

Penobscot Community Health Care's Guidance Document for Transitioning Off Methadone

Purpose: As of May 1st, 2016, MaineCare will no longer pay for new-start methadone prescriptions for pain without a prior authorization or cancer/hospice exception. Patients on existing methadone prescriptions for pain will be given a 180-day grace period to allow for tapering or transitioning to another opioid.

Background:

- Methadone is a high-risk medication that accounts for a small percentage of all opioid prescriptions in the U.S., but is involved in one-third of opioid-related overdose deaths.¹
- Due to the unpredictable pharmacokinetics and nonlinear morphine equivalency of methadone², we recommend replacing methadone with an alternate long-acting opioid rather than attempting a taper of methadone. (See Appendix 1)
- There is a lack of evidence to support long-term use of opioids for chronic, non-cancer pain.³⁻⁵ For this reason, after methadone is replaced with another opioid, we recommend attempting a taper to discontinuation in conjunction with non-opioid and non-pharmacologic support methods.

Procedure for Transitioning Off Methadone: (See Appendix 2)

1. Calculate the morphine milligram equivalents (MME) that the patient is receiving from methadone daily. The Washington State Agency Medical Directors' Group Opioid Dose Calculator is recommended: <http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>
2. For methadone prescriptions that deliver greater than 200 MME daily, decrease the dose by 20% of the original dose every 2 weeks until 200 MME is reached (methadone 25 mg/day).
3. Discontinue methadone and replace with another long-acting oral opioid.
 - a. Preferred: Morphine SR (MS Contin[®] tablets, Kadian[®] capsules)
 - b. Alternate: Oxycodone ER (OxyContin[®] tablets)
4. Initiate the new opioid at a total daily dose that delivers 50% of the methadone MME that was discontinued.
5. Recommended: Two months after the replacement opioid is started, begin a taper to discontinuation.
 - a. Decrease by 20% of the original long-acting opioid dose every 2 weeks.
 - b. When 20% of the original dose remains, decrease by 10% of the original dose for 2 weeks, *if possible*, then stop.
6. Considerations: These recommendations are intended to serve as a starting point, but may require adjustment based on individual patient tolerance. Due to limitations in available dose formulations, it may be impractical or impossible to taper by exactly 20% or 10%. Dose reductions generally range from 15-25% for a 20% target, and 8-12% for a 10% target. Long-acting opioids cannot be split, crushed, or chewed.
7. Supportive measures may include:
 - a. Non-opioid analgesics
 - b. Comfort Pack if withdrawal symptoms occur (See Appendix 3)
 - c. Referral to counseling and/or substance use disorder (SUD) screening with referral to SUD counseling

Long-Acting Opioids: How Supplied		
Morphine SR tabs (MS Contin®)	Morphine SR capsules (Kadian®)	Oxycodone ER (OxyContin®)
15 mg	10 mg	10 mg
30 mg	20 mg	15 mg
60 mg	30 mg	20 mg
100 mg	40 mg	30 mg
200 mg	50 mg	40 mg
	60 mg	60 mg
	80 mg	80 mg
	100 mg	
	200 mg	

Example Conversion and Taper #1: Switch to Morphine SR

Original Prescription: Methadone 10 mg four times daily (10 mg/10 mg/10 mg/10 mg)

1. Calculate MME of methadone

MME = 320 mg/day

2. Decrease methadone dose by approx. 20% every 2 weeks until 25 mg/day is reached

20% of 40 mg = 8 mg (~5 mg)

Methadone 10 mg/10 mg/10 mg/5 mg x2 weeks, then

Methadone 10 mg/5 mg/10 mg/5 mg x2 weeks, then

Methadone 10 mg/5 mg/5 mg/5 mg x2 weeks (MME = 200 mg/day)

3. Replace methadone with long-acting opioid at approx. 50% of methadone MME

Morphine SR 50 mg twice daily (MME = 100 mg/day)

4. After 2 months, initiate taper decreasing dose by approx. 20% every 2 weeks

20% of 100 mg = 20 mg

Morphine SR 40 mg in the AM and 40 mg in the PM x2 weeks, then

Morphine SR 30 mg in the AM and 30 mg in the PM x2 weeks, then

Morphine SR 20 mg in the AM and 20 mg in the PM x2 weeks, then

Morphine SR 10 mg in the AM and 10 mg in the PM x2 weeks

5. When 20% of original dose is reached, decrease by 10% of original dose for 2 weeks, then stop

10% of 100 mg = 10 mg

Morphine SR 10 mg once daily x2 weeks, then stop

Example Conversion and Taper #2: Oxycodone ER

Original Prescription: Methadone 20 mg in the morning and 30 mg in the evening

1. Calculate MME methadone

MME = 500 mg/day

2. Decrease methadone dose by approx. 20% every 2 weeks until 25 mg/day is reached

20% of 50 mg = 10 mg

Methadone 20 mg in the AM and 20 mg in the PM x2 weeks, then

Methadone 20 mg in the AM and 10 mg in the PM x2 weeks, then

Methadone 15 mg in the AM and 10 mg in the PM x2 weeks (MME = 200 mg/day)

3. Replace methadone with long-acting opioid at approx. 50% of methadone MME

Oxycodone ER 40 mg twice daily (MME = 120 mg/day)

4. After 2 months, initiate taper decreasing dose by approx. 20% every 2 weeks

20% of 80 mg = 16 mg (~15 mg)

Oxycodone ER 40 mg in the AM and 25 mg in the PM (10 + 15) x2 weeks, then

Oxycodone ER 25 mg in the AM (10 + 15) and 25 mg in the PM (10 + 15) x2 weeks, then

Oxycodone ER 25 mg in the AM (10 + 15) and 10 mg in the PM x2 weeks, then

Oxycodone ER 10 mg in the AM and 10 mg in the PM x2 weeks, then

Oxycodone ER 15 mg once daily

5. When 20% of original dose is reached, decrease by 10% of original dose for 2 weeks, then stop

10% of 80 mg = 8 mg (~5 mg)

Oxycodone ER 10 mg once daily x2 weeks, then stop

No oxycodone ER products are available smaller than 10 mg. In this case, it is appropriate to stop after 2 weeks of 10 mg daily and offer symptom relief for withdrawal symptoms if necessary.

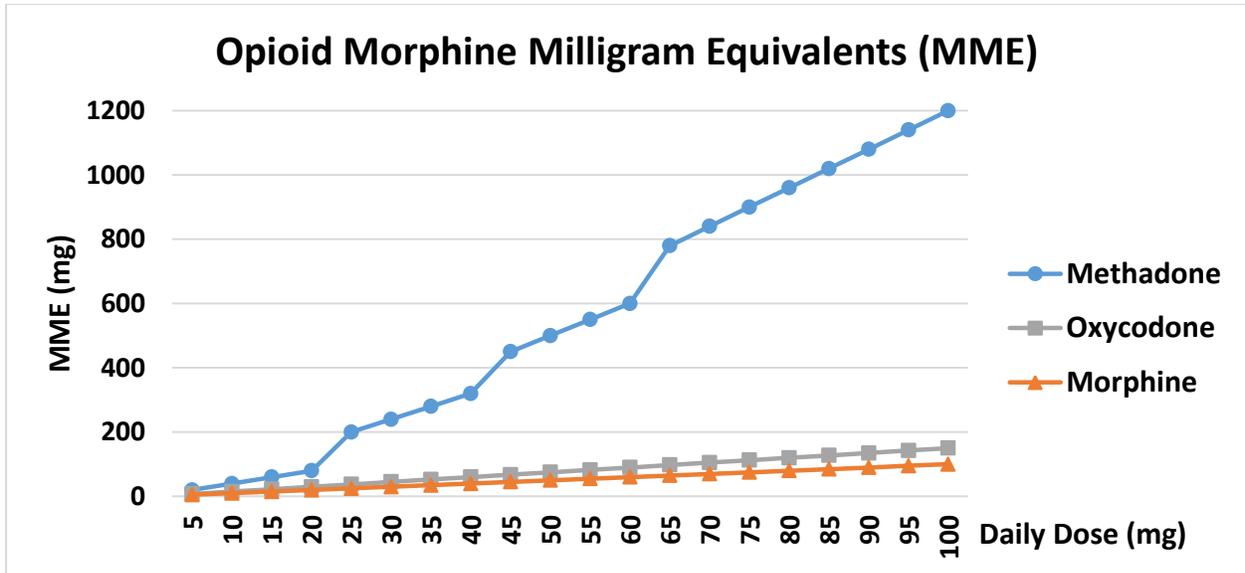
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References

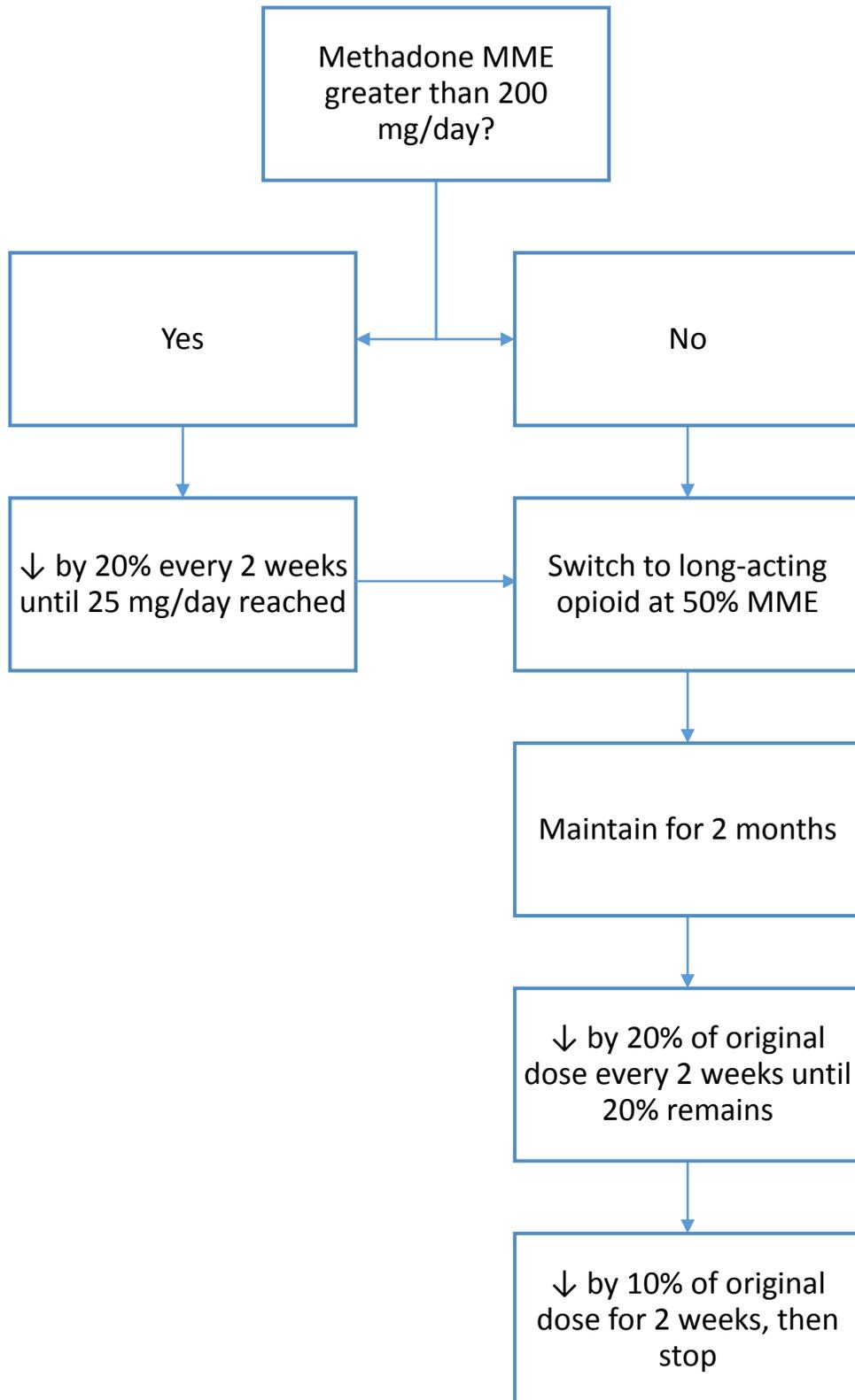
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3. American Pain Society, American Academy of Pain Medicine Opioids Guidelines Panel. Guideline for the use of chronic opioid therapy in chronic noncancer pain: evidence review. Chicago, IL: American Pain Society; 2009.
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Appendix 1. Nonlinear Morphine Equivalency of Methadone



Methadone exhibits a non-linear morphine equivalency relationship due to its long half-life and accumulation with chronic dosing. Methadone MME may change dramatically from as little as a 1 mg adjustment in daily dose.

Appendix 2. Methadone Taper Algorithm



Appendix 3. Example Comfort Pack Standing Order

Purpose:

Certain clinical situations (contract violations, incarceration, etc.) may necessitate abruptly stopping a prescription opioid medication, leading to acute withdrawal. Opioid withdrawal syndrome in adults is not life-threatening but can be extremely unpleasant. Common symptoms include anxiety, restlessness, insomnia, stomach cramps, vomiting, diarrhea, fever, chills, sweating, muscle spasms, tremor, tachycardia, and hypertension. Depending on the withdrawn opioid, withdrawal symptoms may last for days to weeks. Short-term prescriptions for symptom management are typically prescribed to patients during this time as a comfort measure.

Standing Order:

A standard comfort pack order set will be available in the electronic medical record for patients experiencing opioid withdrawal. Providers may order the default comfort pack or select from the list of alternate agents as appropriate for each patient’s symptoms. Default quantities are for 3-day supplies (with the exception of clonidine) but may be increased or provided with refills based on patient needs and half-life of the withdrawn opioid.

Opioid Withdrawal Comfort Pack Order Set
Cholinergic Overload
<input type="checkbox"/> Clonidine 0.1 mg #18 1 tablet three times daily for three days, then 1 tablet twice daily for three days, then 1 tablet once daily for three days, then stop **Dispense in 3-day supplies, hold if BP < 90/60**
Nausea/Vomiting/Insomnia
Default: <input type="checkbox"/> Diphenhydramine 25 mg #36 1 to 2 capsules every 4 hours as needed (max 6 doses/day) Alternate: <input type="checkbox"/> Promethazine 25 mg #12 1 tablet every 4 hours as needed (max 4 doses/day)
Diarrhea
Default: <input type="checkbox"/> Loperamide 2 mg #24 2 tablets first dose, then 1 tablet after every loose stool (max 7 doses/day [8 tabs/day]) Alternate: <input type="checkbox"/> Bismuth subsalicylate 262 mg #48 2 tablets every 30 to 60 minutes as needed (max 8 doses/day)
Muscle Spasms/Twitching
Default: <input type="checkbox"/> Cyclobenzaprine 10 mg #5 ½ (one-half) tablet every 8 hours as needed (max 3 doses/day) (continued)

Muscle Spasms/Twitching (continued)
Alternate: <input type="checkbox"/> Baclofen 10 mg #5 ½ (one-half) tablet every 8 hours as needed (max 3 doses/day)
Aches
Default: <input type="checkbox"/> Acetaminophen 325 mg #24 2 tablets every 4 hours as needed (max 6 doses/day)
Alternate/Add-On: <input type="checkbox"/> Ibuprofen 400 mg #18 1 tablet every 4 hours as needed (max 6 doses/day)