Compass Opioid Stewardship in Practice Microlearning Series

COMPASS HEALTHCARE COLLABORATIVE
Sustainable Healthcare Transformation

Module 12: Transitioning from Long-term Methadone to Buprenorphine

Welcome to Compass Opioid Stewardship in Practice. Each week, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, this session is built for busy clinicians like you.

This week's session is brought to you by Dr. Christine Blake Smith, DO; Clinical Coach in the Compass Opioid Stewardship Program.

Case Presentation

This week's case explores a 54 year old female with chronic pain transferring to a new practice in December of 2021 after her provider lost his license. She had been on methadone for well over a decade and had already been tapered down to 50mg per day (235 MME) in divided doses. She came in wanting to transition to buprenorphine.

Goal

Our clinical goal is to increase patient safety by transitioning from methadone to buprenorphine in this chronic pain patient on long-term methadone therapy for chronic pain management for over a decade.

Achieving our Goal

- It is recommended to taper to 30 to 40 mg of methadone per day before attempting a transition.

- **First step, tapered the methadone. Her methadone taper:**
  - 50mg/day Month 1 (235 MME)
  - 40mg/day Month 3
  - 37.5mg per day in Month 10
  - 35mg per day in Month 15
  - 32.5mg per day in Month 22
  - 30mg per day Month 27 (total of 141 MME)

    Taper was slower than hope due to other life stressors impacting patient

- Patient was then at a level that the transition to buprenorphine can begin.
- However, due to the long and variable half life of methadone and due to the fact that it is highly lipophilic (releases from the fat tissue for a very long period of time which complicates the withdrawal/transition to buprenorphine), the patient was nervous about moving directly from Methadone to Buprenorphine.
- After a long discussion, we decided to begin a transition to oxycodone (which is still much more safe than methadone and in itself is a big step) in preparation to transition to buprenophine.

- The methadone was decreased from 30mg to 10mg and a total of 30mg of oxycodone per day was added (total of 92 MME).

- **Second step: tapered the oxycodone off and micro-titrated the buprenorphine up.**
  - The process started while using only oxycodone. A buprenorphine patch was introduced and gradually adjusted over four weeks:
    - Step 1: Started with a 5mcg patch for one week.
    - Step 2: Increased to 10mcg the next week.
    - Step 3: Increased to 15mcg the following week.
    - Step 4: Reached a final dose of 20mcg.
  - During this time, the oxycodone was slowly reduced. It went from a high of five tablets a day down to just a quarter of a 10mg tablet, used only when needed for breakthrough pain or withdrawal symptoms.

- The buprenorphine patch had to be stopped because it was causing clear skin reactions to the adhesive. As a result, the treatment was switched to a sublingual tablet (buprenorphine/naloxone 2mg/0.5mg). The new routine was taking 1/4 of a tablet twice a day.
- The patient is now pain controlled, has no symptoms of withdrawal, tolerated the taper and transition quite well overall

Clinical Pearls

The clinical pearls we want you to remember are:

- Methadone is not recommended for chronic pain management due to: Unpredictable pharmacokinetics: long and variable half-life (8–59 hrs), risk of accumulation & delayed respiratory depression, QTc prolongation & torsades risk → ECG monitoring required (especially >30–40 mg/day), CYP450 interactions (lots of drug–drug risks), high overdose risk in the outpatient setting if not carefully monitored, requires prescribers with expertise in methadone titration and monitoring
- State laws on outpatient methadone prescribing for pain vary. Methadone for opioid use disorder (OUD) can ONLY be dispensed in a certified opioid treatment program (OTP).
- It is recommended to taper methadone to 30-40mg per day before beginning a transition to buprenorphine.
- The transition in this patient case was done as a version of a "micro titration" as opposed to putting the patient into withdrawal before beginning buprenorphine. (Many find the micro titration much easier for patients to tolerate and find it easier to transition a patient from a short acting opioid to buprenorphine as well).
- Consistent contact with pharmacy staff is helpful when there are this many moving parts with the controlled prescriptions (such as tapering and titrating).
- Changes can be small and slow, just keep supporting the patient, encourage them, congratulate them for their successes and keep nudging forward. This is STILL SUCCESS!
- It's ok to start small. There are many ways to transition a patient to buprenorphine and multiple products are available.

- **Buprenorphine products approved for chronic pain treatment:** "Belbuca" buprenorphine buccal tablets come in a wide range between 75 and 900mcg tablets and "Butrans" transdermal buprenorphine patch comes in 5mcg/hr to 20mcg/hr patches that are worn for a full week at a time. Butrans is now available in a generic buprenorphine patch which has increased patient access.
- Belbuca and Butrans are FDA approved for chronic pain management but these doses are much smaller than the doses that are available in sublingual buprenorphine tablets (Subutex) or in oral buprenorphine/naloxone film or tablets (Suboxone).
- **Buprenorphine products approved for opioid use disorder (OUD):** sublingual buprenorphine tablets (Subutex) are available in 2 mg or 8 mg doses. Sublingual buprenorphine/naloxone (Suboxone) tablets or films range in strength from 2mg-0.5 mg to 12mg-3mg per dose. The usual dose for OUD is 16-24 mg of buprenorphine per day but can go up to 32 mg/day in some cases.
- For patients with chronic pain, ALL of the buprenophine options above CAN be used but if sublingual buprenorphine is prescribed, this off label use is common but must be appropriately documented.
- Buprenorphine is prescribed in divided doses for chronic pain management, whereas buprenorphine for OUD is typically given once per day.
- The Compass Opioid Stewardship Program provides opioid tapering and buprenorphine initiation resources to help. Transitioning from methadone to buprenorphine can be more complicated. For more personalized technical assistance on this topic, we encourage you to reach out to your Clinical Coach to schedule a coaching session

Thank You

This education has been brought to you through the generous support of the Centers of Medicare and Medicaid Services. Thanks for reading this week's Compass Opioid Stewardship in Practice Microlearning Series. Thank you for being part of the Compass Opioid Stewardship Program. And thank you for all you do caring for your patients.

Resources

- Opioid and Benzodiazepine Tapering: How -To Guide
- Opioid Tapering: The Risks and Benefits
- Buprenorphine for Pain Management: MME Based Product Decision Guide