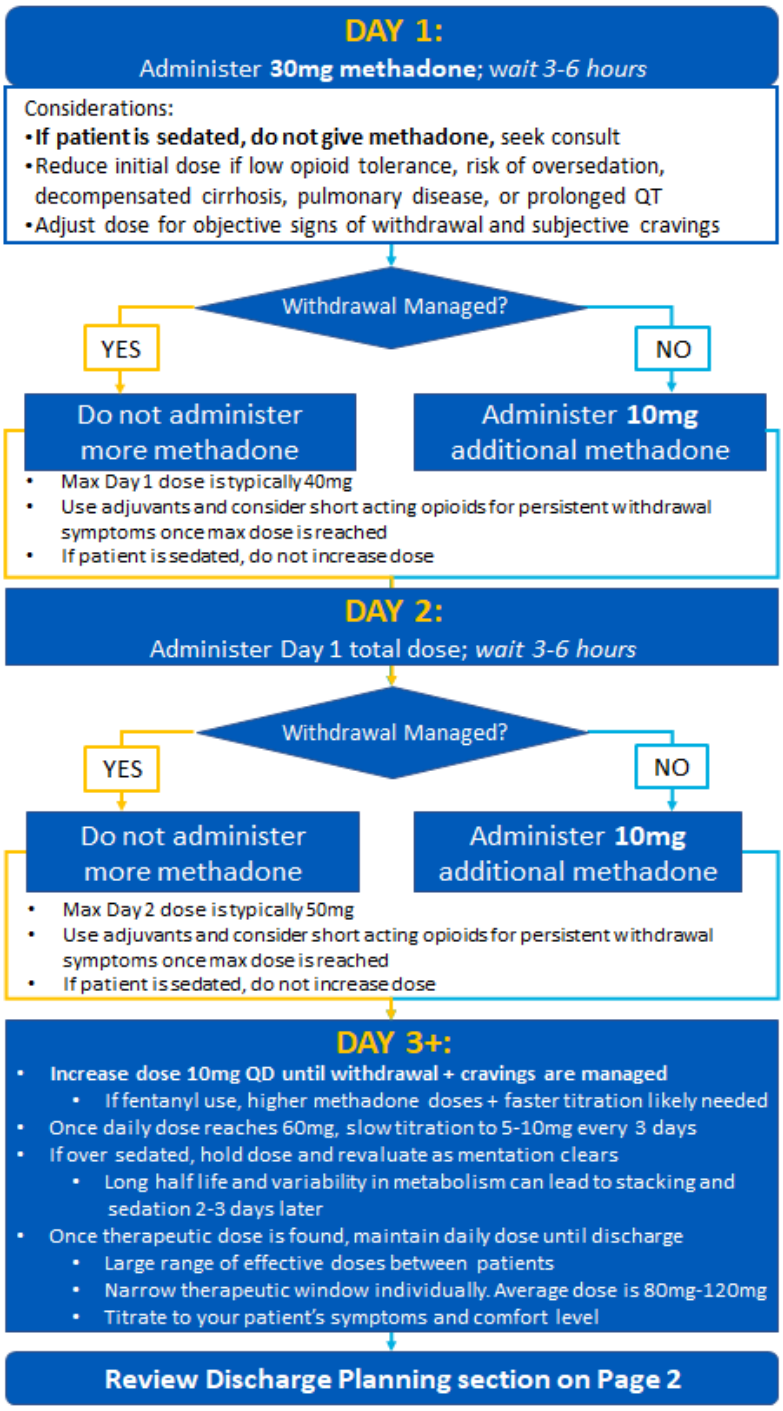
SHOUT TEXAS

Methadone Administration Quick Start Guide

This guide is intended as a quick reference for clinicians treating patients with opioid use disorder (OUD) in a hospitalized setting who are interested in and appropriate for **methadone initiation**.

Specialized certification or licensure is NOT REQUIRED to administer methadone to hospitalized patients

If Patient is Starting or Restarting Methadone:



Identifying Patients:

At least one of the following applies:

- Observed or reported opioid withdrawal
- Observed or reported opioid dependence

AND

- Documented OUD at current admission or ongoing within the last year

AND:

- Additional admission diagnosis other than opioid withdrawal or OUD

Note: Methadone can be administered and prescribed for pain in the absence of OUD, opioid dependence, or withdrawal

Consult with specialist (Psych, Palliative, Pain Mgmt)

- Medically unstable
- Known QTc >500 or at risk for cardiac arrhythmia

Considerations:

Do not delay initial dosing

- Patients do not need to be in withdrawal to start methadone. Administering methadone will NOT precipitate withdrawal
- Patients do not need to commit to ongoing outpatient treatment before initial dosing
- A urine drug screen and lab testing are NOT necessary prior to methadone administration, especially if the patient is already experiencing withdrawal symptoms
- Pregnant patients should have prompt women's health consult after initial dose

Educate on the patient experience

- Management of methadone side effects
- In-person daily dosing at NTP required for methadone treatment after discharge

Complete prior to discharge

- Physical examination (H&P)
- Drug screen and labs (see page 2)
- EKG

Review discharge planning section on Page 2

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If Patient is Continuing Outpatient Methadone

If a patient is stable on a home dose of methadone, without a lapse in dosing that has resulted in moderate to severe withdrawal symptoms: verify home dose with the outpatient provider and continue home medications or the outpatient provider's recommendation without following the protocol above.

Note: Methadone does not appear in the PDMP; the patient's Narcotic Treatment Program (NTP) must be contacted.

Methadone 101

Benefits

- Safe, cost-effective, and evidence-based
- Reduces mortality by 59%
- Relieves withdrawal
- Suppresses opioid cravings
- Improves functioning
- Safe in pregnancy and breastfeeding (potential benefit from split dosing)

Complicating Factors:

- Oversedation (especially if low tolerance or other sedatives)
- Age >65
- Severe liver or cardiopulmonary disease

Side Effects

- CNS depression
- Headache, nausea, constipation, and sweating
- Allergic reactions
- Changes in heart rhythm / QTc prolongation
- Low blood pressure

Complicating Factors and Considerations

- EKGs for QTc measurement are generally not needed prior to starting methadone, unless history of syncope, arrhythmia, structural heart disease, prolonged QTc and/or QTC prolonging medications
- Monitoring ECG typically starts around 100mg
  - Monitor QTc >450ms; consult Cardio if QTc >500ms

Information on other medications to treat OUD can be found in the SHOUT Texas Toolkit.

Care Transition Planning

Hospitalization is an opportunity to obtain all required intake testing needed to establish care with a NTP. Confirm these requirements with intended NTP as soon as identified and prior to discharge.

- Drug screen
- ECG if obtained (many NTPs do not have ECG machines)
- Labs including CMP, CBC, RPR, quantiferon gold or (PPD), HBV serologies, HCV Ab with reflex viral load, HIV Ab/Ag, urine gonorrhea/chlamydia, urine pregnancy test, urinalysis

Discharge Planning

Medically-supported withdrawal by tapering methadone or other opioids during hospitalization or stopping on discharge increases risk of fatal overdose. Make every effort to link patients to ongoing outpatient treatment.

- Patients can be administered methadone in the ED daily for up to three days while referral to treatment is facilitated. Hospitalized patients should receive methadone for the duration of hospitalization.
- Counsel patients on safe medication administration and storage; risks of concurrent alcohol, opioid, benzodiazepine, or sedative use; and overdose risks.
- **Always coprescribe as-needed naloxone for overdose reversal and offer education for loved ones**

If patient is new to methadone or unestablished with a Narcotic Treatment Program (NTP)

- Identify a preferred NTP for the patient to obtain outpatient dosing after discharge. Complete ROI process.
- Outreach to NTP prescriber or intake staff to alert them of the patient's intent to establish care.
  - Confirm patient's out of pocket cost or eligibility for funded treatment with NTP.
  - Confirm geographic proximity to clinic, transportation, and photo ID acceptable to local clinic.
- Complete telehealth intake appointment with NTP if possible (requires physical and UDS)
- Fax to NTP or provide patient with documentation:
  - MAR with confirmation of methadone doses
  - Intake testing listed in "Care Transition Planning" section and any others requested by NTP

If patient is already established at an NTP

- Provide a last dose letter that contains date, time, last dosage, and prescriber contact information at discharge for the patient to provide to their NTP at their next dosing or take home pick up.