Decision Support Tool for Selecting OAT Medications

	Buprenorphine-based formulations			
	Buprenorphine	Extended-release buprenorphine	Methadone	SROM
Retention in treatment	May be slightly lower than methadone; retention improves at higher doses (above 16mg)	Substantially higher than placebo, but no direct comparisons with oral OAT have been studied	Potentially slightly better treatment retention than buprenorphine	Non-inferior to methadone
Initiation				
Requires withdrawal prior to induction	**Traditional induction:** Yes. Requires moderate withdrawal prior to induction **Low-dose induction:** No. Does not require prior withdrawal, allowing for comfortable start	No. Does not require a period of withdrawal, but requires prior stabilization on sublingual buprenorphine	No. Does not require a period of withdrawal. May be easier to initiate	No. Does not require a period of withdrawal. Comparable process to methadone, with faster titration
Time to achieve therapeutic dose	**Traditional induction:** (1–3 days) Shorter time to achieve therapeutic dose **Low-dose induction:** (5–10 days) Takes longer to reach therapeutic dose	Two months on 300mg injections, followed by 100mg maintenance dose (following stabilization on SL buprenorphine)	(May take weeks) Longer time to achieve therapeutic dose	1–2 weeks

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Visit the Acute Care Education for Nursing/Allied Health course for more information.

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Initiation (cont'd)				
Requires stabilization on oral OAT prior to initiation	N/A	Requires stabilization on sublingual buprenorphine prior to initiation	N/A	N/A
Safety				
Risk of overdose	Low. Due to ceiling effect for respiratory depression in the absence of co-occurring use of central nervous system (CNS) depressants	Low. Due to ceiling effect for respiratory depression in the absence of cooccurring use of central nervous system (CNS) depressants	Higher. Particularly during treatment initiation	Comparable safety profile to methadone, though less well-described
Drug-drug interactions	Few	Few	Higher potential for adverse drug-drug interactions (e.g., antibiotics, antidepressants, antiretrovirals)	Fewer than methadone
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Risk of precipitated withdrawal during initiation	Yes	No, due to need for stabilization on SL dosing first	No	No
Side effects	Milder side effect profile	Medication adverse effects are similar to buprenorphine Injection site pain and pruritus	More severe dose dependent side effect profile (e.g., sedation, weight gain, erectile dysfunction, cognitive blunting)	Comparable to methadone, though less well-described Possibly fewer subjective side effects

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Dosing				
Dosing	Health Canada-approved maximum dose of 24mg, but higher doses (up to 32mg) may be necessary for some patients Alternate day dosing possible May be suboptimal for individuals with very high opioid tolerance	**First two months:** Monthly dose of 300mg **Maintenance dose:** Monthly dose of 100mg (though some patients may benefit from remaining at a 300mg maintenance dose)	No maximum dose specified in the product monograph	No maximum dose specified in the product monograph
Take-home doses	Suitable for immediate take-home doses, including take-home initiation when indicated, which may contribute to increased patient autonomy and cost savings Advantageous for rural and remote locations	N/A	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability	Take-home dosing can be started gradually after 4 consecutive weeks of: • Medication adherence with DWI • Clinical and psychosocial stability
Rotation	Easier to rotate from buprenorphine to methadone or SROM	Rotation to other OAT medications is challenging. Avoid transitioning to a full agonist, if possible Consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other regional addiction medicine supports	Risk of precipitated withdrawal when rotating to buprenorphine May be rotated directly to SROM	Risk of precipitated withdrawal when rotating to buprenorphine May be rotated directly to methadone

	Buprenorphine-based formulations			
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Tapering off	Milder withdrawal symptoms; easier to discontinue. May be a better option for individuals with lowerintensity physical opioid dependence	Milder withdrawal symptoms Buprenorphine concentrations are decreased slowly over time following the last injection and may take months for buprenorphine to leave the system completely	More severe withdrawal symptoms	Comparable to methadone