College of Physicians and Surgeons of Saskatchewan

Health

Saskatchewan Health

SASKATCHEWAN METHADONE GUIDELINES FOR THE TREATMENT OF OPIOID ADDICTION

Saskatchewan, May 2002.

College of Physicians and Surgeons of Saskatchewan

Saskatchewan Health

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01 INTRODUCTION

1. General comments

These guidelines represent a new approach to practice in Saskatchewan for the prescribing of Methadone in the ıtment of opiate addiction. Methadone remains the only opioid currently approved for long-term pharmacological treatment of this condition. New drugs may be approved, and the Guidelines will be reviewed annually and modified as needed.

Recognition that intravenous drug users are now the major source in the spread of Hepatitis C and HIV is focussing increased interest on this group of patients and their management. This document therefore relies on the available

Most people needing opiates take them for short periods and have no trouble getting off them. However about 0.25 % of the population develop drug addiction. Some receive their first opiates by prescription; others from the illicit street market.

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There are therefore three main types of opiate analgesic user:

(1) The appropriate user with enough medication.

(2) The appropriate user under treated, asking for more; the "pseudo-addict".

(3) The inappropriate user, with compulsion, poor control, and consequences; the "Addict".

It is often difficult to distinguish between types (2) and (3); only the third category may really benefit from, and need, Methadone.

(1) The appropriate user with enough medication

Most dependents in steady state are chronic pain patients on appropriate analgesia with no illegal activity and no indication for Methadone for addiction.

(2) The appropriate user undertreated, asking for more; the "pseudo-addict"

ıte or chronic pain patients may well be undertreated; and repeatedly ask for more analgesia. This has the appearance of "drug-seeking", and can be very difficult to differentiate from true addiction. When properly supplied with analgesics they do not escalate use or demand more, and are therefore not the opiate addicted patients in category 3 below, and Methadone is not needed for them.

(3) The inappropriate user, with compulsion, lack of control, and consequences; the "Addict"

The street opiate patients we treat have commonly progressed through several stages:

a. **Recreational occasional use**, often with other drugs initially; to

b. **Recreational steady use**; to

c. **Dependency/Addiction**, usually with illegal behaviour to support drug use. (Some exceptions to this.)

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The end product for these patients is **inappropriate use of drugs**, and for most of them a variety of other consequences in four areas: medical health (physical and mental), social health, legal health; and often spiritual angst.

1. From the purely **medical viewpoint** (physical and mental health), since we are dealing with analgesics, there are at least three categories of Opiate addicted patients suitable for Methadone treatment, all of them usually experienced in using "pain" as a means of obtaining opiates from physicians, these being patients who:

a. Need Methadone to control analgesic use.

b. Need Methadone to control Opioid Addiction.

2. From a **social viewpoint**, if adequately supplied with legal opiates, opiate addicted persons in steady state can behave entirely normally and do all the things the rest of us do; they simply need their drug of addiction. However they usually have to obtain their supplies illegally; when these patients are treated with Methadone, one effectively converts (illegal) opiate addicts into (legal) Methadone dependents. While stable on Methadone they can then get on with, or restructure, their lives, then potentially come off Methadone with a comprehensive program of relapse prevention.

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3. From a **legal viewpoint**, opiate addicts need their drugs daily. During most of the 20th Century involvement with opiates (and some other drugs) had been considered anti-social; many addicts were therefore unable to obtain drugs legally, and resorted to illegal behaviour to obtain them. In consequence most opiate addicts have legal records, and the group in general is often regarded as a fundamentally illegal body. Experience suggests however that most of these patients have no inherent tendency to illegal behaviour, and on treatment behave normally and re-integrate well in society. Thus there are at least three types of patients from the legal viewpoint. It is interesting that Methadone, in the stabilised patient, sometimes helps differentiate between them:

a. Those with evident inherent anti-social tendencies (or worse).

b. Those with no evident inherent anti-social tendencies.

c. Those whose experience puts them variously in both categories.

Opiate addicted patients in correctional facilities present a particular problem, since there are logistical and other difficulties in administering either opiates or Methadone in this environment. There has been considerable progress in management of these patients, and work will continue to improve treatment and prospects for them in the Federal and Provincial systems.

Currently patients in existing Methadone programs can continue their Methadone in Federal and Provincial Correctional Facilities. The Federal system has now moved to allow patients diagnosed with opiate dependency to be started on Methadone while in Federal Correctional Facilities.

(See the section on Correctional Facilities.)

4. Rehabilitation (in all areas) - the real goal.

The goals of Methadone treatment are:

1. To reduce harms of drug use.
2. To treat medical and psychiatric comorbidity
3. To bring substance Addiction into remission.
4. To achieve the highest possible level of psycho social function.

Methadone can be very effective for managing the narcotic drug use problem; however improving the medical (physical and mental), social, and legal health involves many other components, and is the real long term benefit and goal of this therapy.

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At the outset, however, patients' long term rehabilitation prospects are difficult to assess. Patients vary considerably in prior formal education, skill training, maturity, and in general life experience. In consequence a Methadone practitioner may encounter a full range of patients such as:

bioavailability and at least three functions: analgesia for about 6-24 hours, suppression of opioid withdrawal and craving for about 16-36 hours, and a mood stabilising effect for longer periods. It is chemically unrelated to opiates.

Methadone was developed in Germany in 1941 during the Second World War and was found to have analgesic properties. Research in the late 1940s by Isbell and colleagues at the Addictions Research Center in Lexington, Kentucky, showed that it could also be used to treat withdrawal symptoms in heroin-dependent individuals. Halliday in Vancouver (1963), then later Dole and Nyswander in New York (1967) demonstrated the feasibility of using Methadone as a maintenance medication. Some of the original patients in the New York programme are still on Methadone for over 30 years later and doing well with no evidence of ill-effects.

Methadone maintenance involves the daily administration of Methadone over an extended period as treatment for opiate-addicted individuals. A single adequate dose administered to a stabilised individual suppresses withdrawal and craving for about 24 hours without causing euphoria or sedation. This enables individuals to function normally and to perform mental and physical tasks without impairment. In sufficient dose Methadone appears to "block" some of the effects of other opiates. However they are chemically different drugs, and opiates can be prescribed along with Methadone when situations warrant, e.g. post-op pain control, or chronic pain. Note that the analgesic effect of Methadone varies greatly from patient to patient and from pain type to pain type.

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Methadone is available in Canada as a very soluble powder and a liquid form "methadol"; it is well absorbed from the gut, with peak serum levels in about 2 - 4 hours. The serum elimination half life is 15 - 40 hours, and it is metabolised mainly by the liver. It has no known active metabolites.

Methadone Prescribing

Narcotic prescriptions are subject to the *Controlled Drugs and Substances Act* (CDSA) and the *Narcotic Control Regulations*. The authority to prescribe methadone is actually an exemption pursuant to section 56 of the CDSA from the application of subsection 5(1) of the CDSA with respect to methadone. Exemptions are issued by the Office of Controlled Substances, Health Canada, to approved physicians as recommended by the College of Physicians and Surgeons. Exemptions are issued for either Pain Control (palliative care or chronic pain) or Addiction or for both when appropriate or requested. (See section on Prescribing and Dispensing Issues).

7. Benefits of Methadone Maintenance Therapy

Numerous studies have shown that maintaining opioid- addicted individuals on Methadone has almost immediate harm reduction benefits to patients and society, and many significant longer term personal and societal benefits including:

- improved physical and mental health;
- improved psycho-social functioning such as:

    1. increased self esteem, personal, family and community involvement;

    2 .improved educational status, vocational training and employment;

    3. reduced illicit drug use and decreased illegal activity;

- cost-effective treatment:

    1. much less expensive than not treating them. (USA costs $21,500 untreated, $1,750 treated, over six months - NIDA, Dec 1994).

1. at least seven times the cost of treatment.

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8. Methadone Clinics and Other Essential Services.

While not all opioid-addicted individuals are interested in or are necessarily appropriate candidates for Methadone treatment, the demand for Methadone treatment exceeds its availability. There is also strong support for developing new models of Methadone treatment in order to serve a wider range of opioid users.

Assistance in non-medical bio-psycho-socio-spiritual issues is clearly required. Ideally this should be provided in a co-ordinated, integrated, multi-disciplinary approach with input from Agencies such as Addictions Services, Social Services, Education, Corrections, Justice, Mental Health, Spiritual Advisors, etc.

Methadone has been prescribed continuously in Regina since 1972; in Saskatoon during the seventies; and for the last several years in Moose Jaw and Ft. Qu'Appelle. Since expansion of the services in 1997, most Saskatchewan Methadone Maintenance Clinics are now held in regular family / general practice settings, the patients integrated with other patients, prescriptions being written by the physician to be picked up at community pharmacies.

In Feb 1997, because of a perceived need to have Methadone treatment available in Saskatoon, an ad-hoc committee with representation from physicians, pharmacists, Addictions Services, Social Services, Police, Corrections, Probation, Parole, etc. was established to assist in dealing with problems that arose in the treatment of opiate addicted patients. This committee continues to meet to provide direction to the Saskatoon programme. While the physicians have ultimate responsibility, this committee provides a network for sharing of information and assists each person involved with the patient to achieve maximum benefits for the patient. A similar committee was formed in Prince Albert, which has allowed that programme to grow quickly. Because Methadone patients require assistance in a number of areas we would expect the programme in each community to benefit from such a committee.

It is generally agreed that, Opiate Addiction, now being seen as a primarily medical problem at the outset, should be assessed, tested, diagnosed, and treated in medical clinics run by physicians along normal medical lines subject to all the privileges and responsibilities accorded by the College of Physicians and Surgeons of Saskatchewan.

Educational audits will be performed by the College of Physicians and Surgeons to ensure that physicians properly understand the principles and practice of the assessment and management of these patients, and that patients benefit maximally.

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02 TERMINOLOGY

ADDICTION: A relapsing chronic disease, characterised by impaired control over the use of a psychoactive substance and/or behaviour. Clinically it presents as inappropriate drug use, physical, mental, social, legal, and spiritual problems. Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal.

CRAVING: A bio-psychological arousal and urge to return to addictive behaviour, characterized by a strong desire, pre-occupation and possible impulsivity.

DEPENDENCY-PHYSICAL: Physiological state of adaptation to a specific psychoactive substance characterized by

Guideline the term is used in the medical sense throughout.

OPIATE: A substance derived from or containing opium. Thus all opiates are opioids.

OPIOID: An all-inclusive term which describes drugs with morphine-like activity, whether natural products of opium, semi-synthetic like heroin, or entirely synthetic like demerol and Methadone.

PEAK TO TROUGH RATIO FOR SINGLE DOSE METHADONE: Measures the amount of drug at its projected highest blood level, about 2 hours after ingestion, with that at an earlier period, just before a dose, and compares the numbers. This often is a better way to assess the physical effectiveness of a drug over a twenty four hour period, and with Methadone is useful to determine the patient's need or suitability for split dosing by helping to identify rapid metabolizers.

RECOVERY: Recovery is the BEST RETURN OF FUNCTION, which may or may not include abstinence from drugs.

SSRI: Selective Serotonin Re-uptake Inhibitor. A relatively recent class of anti-depressant medications such as fluoxetine, luvoxitine, with wide safety margin and no known overdose potential.

TCA: Tri-Cyclic Antidepressants. An older group of medications such as amitriptylene, nortriptylene, with potential for overdose.

TOLERANCE: State in which an increased dosage of a substance is needed to produce a desired effect.

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03 CRITERIA FOR ADMISSIONS

1. NEW PATIENTS, NOT YET ON METHADONE

(1)The patient must want to be treated.

(2)Dependency/Addiction must be established.

(3)There should be evidence of extensive past and current opiate/opioid use and:

failed attempts at personal withdrawal and / or

failed attempts at structured/residential "detox" and / or

failed treatment attempts.

(4)No age limit.

(5)Previous unsuccessful Methadone treatment should not exclude a patient from further Methadone treatment.

2 EXISTING PATIENTS - TRANSFERS FROM OTHER METHADONE PRESCRIBERS

(1)Collect all the transfer information from the other clinic.

(2)Continue methadone as before.

(4)Reassess as time goes on, and adjust as necessary.

For all of the above obtain:

1. Past medical history from their family physician and
2. their Triplicate Prescription Program information from the College of Physicians and Surgeons of Saskatchewan.

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04. PATIENT ASSESSMENT and AGREEMENT

(1) Informed Consent

Informed consent must be obtained prior to initiating the treatment process.

(2) Medical Assessment

A medical assessment must be done prior to admitting an individual to a methadone maintenance program. The purpose of the assessment is to:

- determine a patient's suitability for methadone treatment (i.e. establish a diagnosis of opiate/opioid dependence)
- determine a patient's fitness for Methadone treatment, in particular no current respiratory contraindications at the time of initial dosing.
- arrange screening for medical complications associated with drug use (liver function tests, Hep B, Hep C, HIV/AIDS, TB) including informed consent and pre- and post-test counselling procedures
- identify factors that put the individual at further risk for harm (e.g., unsafe sexual practices, emotional or physical abuse, lack of birth control, suicidal ideation, etc.)
- recommend a treatment plan to the patient.

(3) Psychosocial Assessment

Psychosocial assessment by an Addiction Counsellor would be the most complete and comprehensive, however it may not be immediately available. The physician's psychosocial assessment may therefore be the first to take place and would then be the one relied upon initially. Pharmacists, having the most regular contact with patients, would be in a position to conduct an informal psychosocial assessment. All parties are encouraged to work together to share information for the benefit of patients. Prospective patients should be informed of this co-operative approach, with its inherent limits to confidentiality.

Psychosocial assessments should be ongoing, with the initial Addiction counsellor's assessment done as proximal to the medical assessment as possible. It should be repeated as often as necessary during the course of treatment. The use of a well-validated instrument is recommended. The purpose of the psychosocial assessment is to:

- gain an overview of problems in life functioning and establish baseline data across various areas (drug and alcohol use, medical, psychiatric, social/family/employment, legal).
- identify psychosocial issues that require the assistance of other professionals.
- to assist the physician in developing a treatment plan, outlining objectives and conditions/expectations.

Full comprehensive care for opiate addicted patients includes Methadone and such other health, pregnancy, social, and legal services etc. as the patient may require. Clinics vary in the range of services they provide, from full comprehensive, to various partial services, to Methadone alone.

The Treatment Agreement should specify the range of services offered, and in particular if the facility does not offer full comprehensive care the Treatment Agreement should specify that the physician will prescribe Methadone for them but will not provide other services. It is the patient's responsibility to arrange to have a family physician to cover other health care services. The agreement must indicate that FP / GP and other physicians involved in care will be informed about the Methadone treatment.

A typical model agreement is appended.

(5) Treatment Plan

This plan is recommended by the physician. It is a road map for the patient and physician. It assists an auditor in assessing the thinking of the physician in arriving at therapeutic decisions. The plan should be evident in reviewing a physicians records.

(6) Patient Orientation

The patient should receive an orientation to the program including information about Methadone. The patient should be given an opportunity to ask questions about Methadone or any other currently prescribed drug. Relevant written information about the clinic, appointments, Methadone, other drugs, health matters like Hepatitis C, HIV, etc. should be made available. See appendix for sources of information.

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05. PATIENT INFORMATION PRIOR TO TREATMENT

Before treatment is started, and in particular before the first prescription for Methadone is issued, all patients should sign, and receive a copy of, the treatment agreement and receive information about:

1. The Clinic hours, processes, personnel, etc.

2. Methadone

3. Available drugstores dispensing Methadone.

Typical examples of these documents are appended.

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06. METHADONE DOSING ISSUES

1. New Patients - Induction on Methadone

The initial dose of Methadone is administered after the medical assessment has been completed and a diagnosis of opiate Addiction has been established. This induction phase may take up to six (6) weeks to achieve control of opiate withdrawal and craving; control of needle craving may take much longer. Oral 24 hour acting morphine, such as Kadian, may be needed to control withdrawal over the first few weeks, the dose diminishing as Methadone becomes effective.

can be deceptive, and can cause a respiratory depressant effect which may not become apparent up to ten days after starting Methadone.

Outpatient therapy. The following protocol is suggested:

The initial dose should not exceed 30 mg of Methadone per day for at least three days.

Thereafter, if the patient has had no significant respiratory problems, the dose may be adjusted upward by 10 mg every second day, until a daily dose of 60 mg has been reached, at which time the patient should be re-evaluated. Remember it requires 5 doses to achieve a steady state due to the long half life of Methadone.

After 60 mg, dose changes (5-10 mg) should only be made every 7 - 14 days or longer as needed. The individual dose at stability varies, but the majority of patients will settle between 60 and 100 mgs. If the patient is receiving 80 mg of Methadone or more and continues to use drugs, or complains of withdrawal and/or urges to use, the physician may increase the dose. After several stable months many patients find daily Methadone needs may diminish with continued good effect, and dose reductions may be possible.

Inpatient therapy.

These patients should start Methadone at the same level and time frame up to 60 mgs; but subsequent increases could potentially be at a faster rate provided the patient can be observed for the respiratory depressant effect.

2. Stabilisation Phase - Maintenance Dosing

Once a patient has been stabilised on Methadone, dose increases or decreases may be made only after the physician has assessed the patient.

Although maintenance doses of Methadone should be individualised to suit each patient, research evidence shows that higher doses of Methadone (>60 mg) are associated with better retention rates in treatment and less illicit opiate use. Doses over 100 mg are not often needed.

A maximum of 120 mg is suggested for most patients. Obtain consultation for patients who appear to need more than 120 mg per day.

Criteria for dose increases include:

1. signs and symptoms of withdrawal (objective and subjective)

2. amount and/or frequency of opioid drug use not decreasing

3. persistent cravings for opiates

Once stable, fast metabolizers may need split doses:

A small percentage of patients metabolize Methadone rapidly, e.g. pregnant patients, hard workers/exercisers, some taking other drugs like anti-epileptics, and may therefore experience withdrawal even at a relatively high dose. Splitting the daily dose 50/50 am/pm is often effective. Peak - Trough serum ratios in considerable excess of 2:1 may confirm that the dose is not holding for 24 hours. Total dose adjustments may also be necessary. Split doses are not recommended for new patients. Blood should be taken immediately before a Methadone dose and then 2-4 hours later to obtain the peak-trough measurement.

Criteria for dose decreases (once stable) can include:

many reasons. The prescribing physician must assess the situation and determine the correct dose for this process.

For safety reasons, the following system is suggested for restarting a previously stable patient after missing consecutive days of Methadone.

miss 1 - 2 days- restart at the full stable dose.

miss 3 - 5 days- restart 50% am, 50% pm, then full dose next day if OK.

miss 6 - 9 days- restart 50% then gradual increase to previous full dose.

miss 10 + days- restart from the beginning at 30 mg.

4. Deferral to Medicate

Patients should not receive Methadone if they appear to be intoxicated, particularly with alcohol; patients may be asked to wait to be reassessed some hours later prior to administration of Methadone.

5. Replacement of vomited doses

A physician or pharmacist may replace a vomited dose under the following situations:

- the vomiting was observed by a responsible individual eg: pharmacist or nurse
- the vomiting occurred less than 15 minutes after ingestion, full replacement
- between 15 and 30 minutes, ½ the dose would be replaced
- after 30 minutes no replacement is given

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07. URINE TESTING

Urine drug tests are one of the ongoing means of assessing progress on Methadone, providing an informative window on issues around continued drug use, and on patients' behaviour generally. They can be used constructively to assist forward movement to good control of drug use and behaviour with the well documented benefits. They should only be used punitively as a last resort.

A Urine Drug Screen is a panel of several tests done at one time. This can include stimulants like amphetamines, methylphenidate, or cocaine; depressants like barbiturates, benzodiazepines, opiates, Methadone; others like PCP, ethyl alcohol, cannabinoids.

1. Urine drug screens are done to ensure that patients are ingesting the Methadone that is prescribed for them and to detect whether they are taking any other non-prescribed drugs. The validity of the urine screen results increases if the collection is done randomly under supervision.

2. A minimum of one urine drug screen is advised prior to initiation of Methadone treatment.

3. Randomly collected urine samples are the most useful in assessing patient compliance with a treatment agreement. Testing should occur at least two times per month during the stabilisation period.

occasionally subject to error; care is recommended in confronting patients with lab test reports.

Usually the lab tests for a combination of parent and/or metabolites of drugs, i.e. substances already altered by body metabolism and excreted in altered form in the urine. Currently (October, 2002) the Provincial Laboratory tests are according to what is shown in Table 07.

Laboratory tests also have a minimum test level (the "cut-off") below which the results are reported as negative;, whether or not the substance is present in smaller amounts. (See Table on the following page).

There are two different test procedures, a fairly simple ELISA/EMIT (enzyme linked immunoassay), the more complex Gas Chromatography / Mass Spectrometry ("GC/MS") confirmatory test. Most samples are tested by the ELISA/EMIT procedure. GLC is done infrequently, and the GC/MS procedure is done only if absolutely essential, usually in medico-legal cases.

The current tests and cut-off levels for drugs are listed in the Table below:

Drug Cut-off Time detectable after last dose

(These drugs are part of the routine drugs of abuse panel measured by EMIT/ELSIA).

Amphetamines 1000 ng/ml 1 - 2 days. parent/metabolite

Barbiturates 200 ng/ml variable, hours to weeks. parent

Benzodiazepines 200 ng/ml 3 days to six weeks. parent/metabolite

Cannabinoids (THC) 50 ng/ml 1 to 4 weeks. parent/metabolite

Cocaine 300 ng/ml 2 - 4 days. metabolite

Methadone 300 ng/ml 1 - 3 days. parent

Opiates 300 ng/ml 1 - 2 days. parent/metabolite

Phencyclidine 25 ng/ml 1 - 30 days. parent/metabolite

(The following drugs are not part of the routine drug screen, they are measured by GLC, and are done only by special request).

Alcohol 10 mmo/L 2 - 14 hours parent

Demerol 300 ng/ml 1-2 days. parent

Methaqualone 300 ng/ml 1 - 7 days. parent

Propxyphene 300 ng/ml 1-2 days. parent

Methylphenidate 50 nmol/L 1 - 2 days. parent

(Methylphenidate is measured by ELISA method. It is not part of the routine drug screen, it must be requested separately. The measurement of methylphenidate is not very specific, about 5% of samples tested give a false positive result. Confirmation of a positive result is done only for medico-legal purposes or other compelling reasons and must be requested separately).

Counselling services are to be driven by the needs and motivation of the patient, and should be encouraged. MMT patients have a high frequency of psychiatric comorbidity and will need additional psychosocial services. The physician may have to educate the patient on the benefits of counselling.

Counsellors can be variously involved in several key areas, such as the initial patient assessment, direct interventions with the patient, interventions on behalf of the patient, and case management and outcome assessments. Numerous skills are therefore required depending on the areas involved In addition to empathy the counsellor would need to be knowledgeable about dependency and addiction in general, opiates in particular, the various aspects of opiate dependency/addiction, and of course the science and use of Methadone and any other drugs used by these patients. Relapse prevention coaching is a vital role for counsellors.

A provincial committee has been struck to develop Provincial Counseling Guidelines.

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09. PRESCRIBING and DISPENSING ISSUES

1. The Major problem for Opiate Addicted Patients.

The major problem for all these patients is the disease of opiate Addiction.

Saskatchewan's use of the Triplicate Prescriptions has made it easier to identify these patients; scripts are numbered and registered individually with only one drug per script; patients are well aware of this, and most find it a benefit.

( )d therapy therefore includes helping the patient gain control over such drug use while trying to assess and deal with those factors thought or found to be precipitating the behaviour.

Because of the patient's history of inappropriate drug use it is best for the Methadone prescribing doctor to handle the prescriptions for all the psychotropic and analgesic drugs, issuing all the medications for the same total period. Many patients ask for quite short dispensing periods matching their Methadone drink-and-carry schedules. Prescriptions can be written with long total periods but specifying short dispensing periods. The use of other psychotropic drugs should be based on a clear psychiatric diagnosis. A specialist consultation should be considered.

2. Authority to Prescribe Methadone

Prescribing is restricted to doctors specifically exempted by Health Canada under section 56 of the *Controlled Drugs and Substances Act*. Methadone exemptions are issued for Pain Control or Addiction; or for both when appropriate or requested.

Exempted practitioners are subject to Provincial College jurisdiction; can prescribe for patients residing in their own Province; and on an interim basis for those who move away from or to the Province.

For patients who move away the prescribing doctor is responsible for ensuring a continued supply of Methadone in the new area if possible; ideally this includes finding a doctor and / or pharmacy in the new location who can continue the prescription.

In Saskatchewan the College of Physicians and Surgeons requires new physicians wishing to prescribe methado