

Methadone Maintenance and the Opiate-Dependent Inpatient

General Statements

New York State and Federal Laws **prohibit** the use of **methadone** for **maintenance** or **detoxification** of substance abusers except through New York State Office of Alcohol and Substance Abuse Services (OASAS) certified opioid treatment programs (OTPs). The law does allow for treatment of withdrawal symptoms if a patient is admitted and treated for another medical or surgical condition as an inpatient. (For methadone use as an analgesic, see section entitled “Use in Refractory Pain.”)

In general, the law allows for administration and/or adjustments of methadone dosages (up or down) if deemed medically necessary, providing that the prescriber adheres to the guidelines outlined below. Prescribers are required to place a note in the patient’s medical record to explain the prescribing rationale when medical necessity requires that methadone is weaned or that additional doses beyond the initially allowed 30 mg are required.

There are basically 2 scenarios for opioid-addicted inpatients in which methadone is a consideration. They are either participants in an approved program or they are active drug users.

Inpatients Enrolled in a Methadone Program

If a patient is enrolled in an **approved methadone program**, the hospital (preferably the prescriber) must contact the clinic to ascertain the patient’s present dosage and the time of the last dose received. This information must be documented in the patient chart and relayed to the Pharmacy Department. (If the dosage cannot be verified, the regulations for an active opioid user are to be followed. See the paragraph below). The program participant is to receive the dose that they were getting at the clinic, the only exceptions being medical necessity to decrease the dose or patient refusal to take the full dose. It is critical that a healthcare practitioner notifies the clinic any time there has been an emergent need for change in a participant’s methadone dose. Also, the clinic must be contacted at the time of discharge to inform the clinic of the date and time of the patient’s last dose of methadone. The clinic may require other medical information such as last doses of other medications such as CNS depressants or other medications that may have drug interactions with methadone. In general, **communication** between the hospital and the clinic are necessary for proper treatment of these patients.

Active Opioid Users

If a patient is an **active opioid user**, federal law (Federal Code of Regulations Title 42 Public Health) allows for the administration of methadone for the treatment and prevention of withdrawal symptoms. The initial dose **may not exceed 30 mg**, and an additional 10 mg may be given if needed (usually after 3 hours). Only under extraordinary circumstances does the law allow for a greater than 40 mg initial dose of methadone in the first 24 hours. The rationale for the medical necessity to exceed the 40 mg per day limitation in addition to the assessment that the 40 mg did not suppress opiate abstinence symptoms **must be documented** in the patient medical record.

Safely prescribing doses in excess of 40 mg per day requires a thorough understanding of methadone pharmacokinetics. Peak plasma concentrations are achieved in 1 to 7.5 hours and the terminal half-life of methadone is reported as 9 to 87 hours in adults (reference: Lexi-Comp Online 2016). For these

reasons, a practitioner can easily overdose a patient on methadone, especially after a few days when accumulation has occurred. Peak effect with continuous oral dosing will be achieved in 3 to 5 days (reference: Lexi-Comp Online 2016). It is advisable that after the 40 mg dose is reached, treating symptoms with other medications such as antiemetics is considered prior to giving additional doses of methadone. Patients who were taking any form of buprenorphine should not receive methadone or other opiates while buprenorphine is onboard.

While it is true that participants in a methadone treatment program may receive doses of 80 mg per day or more, it is rare that 30-40 mg per day alone is not enough to quell objective withdrawal symptoms. High doses of methadone are used to block the euphoric effects of opiates by saturating receptor sites, and additionally to blunt the drive to seek to get “high”. The higher doses are not medically necessary for use in a hospital inpatient. It is expected, therefore, that an active user opiate-dependent individual admitted to the hospital will receive a daily dose of approximately 30 mg of methadone to prevent withdrawal until discharge or that the patient will be detoxified from opiates if medically necessary.

It is against the law to admit an opiate-dependent substance abuser purely for the sake of opiate detoxification unless it is done within the parameters of a state approved inpatient detoxification program which Stony Brook University Hospital does NOT have. These patients should be referred to a certified treatment program. St. Charles Hospital, South Oaks and LIJ Hospital are area hospitals that have certified detoxification programs. Due to patient rights, however, a prescriber may reduce the methadone dose of an inpatient at any institution if directly insisted upon by the patient.

Methadone in Pregnancy

The complex pharmacokinetics of methadone are further complicated by pregnancy. There is current literature which suggests that this population may routinely require more methadone than the general population to control opiate withdrawal symptoms. Although the initial dose would be 30 mg as required by law, subsequent doses of 10 mg are usually necessary. Typical stabilization doses during pregnancy are quoted as 80 mg to 100 mg daily. Careful monitoring and skilled assessment are critical. (Chronic Opioid Use During Pregnancy: Maternal and Fetal Implications. Clin Perinatol 40 (2013) 337-350.)

Neonates Born to Opiate Dependent Mothers

Neonatal abstinence syndrome is a concern when a **neonate is** born to an opiate-dependent mother. Methadone is not the drug of choice to prevent and treat withdrawal in the neonate. Oral morphine is used at this institution for this purpose. Methadone may, however, be used in **older children** with iatrogenic opiate dependence resulting from the treatment of pain with opiates; in this situation, methadone may be legally weaned. For guidelines or more information regarding treatment and prevention of withdrawal symptoms in neonatal and pediatric patients, please contact the PICU or NICU practitioners.

Additional Considerations

As demand for services is presently very high and treatment availability is limited in the County-operated OTPs, it is advised that a healthcare practitioner (preferably from Social Service) contacts the Hauppauge or Riverhead Intake Clinic as soon as possible to discuss options and to schedule an intake interview and screening. Patients who are pregnant or HIV positive are given priority.

Additionally, it is highly recommended that a **urine toxicology screening** is done on the patient to screen for benzodiazepine or barbiturate abuse. Healthcare practitioners must be aware of persons concomitantly abusing these CNS depressant drugs due to the potential for fatal drug interactions with methadone. Urine screening is not necessary for patients who are already enrolled in an approved clinic.

Use in Refractory Pain

Although the use of methadone as an analgesic is not the topic of this discussion, it is most likely worth mentioning. Prescribers can continue methadone for inpatients when used for pain in patients that were on it prior to admission, however the dose and frequency should be confirmed through I-STOP PMP. Dosages may be adjusted as necessary when treating pain with methadone since prescribers are allowed by law to treat pain in any manner judged to be clinically appropriate. For newly initiated methadone therapy for refractory pain, however, it is highly recommended (and required in some cases) that Pain Service or Palliative Care is consulted.

Clinical Screening and Monitoring

From a clinical standpoint, the initiation of methadone for any reason must be accomplished with caution and an adequate understanding of the pharmacodynamics and pharmacokinetics of the drug. Proper cardiac screening and monitoring is essential due to the potential for methadone to cause QT prolongation. Drug interactions are another concern, particularly if the drug in question also has QT prolongation as a potential adverse effect. (See Lexi-Comp for monitoring recommendations.)

Outpatient Treatment

Please note that **private physicians** are prohibited from prescribing or administering methadone for the purpose of maintaining or detoxifying an opiate-dependent substance abuser on an outpatient basis. Maintenance and treatment can only be provided by OASAS licensed clinics. Private physicians may, however, prescribe methadone for **pain control** in patients who are refractory to other analgesics. For these patients who become inpatients, our practitioners may treat pain in any manner judged to be clinically appropriate. The usual oral dose of methadone for analgesia is 2.5 to 10 milligrams every 3 to 4 hours as needed. Once a day dosing is not appropriate for pain management.

Private **authorized** practitioners may prescribe maintenance buprenorphine (SUBUTEX®, BUPRENEX®, BUTRANS®) or medications containing buprenorphine/naloxone (SUBOXONE®, BUNAVAIL®, SUBZOLV®) to detoxified opiate substance abusers without clinic affiliation. The administration of buprenorphine to someone maintained on methadone could result in withdrawal since buprenorphine is a partial opiate agonist and is likely to reduce the effect of any pure opioid agonist (such as methadone) due to competition and antagonism at receptor sites. Administering methadone to a person who is maintained on buprenorphine is also to be avoided because the buprenorphine will cause the effects of the methadone to be unpredictable. (Reference: Lexi-Comp online 2016).

Suffolk County Resources

Contact information for the Suffolk Clinics is provided below. Please take some time to understand the law and our policies so that we can be in compliance while providing the best possible care to our patients and community.

Suffolk County Program Administrator: Thomas Schmidt, Ph.D. (631) 853-8515

Suffolk County OASAS Clinics:

Hauppauge Intake Clinic

(631) 853-7373

(631) 853-7374

Manager: Laura Caraftis, LCSW

Riverhead Intake Clinic

(631) 852-2680

Manager: Lynn Campbell, LCSW

Huntington Maintenance Clinic

(Not an intake center for new patients; will accept transfer patients enrolled in programs in other counties)

(631) 854-4400

Manager: John Malone, LCSW

North County Maintenance Clinic

(Not an intake center for new patients)

(631) 853-6410

Manager: Pamela Kiernan, LCSW

All clinics are open 6 AM – 2PM, Monday – Friday, all clinics except North County are open on Saturdays from 7 AM – 3 PM and Hauppauge is open Sundays from 7 AM – 3 PM. All clinics are closed on County Holidays with the exception of Hauppauge which operates from 7 – 11 AM on these days. Hauppauge is, however, closed on Thanksgiving and Christmas. The clinics are networked and utilize an electronic dispensing system so the dose and date of the last dose of medication given can be accessed from any clinic if necessary.

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