META:PHI 2025 Webinar Series

Methadone prescribing: the basics

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META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Disclosures

- In Oct 2024, Dr Kahan received an honorarium from Indivior for a presentation on methadone

Learning objectives

- Discuss the benefits and risks of methadone compared to buprenorphine
- Describe a protocol for prescribing methadone, including initial dose, dose titration and optimal dose
- Describe the patient assessment, lab tests, & harm reduction interventions
- Discuss how and when to prescribe take-home doses

Questions

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Pharmacology of methadone

Pharmacology of methadone

- Methadone is a full mu agonist
- Highly potent – 1 mg methadone is the analgesic equivalent of around 8 mg morphine
- Reaches a peak concentration in 2.5-4 hours post-dose
- Half-life long and variable
- At the start of treatment, half-life is up to 5 days
- With ongoing dosing and enzyme induction, half-life declines to 22 hours average
- It takes 5 days to reach steady state with dose increases – although 80% of steady state is reached after 3 days
- This means that methadone accumulates in the serum over several days – the level is higher on day 3 of a dose increase than day 1

Sunilkumar MM, Lockman K. Practical Pharmacology of Methadone: A Long-acting Opioid. Indian J Palliat Care. 2018 Jan;24(Suppl 1):S10-S14.

Dispensing

- Methadone is dispensed in unit bottles as a coloured and flavoured liquid (Methadose)

	Methadose (Mallinckrodt)	Sandoz Methadone (Sterinova)	Metadol-D (Paladin)	Compounded methadone	Methadose Sugar-Free (Mallinckrodt)
Properties	Pink, cherry-flavoured, contains sugar	Blue, cherry-flavoured, sugar-free	No colour, unflavoured, contains sugar	No colour, unflavoured, sugar-free	No colour, unflavoured, sugar-free
Concentration	10mg/mL	10mg/mL	10mg/mL	10mg/mL	10mg/mL
Formulation	Commercially concentrated	Commercially concentrated	Commercially concentrated	Compounded by the Product Distribution Centre and delivered to the patient's pharmacy	Commercially concentrated

BCCSU Methadone Chart
Methadone-Chart.pdf

- Early in treatment, it is generally dispensed under the observation of the pharmacist
- Take-home doses are gradually introduced when the clinician feels it is safe to do so
- Methadone is also available as tablets, but these are rarely prescribed
  - Tablets are not recommended for patients with Opioid Use Disorder because they easily injected
  - They are used for severe chronic pain, but they are not covered by ODSP and are expensive

Adverse effects

- Same as other opioids – sedation, fatigue, sleep apnea, constipation, nausea, sexual dysfunction
- At very high doses and if other risk factors present, methadone can prolong QT interval and (rarely) cause Torsades de pointes (ventricular arrhythmias)
- Methadone is very potent and can cause respiratory suppression and death, especially in the first couple of weeks of treatment
- Gradual onset of overdose symptoms: ‘nodding off’, slurred speech
  - Patients who have overdosed can appear relatively alert when engaged in conversation
  - When alone, they fall asleep and die

Effectiveness of methadone

- Multiple controlled trials and systematic reviews have shown that methadone is effective in reducing overdose and total mortality, and reducing hospitalizations from bacterial infections
- It markedly reduces overdose risk, even in fentanyl users
- It does this by:
  - Reducing the amount and frequency of use
  - Building/maintaining tolerance to opioid-induced respiratory suppression

Safety and effectiveness of methadone versus sublingual buprenorphine

Methadone is more effective than buprenorphine at retaining patients in treatment

- Controlled trials and observational studies have consistently shown that patients remain in treatment longer with methadone than with buprenorphine
- Meta-analysis (Degenhardt 2023): Risk ratio 0.76 methadone vs buprenorphine
- This is likely because methadone is a potent, full mu agonist whereas buprenorphine is a partial agonist with a ceiling effect
- Methadone is more effective at relieving withdrawal symptoms and cravings in high potency, high dose opioid users
- Withdrawal from methadone may be more intense, which could also keep patients in treatment

Degenhardt L, Clark B, Macpherson G, Leppan O, Nielsen S, Zahra E, Larance B, Kimber J, Martino-Burke D, Hickman M, Farrell M. Buprenorphine versus methadone for the treatment of opioid dependence: a systematic review and meta-analysis of randomised and observational studies. Lancet Psychiatry. 2023 Jun;10(6):386-402.

Buprenorphine is much less likely to cause a fatal overdose than methadone

- In the US in 2020, there were 52 deaths per month (620 deaths per year) with methadone but no other opioids present in the serum (Kleinman 2023)
- The large majority of these deaths were from diverted methadone
- Death with buprenorphine but no other opioids present is rare
- Even an excessive dose of buprenorphine does not fully suppress the respiratory center in adults

Kleinman RA, Sanches M. Methadone-involved overdose deaths in the United States before and during the COVID-19 pandemic. Drug Alcohol Depend. 2023 Jan 1;242:109703.

Methadone may be more likely to cause side effects than buprenorphine

- Sedation
- Sexual dysfunction (Yee 2019)
- Cardiac arrhythmia due to QT prolongation

Yee A, Loh HS, Loh HH, Riahi S, Ng CG, Sulaiman AHB. A comparison of sexual desire in opiate-dependent men receiving methadone and buprenorphine maintenance treatment. Ann Gen Psychiatry. 2019 Oct 22;18:25.

Methadone versus extended-release (ER) buprenorphine (Sublocade)

- Retrospective cohort study (Lee 2023): Buprenorphine ER associated with fewer non-fatal overdose events than methadone
- Buprenorphine ER has a higher and more constant serum level than buprenorphine-naloxone, so may be more effective at relieving withdrawal symptoms and cravings, retaining patients in treatment, and preventing overdose
- In a pragmatic RCT comparing patients on buprenorphine ER to those on buprenorphine/naloxone or methadone, the buprenorphine ER group had higher rates of opioid abstinence and higher treatment retention (Marsden 2021)
  - However only a few patients were on methadone
- RCT comparing buprenorphine ER to methadone are currently being conducted

- Lee K, Zhao Y, Merali T, Fraser C, Kozicky JM, Mormont MC, Conway B. Real-world Evidence for Impact of Opioid Agonist Therapy on Nonfatal Overdose in Patients with Opioid Use Disorder during the COVID-19 Pandemic. J Addict Med. 2023 Nov-Dec 01;17(6):e374-e381. doi: 10.1097/ADM.0000000000001213. Epub 2023 Aug 11. PMID: 37934531.
- Marsden J, Kelleher M, Gilvarry E, Mitcheson L, Bisla J, Cape A, Cowden F, Day E, Dewhurst J, Evans R, Hardy W, Hearn A, Kelly J, Lowry N, McCusker M, Murphy C, Murray R, Myton T, Quarshie S, Vanderwaal R, Wareham A, Hughes D, Hoare Z. Superiority and cost-effectiveness of monthly extended-release buprenorphine versus daily standard of care medication: a pragmatic, parallel- group, open-label, multicentre, randomised, controlled, phase 3 trial.EClinicalMedicine. 2023 Nov 17;66:102311.

How to manage your fears about methadone

- Have a mentor if you are a new prescriber
- Follow the dosing guidelines
- Dose titration is based on the patient's level of risk for methadone toxicity
- Fentanyl is far more potent than methadone, so fentanyl users have high opioid tolerance and are at low risk of methadone toxicity
- The risk of treatment drop out vastly outweigh the risks of methadone toxicity from inappropriate prescribing
- **All RAAM clinicians should feel comfortable prescribing methadone when indicated**

Criteria for choosing methadone

Patient preference

- Many patients have tried methadone and/or buprenorphine
- They often have strong preferences for one over the other
- Best to go with these preferences
- Patients who expect a good outcome with treatment are more likely to do well

Previous experience with opioid agonist treatment

Methadone should be considered if:

- Patient has previously done well on methadone: reduced high risk opioid use, fewer opioid-related overdoses, infections; improved mood and function
- Buprenorphine SL or XR treatment was unsuccessful: repeated missed doses or treatment drop out, or ongoing high risk opioid use

Higher risk of methadone toxicity

- Heavy alcohol use, benzodiazepine use, gabapentin use
- Low opioid tolerance (e.g. moderate prescription-based opioid use)
- Medical conditions: respiratory impairment (e.g. COPD)
- Older age

- Buprenorphine is preferred if risk factors are present
- If methadone is tried, use lower initial dose and titrate more slowly

Higher risk of treatment drop out

- Fentanyl or heroin use
- Concurrent mental illness
- Homelessness
- Heavy use of other substances e.g. crystal meth

- Methadone preferred over sublingual buprenorphine if at high risk of treatment drop out

Difficulty attending the pharmacy daily

- Methadone should be dispensed daily under observation for at least the first month of treatment, with gradual introduction of take-home doses (see later)
- This reduces the risk of diversion or overdose death
- Patients are at higher risk of missing doses if they have concurrent mental illness, stimulant use, homelessness, or lack of transportation to pharmacy
- If patient misses several doses in a row, the dose is lowered, the dose is reduced, resulting in subtherapeutic doses and treatment drop out
- Youth also tend to have difficulty with daily pharmacy visits and frequent clinic visit
- Buprenorphine is preferred for these patients
  - Safer to give carry doses earlier in treatment
  - Injectable removes the daily dosing requirements

Methadone Dosing

Initial dose

- Depends on patient's risk of toxicity, and the amount and potency of their opioid use
  - Risk factors for methadone toxicity: heavy alcohol use, benzodiazepine use, gabapentin use, lower opioid tolerance (e.g. prescription-based opioid use), COPD, older age, sleep apnea
- Initial dose for patients at risk for toxicity: 10-25 mg
- Standard initial dose (no known risks): 30 mg
- Initial dose for fentanyl users: 40 mg (BCCSU recommendation)
- New META:PHI guidelines: up to 50 mg for high dose (at least 1 gram/day) for fentanyl users who are known to your clinic

Titration

- With each dose increase, the patient should experience longer and more complete relief of withdrawal symptoms and cravings
- Doses should be increased by no more than 5-15 mg every 3-5 days, to avoid sedation with bioaccumulation
- Increase by 15 mg if patient is still experiencing marked withdrawal symptoms, and is at lower risk of toxicity
- Increase by 5-10 mg if patient's withdrawal symptoms have substantially lessened, or is at higher risk of toxicity
- Increase every 3-4 days during first couple of weeks, until the patient experiences significant relief from their methadone dose

Optimal dose

- Optimal dose: Relief of withdrawal symptoms and cravings for up to 24 hours, marked reduction in opioid use, minimal sedation
- Optimal dose usually in the range of 80-120 mg per day
- It can take several weeks to reach the optimal dose
- Higher initial doses for fentanyl users will shorten the time to reach an optimal dose

Slow-Release Oral Morphine (SROM)

- Can be used as a sole opioid agonist treatment, or in combination with methadone in people who use fentanyl or heroin
- People who use fentanyl have very high tolerance to opioids
- Methadone may provide little relief of withdrawal symptoms and cravings until a dose of ~80 mg
- Some drop out of treatment before reaching this dose
- SROM reaches a peak in the serum 10 hours after dosing, when the effect of methadone is wearing off early in treatment
- Adding SROM to methadone can help retain patients in treatment (provide closer to 24h of coverage)
- Initial dose of SROM for heavy fentanyl users: 200-300 mg
- Can be titrated by 100-200 mg every 2-3 days
- After an optimal dose of methadone is reached, the SROM can be tapered down, or maintained if the patient feels it is benefitting them

Wrap-around Care

Assessment

- Type of opioid, frequency of use, route of delivery (injection, smoking, oral), time of last use
- Opioid-related problems: withdrawal symptoms, overdoses, injection-related infections, legal difficulties, reasons for use
- Previous OAT experience (e.g. previous methadone treatment: maximum dose reached, length of time on methadone, reason for discontinuing)
- Other substances used (alcohol, cocaine, meth, benzodiazepines)
- Prescribed medications (e.g. gabapentinoids, benzodiazepines)
- Medical conditions e.g. COPD, hepatitis C
- Psychiatric diagnosis and hospitalizations
- Social situation – housing, social supports, child-care
- General practitioner

Lab tests

- CBC, liver enzymes, Hepatitis B, C, HIV serology, VDRL, Urine HCG
- ECG

- Don’t delay starting methadone pending assessment or lab tests
  - *Unless* there's a family Hx of **prolonged QT syndrome** or **sudden cardiac death**
  - The only lab test that should be obtained on first visit is **Urine Drug Screen** (point of care test)
  - Prescriber may overestimate tolerance and cause methadone toxicity if patient claims to be using fentanyl yet UDS is negative for fentanyl

Lab tests

- ECG should be requested for doses of 80-100 mg or above, especially if patient at higher risk for arrhythmias:
    - previous heart surgery
    - structural heart disease
    - risk for electrolyte abnormalities (e.g. diuretics)
    - on drugs that prolong QT (e.g. antipsychotics, cocaine, amphetamine)

Harm reduction

- Give take-home naloxone kit and explain its use
- Explain overdose prevention strategies:
  - Always carry naloxone kit
  - Never use alone, even in your own house
  - Don’t mix opioids with alcohol or benzodiazepines
  - Use ‘test dose’
- Give supply of clean needles or inhalation equipment and counsel on sterile injection/inhalation techniques

Harm Reduction Fundamentals (units to complete):
Harm Reduction Fundamentals: A toolkit for service providers | CATIE - Canada's source for HIV and hepatitis C information

Harm Reduction Resources (needle syringe program COP)
75a035b1-1d7d-439e-8571-3f17d32640f5.pdf

CCSA Harm Reduction Resources
Resources (Opioids) - Harm Reduction | Canadian Centre on Substance Use and Addiction

Counselling during early titration

- Daily observed dosing is temporary
- If you feel you must use, use just enough to relieve withdrawal symptoms
- Try to avoid alcohol, benzodiazepines, gabapentin
- As you approach an optimal dose, your withdrawal symptoms and cravings will diminish and your sleep, energy level, mood and daily function will improve
- Try to avoid drug dealers/negative influences and spend time with family, friends
- Be patient – don’t be discouraged by setbacks - give methadone a good try

Take-home Doses

Take-home doses

- Take-home doses can be diverted, putting methadone-naïve patients at risk of overdose
- Yet patients will drop out of treatment if they have to attend the pharmacy daily for an indefinite period
- Evidence shows that the gradual introduction of take-home doses to patients who have reduced problematic substance use is the most effective policy for retaining patients in treatment while minimizing diversion

Take-home doses (2)

Decision to prescribe carries based on:

- Length of time on methadone
- Ability to store medication safely
- Stability (e.g. no psychosis or suicidality)
- Substance use
- Missed doses

Lam V, Latreille S, McLeod A, Munro C, Wyman J, Zhang M. A new framework for methadone carries: A person-centered evidence-informed approach to methadone take-home "carry" dosing. Toronto, ON: META:PHI; 2023.

Take-home doses (2)

The goal of this approach is to **balance the benefits and risks** of methadone carries.

SIX GUIDING QUESTIONS FOR MAKING DECISIONS ABOUT CARRIES

1. Can the carries be kept **safe**?
2. **How long** has the person been taking methadone?
3. How is the person managing their responsibilities(i.e., **stability**)?
4. Does the person take **most of their observed doses**?
5. Are the person's recent **substance use patterns** lower or higher risk?
6. What do the person's **urine drug tests** show?

Lam V, Latreille S, McLeod A, Munro C, Wyman J, Zhang M. A new framework for methadone carries: A person-centered evidence-informed approach to methadone take-home "carry" dosing. Toronto, ON: META:PHI; 2023.

CARRY PRINCIPLES_ONE-PAGER_v3

Carry schedule

- Minimum 4 weeks suggested before take-home doses
- After four weeks, up to three non-consecutive carries per week (if patient meets criteria)
- Can then increase by one carry per week every two to four weeks
- Once patient receives six carries per week, at least six months of stability recommended before further increases in carries
- The clinician can make exceptions to this schedule based on patients' work and family commitments, health or family emergencies, difficulty attending pharmacy, etc.

Substance use

- Self-report of substance use should be verified by point of care urine drug screen
- UDS up to four times per month during methadone initiation and titration
- Once every month or two (during office visits) after that
- Suggested schedule:
  - No or only one carry per week for high-risk substance use associated with blackouts, overdoses, impaired judgment, function, stability
  - 3-4 carries per week for substance use that doesn't pose a safety risk and doesn't impair judgment, function, stability
  - Up to six carries a week for no or non-problematic substance use

Missed doses

- If patients miss several days in a row, they lose tolerance and their methadone dose could cause toxicity
- If four days in a row missed, then reduce dose by 50%; can increase dose by 10 mg per day x 3 days then reassess
- If five days in a row missed, reduce to 30 mg, and increase as needed by 10-15 mg every 3-5 days

Methadone prescribing in RAAM clinics

RAAM clinics with limited hours

- Methadone patients and pharmacists sometimes have to contact the methadone prescriber urgently, for example if:
  - Several doses in a row were missed and it needs to be lowered
  - The patient missed their last appointment and needs a new script
  - The patient urgently needs a take-home dose
- It is difficult to manage these urgent script requests if the RAAM clinic is only open a few hours a week

Suggestion…

- Start methadone when indicated
  - If you refer the patient to a different clinic to initiate methadone treatment, they probably won't attend and you'll have missed an opportunity to engage them with treatment
  - Give a longer script (e.g. a week) even if you want to see the patient in 3 days
- Transfer them to a community methadone clinic with longer hours and more staff within the first 3-4 weeks of treatment

Questions

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Case 1

- A 20yo presents reporting Percocet and D8 use, 1-3 pills at a time, 2-3 times a day, most days of the week, oral use only, sometimes crushed
- Uses Xanax when offered, a few times a month, 1-2 pills at a time
- Cannabis use daily, smoked, from dispensary
- Cigarette use, 5-8/day
- Overdose one week ago, three Narcan, CPR, brought to the ED, discharged same day
- Partner is on methadone, and wants to do the same
- Hx generalized anxiety disorder and major depression
- No meds
- No allergies
- Lives with partner in an apartment

Case 2

- 24yo using fentanyl for the last year, IV & smoked, at least 2-3g/day
- No reported overdoses/poisonings
- Reports occasional alcohol use
- No purposeful benzo use, but suspects it's in their fentanyl
- Looking to decrease use, not sure if they're ready to stop yet

Case 3

- 52yo male on methadone 80mg once daily observed dosing for 2 months
- Ongoing fentanyl use daily, smoked only, a few points per day
- Misses his dose a few times per week, no more than 2 consecutive misses
- Hasn’t come in for an assessment since the first three weeks of treatment
- The pharmacy communicates missed doses and requests prescription renewals each week

Case 4

- 44yo patient on 150mg of methadone once daily for 3 years
- Hx fentanyl use and crystal methamphetamine
- Returns to use of crystal meth and occasional benzos 2 months ago
- Reports feeling withdrawal symptoms and wants a dose increase of methadone
- Hx PTSD, anxiety, depression, borderline personality disorder
- Allergy: penicillin, reported as a child
- Meds: Venlafaxine 150mg once daily, Prazosin 2mg QHS
- Last labs 1 year ago, all within normal limits, no ECG on file

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Common Questions

- What if a patient wants you to choose their OAT for them?
- If it's not fentanyl, how do I figure out my methadone starting dose?
- When do I repeat labs/ECG?
- If I start both methadone & SROM, how do I titrate both?
- Can I titrate methadone without seeing the patient?
- How do I manage the common side effects of methadone?

What if the patient wants you to choose their OAT

Considerations

- Preference
- Tolerance
  - Opioid, route, frequency
  - Risks for toxicity
  - Sedatives (alcohol, benzos, gaba)
  - Age/frailty
  - Respiratory (COPD, sleep apnea)
- Accessibility
  - Pharmacy location, hours, delivery
  - Transporation
  - Mobility
- History
  - What has/hasn't worked in the past

OATDecisionAid.pdf

	Buprenorphine		Methadone	Kadian
	Suboxone	Sublocade		
What does it do?	Helps opioid withdrawal symptoms and cravings			
How much do we know about it?	Used in Canada since mid-2000s and has lots of research evidence	Approved for use in 2019 – not many studies yet	Has been used since the 1960s and has the most research evidence for OAT	Has been around since the 1990s mostly as a treatment for chronic pain– some studies but evidence isn't as strong for OAT use
How do I take it?	Tablet that dissolves under the tongue	Injection under the skin of the belly	Drink (often orange-flavoured and coloured)	Capsule that you swallow whole or opened and sprinkled into a cup or food
How often do I take it?	Usually once a day	Usually once a month	Usually once a day	Usually once a day
Where do I take it?	Dose is taken at the pharmacy at first, then usually at home within weeks	Usually done at a clinic	Dose is taken at the pharmacy every day for at least one month, then take-home doses start gradually	Dose is taken at the pharmacy every day for at least one month, then take-home doses start gradually
How do I start it?	Various ways: Can be started in withdrawal 12–18 hours after last opioid use OR started at a "micro" dose and increased very gradually	You have to take buprenorphine tablets at a dose of 8 mg or more for at least a day or two before your first injection	You can take your first dose anytime Sometimes combined with Kadian at the start of treatment	You can take your first dose anytime
How fast can I increase my dose?	The dose can be increased every day	There is one standard dose of the injection	The dose can be increased every three to five days	The dose can be increased every two days
When will I start feeling better?	You can usually get to a helpful dose within a few days if you start it in withdrawal	You will probably already be at a good dose from the tablets when you get your first injection	It can take one to two weeks to start feeling better, and one month to reach a dose that feels really helpful	It can take one to two weeks to start feeling better, and one month to reach a dose that feels really helpful

How do I figure out my starting dose?

Tolerance and Risk of Toxicity

- **High risk of toxicity:** Advanced age, frailty, significant alcohol or benzodiazepine use (i.e., use that causes intoxication or sedation), advanced COPD, severe liver dysfunction, recent start of sedating medications, interruptions in opioid use resulting in loss of tolerance.
- **Risk of toxicity:** Moderate alcohol or benzodiazepine use, concurrent use of medications that are sedating or interact with methadone by prolonging the half-life, sleep apnea, liver dysfunction.
- **No major risk factors for toxicity:** No concurrent health conditions, substance use, or medications that increase risk.

How do I figure out my starting dose?

- **Low tolerance and/or high risk of toxicity:** Initial dose of 5–10 mg (buprenorphine should be considered in these cases)
- **Moderate tolerance and risk of toxicity:** Initial dose of 10–20 mg
- **Moderate tolerance and no major risk factors for toxicity:** Initial dose of 20–30 mg
- **High tolerance and risk of toxicity:** Initial dose of 20–30 mg
- **High tolerance and no major risk factors for toxicity:** Initial dose may be up to 40 mg
- **Very high tolerance AND no major risk factors for toxicity AND known recent experience of high-dose methadone at a steady state[1]:** Initial doses of up to 50 mg may be considered (the rationale for the higher starting dose and the patient's consent should be documented)

How do I figure out my starting dose?

- Initial dose for patients at risk for toxicity &/or lower tolerance: 5-25 mg
- Standard initial dose: 30 mg
- Initial dose for fentanyl users: 40 mg (BCCSU recommendation)
- New META:PHI guidelines: up to 50 mg for high dose (at least 1 gram/day) for fentanyl users who are known to your clinic

When do I repeat labs/ECG?

Repeat labs & ECG **annually**, or more often with health changes/risk dependent

Especially in patients...

- On methadone 100mg or greater
- With structural heart disease
- Previous heart surgery
- Using drugs that prolong QT (e.g. antipsychotics, stimulants like cocaine and amphetamine)
- At risk for electrolyte abnormalities (e.g. diuretics)

If I start both methadone and SROM, how do I titrate?

- Assuming patient is using fentanyl and is at lower risk for methadone toxicity:
  - Starting dose of methadone should be no more than 30 mg, if combining with SROM
  - SROM starting dose is 200-300 mg
  - Titrate methadone by 5-15 mg every 3-5 days, as per protocol
    - Try to achieve a dose of at least 80 mg methadone
  - Titrate SROM by 100-200 mg – can titrate every 2 days as no bioaccumulation

Can I titrate the dose without seeing my patient?

- No more than 1 pre-planned dose increases should occur without assessment
- Patients new to methadone should not have pre-planned dose increases

How do I manage the common side effects of methadone?

- Sedation, constipation, sexual side effects (decreased libido), sweating
- Determine if the symptom is related to methadone
  - This may require labs
  - Assess health history
    - Other med changes? E.g. over the counter, natural products
    - Other life changes? e.g. work, sleep, relationship, diet
- If stable, try a small dose decrease and monitor for effect
  - Decrease by 5mg once weekly for one to two weeks
  - Monitor for worsening withdrawal/cravings
- If unstable/not like to tolerate dose changes, consider symptom-based treatment
  - PEG, anti-emetic, alpha agonists, anticholinergics

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If you're just starting to prescribe methadone

- Connect with an experienced methadone prescriber who will respond to your clinical questions and issues.

  Katie Dunham (katie_dunham04@hotmail.com) Meldon Kahan (meldon.kahan@wchospital.ca)

  Jennifer Wyman (jennifer.wyman@wchospital.com)

- This webinar will be reviewed at the META:PHI Dialogue call on Tuesday, Oct 7, 8:00 am EST. Participants are welcome to share experiences, discuss case studies, and ask any questions not addressed today. Contact laurie.smith@wchospital.ca for the meeting link.

- Additional resources:
  - Methadone Treatment for People who use Fentanyl: Recommendations META:PHI, 2021
  - Opioid Agonist Therapy: A synthesis of Canadian Guidelines for Treating Opioid Use Disorder. CAMH, 2021

Thank you

- If you found this webinar valuable, please attend part 2 on October 22:
  - **‘Methadone Prescribing: Beyond the Basics’**
  - Presenters: Jennifer Wyman, Anita Srivastava, Andrew McDonald
  - Register HERE