How to Choose the Right Medications for Opioid Use Disorder

Introduction

The purpose of this fact sheet is not to provide details on pharmacology or the use of these medications, but rather to help you decide which might be best for a given patient. For more detailed information on each agent, see the appropriate medication fact sheet.

Buprenorphine (Subutex) or Buprenorphine/Naloxone (Suboxone)

Buprenorphine is considered first line. Unlike methadone, you can prescribe it from a standard office setting and write for a month at a time. As a partial agonist, its ceiling effect makes overdose on buprenorphine alone unlikely. It is easier to initiate than naltrexone, which requires a period of abstinence, and can be quickly increased to therapeutic dose, whereas methadone can require a lengthy titration period.

There are two formulations of buprenorphine: buprenorphine monoproduct and buprenorphine/naloxone combination. The idea of the naloxone co-formulation is that it deters diversion or misuse by injection, but this isn't an absolute. Because there's less stigma attached to the co-formulation and it's much more broadly available, it's the favored formulation. Some may use the monoproduct during pregnancy to reduce medication exposure.

Best for: Most patients

Methadone

Methadone, for now, can only be prescribed at federally licensed opioid treatment programs (OTP)—colloquially known as "methadone clinics." Patients initially must show up six days per week to receive their dose and attend individual counseling sessions at least twice per month, or go to weekly group sessions. Clinic visits can be spaced out with "take-home privileges" after a period of stability, but intervals are rarely more than weekly. "Guest dosing" can be arranged at other OTPs when the patients travel, though this needs to be set up ahead of time.

Best for:

- Patients who benefit from increased structure—that is, observed dosing and daily monitoring. This includes patients who have had multiple accidental overdoses, those who have diverted their meds, and those with severe psychiatric or medical problems.
- Underserved and uninsured patients. Since methadone clinics are often publicly funded, patients will pay less out of pocket.
- Patients who continue to experience opioid cravings even on the maximum dose of buprenorphine (24–32 mg). The partial agonism of buprenorphine may not be sufficient for patients who have a very high tolerance. This may result from a history of using large amounts of high-potency opioids, typically fentanyl. As a full agonist, methadone has no ceiling effect, so the dose can be raised as high as needed to prevent cravings.

Naltrexone Monthly Injections (Vivitrol)

Vivitrol is a long-acting injectable form of naltrexone, which is an opioid receptor blocker like naloxone. It has two clinical effects. First, it decreases cravings, similar to the way it works for alcohol use disorder. Second, it blocks the effects of opioids if they are consumed within four weeks of administration, creating a behavioral incentive not to use opioids. Its biggest drawback is that it can only be given to patients who have been abstinent from opioids for a week (10–14 days for methadone).

Best for:

- Patients who have successfully gotten off all opioids and can remain abstinent from opioids for one week (that usually means an inpatient or residential setting).
- Unhoused patients—they do better on injectable naltrexone than buprenorphine, according to at least one study (Nunes EV Jr et al, *Am J Psychiatry* 2021;178(7):660–671).
- Patients who can't have any opioids in their system, typically due to workplace requirements (eg, health care workers, long-distance drivers, heavy machinery operators, etc).