MACS
Maryland Addiction Consultation Service
Fact Sheet

Transitioning from Methadone to Buprenorphine: General Guidance for Clinicians

Switching a patient from methadone to buprenorphine can be appropriate in some situations but requires careful planning. Unlike other medication changes, this transition is not based on a direct dose equivalent and carries a risk of precipitated withdrawal. Because patient factors, treatment setting and timing all strongly affect success, **individualized consultation is strongly recommended**. Importantly, patients doing well on methadone should not be pressured to switch. Methadone remains a highly effective treatment for opioid use disorder.

For these reasons, we recommend that providers contact the **Maryland Addiction Consultation Service (MACS)** warmline for case-specific, expert-guided support on methadone to buprenorphine transitions.

Warmline: 1-855-337-MACS (6227) | www.marylandmacs.org

1. Why Consider Changing from Methadone to Buprenorphine?

- Patient preference and/or treatment goals, including interest in office-based treatment or greater autonomy in recovery
- Determination that buprenorphine is an effective treatment through shared decision making with the patient
- Likely to be successful in a less structured treatment environment
- Presence of challenges associated with methadone treatment, including transportation, employment/caregiving responsibilities, or moving to an area without an opioid treatment program (OTP)

Medical considerations

Intolerable side effects	Clinically significant drug interactions (e.g., CNS depressants, medications that increase QTc prolongation)	Cardiovascular concerns (e.g., QTc prolongation)

2. Key Challenges

- **Precipitated withdrawal:** Methadone is a full opioid agonist with a long and variable half-life. Buprenorphine is a partial agonist with very high receptor affinity. If buprenorphine is started too soon, it displaces methadone from opioid receptors and can cause rapid, severe withdrawal.
- **Methadone clearance and current dose:** Methadone accumulates in tissue and clears unpredictably
- **Patient hesitation:** Patients might have anxiety regarding a transition to buprenorphine, especially with prior negative experience **with precipitated withdrawal**, which can lead to treatment dropout
- **Variability in patient response:** Because methadone metabolism varies by patient, standardized protocols do not work for everyone.

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3. General Approaches (Overview Only)

There is no single correct method. Approaches depend on methadone dose, patient preference, and setting.
Consultation is recommended before attempting.

A. Traditional Taper and Initiation

- General concept:
  - Gradually taper methadone (often to ~30 mg/day, though not always required)
  - Stop methadone
  - Start buprenorphine initiation **at a low dose and titrate upwards quickly if well tolerated**

B. Low Dose Initiation (multiple published strategies such as Bernese Method)

- General concept:
  - Continue methadone
  - Start very small doses of buprenorphine
  - Slowly increase buprenorphine while methadone is reduced

C. Bridge or Specialty-Setting Transitions

- Inpatient transition, residential programs, or monitored withdrawal with adjunctive medications

4. Setting Considerations

- Inpatient/hospital settings can also use buprenorphine formulations approved for pain (transdermal patch, buccal film, injectable). In addition, in these settings, patients could be placed on a short-acting opioid to replace methadone prior to buprenorphine (e.g., morphine, oxycodone)
- Methadone to buprenorphine transitions are generally not recommended in emergency settings.
- Communication between the OTP and the receiving prescriber is recommended to avoid treatment gaps.

Important Reminders

- There is no direct methadone-to-buprenorphine dose conversion
- **Transition from methadone to buprenorphine can cause severe precipitated withdrawal**
- **Individual patient factors must be considered when initiating the transition**
- Patient education and shared decision-making are critical
- Contact MACS for more specific guidance

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