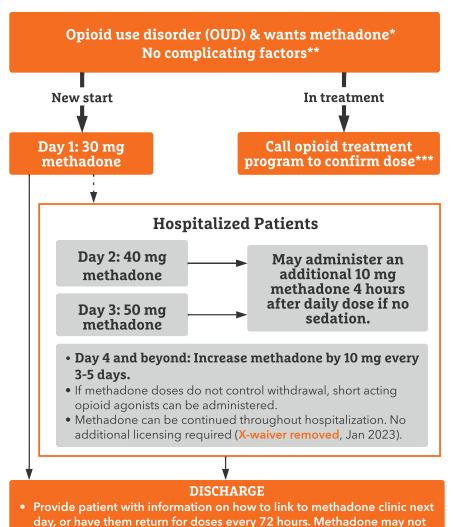


Methadone Quick Start

Follow-up clinic (phone, address, intake hours):



Methadone vs buprenorphine (bup) for patients*

- Methadone ED starts are only suggested when patients are able to follow up in a methadone clinic (OTP) within 72 hours. Work with local clinics to expedite follow up.
- Methadone and bup are both great options that decrease all cause mortality and overdose.
- If a patient is struggling to wait for withdrawal to start bup, methadone may be an option.
- You usually must go to an OTP for daily dosing.
- If methadone dose too high or if mixed with other depressants, may cause sedation.

Complicating Factors**

- RR <10 or sedated
- Low opioid tolerance
- Allergy to methadone
- Known QTc ≥500 (do not need to check EKG to start methadone routinely)
- Recent use of benzodiazepines, alcohol, or other sedatives
- Severe liver disease
- Medically unstable
- Methadone safe in pregnancy & breastfeeding

Patients already in methadone treatment***

- Call clinic to confirm dose amount and when it was last administered.
- If unable to confirm dose, treat as a new start until able to confirm.
- Methadone dispensed from a clinic is never listed in CURES, and some hospitals urine toxicology will not show methadone.
- If 1-2 days missed, administer the full dose.
- If additional days missed, ask the clinic for recommended dosing. Ex: 90% if 3 days missed, 80% if 4 days missed, 70% if 5 days missed, 60% if 6 days missed, 50% if 7 days missed, 40% if 8 days missed.

Regulations

- General acute care hospitals may treat addiction with methadone under their existing license.
- ED may administer methadone for 3 days in a row. If a patient is hospitalized, administer throughout their hospitalization.
- Methadone cannot be prescribed for the treatment of OUD.

be prescribed at discharge for the treatment of OUD.

Patient should have naloxone 4mg/0.1ml in hand at discharge.

- Hospitals can apply to the DEA for a waiver to dispense a 72 hour supply of methadone to help patients connect to a clinic.
- OTPs can only provide methadone if patients have been opioid dependent for at least 6 months.

Pharmacologic notes:

- Can use adjunctive medications for withdrawal symptoms.
- In cases of high tolerance, including fentanyl use, may need additional dose of full opioid agonists to control withdrawal; only while patient is in the hospital.
- Sedation from methadone peaks at 3-4 hours after each dose, patients experiencing sedation should not receive additional doses.
- Half-life of methadone is more than 24 hours, so doses can stack and sedation can occur after multiple days at the same dose.
- Bup should not be given to patients who are currently taking methadone, as this would cause withdrawal.
- Methadone has many significant drug-drug interactions. Before starting new medications, always check the effect on methadone levels to avoid over-sedation or withdrawal.

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MEDICATION INTERACTIONS

Medications that increase methadone metabolism/decrease methadone effect (INCREASED RISK FOR OPIOID WITHDRAWAL)

- Phenytoin
- Dexamethasone
- Ritonavir containing drugs incl: nirmatrelevir/ritonavir (Paxlovid)
- Phenobarbital
- Rifampicin/rifabutin
- Vitamin C (ascorbic acid)
- Carbamazepine
- NNRTIs (efavirenz, nevirapine)
- St John's Wort

Medications that decrease methadone metabolism/increase effect (INCREASED SEDATION/CNS DEPRESSION)

- SSRI Antidepressants
- Cimetidine
- Chlorpromazine
- Azoles

- Fluoroquinolones (increased sedation and prolonged QTc time)
- Risperidone
- Grapefruit juice

- Diltiazem
- Dextromethorphan
- Indinavir

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