BCCSU

Methadone Guidance

This document provides a high-level overview on the guidance of methadone for the treatment of opioid use disorder (OUD). For full guidance please refer to the BC Centre on Substance Use's A Guideline for the Management of Opioid Use Disorder.

FORMULATIONS

Table 1: Summary of methadone options

Methadose	Metadol-D	Compounded Methadone	Methadose Sugar-free
• **Regular benefit** • Cherry-flavoured • Contains sugar • Commercial solution • Interchangeable with Metadol-D	• **Regular benefit** • Unflavoured • Sugar-free • Commercial solution • Traditionally diluted (e.g., in Tang, Crystal Light) • Interchangeable with Methadose	• **Non-benefit. Special authority approval required** • Unflavoured • Sugar-free • Compounded • Must be diluted (e.g., in Tang, Crystal Light)	• **Non-benefit. Special authority approvals required** • Unflavoured • Sugar-free • Commercial solution • Must be diluted (e.g., in Tang, Crystal Light)

INITIATION

- During initiation, prescribers should see individuals in person or virtually at least weekly
- Clinical assessment is necessary before adjusting methadone doses

Determining the starting dose

Table 2. Starting doses for methadone based on individual's opioid tolerance

Level of tolerance	Suggested starting dose
No/low tolerance | opioid-naïve High risk of toxicity Includes people who have completed withdrawal management, those not currently using opioids but at risk of return to use, individuals with heavy use of other sedating agents, and people with severe comorbidities that affect toxicity risks	5–10mg/day
Unknown/moderate tolerance Moderate risk of toxicity Includes people who use benzodiazepines or other sedatives (prescribed or unprescribed), people with alcohol use disorder	10–20mg/day
Known high tolerance Lower risk of toxicity Includes people actively using opioids	20–30mg/day
Known very high tolerance Very low risk of toxicity Characterized specifically by previous methadone experience and current fentanyl use	30–40mg/day*

* Higher doses may be considered with caution on a case-by-case assessment of risks and benefits; rationale for higher doses should be documented and person's informed consent should be obtained. Close monitoring should also be arranged for individuals receiving higher starting doses.

Scan to download file

Providence Health Care How you want to be treated. | THE UNIVERSITY OF BRITISH COLUMBIA | Providence Research We're all in. | SFU | CRISM BRITISH COLUMBIA | STPAUL'S FOUNDATION

BCCSU

Methadone Guidance

INITIATION (CONTINUED FROM PREVIOUS PAGE)

Dose escalation

Table 3: Suggested dose escalation

Opioid Tolerance	Dose Increase
High opioid tolerance (i.e., documented history of fentanyl use) and experience with methadone	• Titrated by a maximum of 15mg every 3 days • Once the daily dose reaches approximately 85mg, the titration process should be slowed to a maximum of 10mg every 3–5 days
Lower or unknown tolerance, no active fentanyl use, or those who have no history of OAT with methadone	• Doses should be increased more cautiously (e.g., 5–10mg every 3–5 days)

- It can take several days for methadone to reach a steady concentration and maximum therapeutic effect, which can also cause delayed emergence of serious adverse effects like respiratory depression
- If there are concerns of methadone toxicity, see the person at 3-hours post-dose
- Assess person at least weekly either in person or virtually during periods of frequent dose titrations

STABILIZATION

The optimal therapeutic dose varies widely among individuals

- Historically ranged from 60mg–120mg
  - However, this is based on evidence collected before the emergence of fentanyl in the unregulated drug supply
- Doses of 150mg or higher may be required in some individuals to meet therapeutic goals

MISSED DOSES

Table 4: Suggested protocol for managing missed methadone doses

Consecutive missed once-daily doses	Suggested dose adjustment
1-3	Same dose (no change). Resume without dose reduction
4	Cancel prescription. Assess. Resume at 50% of previous dose or at 30mg–40mg (whichever is higher)
5 or more	Cancel prescription. Assess. Restart at 30–40mg (depending on tolerance)

Note: For split dosing (BID or more frequently), count fully missed days rather than doses. Use clinical judgement in adjusting dosage for individuals who have missed a part of their total daily dose over a number of days.

Consider a smaller reduction if risk of tolerance loss is low (e.g., if person has used other opioids since last methadone dose). Consider a more conservative dose adjustment schedule for individuals who have not used unregulated opioids

BCCSU

Methadone Guidance

TAKE-HOME DOSING

- Consider take-home dosing collaboratively with the person in consideration of risks and benefits
- Take-home methadone doses should start as individual non-consecutive doses for individuals who meet the take-home dosing criteria
- Additional take-home doses can be offered gradually (e.g., every 2 weeks) to individuals who:
  - Consistently manage previous take-home doses
  - Sustain medication adherence
  - Experience improving clinical and psychosocial stability
- Exercise caution considering take-home doses for people who are still in the titration phase
- Confirmation that criteria listed below have been met should be clearly documented

Individual Criteria for Methadone Take-home Doses

Table 5: Protocol for methadone take-home doses

Number of take-home doses per week	Minimum time on methadone	Conditions/Criteria
0 (Not a candidate for take-home doses)	-	**Any** of: • Inability to safely store medication • Unstable psychiatric illness or other acute mental health crisis • Frequent missed doses and appointments • Ongoing high-risk or uncontrolled substance use patterns (e.g., causing frequent overdoses, blackouts, or hospitalizations)

1–3
 	
(non-consecutive take-home doses)
	4 weeks	**All** of:
		• Ability to safely store medication
		• Evidence of medication adherence (e.g., UDT positive for methadone)
		• Clinical and psychosocial stability, including:
		  ◦ Ability to keep appointments and manage medication
		  ◦ No acute behavioral or psychiatric issues at point of assessment
		  ◦ No high-risk or uncontrolled substance use patterns that cause frequent overdoses, blackouts, or other severe safety risks

4–6
 	
(consecutive take-home doses)
	12 weeks	**All** of:
		• Consistent medication adherence with rare missed doses and appropriate management of non-consecutive take-home doses
		• Improved clinical and psychosocial stability, including:
		  ◦ Rare missed appointments
		  ◦ Minimal unprescribed substance use, in alignment with treatment plan and indivdual goals, with no recent overdoses or blackouts

BCCSU

Methadone Guidance

TAKE-HOME DOSING (CONTINUE FROM PREVIOUS PAGE)

Monitoring of take-home dosing for methadone

People receiving take-home methadone dosing should be seen at least monthly to assess progress and stability. The following are considerations for follow-up and reassessment:

- Indication of increased use of unregulated opioids and other CNS depressants
- Missed appointments or doses, or repeated reports of lost, spilled, stolen, or vomited doses
- Requests to increase a previously stable dose
- Unable to attend the clinic or lab for UDTs

Signs of instability

- Assess and potentially reduce take-home dosing days or return to daily witnessed ingestion, if appropriate
- Increase clinical appointment frequency and refer to psychosocial treatment and community supports
- If instability persists, explore alternative opioid agonist treatment after discussing with the individual

Evidence of diversion

- Prescribe witnessed doses following a discussion with the person to ensure that the medication is appropriately meeting their needs
- Consider transitioning to another medication in collaboration with the person, if appropriate
- In the case of negative UDT results for OAT, assess loss of tolerance and consider restarting or resuming OAT at a lower dose to minimize risk of drug poisoning

URINE DRUG TESTING

Table 6: Suggested urine drug testing frequency

Treatment stage	UDT schedule
Initial confirmatory testing	Performed to confirm unregulated opioid use prior to initiating OAT
Methadone	
Initiation, titration, and stabilization	**Monthly** or more or less frequently as required and when clinically indicated. In circumstances where UDT is occurring less than monthly, safety can be increased with daily witnessed ingestion.
Maintenance	When clinically indicated
Take-home doses	**6–8 tests per year** or when there are any safety concerns Frequency of UDT is as required when clinically indicated

Scan to download file