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Methadone for Pain Management: Improving Clinical Decision Making

Recommended Prescriber Practices from the **American Academy of Pain Medicine**

1. Patients with intermittent chronic pain requiring opioid medication only "as needed" or who have a history of medication non-compliance are not good candidates for methadone therapy.

2. Initiate therapy at a low dose – 15 mg or less per day in divided doses; lower doses are recommended for older patients, frail patients, or individuals with at-risk co-morbidities (e.g. COPD).

3. Increase dose no more often than once per week.

4. Increase dose slowly, with total daily dose increases not to exceed 5-10 mg per week.

5. Assess patient's risk for developing a prolonged QT interval and provide appropriate surveillance of ECG. For example, patients with cardiac disease taking other QT interval prolonging drugs, patients with electrolyte abnormalities (renal insufficiency/diuretic therapy/hemodialysis), patients with poorly controlled DM, or patients taking 60-100 mg or more of methadone a day. Repeat ECG following dose increases in these high risk patients. Decrease dose or discontinue therapy if QT interval exceeds 470 milliseconds in men or 480 milliseconds in women (Johnson and Ackerman 2009).

6. Perform StopBANG screening for potential OSA. Evaluate for sleep apnea in patients with a history of sleep-induced airway obstruction or untreated sleep apnea, or patients exceeding 50 mg methadone per day. Prescribing of methadone should be contingent upon compliance with OSA treatments.

7. Don’t prescribe for patients with known sleep disordered breathing who are non-compliant with their respiratory assistive devices.

8. Evaluate additional respiratory depressant risk factors related to use of sedatives with methadone.

9. Communicate with patient the critical importance of not using more methadone than directed even if the pain is not well controlled.

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10. Use immediate release opioid formulations during methadone dose titrations if the initial dose of methadone is inadequate to manage the pain. Use a dosage of the IR opioid that would be safe but effective. For example, oxycodone 5 mg q 4 hours NTE 6 per day and one week supply.

Outcomes

Standardize the implementation of risk reduction strategies and patient safety practices in prescribing methadone for the treatment of chronic pain.

- ☐ Reduce incidence of unintentional opioid associated overdose deaths.
- ☐ Reduce incidence of methadone overdoses due to too rapid dose escalation.
- ☐ Reduce incidence of methadone overdoses due to too high of a starting dose.
- ☐ Reduce incidence of overdoses due to opioid rotation to methadone.
- ☐ Reduce the risk of lethal cardiac dysrhythmias due to methadone.

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