



Frequently asked questions

Medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD)

What are the benefits to clients of encouraging use of MOUD and MAUD?

According to the National Institutes of Health (NIH), methadone and buprenorphine reduce risk of death after opioid overdose. With MOUD, the relapse rate for those with OUD decreases to 50% at one year. More promising statistics have been demonstrated for those whose treatment includes psychosocial interventions. Outdated substance use disorder (SUD) treatment models are often one-size-fits-all. Traditional SUD services are often solely based on an “abstinence-only” philosophy and often do not follow a medical model of treatment. Evidenced-based services that incorporate MOUD address the biological processes of physical dependence and cravings – a major cause of relapse. As with most medical conditions, MOUD takes a chronic, biological-based condition approach understanding that multiple streams of care are needed to gain control and manage this fatal disorder. While all MOUD regimens are effective in treating SUD, they may not be equally effective for all individuals. There are many forms of MOUD, for both OUD and alcohol use disorder (AUD), with multiple ways of administration. As a result, treatment can be narrowly tailored to each individual’s needs.

Isn’t MOUD just exchanging one drug for another?

All disorders of addiction are chronic conditions with very real biochemical components. Research is conclusive that SUD is linked to specific receptors involved with the “reward system” in the brain. This is especially true for OUD, which also involves receptors that are responsible for pain relief and feeling pleasure. For treatment, MOUD works on these same receptors in varying ways. When taken as prescribed and under appropriate supervision, MOUD is not addictive. Unlike heroin, MOUD does not induce feelings of euphoria or cause habitual, unhealthy or compulsive use. When taken as directed, MOUD does not cause either intoxication or withdrawal as seen with prescription pain medications and heroin.

More importantly, continual use of MOUD enhances long-term recovery by decreasing cravings. In fact, studies have shown that after short-term use of MOUD for “detox” only, relapse is most likely to occur, and can result in a fatal overdose. Misguided beliefs about MOUD and how it works only continue to stigmatize individuals suffering from SUD.

How safe is MOUD?

The World Health Organization has placed methadone and buprenorphine for the treatment of OUD on their list of “essential medications.” The American Society of Addiction Medicine (ASAM), National Institute of Drug Abuse (NIDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) recognize MOUD as the standard of care and evidence-based treatment for individuals suffering from SUD.

When used as prescribed under appropriate supervision, MOUD can safely be taken without damaging side effects. But, as with any medication, there are potential side effects. When experienced, these side effects are known to be minor with no long-term health risks, and most reduce over time once a stable dose of medication is reached.

The decision about MOUD should be made only after discussion with a medical professional about the potential side effects, as well as obtaining a clear understanding of the risks and benefits of incorporating – and not incorporating – MOUD into a long-term treatment plan.

What exactly is methadone and how does it help clients in overcoming their dependence?

According to the U.S. Office of National Drug Control Policy, methadone is “a rigorously well-tested medication that is safe and efficacious for the treatment of narcotic withdrawal and dependence.” Pharmacologically, methadone is a man-made opioid. It is known chemically as a “full agonist.” In other words, it completely binds to the opioid receptors in the brain like all other prescription pain medications, including heroin. Methadone is available in the form of a pill or oral solution, and has been available in the U.S. for more than 70 years.

Methadone is prescribed under strict state and federal guidelines only by providers with the appropriate training, certification and credentials. When used to treat chronic pain, methadone can be prescribed by a physician and filled in a pharmacy. When used to treat OUD, methadone can only be provided in an opioid treatment program (OTP).

Methadone is long-acting and does not generate the euphoric feeling like that of a short-acting opiate, such as heroin. When provided at the correct dose, methadone does not cause impairment to mental function or daily activities. Instead, methadone eliminates acute symptoms of opioid withdrawal and relieves craving.

What is buprenorphine?

Buprenorphine has been available since 2002 for the treatment of OUD. It can be prescribed by a qualified medical provider and filled in a pharmacy. Unlike prescription pain medications, medical professionals must have a special license through the Food and Drug Administration (FDA) to prescribe buprenorphine.

Like all other opioids, buprenorphine acts on the opioid receptors in the brain. Unlike methadone, prescription pain medications and heroin, buprenorphine does not completely bind to opioid receptors. As such, it is chemically known as a “partial agonist” and only binds to parts of the opioid receptor resulting in relief from symptoms of withdrawal and decreased cravings.

Buprenorphine does not require increasing dosage with long-term use to achieve its effects, which is different from full agonists. And, even in high doses, buprenorphine does not cause the respiratory depression.

Since 2002 buprenorphine has been FDA-approved in many different forms and routes of administration including a pill, dissolvable tablet and buccal film. As a result, buprenorphine can be tailored to the needs of individuals within a comprehensive, long-term treatment plan.

What is naltrexone and what is the difference between agonist and antagonist MOUD?

FDA approval of MOUD allows individuals to seek treatment without the preoccupation of physical cravings or the anxiety of impending withdrawal. MOUD can be tailored to individual needs and can be provided in multiple settings. A simple way to remember the different forms of MOUD is to understand how they work on the opioid receptors to achieve the same result of long-term recovery and prevention of fatal overdoses.

Three different classes:

- Full agonist (methadone)
 - An opioid that binds completely to the opioid receptor in the brain
 - May only be dispensed in a federally regulated methadone clinic for the treatment of OUD
 - Must be taken on a daily basis
 - Eliminates withdrawal symptoms and relieves drug cravings
 - Does not require increased dosing to achieve the same therapeutic effect

- Partial agonist (buprenorphine)
 - Binds partially to the opioid receptor in the brain
 - May only be prescribed by a physician, nurse practitioner or physician assistant that has the appropriate FDA license/Data 2000 Waiver Certification
 - Can be filled by a community pharmacy
 - Must be taken as prescribed in a pill, dissolvable tablet, buccal film, 6-month implantable rods or 30-day IM injection
 - Eliminates withdrawal symptoms and relieves drug cravings
 - Does not require increased dosing to achieve the same therapeutic effect
 - Does not induce respiration depression resulting in fatal overdoses
- Antagonist (naltrexone)
 - Inhibits opioids introduced into the system from binding to the opioid receptors in the brain that cause euphoria, dependency, respiratory depression and overdose
 - Does not require appropriate FDA-licensure and may be prescribed by a physician, nurse practitioner or physician assistant acting under the scope of their licensure
 - Can be filled by a community pharmacy in oral form
 - Does not require increasing dosage to achieve the same therapeutic effect
 - Must be taken as prescribed in a pill or 30-day IM injection
 - FDA approved to reduce heavy drinking for persons with AUD

As with any medication, there are potential side effects. Deciding which form of MOUD best meets the needs of an individual should take into consideration the following:

- Substance use history
- Medical and mental health history
- Past treatment history
- Psychosocial needs and recovery goals

The decision about MOUD should be made only after discussion with a medical professional about the potential side effects, as well as obtaining a clear understanding of the risks and benefits of incorporating – and not incorporating – MOUD into a long-term treatment plan.

How long does MOUD and MAUD last?

Incorporating MOUD and MAUD into any treatment plan should be designed to address each individual's unique situation. Duration of treatment varies and should take into consideration the individual's treatment response, needs and circumstances. There is no FDA limit on how long an individual may use any MOUD/MAUD in their treatment. The rule of thumb is that one should remain on MOUD/MAUD to achieve and maintain their recovery goals.

What guidance does the FDA give regarding MOUD during pregnancy?

Methadone has been used for pregnant women with OUD since the 1970s and has been recognized as the gold standard of care since 1998.

In addition, The FDA issued safety labeling changes for buprenorphine products when prescribed for use during pregnancy. Research has demonstrated the following benefits from methadone and buprenorphine treatment during pregnancy:

- Stabilizes fetal levels of opioids
- Reduces repeated prenatal withdrawal
- Improves neonatal outcomes
- Increases maternal HIV treatment and reduces the fetal transmission
- Promotes better prenatal care

What MAUDs are available?

There are several FDA-approved MAUDs, which include:

- Medications used to reduce reward from alcohol intake:
 - Naltrexone, Revia® and VIVITROL® (naltrexone IM injection)
- Medication used to reduce cravings
 - Campral EC (acamprosate)
- Medication used to cause adverse effect of alcohol ingestion
 - Antabuse® (disulfiram)



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