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Population Pharmacokinetic and Pharmacodynamic Analysis of Buprenorphine for the Treatment of Neonatal Abstinence Syndrome

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Introduction
Neonatal abstinence syndrome (NAS) is a condition affecting newborns exposed to an opioid in utero. Symptoms of NAS include excessive crying, poor feeding, and disorders of autonomic control. Up to 2/3 of infants will require pharmacologic therapies to reach symptom control. Opioids including morphine and methadone are the current first-line treatments. Buprenorphine is being investigated as a treatment of NAS. The purpose of this analysis was to evaluate the pharmacokinetics (PK) and pharmacodynamics (PD) of buprenorphine in infants with NAS.

Methods
The Blinded Buprenorphine Off Neonatal morphine solution (BBORN) trial (NCT01452789) was a double-blind, double-dummy, randomized, controlled trial that assessed the efficacy of buprenorphine and morphine in NAS. Blood was analyzed from patients who received buprenorphine. All infants were monitored using the MOTHER NAS Scale, a modified Finnegan scoring instrument.

Terminally treated for NAS if they had 3 scores ≥14 or a single score ≥12. The neonates allocated to the buprenorphine group were treated with equivalent buprenorphine 5.3 µg/kg every eight hours. Doses were up-titrated by 25% for inadequate symptom control up to a maximal dose of 20 µg/kg.

When the infant was stabilized, the dose was tapered at a rate of 10% daily until within 10% of the starting dose. Blood for PK analysis was drawn in all study patients using a sparse sampling regimen. Buprenorphine and norbuprenorphine concentrations were analyzed using liquid chromatography-mass spectrometry. The limit of quantification was 0.1 ng/mL for both buprenorphine and norbuprenorphine.

The data were used to validate and adapt an existing model of buprenorphine PK in neonates (Moore, Pharmacotherapy, 2015 Jul;35(7):670-80; PMID:26172282) that this reference model utilized a 2-compartment model with PK parameters scaled allometrically by weight and maturation functions on clearance and peripheral volume of distribution. The model was then extended to norbuprenorphine. Norbuprenorphine formation was modeled as a fraction of previously established clearance of buprenorphine. The PK model was formulated as multi-compartment with multiple pathways. The model parameters were also scaled by weight allometrically. The mean and standard deviation of the distribution were used to link the PK to the PD model of NAS.

Conclusions
- The findings confirm an existing PK model of buprenorphine in neonates and extend the model to describe the PK of norbuprenorphine and the PD of buprenorphine in NAS.
- This is the first PD model of a drug effect in NAS. It appeared to well describe relevant features of the NAS disease course.
- Exposure to buprenorphine was linked to stabilization of NAS. Clearance as the inverse of exposure appeared to be the primary driver of clinical efficacy.

Future Directions
- This PK/PD model can be used to simulate dose regimens which may facilitate quicker stabilization or less frequent dosing.

Acknowledgements
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Figure 1. PK and PD Model Schematic

Patient Demographics

<table>
<thead>
<tr>
<th>Demographic Factors</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>39%</td>
</tr>
<tr>
<td>Birth Weight (kg)</td>
<td>3.10 (0.45)</td>
</tr>
<tr>
<td>Age at Last Dose (day)</td>
<td>21 (11.6)</td>
</tr>
</tbody>
</table>

Figure 2. Buprenorphine GOF

Figure 3. Norbuprenorphine GOF

Figure 4. NAS Score GOF

The goodness-of-fit (GOF) plots demonstrate that the model was generally able to describe the data well.

Figure 5. Relationship Between Clearance of Buprenorphine and Time to Stabilization

Figure 6. NAS Severity Influenced Required Buprenorphine Exposure

Figure 7. Relationship Between Average Concentration of Buprenorphine and Time to Stabilization

Conclusions
- Exposure to buprenorphine drives clinical efficacy in NAS. The graphs show that time to stabilization of NAS was linked to the initial severity of NAS and the total exposure to buprenorphine. In Figure 5, neonates with higher clearances were exposed to less study agent and had higher times to stabilization. Figure 6 shows that more severe NAS generally required a higher AUC of buprenorphine to stabilize. Figure 7 demonstrates that higher average concentrations of buprenorphine were correlated with faster time to stabilization.

Figure 8. NAS Predictive Checks

a) 1000 simulations of average NAS score. The solid line and blue shaded area represent the median and 95% CI of the simulation, and the dashed lines represent the median and 95% CI of the observed data.

b) Histogram of 1000 simulated times to stabilization with the dotted lines as the median and 95% CI of the simulation. Black line is median of the observed data.

These graphs further demonstrate that the PD model was effective in the description of the course of NAS and the time to stabilization.