

Methadone Maintenance Treatment:

Quick Guide to Keep Your Patients, Staff, and Community Safe



In the current climate of opioid abuse and street drug contamination, a crucial part of providing care is ensuring that patients have access to effective treatment to manage opioid addiction. Methadone maintenance treatment is one of the recognized pillars of opioid replacement therapy (ORT). While pharmacists are encouraged to provide this important treatment for patients, it is essential that they practice safe dispensing. At least one pharmacist at each pharmacy that provides ORT must have specialized training in ORT. The pharmacist with specialized training is responsible for developing the pharmacy's ORT policies and procedures and training all pharmacists who will be dispensing methadone and/or buprenorphine at their practice site.

Please note that methadone used for analgesia is dosed more frequently than when used for ORT. It is essential that the pharmacist dispensing methadone for the treatment of pain has the requisite knowledge and works collaboratively with the prescriber to prevent potential harm to these patients.

Please see the [Opioid Replacement Therapy Guidelines for Manitoba Pharmacists](#) for more information on the required training.

Safe Methadone Dispensing for ORT

Storing Methadone

Ensure proper storage. Store all methadone in a safe and secure place in the pharmacy, separate from other liquids. If prepared doses are stored in a refrigerator, a refrigerator locking device should be strongly considered to minimize the risk of diversion.

Assessing New Prescriptions

Assess any new prescriptions carefully. When assessing a new prescription, ensure the dose is clear and legible. Be careful not to mistake units of measure (ie. mL vs. mg). Communicate with the prescriber if there are any questions or concerns.

Uphold safe transitions of care.

Pharmacists need to communicate with fellow healthcare providers during transitions in care. If starting to provide care for a patient who is on methadone, it is crucial that the pharmacist communicates with a provider who knows the patient's methadone history. This helps minimize disruptions in care or errors in dosing. Confirm the strength, quantity of carries and date and time of last observed dose prior to providing a dose.

Preparing Methadone

Check for drug interactions each time you fill a methadone prescription. This process should include periodic DPIN searches. Mixing methadone with other medications can result in toxicity and can be lethal to patients. In most ORT-related deaths, concurrent use of sedating substances, such as benzodiazepines and alcohol, was found to have contributed to the cause of death. Speak to the prescriber if the patient is taking any medications that may interact with methadone.

Reduce distractions when preparing methadone doses.

Do not pour or measure out a dose when you can be easily distracted. Have staff assist in minimizing interruptions when preparing methadone doses. If an interruption occurs, the pharmacist may need to restart the preparation/checking process from the beginning. Doses must be properly labelled.

Perform an independent double check. When preparing methadone doses, a pharmacist must always be involved to double check that the correct dose is measured.

Ensure proper labelling for safety. All carry doses must have clear labelling that the contents of the bottle may cause harm or death if taken by someone other than the person whose name appears on the prescription label.

Methadone Maintenance Treatment (Cont'd)

Dispensing Methadone

Ensure first-time patients present a lock-box at pickup. Patients are required to present their lock box prior to receiving take-home methadone doses for the first time. Storage of methadone in a locked box will help prevent ingestion by anyone other than the patient.

Prevent methadone dose mix-ups. Before giving the patient his/her dose, confidentially confirm the patient's NAME and DOSE. Advise pharmacists to use a secondary identifier, such as date of birth, or a photo, to identify patients. Rather than providing birthdate information for confirmation, it is better to ask the question, 'what is your date of birth?'

If two or more patients have identical or similar names, consider using an alert that will notify the dispensing pharmacist of this situation.

Educate patients to read the dose on their bottle prior to ingesting the methadone. This will further ensure an accidental dose mix up does not occur.

Assess the patient for sobriety. For safety reasons, ensure patients are sober prior to giving them their methadone. Look for signs of intoxication such as slurred speech, drowsiness, the smell of alcohol and/or other unusual behavior.

Prevent diversion. After giving your patient his/her ORT dose for witnessed ingestion, always maintain a sight line on the patient with the dose to ensure it is not diverted. After witnessing a dose, engage the patient in conversation to ensure they are not "cheeking" the dose.

Inform prescribers or programs when a dose is missed. If a patient misses a dose, it is important that the pharmacist let his/her program or prescriber know about the missed dose. This helps the program assess the stability of the patient. The prescriber may require the patient to make up a missed witnessed dose on a scheduled carry day. If a patient misses three consecutive days of methadone dosing, he/she MUST be re-assessed by an authorized prescriber and issued a new prescription, possibly at a lower dose.

Recognize and manage medication incidents.

If you accidentally give the patient the wrong dose, the pharmacist must inform the patient of the error immediately. When a patient ingests more than their prescribed dose, it can result in a medical emergency and pharmacists must use their professional judgment to assess the severity of the medication incident and ensure the patient's safety; follow-up is critical. The pharmacist should refer or help the patient to seek medical assistance, inform the prescriber of the event, and a medication incident report must be completed.

Your pharmacy should have a structured, consistent procedure in place when it comes to preparation and dispensing of methadone. This ensures that if an error occurs, the current system can be assessed and changes can be made as necessary.

References:

1. Methadone Medication Incidents: ISMP Canada, Pharmacy Connection Summer 2013. P 41 https://www.ismp-canada.org/download/PharmacyConnection/PC2013Summer_MethadoneMedicationIncidents.pdf
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3. Methadone Maintenance: Strategies to Improve Safe Prescribing and Dispensing. <http://img.medscape.com/images/841/263/841263.pdf>
4. Best Practices - Methadone Maintenance Treatment. 2002, Government of Canada. Last updated 2008
5. Methadone Practice Directive. New Brunswick Pharmaceutical Society. 2012
6. Opioid Replacement Therapy Guidelines for Manitoba Pharmacists. Updated Sept 2017.