Transitioning Methadone to Buprenorphine

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Disclosures

I have no financial interests or relationships to disclose.

I will be discussing the following "off-label" treatments:

- **clonidine for opioid withdrawal**

Outline

- Methadone pharmacology
- Methadone clinic regulations
- Methadone vs. Buprenorphine
- Patient selection
- Transition protocols

Methadone

- Full opioid agonist for treatment of opioid use disorder
- Prevents withdrawal, reduces cravings, blocks the effects of other opioid use
- Reduced risk of:
  - Mortality
  - HIV and HIV-risk behaviors
  - Hepatitis C
  - Criminal behavior

Methadone Oversight

Regulated by:

- **Drug Enforcement Administration (DEA)**
- **Food and Drug Administration (FDA)**
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
- **State Narcotics Enforcement Division (NED)**
- **State Department of Health**

Certified, Registered, Licensed, Accredited by:

- **DEA**
- **SAMHSA**
- **NED**
- **One of 3 approved accreditation agencies**

Methadone Clinic Standards

Daily in-clinic dosing

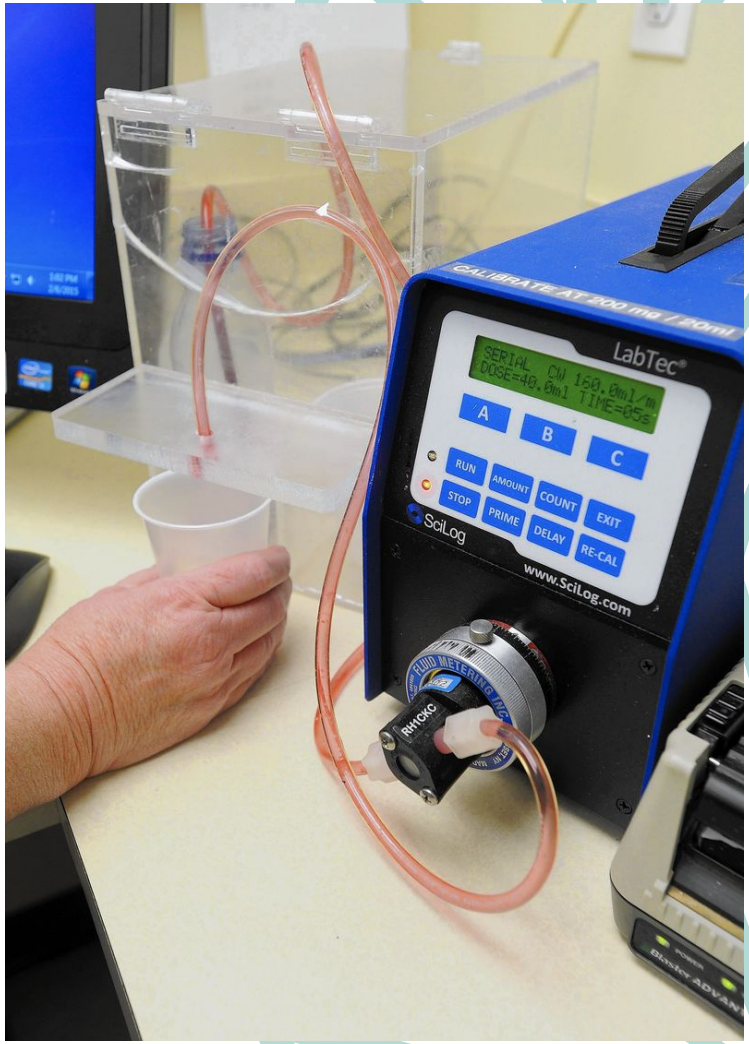
- liquid (harder to “cheek”)
- “take-home” doses earned over time

Random urine drug screens

Counseling

HIV/infectious disease screening and prevention education

Housing and vocational services (on-site or referral)



Methadone vs. Buprenorphine

Methadone	Buprenorphine
Prevents withdrawal, reduces cravings, blocks the effects of other opioid use	
Dispensed in a clinic	Available by prescription
Full agonist	Partial agonist
More abuse potential	Less abuse potential
More overdose risk	Less overdose risk (ceiling effect)
Higher treatment retention	Lower treatment retention
More suppression of heroin use	Less suppression of heroin use
Better for severe dependence	Limited to mild-moderate dependence

Patient Selection

Methadone

- Severe dependence
- High risk of drop-out
  - IV users
  - Multiple tx attempts
  - Co-occurring mental illness
  - Unstable housing
  - Few social supports

Buprenorphine

- Mild-moderate dependence
- High risk of toxicity
  - Elderly
  - Benzos/alcohol
  - Low opioid tolerance
- Housed
- Social supports available

Why switch?

Greater convenience and privacy with office-based prescriptions

Fewer office visits

Potentially reduced side effect profile (esp QTc prolongation)

Less risk of overdose

Insurance coverage

Less perceived stigma

Good candidate:

Psychosocial stability

Motivated and committed to the treatment plan

Pregnancy

If already stable on methadone, continue methadone

Switching may increase risk of

- **Relapse**
- **Withdrawal, which can cause preterm labor or fetal death**

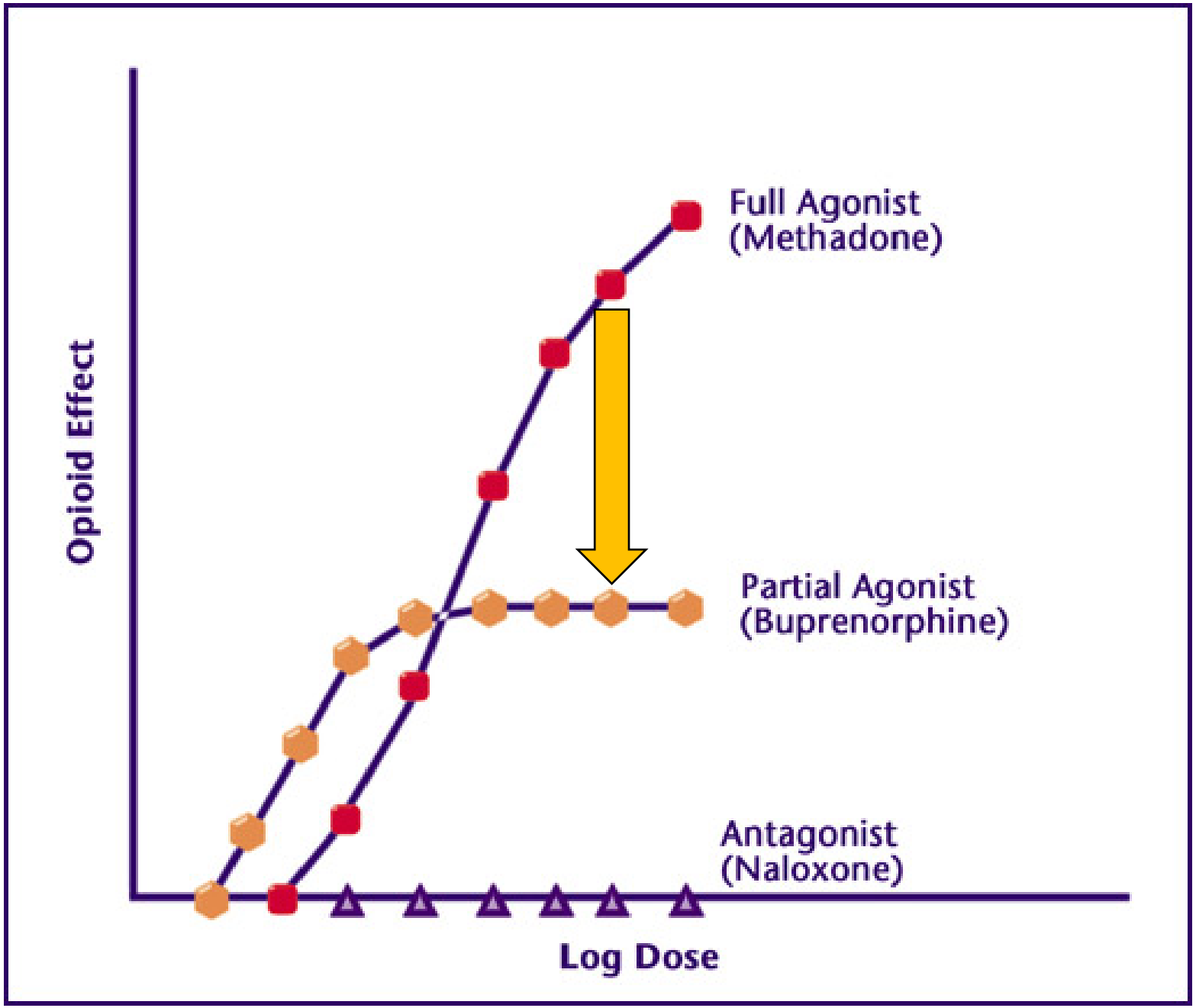
If not on any MOUD, start either methadone or buprenorphine

- **Higher treatment retention with methadone vs. slightly lower risk of neonatal opioid withdrawal syndrome (NOWS) with buprenorphine**

Medically-supervised withdrawal (“detox”) NOT recommended in pregnancy

- **Risk of relapse and withdrawal too high**

NOWS is temporary, fetal death is forever


Opioid Effect
Full Agonist
(Methadone)
Partial Agonist
(Buprenorphine)
Antagonist
(Naloxone)
Log Dose

Opioid Withdrawal

	Half-life	Onset of withdrawal	Duration of withdrawal
short-acting opioids (heroin, hydrocodone, oxycodone)	2-4 hours	6-12 hours	4-10 days
methadone	12-60 hours	24-48 hours	10-20 days

Recommended Transition Protocol

Taper methadone dose to 30-40mg

- **Decreases likelihood of precipitated withdrawal**
- **Can decrease 10mg/week at higher doses, then slow down as dose decreases**
- **At lower doses, tapers any faster than 1-2mg/week will have at least some withdrawal symptoms**
- **Individualize taper schedule to minimize significant discomfort**

If unable to taper to 30mg, taper to the point of objective withdrawal

Hold dose for at least 1 week

Then STOP methadone

After stopping methadone

Wait 36-72 hours, or until COWS ≥ 13 (moderate withdrawal)

- **Rely more on objective withdrawal than amount of time passed**

Consider comfort meds

- **Ondansetron for nausea**
- **Clonidine for anxiety/agitation**
- **Dicyclomine for abdominal cramps**
- **APAP / NSAIDs for muscle pain**

Buprenorphine Induction

In office, rather than home induction

Start 2mg buprenorphine

Continue to dose 2mg every 2 hours until withdrawal subsided

Up to 16mg on the first day

- **May need higher induction doses than normal, then can decrease**

IF precipitated withdrawal

- **Continue dosing buprenorphine 2mg every 1-2 hours, up to 32mg**
- **Support with comfort meds**

Protocol 2: short-acting agonist bridge

Cross-taper or switch to short-acting agonist (e.g. morphine), then transition to buprenorphine as usual

Lessen intensity of withdrawal symptoms

Case reports done in inpatient setting only

- **Would require close coordination with methadone clinic**
- **Concern for accidental overdose with access to 2 full agonists as an outpatient**

Protocol 3: Microdosing (Bernese Method)

- **Continue methadone while concurrently titrating up on buprenorphine**
- **Decreased risk of significant withdrawal**
- **May not need much tapering of methadone dose**
- **Demonstrated use in outpatient setting**

Day	Buprenorphine dose	Methadone dose
1	0.5 mg QD	Full
2	0.5 mg BID	Full
3	1 mg BID	Full
4	2 mg BID	Full
5	4 mg BID	Full
6	8 mg QD	Full
7	8 mg qAM + 4 mg qPM	Full
8	12 mg OD	Stop

General Considerations

Close follow-up

Psychotherapeutic supports

Naloxone during transition

Without MOUD, opioid relapse rates are ~ 90%

- **80% of relapses occurring within the first month**

EITHER methadone OR buprenorphine is better than nothing