Treatment of Opioid Use Disorder

February 2024

Table 1: Considerations When Choosing Buprenorphine or Methadone (Preferred Agents for Opioid Use Disorder Treatment)

Consideration	Buprenorphine	Methadone
Effectiveness	Treatment of OUD with BUP or methadone is associated with reducing other opioid use, promoting treatment retention, and reducing all-cause and overdose-related mortality.	
Patient preferences	May be preferable for patients who are new to pharmacologic OUD treatment, have had previous success with BUP, do not like or want to take methadone, or who have requested this medication.	May be preferable for patients who have had previous success with methadone, do not like or want to take BUP, or who have requested this medication.
Setting	Available through various treatment settings, including office-based prescription or specialty OTPs.	• Available only through a specialty OTP or a mobile medical unit (in New York State). • Effective for 1 year after the end of the COVID-19 Public Health Emergency, OTPs have increased flexibility to provide unsupervised take-home doses of methadone, potentially up to 28-day supplies, depending on the patient's time in treatment and the OTP clinician's assessment of therapeutic risks and benefits.
Initiation	• Opioid withdrawal is required for standard initiation. • Low-dose BUP with opioid continuation (previously known as microdosing or micro-induction) is an alternative strategy that does not require onset of opioid withdrawal.	Opioid withdrawal is not required for initiation.
Titration	• Sublingual doses can be increased to an FDA-approved maximum of 24 mg per day to suppress opioid cravings and prevent withdrawal. • Sublingual dose increases up to 32 mg daily may be indicated for individuals with ongoing withdrawal symptoms, cravings, or opioid use, but clear documentation of rationale and prior insurance authorization may be required. In New York, as of January 18, 2024, the state Medicaid program covers up to 32 mg BUP daily for OUD treatment without prior authorization.	Dose can be increased gradually to suppress opioid cravings and prevent withdrawal, with no maximum dose.

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Adverse effects and safety	• Lower risk of respiratory depression and sedation than full-agonist opioids. • Opioid-related adverse effects can occur, including constipation and sleep-disordered breathing.	• Higher risk of respiratory depression and sedation than partial-agonist opioids; dose with caution in patients with severe respiratory disease or who are taking methadone in combination with other sedating substances. • Associated with QT prolongation, particularly with history of arrhythmia, structural heart disease, or concurrent use of other QTc prolonging medications. • Opioid-related adverse effects can occur, including constipation and sleep-disordered breathing.
Medication interaction	Few clinically significant interactions with medications other than full opioid agonists.	Clinically significant interactions with medications that are metabolized by CYP450 enzymes can occur, leading to increased or decreased effects of methadone. • See Medscape: Drug Interaction Checker.
Counseling requirements	Not required unless legally mandated, but clinicians can refer for behavioral therapy and support services.	• Specialty OTPs offer more structured counseling and support services than primary care settings. • In New York State, psychosocial counseling is not required for methadone treatment.
Treatment switch	Switching to XR-BUP or methadone is possible if needed to control opioid cravings and withdrawal despite maximized sublingual BUP dosing.	• Can be considered when benefits outweigh risks. • Closely monitor switch to BUP because of the potential for precipitated withdrawal.

Abbreviations: BUP, buprenorphine; CYP450, cytochrome P450; FDA, U.S. Food and Drug Administration; OTP, opioid treatment program; OUD, opioid use disorder; XR, extended-release.