Medications for Opioid Use Disorder (MOUD)

Approach: Start with a needs assessment (*Can someone tell me about a case where medication for opiate use was an important part of care?*). Hand out blank charts for students to fill out/keep and draw an empty chart on the board that you will fill out. To promote active learning, ask students what they know about each of the medicines; supplement what they do not know with the information below.

Hook: It's common for inpatients with OUD to believe they can "go it alone" and that MOUD just "trading one substance for another." Keep in mind the stigma MOUD patients face (*e.g. waiting outside the methadone clinic every morning; attending an NA meeting where those on MOUD might not be considered "clean"*). You can help explore psychological barriers to MOUD with your patients and in the meantime, provide psychoeducation to help correct misperceptions. MOUD saves lives: it reduces deaths due to overdose *and* suicide and promotes retention in treatment.

Disparities in Care: Black and Latinx patients less likely to be prescribed MOUD after overdose compared with White patients, even after near-fatal overdose (Barnett ML et al., NEJM 2023).

	Basics	**Pros**	**Cons**
Methadone	● Long-acting synthetic opioid ● Full agonist at the mu opioid receptor ● Typical dose range: 80-120mg/day, though doses of 200mg+ are sometimes needed ● When admitting someone on methadone maintenance, call clinic to confirm last dose (date and amount)	● Once-daily dosing ● Treats cravings ● Reduces euphoria from other opioids ● Safe in pregnancy ● Helpful for chronic pain ● Structure of methadone clinic can be helpful for some patients	● Must visit clinic each morning (with adherence, patients can earn "take-home" doses) ● Physical tolerance and dependence ● Opioid side effects (e.g., constipation) ● QTc prolongation (especially with other QT-prolonging meds) ● Higher risk of overdose, especially in initial treatment; added concern if co-occurring alcohol or benzo use
Buprenorphine (Subutex, Belbuca, etc.) **Buprenorphine + naloxone** (Suboxone) Also available in long-acting subQ form (Sublocade, Brixadi) or implant	● Long-acting partial agonist at the mu opioid receptor ● Typical dose range: 8-24mg/day (doses ≥ 16mg/day associated with better outcomes); some may need 32mg/day for receptor saturation ● Suboxone combines buprenorphine with naloxone in 4:1 ratio to prevent IV use ● Long-acting subQ formulations dosed weekly (Brixadi) or monthly (Brixadi, Sublocade)	● Once-daily dosing ● Treats cravings ● Blocks other opioids (strong affinity for mu receptor, slow dissociation) ● Lower risk of fatal overdose (vs. methadone) ● Allows office-based care with Rx of 1 week to 1 month (vs. daily clinic visits for methadone) ● Safe in pregnancy ● Helpful for chronic pain	● Diversion potential controversial given harm reduction/public health lens ● May be hard to find prescribers (though DEA rules have become much less strict) ● Physical dependence ● Opioid side effects (constipation, respiratory depression especially with co-occurring alcohol or benzos; note that this risk is much lower than full agonists, including methadone)
Naltrexone	● Opioid antagonist ● Monthly injectable 380mg IM q4 weeks ● Oral form not indicated in OUD due to risk of discontinuation	● Long-acting option ● No opioid side effects ● Available in settings that do not allow agonists (e.g., physicians, public safety officers, prisons)	● Much less likely to result in sustained abstinence compare with methadone or buprenorphine ● Must stop opioids for 7-14 days before starting; naltrexone must be stopped ahead of procedures where opioid analgesia may be needed ● Risk of liver toxicity (OK to start if AST/ALT < 3x upper limit of normal); don't need to check LFTs before starting if no clinical concern

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