

Methadone for Pain Management: The Clinician's Role in Reducing the Risk for Overdose

**Clinician Outreach and
Communication Activity (COCA)
Conference Call
August 1, 2012**

Objectives

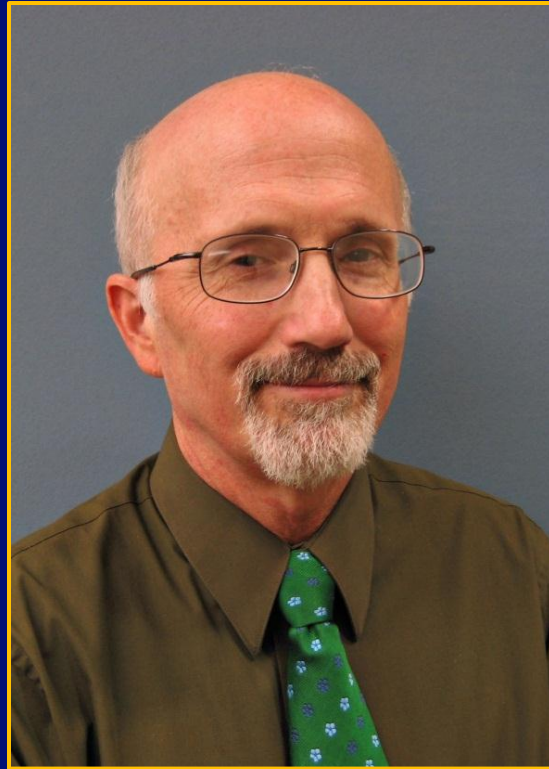
At the conclusion of this session, the participant will be able to accomplish the following:

- ❑ Discuss the role of methadone in fatal drug overdoses in the United States**
- ❑ Compare and contrast methadone prescribing to other opioid analgesics**
- ❑ State circumstances under which use of methadone might be appropriate**

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TODAY'S PRESENTER



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MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 61

July 10, 2012

**Vital Signs: Risk for Overdose from Methadone Used for Pain Relief —
United States, 1999–2010**

Methadone for Pain Management: The Clinician's Role in Reducing the Risk for Overdose

Len Paulozzi, MD, MPH

Division of Unintentional Injury Prevention
National Center for Injury Prevention and Control

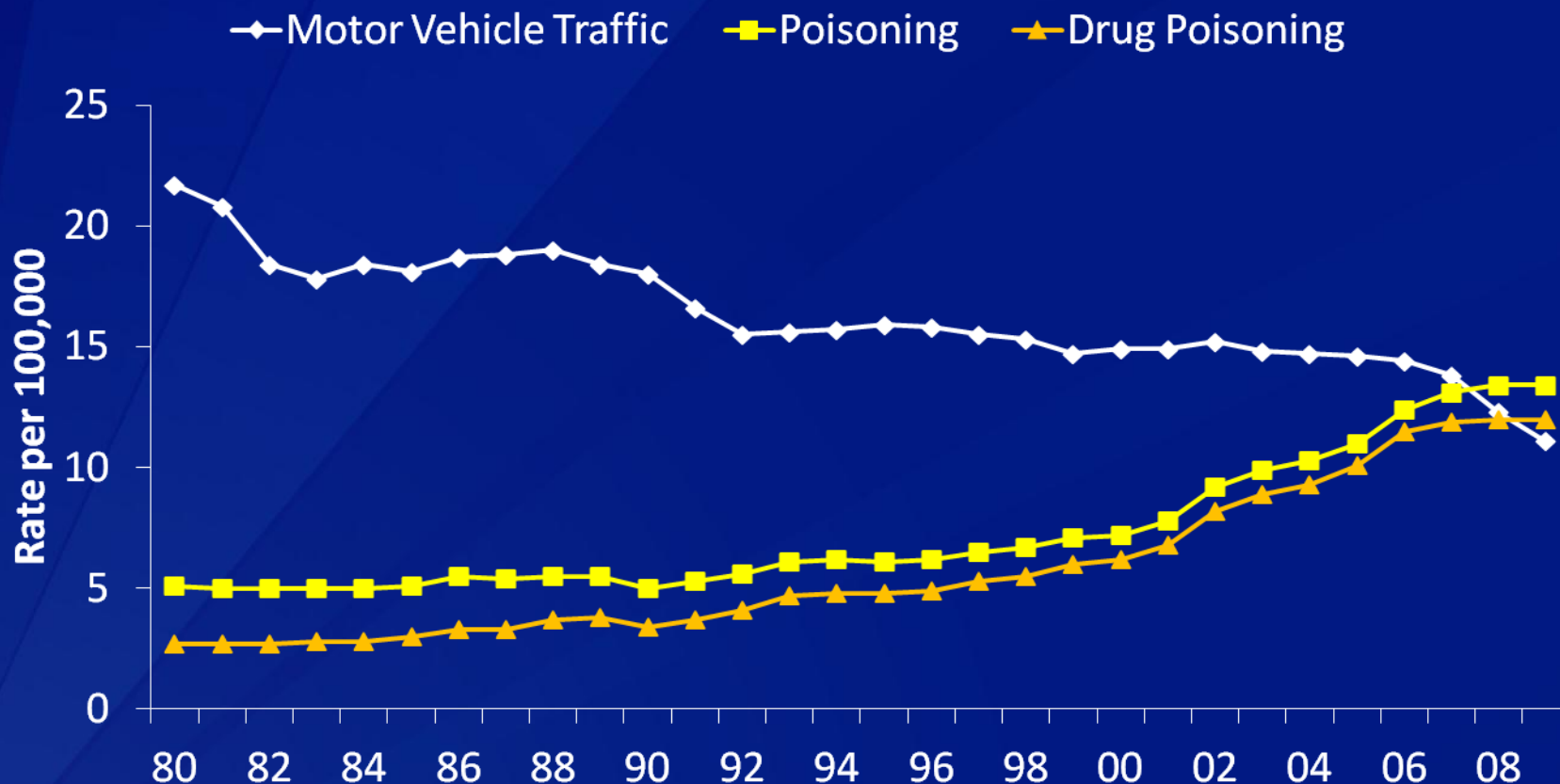
CDC Clinical Outreach Communications Activity

August 1, 2012

National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention

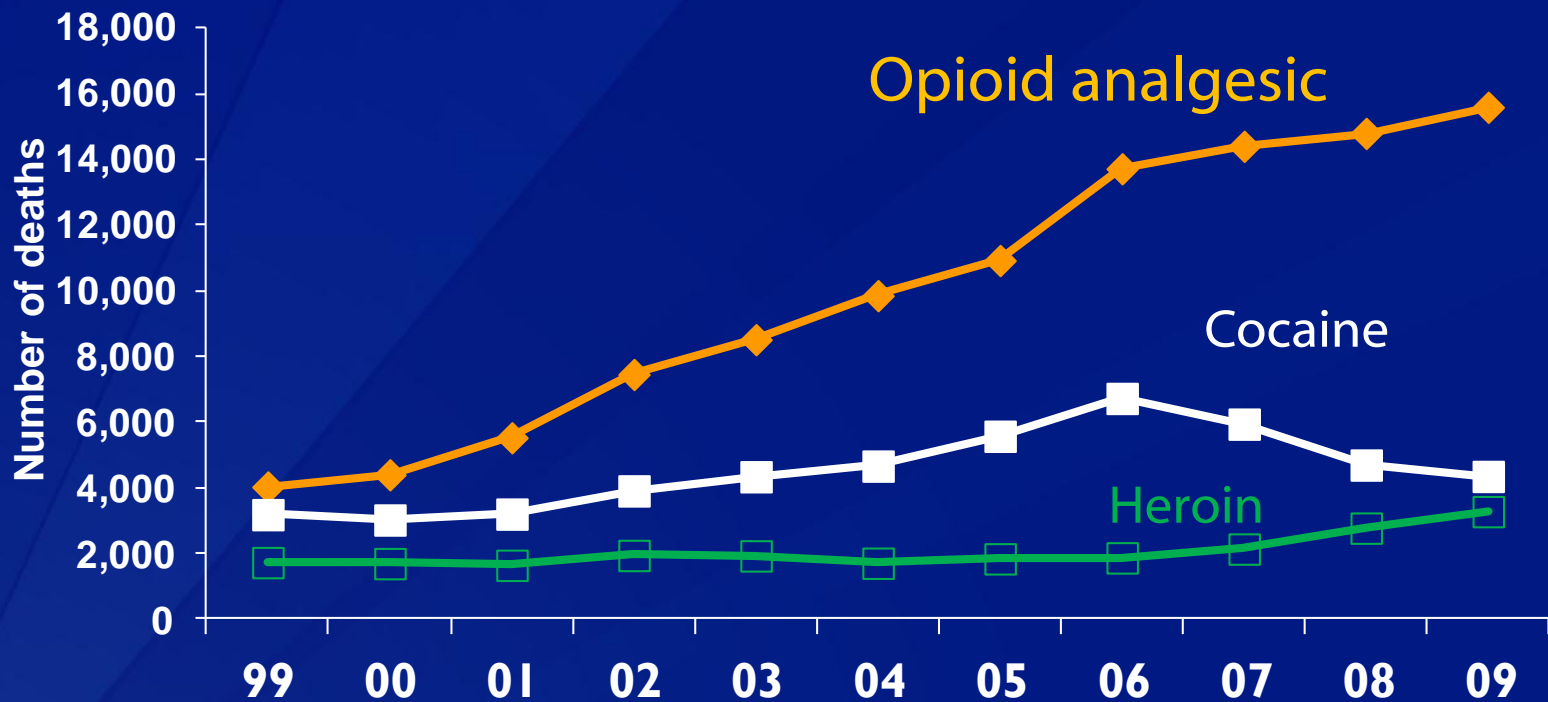


Motor vehicle traffic, poisoning, and drug poisoning death rates of all intents, U.S., 1980-2009



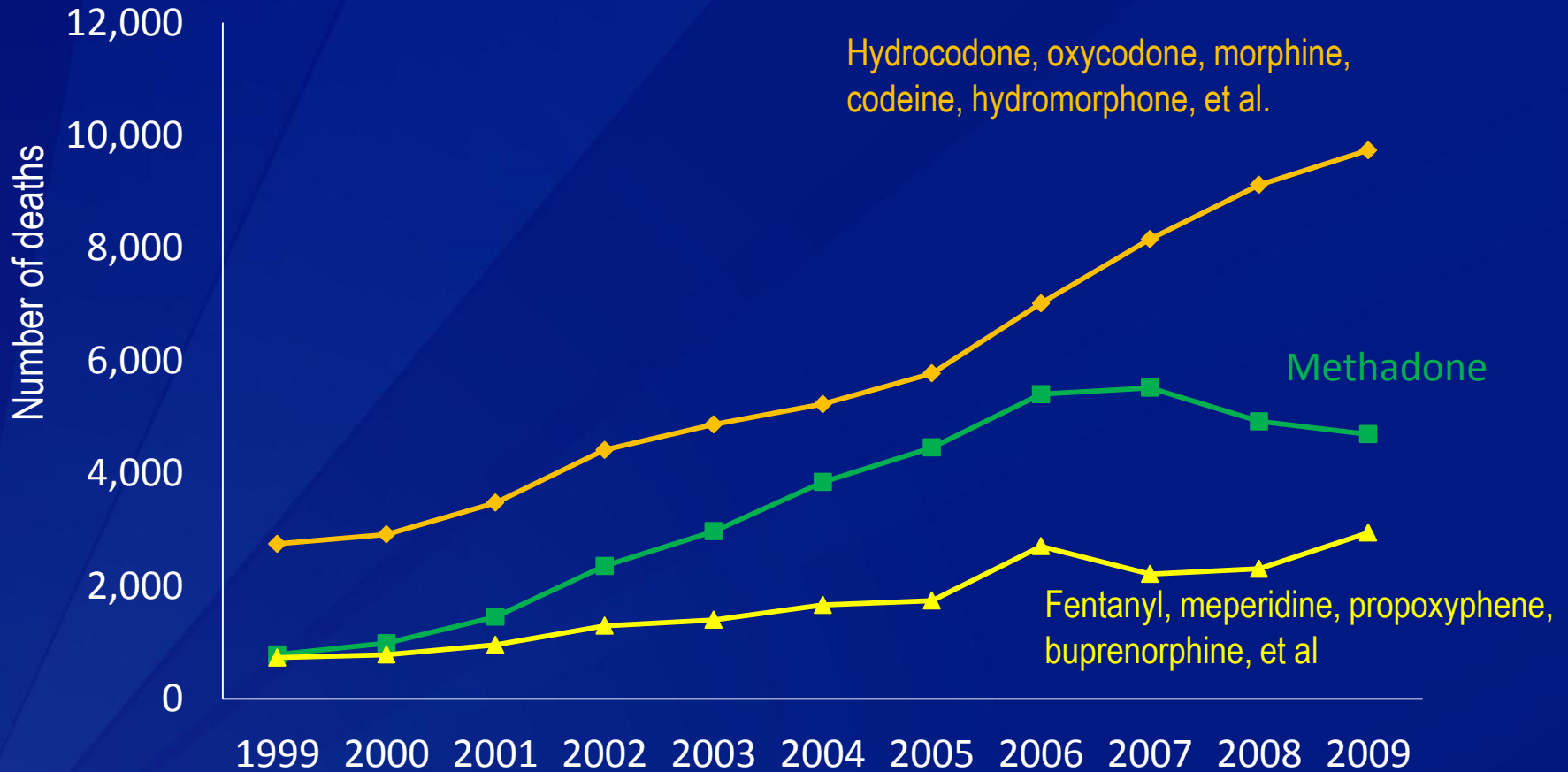
Source: NCHS Data Brief, December, 2011, updated with 2009 mortality data.

Drug overdose deaths of all intents by major drug type, U.S., 1999-2009

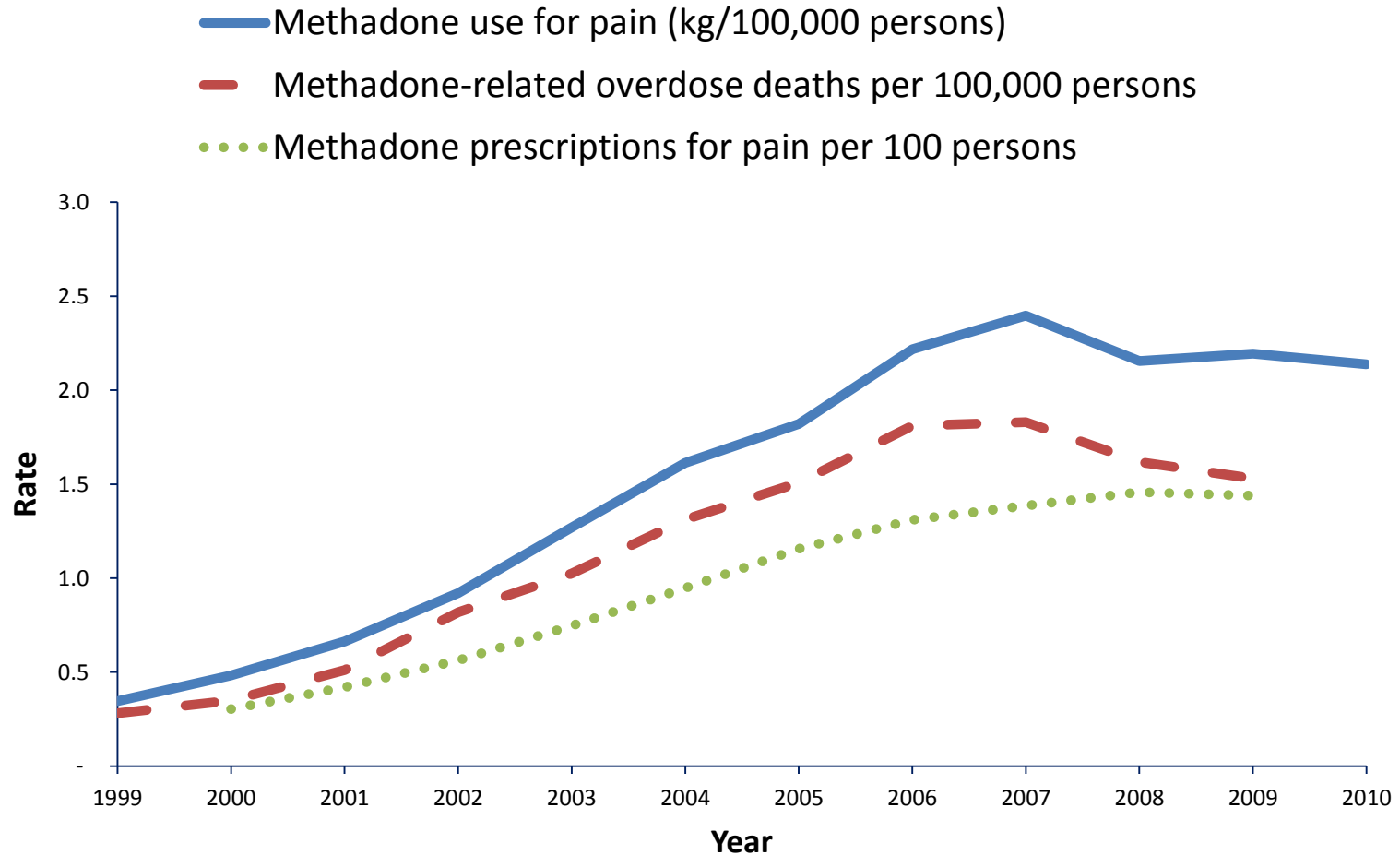


Source: National Vital Statistics System..

Drug overdose deaths of all intents by type of opioid involved, US, 1999-2009



Rising rates of methadone use for pain, methadone-related overdose deaths, and methadone prescriptions for pain, United States

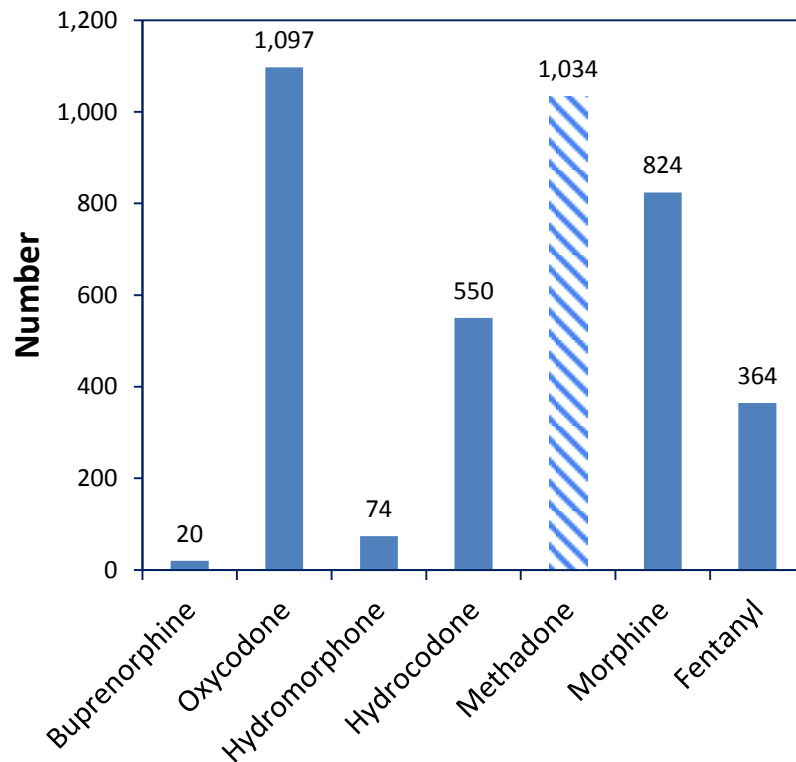


State studies of medical examiner data on methadone overdoses

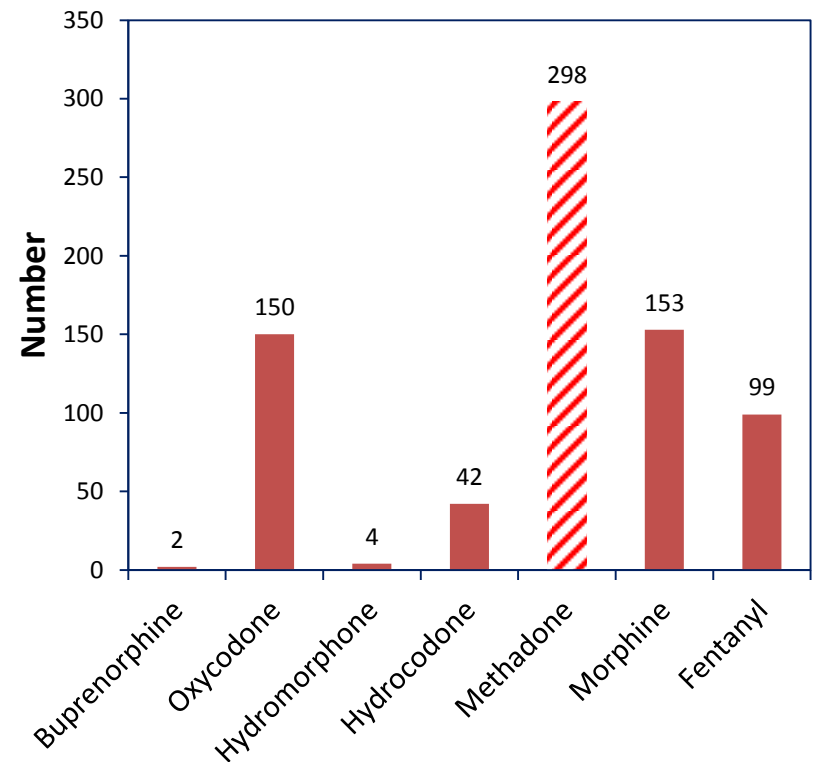
State/Author	Year of Deaths	Number of Deaths	Pct in OTP	Pct with Rx
Utah/Sundwall	1999-2003	114	unknown	42%
Oregon/DOH	2002	103	~25%	33%
Kentucky/Shields	2000-04	95	10%	48%
Maryland/Anon	2004-05	52	15%	2%
West Virginia/Paulozzi	2006	87	12%	32%
North Carolina Medicaid/Whitmire	2007	98	8%	15%

Number of drug-related deaths involving opioids, by type of opioid— Drug Abuse Warning Network Medical Examiner System, 13 states*, 2009

All Drug-Related Deaths



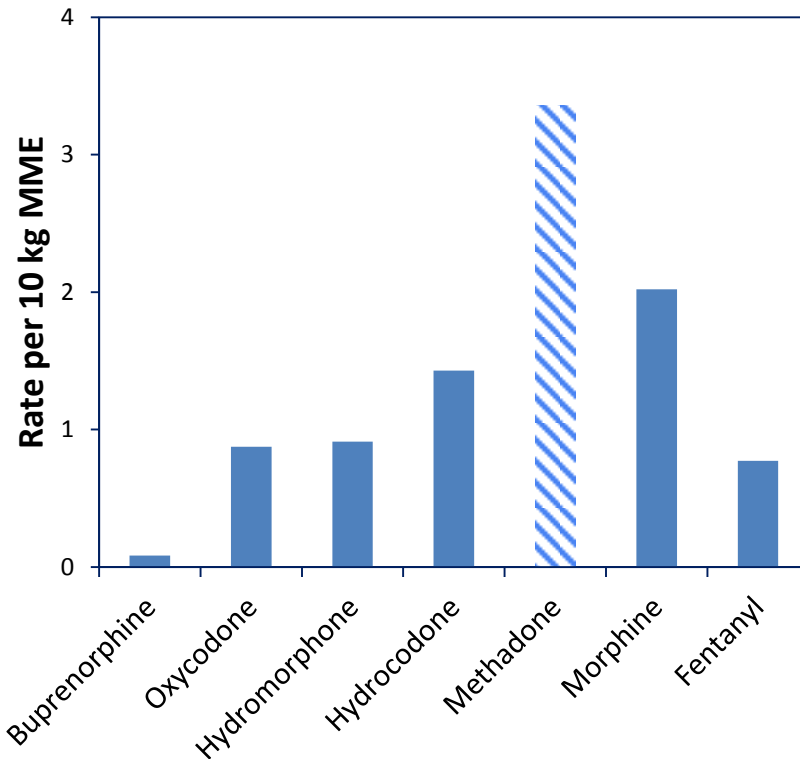
Single-Drug Deaths



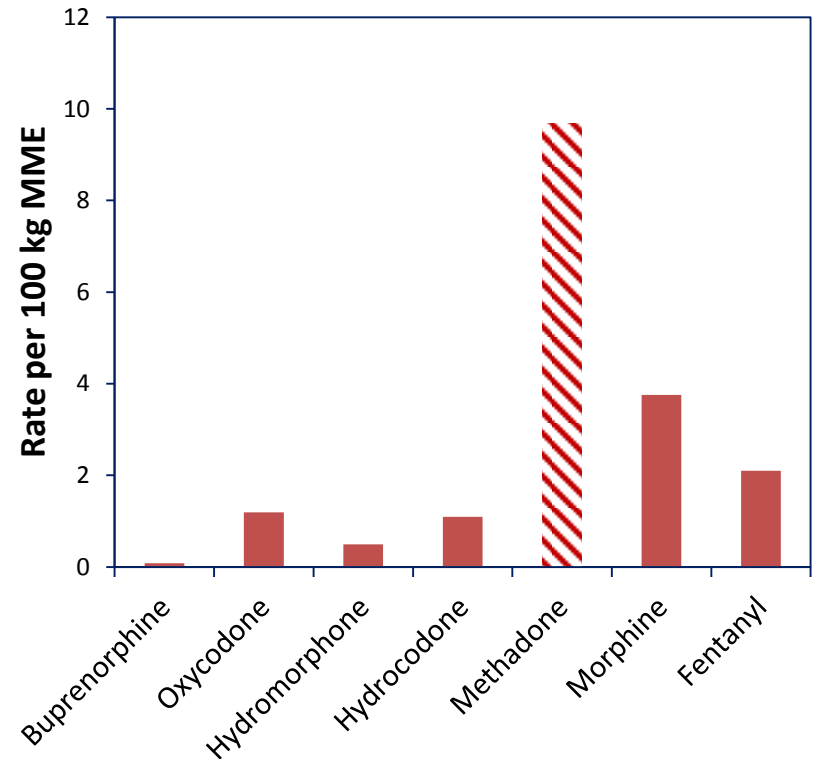
*DE, MA, MD, ME, NH, NM, OK, OR, RI, UT, VA, VT, and WV
MME = morphine milligram equivalent

Rates of drug-related deaths involving opioids, by type of opioid— Drug Abuse Warning Network Medical Examiner System, 13 states*, 2009

All Drug-Related Deaths

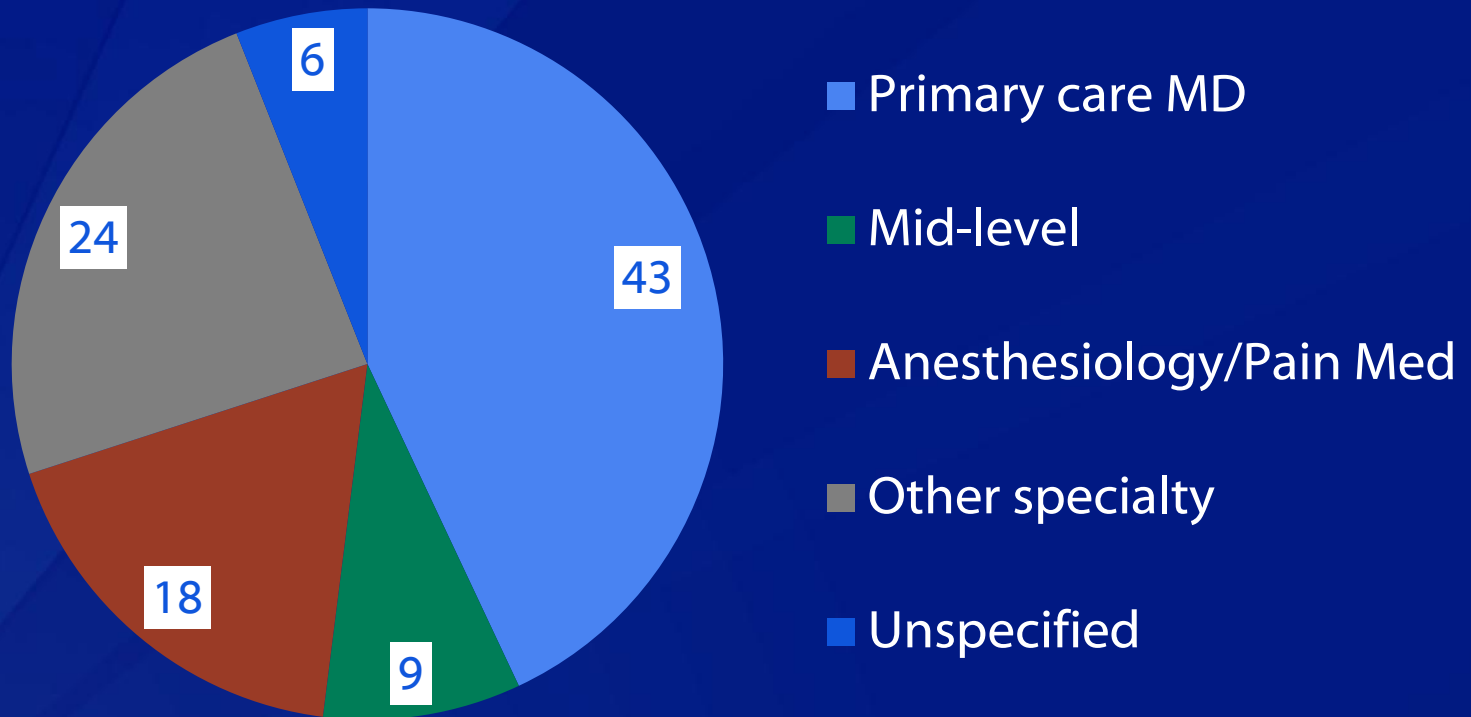


Single-Drug Deaths



*DE, MA, MD, ME, NH, NM, OK, OR, RI, UT, VA, VT, and WV
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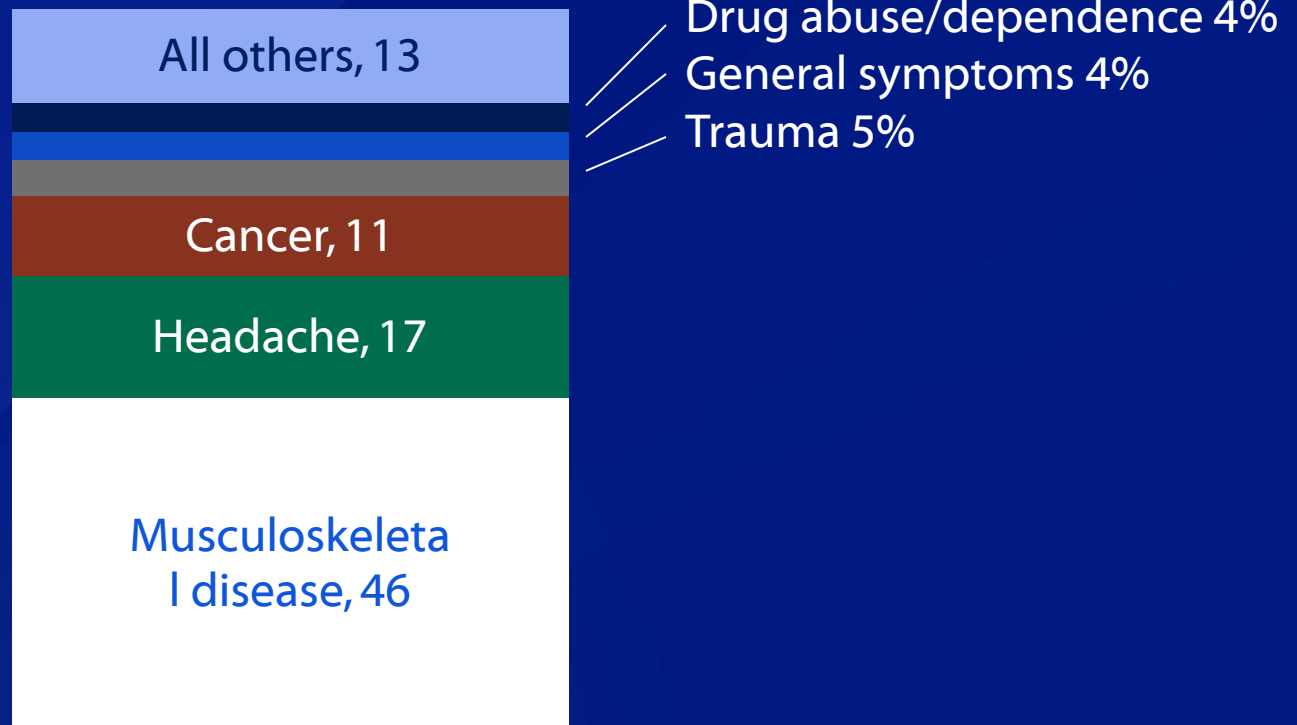
Distribution of methadone prescriptions by prescriber specialty, US, 2009



Source: SDI, Vector One: National. Extracted July 2010

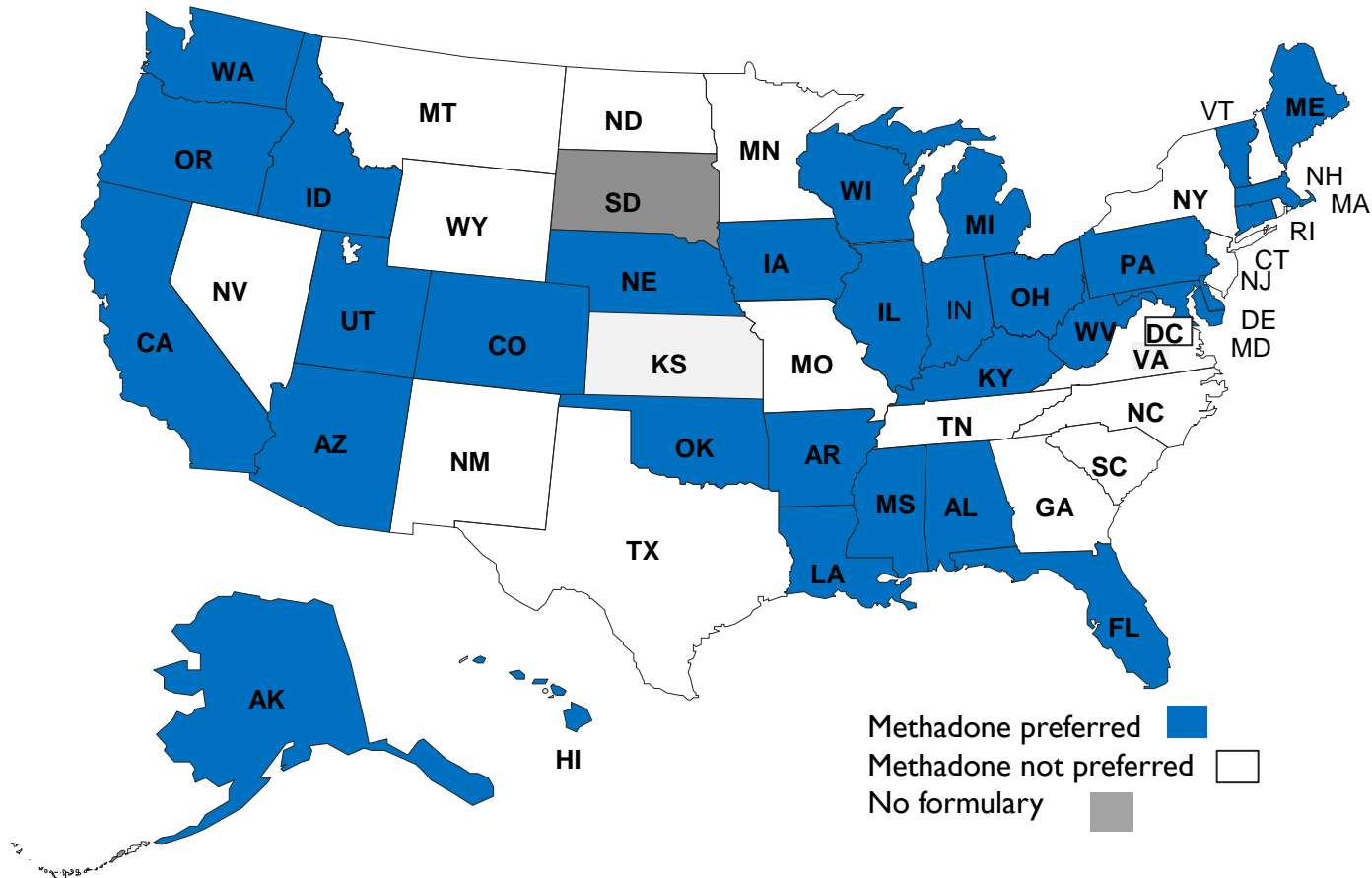
Analysis by Laura Governale of FDA presented at the SAMHSA Methadone Mortality Meeting, July 29, 2010

Percent distribution of diagnoses associated with methadone use, office-based physician survey, US, 2009



Source: SDI, Physician Drug and Diagnosis audit. Extracted July 2010
Analysis by Laura Governale of FDA presented at the SAMHSA Methadone Mortality Meeting, July 29, 2010

Methadone as a preferred long-acting opioid analgesic on the Medicaid formulary, US, 2012



Role of states in prevention

- ❑ Develop and promote the use of safe prescribing guidelines for methadone.**
- ❑ Use prescription drug monitoring programs to identify patients who are using methadone or other prescription painkillers for nonmedical purposes.**
- ❑ Continue to support the use of methadone as a treatment for opioid dependence in opioid treatment programs.**

Role of health insurers in prevention

- ❑ Evaluate methadone's place on preferred drug lists.**
- ❑ Consider strategies to ensure that pain treatment with any dose higher than 30 mg of methadone a day (the recommended maximum daily starting dose) is appropriate.**

Role of health care providers in prevention

- ❑ Follow guidelines for prescribing methadone and other prescription painkillers correctly.**
- ❑ Educate patients on how to safely use, store, and dispose of methadone.**

Thank You

www.cdc.gov/homeandrecreationalafety/poisoning

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention



Methadone for Pain

A Guide for Prescribers

David J. Tauben, MD

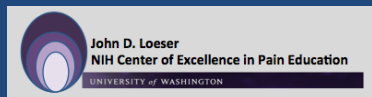
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Disclosures

No conflicts of interest

Grant Support

- Principal Investigator: NIH Pain Consortium
Center of Excellence in Pain Education
- Co-Investigator: R01 NR012450 Doorenbos, AZ (PI) 09/16/11-08/30/16. NIH/NINR: *Palliative Care Symptom Management in Rural Communities*
- Co-Investigator: R42 CA141875: Doorenbos, AZ (PI) 05/13/10-04/30/13 NCI/NIH PATINA: *Pain training in Native American communities*
- Center for Medicare and Medicaid Innovation: U of New Mexico*, NIH R01, STTR, HRSA. TelePain access for remote interspecialty management of complex disease
- Unrestricted educational grant Endo Pharmaceuticals. University of Washington Pain Champions: Look Over the Expert's Shoulder/Pain Champions.

Objectives

- Understand indications for use of methadone
- Be knowledgeable about risks of methadone
- Follow safe methadone dosing practice
- Know why and how to apply guidelines for opioid monitoring

Methadone Basic Clinical Pharmacology

- Potent Mu-agonist
- Absorption variability
 - Oral 36-100%
 - Peak plasma 3-4 hrs (up to 1-8 hrs)
- 30-fold inter-patient variability
 - In steady-state concentrations
 - In peak concentrations
- Expect age and illness related increased toxicities
- Frequent drug-to-drug interactions
- Hepatic CYP metabolism
- No active hepatic metabolites

Methadone Special Features

- NMDA antagonist
 - May reduce opioid tolerance
 - Potential non-opioid analgesic effects
- Weak 5-HT/NE Reuptake Inhibitor
 - May also add benefit for neuropathic pain disorders
- Significant accumulation with repeat dosing
 - Initial $T_{1/2}$ 13-47 hrs → 48-72 hrs
 - Lipophilic & Protein-bound
 - Inhibits its own CYP metabolism
 - <20 mg = 3-4 x MS*
 - 30-40 mg = 8 x MS*
 - 40-60 mg = 10 x MS*
 - >60 mg = 12 x MS*

Indications for Methadone Use

✓ *For Pain Treatment*

- Effective analgesic
- Chronic Opioid Therapy
- Long acting
- Inexpensive

✓ *For Addiction Treatment*

- *Requires special DEA licensing and treatment support*
- Once daily liquid dosing eases administration
- Reduces mortality among heroin users

Clinically Important Comparison: Methadone vs. other Opioids

Differences:

- Marked inter-patient pharmacologic variability
- Significant accumulative dosing potency
- Higher OD incidence and mortality
- Indications:
 - When committed to Chronic Opioid Treatment
 - So-called '*last resort*'

Similarities:

- Monitoring approach
- Side-effects
 - Sedation
 - Respiratory suppression
 - Anticholinergic
 - Cardiac
- Addiction and diversion risks

Methadone M & M

- Adverse events typically occur early in Rx initiation
 - For Pain treatment *and* for MMT
- Co-prescription with sedatives adds significant risk
 - Benzodiazepines
 - Carisoprodol
 - Alcohol
- Co-occurring respiratory disorder increases risk
 - Obstructive and Restrictive Lung disease
 - Sleep apnea
- QTc prolongation and arrhythmia risk at higher doses *and* when used with other drugs that prolong QTc

Methadone & Cardiac Arrhythmias

2006 FDA Advisory

“Prescribing methadone is complex. Methadone should only be prescribed for patients with moderate to severe pain when their pain is not improved with other non-narcotic pain relievers. Pain relief from methadone lasts about 4 to 8 hours. However, methadone stays in the body much longer, from 8 to 59 hours after it is taken. As a result patients may feel the need for more pain relief before methadone is gone from the body. Methadone may build up in the body to a toxic level if it is taken too often, if the amount taken is too high, or if it is taken with certain other medications or supplements.”^{1, 2}

¹<http://www.fda.gov/CDER/drug/advisory/methadone.htm>

²Emphasis added

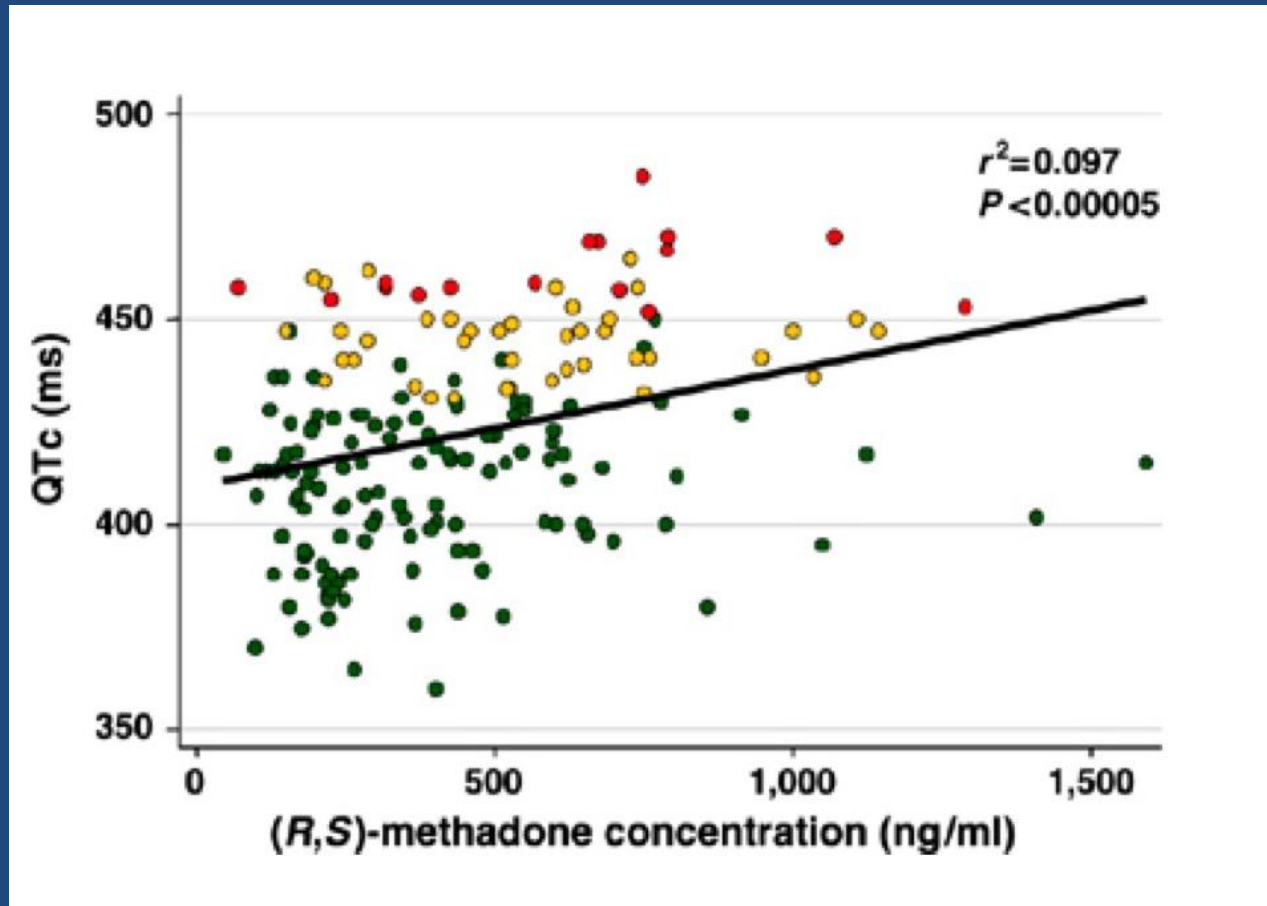
Risks Factors for QTc Prolongation

- Older age; esp. women
- Co-occurring cardiac disease
 - Advanced heart disease
 - Congenital and acquired long-QT syndromes
 - Family history of sudden death
- Low K^+ , Low Mg^{++}
- Concomitant use other QTc prolonging Rx
 - Ca^{++} blockers, propafenone, quinidine
 - Tricyclics, SNRIs, and SSRIs
 - Erythromycin, azithromycin, clarithromycin, quinolones, pentamidine
 - Ondansetron, risperidone

>450-499 msec: Monitor more frequently

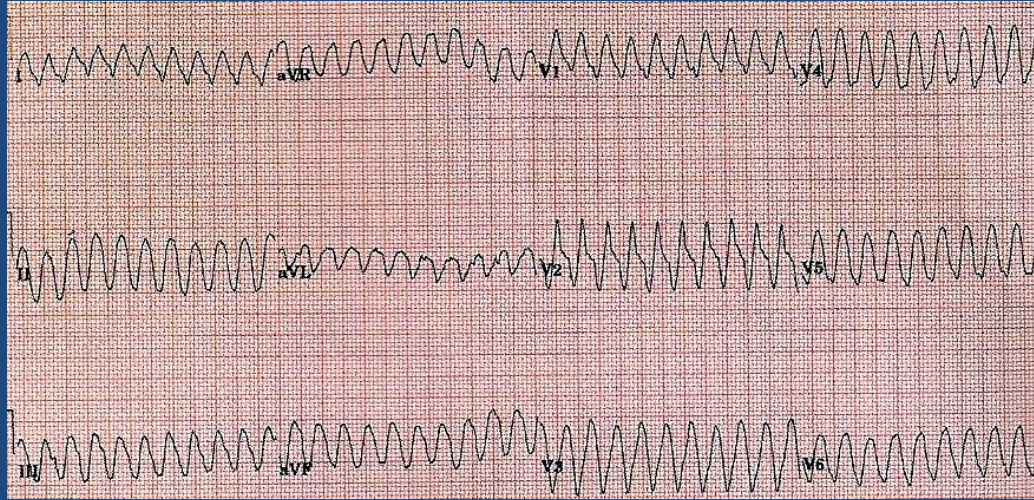
≥500 msec: Consider discontinuation

Methadone Levels and QTc Prolongation



Red dots:
prolonged QTc
Yellow dots:
borderline QTc
intervals
Green dots:
normal QTc values

Torsade de Pointes



Methadone dose range 65-1,000 mg
(780-12,000 MED)

Most doses >250 mg (>3000 mg MED)

Review of case series and reports

Drug-drug interactions

CYP 3A4 inhibitors (RAISE methadone levels)

Use with caution-moderate risk:

Antibiotics

Protease inhibitors (ritonavir, nelfinavir, indinavir)

Macrolides (erythromycin, clarithromycin)

Azole antifungals (ketoconazole, itraconazole)

Quinolones (ofloxacin, moxifloxin)

Others (tetracycline, metronidazole, pentamidine)

Other often used drugs

Trazodone, haloperidol, respirdone, ondansetron,
chlorpromazine, droperidol

Less potent CYP 3A4 inhibitors

Still use caution: may RAISE methadone blood level

Antibiotics

saquinavir, fluconazole, clotrimazole

Psychiatric Rx

- amitriptyline, desipramine, fluoxetine, fluvoxamine, imipramine, sertraline, venlafaxine
- olanzapine, quetiapine

Foods & beverages

grapefruit (especially juice)

Naturopathics

St. John's wort, valerian

CYP 3A4 Inducers

LOWERS methadone blood levels

May need to dose increase to maintain analgesia
and/or prevent withdrawal

- Carbamazepine
- Diphenylhydantoin
- Rifampin

Other drugs associated with *Torsade de Pointes*

---Avoid concurrent use with methadone---

- Cardiac
 - amiodarone, bepridil, disopyramide, dofetilide, ibutilide, procainamide, quinidine, sotalol,
- GI motility & antinausea
 - Chlorpromazine, cisapride, domperidone, droperidol
- Antibiotics
 - clarithromycin, erythromycin, sparfloxacin
- Antipsychotics
 - Haloperidol, mesoridazine, thioridazine, pimozide

Common Clinical Methadone Concerns

- Anticholinergic
 - Urinary retention
 - Constipation
 - Dry mouth
- Weight gain
- Heavy sweating
- Reduced motor coordination
- Cognitive impairments
- Reduced sex hormone release
- Pregnancy cat. C
 - Withdrawal precipitated miscarriage
 - Neonatal abstinence
 - For opioid addicted pregnant women methadone maintenance is standard of care¹
 - Volume of distribution increases in 3rd trimester usually dictating need for a dosage increase¹

¹Andrew Saxon, personal communication

Overview of Methadone Dosing

- “Go low and slow”:
 - Start: 2.5 mg/day BID-TID
 - Increase: at 5-10 day intervals
- Use in opioid-naïve patients: probably never
 - Risk of accidental OD when not tolerant
 - When committing to COT
 - “when... pain is not improved with other non-narcotic pain relievers”¹
- Age ± disease related metabolic adjustments: always
- Drug-drug interactions: when appropriate

¹FDA Advisory 2006: <http://www.fda.gov/CDER/drug/advisory/methadone.htm>

Dosing Recommendations

VA/DoD Guidelines Up-Titration

- ❖ Dose increments of 2.5 mg q 8 h made every 5-7 d
- ❖ Dose increases after 5 to 74 days if no problem with daytime sedation

NOTE: Half-life longer than duration of analgesia

Washington State Agency Medical Directors Group: Opioid Dose Calculator

120 mg MED dose
threshold for
“specialty consultation”



methadone	mg per day*	Morphine equivalents:
up to 20mg per day	20	80
21 to 40mg per day	40	320
41 to 60mg per day	60	600
>60mg per day	80	960

❖ if high risk and/or
adverse effects or lack
of functional response

OPIOID DOSE CALCULATOR		
Optional:	Patient name:	
	Today's date:	April 8, 2012
Instructions:	Fill in the mg per day* for whichever opioids your patient is taking. The spreadsheet will automatically calculate the total morphine equivalents per day.	
	Opioid (oral or transdermal):	mg per day*:
oxycodone	80	120
oxymorphone	40	120
TOTAL daily morphine equivalent dose (MED) =		2720
* Note: All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mcg per hour		
If this value is less than 120mg Morphine Equivalent Dose (MED), please follow Part I of the AMDG Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. Referral for pain management consultation is required before exceeding 120mg MED daily. See: www.agencymeddirectors.wa.gov/opioiddosing.asp www.doh.wa.gov/hsqa/professions/painmanagement/		
If this value is greater than 120mg MED, please follow Part II of the AMDG Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. See: www.agencymeddirectors.wa.gov/opioiddosing.asp		

www.agencymeddirectors.wa.gov/guidelines.asp

factors, incomplete cross-tolerance, and pharmacokinetics.

Conversion Dosing Recommendations

Morphine into Methadone

- 50-67% of calculated equianalgesic dose is conversion dose
- Calculation varies with the total daily dose
- Dose proportion is dependent on MED of previous opioid (PO)
 - Morphine < 200 mg/day:
Methadone 5 mg q8 hr*
(*in opioid tolerant patient)
 - Morphine 200-500 mg:
5-10% of oral MED, given in divided doses q 8 hr
 - MED > 500 mg/day:
Get expert help

VA/DoD Clinical Practice Guideline for the Management of Chronic Pain 2003 v.1

“Rotation” onto Methadone

- Typically can reduce dose to 10-50% of current MED
- High but ineffective doses of previous opioids *may overestimate the methadone dose*¹
- Analgesic effects can range 4-13 days to stabilize
 - Repetitive dose equianalgesia at just 10-20%²
 - Reduction in the calculated equianalgesic dose *in all cases*³
- Conversion ratios are not bi-directional
- Specific reduction formula based on the MED of the opioid taken at the time of the switch
 - *Methadone potency rises as its dose is increased!!*

¹VA/DoD Clinical Practice Guideline for the Management of Chronic Pain 2003 v.1

²Lawlor PG., Turner KS., Bruera HJ. Cancer 1998; 82:1167-1173.

³Knotkova H., Fine PG., MD, Portenoy RK., J Pain Sympt Manag 2009; 38 (3): 426-439.

Methadone Risk Monitoring

- Similar to Other Long-Acting Opioids
 - Opioids are High Risk Drugs
 - Highest doses given to highest risk patients
 - “Principal of adverse selection”
- Chronic Opioid Therapy Risk Assessment Tools- *Use prior to initiation of COT:*
 - ORT, or SOAPP-R or DIRE
 - CAGE-ID or AUDIT

Opioid Risk Tool (ORT)

Physician Form

With Item Values to Determine Risk Score

Name _____ Date _____

Mark each box that applies		Female	Male
1. Family history of substance abuse	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal drugs <input type="checkbox"/> Prescription drugs	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	<input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 4
2. Personal history of substance abuse	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illegal drugs <input type="checkbox"/> Prescription drugs	<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
3. Age (mark box if 16-45 years)		<input type="checkbox"/> 1	<input type="checkbox"/> 1
4. History of preadolescent sexual abuse		<input type="checkbox"/> 3	<input type="checkbox"/> 0
5. Psychological disease	<input type="checkbox"/> Attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia <input type="checkbox"/> Depression	<input type="checkbox"/> 2 <input type="checkbox"/> 1	<input type="checkbox"/> 2 <input type="checkbox"/> 1
Low (0-3) Moderate (4-7) High (≥8)	Scoring totals	<input type="checkbox"/>	<input type="checkbox"/>

10 Questions to Administer:

- On initial visit for ALL new or inherited COT patients
- Prior to LA Opioid Therapy

Scoring

- **0-3: low risk (6%)**
- **4-7: moderate risk (28%)**
- **≥ 8: high risk (> 90%)**

Adherence Monitoring

Urine toxicology based on risk assessment score

Risk Category	UDT Frequency
Low Risk by ORT	Periodic (e.g. up to 1/year)
Moderate Risk by ORT	Regular (e.g. up to 2/year)
High Risk by ORT or opioid doses >120 mg MED/d	Frequent (e.g. up to 3-4/year)
Aberrant Behavior (lost prescriptions, multiple requests for early refills, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)

From: WA State AMDG Guidelines www.agencymeddirectors.wa.gov/guidelines.asp

Methadone Urine Monitoring

- Point of Care

- *Generally* reliable
- Detection for 3-14 days
- Expect 20+% false results¹

False positives²:

Chlorpromazine
Clomipramine
Diphenhydramine
Doxylamine
Quetiapine
Thioridazine
Verapamil

- Confirmation testing by LC or GC/MS

- When results are unexpected *AND* patient does not admit to use of drugs identified on initial testing
- Can request reflex confirmation when false positives and negative results are expected
- Adulterants can interfere with confirmation assay

¹Christo PJ., Manchikanti L., Ruan X. Pain Physician 2011; 14:123-143

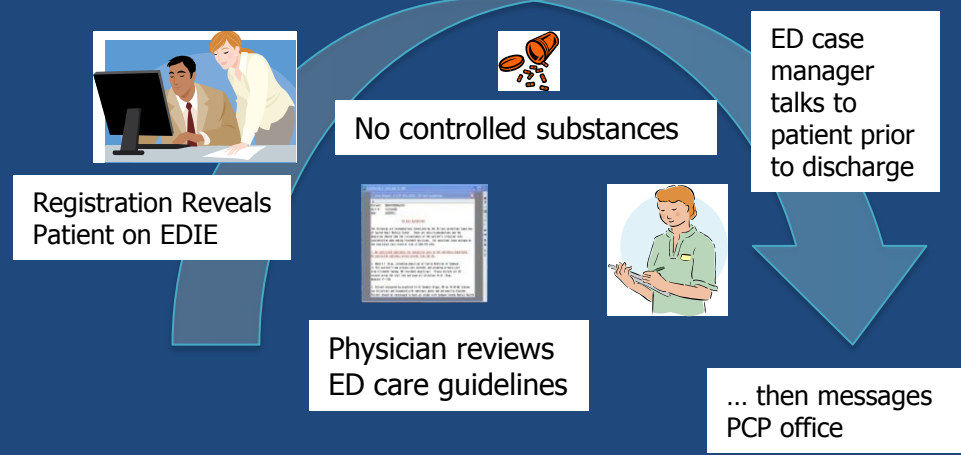
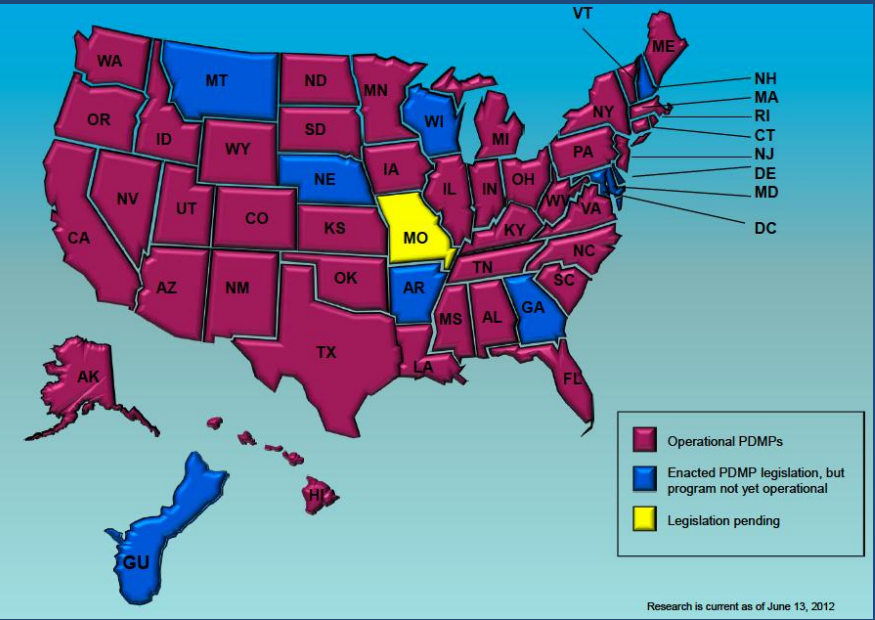
²Herring C., Muzyk AJ., Johnston C. J Pharm Pract 2011 24: 102

Adherence Monitoring

Currently Available Solutions

Prescription Monitoring
 State level programs capturing all scheduled medication prescribing, even cash purchased

Emergency Department Information Exchange(s)
 Save \$70-100,000/year in reduced admissions, labs, excessive exposures to CT imaging in emergency rooms by utilizing this system



Monitoring Co-occurring Conditions

- Sleep apnea
 - *STOP-BANG* screening tool¹
- Depression, Anxiety, PTSD
 - PHQ-9, GAD-7, PCL-C²
- Drug-drug interactions/poly-pharmacy
 - Rx Reconciliation and/or shared EMR system
- Cardiac
 - Advanced heart disease or h/o sudden death
 - “..To ECG or Not to ECG... That Is Still the Question”³

¹Chung F., Yegneswarian B., Liao P., et al. *Anesthesia* 2008; 108:812-821

²UW Pain Toolkit <http://depts.washington.edu/anesth/education/pain/index.shtml>

³Cruciani RA., *J Pain Sympt Manage* 2008; 36: 545-552

Guidelines for Tapering Methadone

- Decrease 20-50% until 30 mg; then by 5 mg/day q 3-5 d until 10 mg/d; then by 2.5 mg/d every 3-5 d¹
- Decrease 10% weekly, use clonidine for symptom management^{2, 3}
- Taper 10% weekly until 30% of initial total MED, then resume by 10% less of new dose weekly⁴
- Taper 10% of daily dose/day to 30% of daily dose every 1-2 wks, once 1/3 of original dose is reached, slow taper to 1/2 of previous rate⁵

¹VA/DoD 2010

²WA AMDG Guidelines 2007

³Utah State Guidelines 2008

⁴WA State HCA NRP Program 2011

⁵Canadian Guidelines 2010

Tapering Methadone

Some Clinical Caveats

- If “Addiction” (aka “Substance use disorder”)
 - >90% relapse onto opioids, prescribed or otherwise
- Following prolonged epoch of high dose use
 - Many patients “de-stabilize” and demonstrate behaviors meeting DSM criteria for SUD
 - (aka “*Complex persistent opioid dependency*”)
 - Often requires protracted taper schedule with frequent plateaus based on clinical response
 - Best outcomes require significant behavioral health support

Prescribing Methadone

Conclusions

- Effective analgesic
- Inexpensive
- Analgesic interval shorter than half-life
- Enormous inter-patient variability
- Accumulative potency/complex dosing
- Complicated DDI and metabolic interactions
- When used carefully--- both effective and safe



Centers for Disease Control and Prevention Atlanta, Georgia

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Those who participate in the COCA Conference Calls and who wish to receive CE credit/contact hours and will complete the online evaluation by **Aug 31, 2012** will use the course code **EC1648**. Those who wish to receive CE credits/contact hours and will complete the online evaluation between **Sep 1, 2012** and **Aug 31, 2013** will use course code **WD1648**. CE certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR CE's obtained through the CDC Training & Continuing Education Online System will be maintained for each user.

Thank you for joining!

Please email us questions at coca@cdc.gov

Emergency Preparedness and Response

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- Specific Hazards
- Preparedness for All Hazards
- What CDC Is Doing
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Methadone for Pain Management: The Clinician's Role in Reducing the Risk for Overdose

= Free Continuing Education Credits

Date: Wednesday, August 1, 2012

Time: 2:00 - 3:00 pm (Eastern Time)

Join By Phone:

Dial-in Number: 1-888-790-6180

Passcode: 1281914

Join By Webinar: <https://www.mymeetings.com/nc/join.php?i=PW7035569&p=1281914&t=c>

Presenter(s):

- Len Paulozzi, MD, MPH**
Medical Epidemiologist
Division of Unintentional Injury Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
- David Tauben, MD**
Clinical Associate Professor University of Washington
Medical Director UW Center for Pain Relief
Director of Medical Student Education in Pain Medicine
Department of Anesthesia & Pain Medicine
Department of Medicine

Overview:

CDC estimates that methadone was involved in 5,000 overdose deaths in the United States in 2009. Nonetheless, many methadone prescriptions are being written for conditions for which it might not be appropriate, and methadone is a preferred drug on many formularies. Prescribing methadone for chronic pain safely requires familiarity with its unique pharmacology and dosing recommendations. Join us for this COCA call where subject matter experts will review the epidemiology of methadone overdoses in the United States and discuss guidelines for appropriate opioid prescribing.

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Join Us on Facebook

CDC Facebook page for Health Partners! “Like” our page today to receive COCA updates, guidance, and situational awareness about preparing for and responding to public health emergencies.



The screenshot shows the Facebook interface for the CDC Health Partners Outreach page. At the top, there is a navigation bar with the Facebook logo, a search bar, and login options for Email and Password. Below the navigation bar, there is a "Sign Up" button and the text "Facebook helps you connect and share with the people in your life." The main content area features the CDC Health Partners Outreach profile picture and cover photo. The profile information includes the name "CDC Health Partners Outreach" and the location "Government Organization · Atlanta, Georgia". The "Wall" section displays a post from the CDC Health Partners Outreach page, dated Monday at 7:08am. The post text reads: "CDC is partnering with NPHIC to host a webinar July 21 (3:00pm ET) on Crisis and Emergency Risk Communication – Radiation. A subject matter expert from the Oak Ridge Institute for Science and Education (ORISE) will address key elements of communicating during a radiation disaster, share CDC research on messaging, and provide lessons learned from Japan's recent nuclear emergency. Register for this FREE webinar today!". The post includes a video player for the "Crisis and Emergency Risk Communication - Radiation Webinar" and a list of users who liked the post: Jessica Guidry, Marta Lugo, Marcy Dalziel Belvin, and 3 others. Below the post, there is another post from the CDC Health Partners Outreach page, dated Monday at 7:08am, which reads: "The Clinician Outreach and Communication Activity (COCA) is sharing a booth with the American College of Veterinary Preventive Medicine (ACVPM) at the 2011 AVMA Convention. Representatives will be available during exhibit hours at booth #1732 to provide information and answer questions." The post includes a video player for the "AVMA Convention" and a list of users who liked the post: Jessica Guidry, Marta Lugo, Marcy Dalziel Belvin, and 3 others.

<http://www.facebook.com/CDCHealthPartnersOutreach>