ED Methadone Guideline

ED Methadone Guideline Criteria

There are two agonist medications used to treat patients with Opioid Use Disorder. One is buprenorphine (Suboxone) which is a partial agonist, and the other is methadone, which is a full agonist. Buprenorphine has multiple logistical benefits, including rapid onset (1 hour), the ability to prescribe the medication and multiple options for outpatient follow up. Therefore, buprenorphine (Suboxone) remains our first line treatment.

However, some patients may have a contraindication to buprenorphine (Suboxone), most commonly that they have not waited long enough since their last use of opioid to start buprenorphine, or they may not want buprenorphine because of a negative past experience or even because they don't like the taste. Further, some patients have tried methadone in the past and have had success, or prefer methadone treatment. The ED methadone protocol is designed for these patients.

The goal of the ED Methadone Guideline is to stabilize patients and facilitate the next day transition to the methadone clinic for treatment of their opioid use disorder. **Methadone can only be administered in the ED to treat acute opioid withdrawal to facilitate a future methadone clinic visit**. Patients are eligible for methadone if they meet all inclusions criteria and have no absolute contraindications. The max first day total dose allowed by current federal regulations is **50 mg**.

Inclusion Criteria

a. 18 years old or older
b. A diagnosis of Opioid Use disorder (OUD) via DSMV Criteria
    i. defined as tolerance or withdrawal, with recurrent use that disrupts life–full DSM criteria here- https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf
c. Active opioid use within the past 7 days
    i. Active is defined as either 1) a clinical ED presentation consistent with an opioid related complication, including opioid overdose, withdrawal, or stigmata of recent injection drug use or 2) If the patient has no clinical evidence of opioid use in the ED and is requesting methadone, a positive urine toxicology screen is required
d. Symptoms consistent with opioid withdrawal.
    i. Opioid Withdrawal is broadly defined as **any** subjective or objective symptoms the patient believes is related to opioid withdrawal (should include a COWS > 0)
e. Interested in methadone treatment (involves daily morning visits to a methadone clinic)
    i. Verify transportation to the methadone clinic
f. A photo ID (driver's license / passport / government issued ID card)

Absolute Contraindications

a. Isolated accidental opioid overdose without prior opioid use (for example, patients who use cocaine that had an accidental exposure to an opioid.) This does not meet the definition of Opioid Use Disorder
b. End stage liver disease with clinical stigmata of liver failure (cirrhosis, LFT > 5x normal)
c. Altered Mental Status (acute alcohol intoxication, psychosis, delirium) or respiratory depression
d. Known prolonged QTc (screening ECG for all patients is not required, as the risk of significant QTc prolongation from an initial dose of methadone is unlikely. However, if the patient is taking multiple other medications that prolong the QTc, a screening ECG can be obtained)
e. Allergy to methadone
f. Patient unwilling to sign release of information (ROI) for relevant treatment providers

Special Considerations- Consider Consult to Addiction Medicine

a. Caution in starting methadone in patients who use other sedating substances (benzodiazepines), or who are on prescribed sedating medications. This can increase risk of sedation and overdose.
b. Caution in starting methadone in patients with alcohol use or alcohol use disorder due to the increased risk of sedation and overdose.
c. Caution in starting methadone in any patient with concurrent benzodiazepine and/or alcohol withdrawal. Recommend inpatient treatment.
d. Patients who have already completed the ED methadone induction protocol in the past should be discussed with the methadone clinic (see resources below) prior to administering methadone. It is permissible to treat patients more than once as long as each instance is clearly a separate episode of care. The determination of a separate episode of care is largely dependent on the clinician's input. For purposes of day-to-day operations, any presentation at least 1 week after last methadone dose in a Lifespan Emergency Department is a separate episode of care, so patients may be reassessed and treated if appropriate.

   That said, separate episodes of care should prompt reevaluation of the need for a higher level of care and candid discussion with patients about whether outpatient direct admission to OTP involves adequate support to help them reach their treatment goals. If patients do not sustain OTP linkage after two separate episodes of 72H methadone care, it is generally a sign that more support is needed. Referral to an inpatient detox program that offers methadone protocol and direct admission is recommended in most of these circumstances. In all cases, a request for a 3rd (or greater) episode of care should prompt interdisciplinary discussion.
e. Pregnancy. Methadone or buprenorphine are first line medications for opioid use disorder in pregnancy. If you have a pregnant patient who is interested in methadone, they may benefit from expedited initiation in a more monitored setting. If available, please consult addiction medicine.

   During business hours please call: Women and Infants Mom's MATTER clinic: 401-430-2700

f. Barriers to linkage with OTP:
   i. Behavior challenges impacting past care at desired OTP
   ii. Required to complete inpatient detox as a condition of OTP return
   iii. Not linked to OTP after past referral
   iv. Request OTP outside of CODAC

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If patient is interested in methadone and meets inclusion criteria without absolute contraindications, please complete the .BEMMETHADONE note:

Document in your note:

History of opioid use

How long has the patient had opioid use disorder?
What drugs does the patient use? (*heroin/fentanyl, pills)*
How do they use? *(Injection, insufflation or snorting)*
How much does the patient use per day?
When was the patient's LAST OPIOID USE?

Prior methadone use

Has the patient used methadone in the past?
Which methadone clinic did the patient attend?
What was their stable or last dose of methadone in mg?
When was their last dose (date)?

COWS:

Document the Clinical Opioid Withdrawal Scale (COWS), which should be > 0 to start methadone (can be entered as a nursing order)

Lab Testing:

No Lab testing is required for patients who present to the ED with:
1) an opioid related complication (overdose, withdrawal) or stigmata of recent opioid use.
2) No personal or family history of prolonged Qtc
3) Not taking psychiatric medications or other medications that could prolong the Qtc.

Urine Toxicology: For patients **without** an opioid related complication (overdose, injection related disease or withdrawal) or any question or concern regarding recent opioid use history, confirmation of drug use through urine screen is required. We recommend including the following labs:
Urine Opioid – captures heroin, morphine, codeine
Urine Fentanyl
Urine Methadone

Electrocardiogram: Consider an electrocardiogram (ECG) if the patient is on medications that could prolong the QTc. Methadone doses 40mg and below are at a low risk to significantly prolong the QTc – the risk increases as doses exceed 100mg per day.

Adjunctive Medications:

If the patient has withdrawal symptoms either before or after their methadone dose, you can give other non-sedating supportive medications in the ED or as a prescription to help with withdrawal, including:

a. Clonidine (0.2mg every 6 hours)
b. Zofran for nausea / vomiting (4mg OD Tablet every 6 hours)
c. Ibuprofen for muscle aches (400mg every 8 hours)
d. Dicyclomine (Bentyl) for GI upset (20mg every 6 hours)
e. Loperamide Initial: 4 mg, followed by 2 mg after each loose stool; Maximum 8 mg/day)

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ED METHADONE PATHWAY

This Pathway should be used for patients who meet the criteria described above, who are presenting to the ED with Opioid Use Disorder with symptoms consistent with opioid withdrawal who are interested in methadone.

Prior to giving Methadone in the ED.

1. The patient must be awake and alert (GCS 15)
2. The patient should not be under the clinical influence of other sedating illicit substances
3. The patient must sign the ED Substance Use Consent form (Located at: https://brownphysicians.org/emergency-medicine-resources/) to allow us to share health information with the methadone clinic.
4. PDMP check completed to evaluate for controlled substance prescription within last 30 days

1) Review the following with the Patient:

1. Methadone requires you to go to the methadone clinic every morning for your dose (we cannot prescribe methadone for the treatment of addiction at this time).
2. You should avoid taking new medications or illicit drugs that could make you sleepy (you can continue your regular home medications).
3. By law, we cannot continuously give you doses of methadone from the Emergency Department. Our goal is to give you a first dose then connect you with a methadone clinic to continue treatment.

2a) Give an initial dose of 40mg PO of Methadone if the patient meets any of the following criteria:

1. They inject fentanyl daily
2. They snort (insufflate) or smoke fentanyl daily
3. They have been on methadone within the past year and their dose was 50mg or higher
   *For patients with persistent withdrawal after an initial 40 mg dose, an additional 10 mg can be provided for a max total dose on day 1 of **50 mg** methadone.

2b) If they do not meet above criteria, give an initial dose of 20mg PO Methadone

3) Prior to discharge, the following 3 documents must be completed and faxed to the methadone clinic (the patient can choose either CODAC OTP clinic, VICTA OTP, or the CTC (previously Discovery) OTP clinic based on patient preference)

1. A signed ED Substance Use Consent form ((Located at: https://brownphysicians.org/emergency-medicine-resources/). Once faxed or emailed, the document goes into the patients chart.
2. The patient Face Sheet
3. A signed Methadone Last Dose and Continuing Care Letter (located below or at https://brownphysicians.org/emergency-medicine-resources/). Once faxed or emailed, the last dose methadone letter needs to be placed in an envelope (see ED clerk for envelope) sealed, and signed over the seal. The patient will to be given to the patient to bring to the methadone clinic upon discharge.

4) When ready to discharge the patient home with the following:

1. Include the Methadone Discharge Instructions for the clinic the patient chose (CODAC)(see below)
2. The Methadone Last Dose Letter needs to be placed in an envelope and given to the patient. The patient must present the last dose letter to the methadone clinic.
3. Please give patient a take home Narcan from the Omnicell. (order in the ED Opioid Use Disorder)

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ADDRESSING COMPLICATIONS

Federal Law states we can administer (not prescribe) methadone to relieve acute withdrawal symptoms as we connect a patient to a methadone clinic. (Title 21, Code of Federal Regulations, Part 1306.07(b)) (https://www.deadiversion.usdoj.gov/pubs/advisories/emerg_treat.htm)

PROBLEM 1: The patient arrives after an opioid overdose

1. You must wait until the patient has a GCS of 15 and is awake and alert
2. Methadone can only be administered in the ED to treat acute opioid withdrawal to facilitate a future methadone clinic visit. There is no legal definition of withdrawal, it is at the discretion of the provider
    a. Please document a COWS score. As long as the score is greater than zero at some point during their ED stay, we can justify opioid withdrawal and methadone can be administered.

PROBLEM 2: The patient arrives to the ED and is experiencing moderate or severe withdrawal symptoms (COWS 8 or greater).

1. Give the initial methadone dose as directed in the protocol
2. If after 3-4 hours they are still experiencing moderate or severe withdrawal (COWS 8 or greater), you can administer an additional 10mg dose once.
3. The max daily dose total is 50mg on day 1 of starting methadone.
4. If the patient continues to have **severe** withdrawal despite the max daily dose of methadone, consider other causes (alcohol, benzodiazepines) and medical admission.
5. If the patient has **mild** withdrawal despite the max daily dose, you can give other non-sedating medications in the ED or as a prescription to help with withdrawal, including:
    a. Clonidine (0.2mg every 6 hours)
    b. Zofran for nausea / vomiting (4mg OD Tablet every 6 hours)
    c. Ibuprofen for muscle aches (400mg every 8 hours)
    d. Dicyclomine (Bentyl) for GI upset (20mg every 6 hours)
    e. Loperamide Initial: 4 mg, followed by 2 mg after each loose stool; Maximum 8 mg/day)

PROBLEM 3: If the patient requires admission after receiving methadone dose.

1. Place an inpatient addiction medicine consult (Addiction Consult) to help continue treatment and arrange follow up at RIH or TMH. At Newport please update the accepting team.

PROBLEM 4: The patient is requesting methadone and has no opioid related complication, no stigmata of opioid use, no withdrawal signs or symptoms and a negative urine toxicology screen.

1. Explain to patient that we cannot administer methadone without confirmation of active opioid use disorder, as it would be dangerous to give methadone to a patient who may be opioid naïve. Provide referral to outpatient SUD treatment center or BH Link.

PROBLEM 5: The patient returns to the ED on Day 2 or Day 3 for dosing after being started on methadone for OUD in the ED.

1. Discuss with patient and determine if and why the patient was not seen in the methadone clinic.
2. Assess the patient
    a. If they are sedated or have a GCS less than 15, they should not receive a methadone dose. This can be due to the fact that many patients still use illicit opioids while stabilizing on methadone. The patient may need to stay in the ED until their mental status improves. Once their mental status improves and they have a GCS of 15, they can be administered the same dose of methadone as the day prior, if clinically appropriate.
    b. If the patient has a GCS of 15 and does not have significant withdrawal symptoms, they can be administered the same dose as the day prior.
    c. If the patient has significant withdrawal symptoms (COWS >7) despite the methadone dose the day before, the patient can be administered an additional 10 mg each day for up to 3 days. For example, if the patient had a day 1 dose of 40mg and they present with a COWS of 8, they can receive up to 50mg on day 2. If they again present in withdrawal, they can receive up to 60mg on day 3.
3. **BY LAW- we CANNOT administer methadone beyond 72 hours or 3 days.**
    a. **There are no exceptions to this rule.**
4. We can NEVER **prescribe** methadone for management of addiction.
    a. **There are no exceptions to this rule.** You can only dispense methadone via 21 CFR 1306 for up to 72 hours. At this time from the ED at Lifespan we are only providing in ED for observed doses.