PCSS Guidance

Topic: Transfer from Methadone to Buprenorphine

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Guideline Coverage:
TIP #40, Treatment Protocols: Patients dependent on long-acting opioids (pgs. 52-54)

Clinical Questions:
1. Which patients receiving methadone should be considered good candidates for transfer to buprenorphine?
2. How should I transition a patient from methadone to buprenorphine?

Background:
Patients receiving methadone may seek transfer to buprenorphine treatment. There are a large number of clinical scenarios that would cause a patient receiving methadone to seek induction onto buprenorphine. It is incumbent upon the physician to weigh the clinical issues carefully prior to agreeing to assist in the transfer. If a patient is stable on methadone, it is generally not advisable to agree to transfer to buprenorphine without a careful evaluation of the factors motivating the desire to transfer. However, if in the physician's medical judgment, buprenorphine treatment is appropriate and the patient is well-informed of the risks and benefits, transfer may be a reasonable option.

Among the potential benefits of transfer to buprenorphine include lower risk of overdose or sedation, lower risk of QT prolongation and ventricular arrhythmias, less severe withdrawal if a dose is missed, the capacity to obtain medication at a local pharmacy and the option of treatment in a doctor's office.

A number of factors might motivate a patient's request to transfer from methadone. These include; a desire to no longer receive his or her treatment from an opioid treatment program, perceived stigma associated with receiving methadone, concern about having methadone in the house, a desire to travel frequently for work, concern about having a large numbers of methadone bottles in one's possession when traveling, concern about losing methadone bottles without the possibility of replacement, less need for the required counseling/medication dispensing/urine collection in regulated opioid treatment programs, and/or living a long distance from a treatment program. In some cases, the development of QT prolongation or a ventricular tachycardia has necessitated that methadone-maintained patients be transferred to buprenorphine to resolve these adverse cardiac effects (Hanon et al. 2010). In addition, some methadone-maintained patients seek induction onto buprenorphine as a transition to antagonist treatment.

Alternatively, the patient may not be doing well on methadone, continuing to use opiates. stimulants (cocaine or methamphetamines) or benzodiazepines and wish to leave the structure of an opioid treatment program. Finally, it is possible that a patient may be buying methadone on the street and is now seeking legitimate treatment.

Patient Education:
When a patient is seeking transfer from methadone to buprenorphine, it is advisable to determine if the request is based on realistic expectations. It is important for the prospective patient to know that, in an effort to lower the patient's level of opioid physical dependence, it is advised that most patients taper their

dose of methadone prior to transferring to buprenorphine. Unfortunately, for some patients, the transfer process may be associated with a period of discomfort, both from tapering methadone and from starting buprenorphine. Individuals on moderate to high-doses of methadone, over 60-100 mg, may not be able to taper without discomfort and a risk of relapse. As the methadone dose is towered, if the patient begins to experience withdrawal that interferes with their functioning or leads to relapse, he/she can be advised that transfer at a later time may be advisable.

Coordination:
If the buprenorphine practitioner is not associated with the patient's methadone clinic, it will be important to work with the methadone physician and treatment team to coordinate the taper and the timing of the transfer. One should work with the methadone clinic staff to insure continuity of care and a smooth transition, and know that if the transfer fails, that the patient may return to methadone treatment. In some cases, the methadone clinic staff may oppose the patient's transfer. The buprenorphine prescriber should be cautious about being perceived as forcing the transfer, yet encourage the patient to advocate on their own behalf if needed and appropriate.

Recommendations:
Level of evidence: **Low - observational studies and a limited number of randomized studies**

Transfer Process:
Currently, there is no consensus on the optimal method for switching patients maintained on methadone to buprenorphine, and the extant literature is varied in terms of strategies used (Lintzeris et al. 2022). Buprenorphine, which is a mu-opioid receptor partial agonist and can precipitate withdrawal when introduced while methadone is still present. Generally, a dose reduction to 30-40mg is recommended (Sokya 2021). However, recently a number of publications have described “microdosing protocols”, in which low doses of buprenorphine (which would not precipitate withdrawal) are initiated and gradually increased. A variety of cross taper schedules have been used (reviewed in Ahmed et al 2021 and Moe et al 2021), with starting doses of buprenorphine ranging from 0.1mg to 1mg and with full cross taper generally occurring in under 7 days (including those on high dose methadone). Generally, adjunctive medications (reviewed in Srivastava et al, 2020) were used to mitigate potential withdrawal symptoms. More research is needed to elucidate the most effective and safest dosing regimens.

Post-transfer Management*
It may be helpful to maintain contact with the patient and provide reassurance and telephone consultation up to 3 times daily for the first few days. This can be an intensive process for the physician as well as the patient, so it may be inadvisable to start the transfer late in the week. After 3-5 days, the patient will be stable and comfortable, but it may be necessary to add medications to assist with some of the discomforts associated with the withdrawal/transfer process. The patient may lose patience with the discomfort and want to return to methadone. The clinician will need to work with the patient either to accomplish this, or to encourage him or her to wait a bit longer, by provide additional therapeutic support and/or increasing ancillary medications.

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PCSS Guidances use the following levels of evidence*:
High = Further research is very unlikely to change our confidence in the estimate of effect
Moderate = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low = Any estimate of effect is very uncertain.

Type of evidence:
Randomized trial = **high**
Observational study = **low**
Any other evidence = **very low**

* Grading quality of evidence and strength of recommendations
British MedicalJoumal. **2004:328:1490-**