Necessary Information for Prescribers

Methadone for Chronic Pain Series

Methadone is available in a variety of forms (tablets, dispersible tablets, liquid), and is manufactured by many pharmaceutical companies.

Methadone should be prescribed only for the treatment of chronic pain by clinicians who are knowledgeable about and skilled in assessing and managing the potential risks associated with its use. Methadone has unique pharmacokinetic and pharmacodynamic properties that require a cautious and highly individualized approach. Serious cardiac and respiratory events, including deaths, have been reported during initiation and conversion of pain patients from other opioid treatments to methadone. Clinicians should be particularly cautious prescribing methadone during treatment initiation, conversion from other opioid medications, and titration.

In order to reduce the serious risks associated with methadone treatment, clinicians should familiarize themselves with the safety information contained in the full prescribing information of the specific product prescribed and adhere to the important clinical considerations outlined below.

**Before initiating treatment with methadone, conduct a comprehensive patient evaluation, including assessment of the risks of overdose and abuse, and manage patients accordingly.**

- Methadone should be administered with extreme caution in patients with impaired respiratory function.
  - Impaired respiratory function includes conditions accompanied by hypoxia, hypercapnia, or decreased respiratory reserve such as asthma, chronic obstructive pulmonary disease or cor pulmonale, severe obesity, sleep apnea syndrome, myxedema, kyphoscoliosis, CNS depression, or coma.
- Patients with a history of substance use disorder of any kind or concurrent psychopathology are at increased risk of misuse, abuse, and addiction.

**Methadone should be used only to treat chronic, moderate to severe persistent pain that is not responsive to non-opioid analgesics.**

- Methadone treatment should be considered only if the potential benefits are determined to outweigh the potential risks and there is no treatment alternative that is likely to pose as favorable a balance of benefits to risks.
- Methadone has a long and variable half-life. It should not be used to treat breakthrough pain or as an as-needed medication.

**Initiate methadone treatment at very low initial doses.**

- Use conventional conversion tables cautiously when switching from another opioid to methadone. Equianalgesic dose ratios between methadone and other opioid analgesics are unreliable, especially when converting from high doses.
- Determining the initial methadone dose when converting from other opioid analgesics is complex and can increase the risk of overdose, especially in patients taking high doses.
- Patients tolerant to other opioids may not be completely tolerant to methadone. Deaths have occurred in opioid-tolerant patients during conversion to methadone.
Use caution when prescribing methadone with sedatives (eg, benzodiazepines)

- Concomitant use of sedating medications to treat comorbid anxiety or sleep disorders can increase the risk of overdose and respiratory depression.

Titrate methadone no more frequently than once per week

- Because of its very long and variable half-life, methadone must be titrated carefully to avoid the potential for delayed adverse events such as overdose.
- While the analgesic action of methadone typically lasts 4 to 8 hours, peak respiratory depressant effects typically occur later and persist longer, which can lead to overdose, particularly during treatment initiation and dose titration.

During treatment initiation and titration, evaluate patients for adequate analgesia and potential overdose

- Counsel patients to contact you if the methadone dose does not control their pain or causes symptoms suggesting that their dose may be too high.

Continue to evaluate patients for their clinical risk of overdose, abuse, addiction, or diversion, particularly patients taking high doses of methadone

- Routine assessment should include aberrant drug-related behaviors, substance use, and psychological issues. Watch for and manage psychopathology when it occurs.
- Assess for sleep apnea in patients on high daily doses of methadone and in patients with risk factors for sleep apnea. Consider temporary dose reduction (approximately 30%) in patients with upper respiratory infections or asthmatic episodes.

For more information on the risks associated with methadone please see the Methadone Education Mini Reference Series

For more information on the proper dosing and administration of methadone please see Methadone Dosing for Chronic Pain: Clinical Considerations for Initiation and Titration.

References