring of prescribed doses, a 'no replacement' medication policy, and drug testing, among others.

Physicians largely ignore the issue of giving patients a medication that does nothing, i.e. naloxone. Patients who are pregnant or nursing are generally prescribed buprenorphine, even though there are no known problems with naloxone during pregnancy. The reason? Doctors say 'why expose the fetus to one more substance, when the substance doesn't really do anything?' I agree with the point, but would extend it further to patients themselves. Don't people have the same right to avoid taking an unnecessary substance—particularly if that unnecessary substance triples the cost of the active part of the medication?

The misinformation over Suboxone has gotten to the point that the State of Wisconsin requires that people on Medicaid use only a certain type of Suboxone, called Suboxone film. Getting Medicaid to pay for Abilify for a patient is virtually impossible without first going through the

less-costly options, but the squishy arguments in favor of Suboxone push the medication up the formulary chain past an alternative that sells for a fraction of the cost.

The requirement for Suboxone film is doubly dubious, as we have the arguments for buprenorphine over Suboxone, and the even less-sound argument for Suboxone Film being favored over the tablet. RB convinced the state that only the film was safe for Medicaid patients, and should be favored over any tablet form of Suboxone, placing future generics at a great disadvantage. It is especially impressive that RB convinced the state that the tablets were unsafe after selling millions of the tablets over the past 9 years. I picture the person making the point: 'the tablet is unsafe…. starting NOW!'

I realize that I tend to ramble, so I'll stop at this point. To summarize, today's *Bloomberg* article described why RB is winning the battle with generics over Suboxone, but the writers of the article, along with many doctors, miss the bigger issue– that misplaced fears, intellectual laziness, and misinformation have protected Suboxone sales from a much greater potential foe– generic buprenorphine. There may be reasons to choose the more expensive Suboxone film, but patients should be provided with accurate information and allowed to make an informed choice—just as they do with other conditions.

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