The GeriJournal

Volume 12, Number 12
December 2017
A publication of GeriatRx Pharmacy

Methadone Matters

Every so often we receive inquiries about methadone, and whether it should or can be used. The requests relate to two different types of residents; those with a history of drug dependency who need methadone for *Methadone Maintenance Therapy* (MMT) or those requiring methadone for pain. I will touch upon the key requirements and concerns for the use of this drug in the institutional setting.

Let's tackle MMT first. Opiate addiction is not a new problem, although fentanyl and other street drugs have brought this challenge to a new level recently. Some longstanding MMT patients are elderly and are seeking LTC and retirement home placement. Other older patients with acute or chronic pain have also become opiate dependent and find themselves in the same situation.

Methadone is an excellent drug for maintenance. It doesn't cause impairment or marked euphoria, if used properly. It has a long duration of action, allowing for once daily dosing.

On the "down" side, its metabolism can be blocked by some medications (CYP 3A4 inhibitors, etc.), Biaxin® being the worst of these. It also can increase the QT interval, a risk factor for fatal arrhythmias. Other QT prolonging drugs, such as Motilium®, Celexa®, Remeron®, Atarax®, amiodarone and most anti-psychotic medications should not be co-administered with it. An ECG must be done, and methadone not considered if the QT interval is greater than 450 msec. Its metabolism is a complex, two-phase process. Once the initial phase is saturated, further drug causes blood levels to skyrocket. Fatal respiratory suppression is possible.

To prescribe methadone, a physician must have a special exemption from the *College of Physicians and Surgeons of Ontario* (CPSO). This involves completion of a detailed program and, due to the challenging nature of this drug, has become somewhat of a specialized practice area. These physicians are experienced with methadone initiation and replacement of addictive opioids, dosing, interactions and monitoring. They do regular blood testing to ensure their patients have not restarted elicit, non-prescribed opiates. When beginning therapy in the community, patients report to their pharmacy each day to take a single, witnessed dose of medication. In this way, they cannot take home and accumulate doses (or sell them), to produce a "high". After a period of weeks with no irregularities, patients are permitted to carry home small amounts of medication, called "carries", and this amount can eventually accumulate to as much as a two-week supply.

Methadone for MMT can be sent to facilities. It is treated like other narcotics, with full verification of receipt and tracking. It is provided in dose-customized diluted format in a one-week supply. An alternative, Suboxone®, is now a popular alternative to MMT. It has less QT activity and a better interaction profile, but pain control may be inferior.

Methadone for pain/analgesia requires a different CPSO exemption than MMT. Dosing is by standard capsule, which is only covered by ODB if other narcotics have failed or caused intolerable side effects. Once the dose is stabilized, it is usually administered BID.

Apotex Tragedy

The loss of Barry and Honey Sherman was a shock to our healthcare community. Barry was a pioneer, building Apotex into the largest generic drug manufacturer in the country. We extend our sympathies to Apotex and the Sherman family.

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