DRUG POLICY ALLIANCE.

MEDICATIONS FOR OPIOID USE DISORDER (MOUD): METHADONE AND BUPRENORPHINE

SEPTEMBER 2025

KEY TAKEAWAYS

- Methadone and buprenorphine are the most studied medications for opioid use disorder (MOUD). They are the safest and most effective method for treating opioid use disorders.
- Both medications promote recovery and save lives by reducing opioid cravings and withdrawal symptoms, while cutting overdose risk in half.
- Despite evidence showing the lifesaving benefits of MOUD, only an estimated 25% of people with opioid use disorder receive MOUD treatment.[1]
- Access to MOUD is limited by strict regulations, cost, health insurance barriers, and not having a pharmacy or doctor who can prescribe it to you.
- Policymakers must take action to remove barriers and increase access to MOUD.

OPIOID OVERDOSE DEATHS ARE AT CRISIS LEVELS

In the past decade, overdose deaths involving opioids have surged.[2] In 2024, over 80,000 people in the U.S. died from an overdose. Opioids, like fentanyl, were involved in more than half of these deaths.[3] Despite a recent decline in the rate of overdose deaths, too many people continue to die from opioid overdose.

Evidence-based treatments can prevent people from dying of opioid overdose, but access remains limited. Policymakers at all levels—federal, state, and local—must act now to improve access to lifesaving treatments, like medications for opioid use disorder (MOUD).

WHAT ARE MEDICATIONS FOR OPIOID USE DISORDER (MOUD)?

MOUD* are the safest and most effective method for treating opioid use disorders (OUD). There are three Food and Drug Administration–approved medications used to treat OUD: methadone, buprenorphine, and naltrexone.

While all three medications reduce cravings for opioids, only methadone and buprenorphine prevent withdrawal and have been proven to reduce overdose risk.

Methadone is a schedule II controlled substance.[4] Buprenorphine is a schedule III controlled substance.[5]

MOUD REDUCE OVERDOSE DEATHS AND IMPROVE HEALTH OUTCOMES

Over five decades of research has consistently demonstrated that medication is the safest option for treating OUD.[6] Methadone and buprenorphine reduce:

- Risk of death, including by fatal overdose
- Use of fentanyl/other synthetic opioids and heroin
- Injection drug use
- Risk of transmitting HIV and hepatitis C
- Involvement in the criminal legal system.[7]

People who receive MOUD stay in treatment longer and have improved quality of life.[8]

* Unless noted otherwise, we use MOUD to refer to methadone and buprenorphine specifically.

METHADONE AND BUPRENORPHINE ARE ESTIMATED TO REDUCE RISK OF DEATH FROM ALL CAUSES, INCLUDING OVERDOSE, BY HALF.[9]

Despite decades of research showing the lifesaving benefits of MOUD, it is estimated that only 25% of people with OUD currently receive them.[10] Strict regulations, unequal access to care, and stigma limit access to MOUD.

ACCESSING MOUD

MOUD are strictly regulated by federal, state, and local laws. Methadone and buprenorphine are regulated differently.

Methadone is Only Available in Opioid Treatment Programs

With very limited exceptions, methadone is only available through opioid treatment programs (OTPs).** These programs must be registered with the Drug Enforcement Administration (DEA) and approved by the Substance Abuse and Mental Health Services Administration (SAMHSA).[11]

OTP regulations are strict: patients need to complete a full medical evaluation before starting treatment, submit to frequent drug tests, and travel daily to take their medication under supervision at an OTP.[12]

"It's a two-and-a-half-hour round trip to go to a methadone clinic so you can't work, you can't have a job. You can't go to school. You get your methadone and go home. You do that every day. Yeah, the system is broken."[13]

- MOUD provider

Buprenorphine Can be Prescribed in Traditional Healthcare Settings

Buprenorphine is available in treatment settings like doctors' offices and community clinics. Many OTPs provide it as well. Medical providers, including doctors, physician assistants, and nurse practitioners can prescribe the medication. It is also accessible through telehealth, using either video or audio-only connections with a healthcare provider.[14]

ACCESS BARRIERS TO MOUD

Federal Policies Are Too Restrictive

In 2024, based on lessons learned from the COVID-19 public health emergency, SAMHSA updated its OTP regulations to lessen some restrictions on methadone treatment. However, too many federal regulatory barriers persist, particularly for methadone. Federal policies do not apply to methadone and buprenorphine equally, causing patients to struggle with finding and staying on a treatment that works best for them.

- **Take-home methadone:** Generally, people must go daily to an OTP to take their methadone on site. Patients considered "stable" can take home a seven-day supply of methadone within their first two weeks of treatment. However, to be considered stable, patients must meet strict criteria. This includes being in good mental and physical health, following their treatment plan, regularly attending their OTP, and storing their medication safely. After one month, eligible patients can receive up to 28 days of take-home medication.[15] Regular travel to an OTP can be time-consuming, costly, and disrupt work and family responsibilities, especially in areas where the nearest OTP requires significant travel. These challenges create significant barriers to methadone treatment.[16]

** Access to methadone is limited to OTPs, except for the "72-hour rule." This rule allows emergency room clinicians to give methadone for up to three days to ease withdrawal symptoms while a person is referred to an OTP or other treatment services. Samantha Huo et al., "Emergency department utilization of the methadone '72-hour rule' to bridge or initiate and link to outpatient treatment." *American Journal of Emergency Medicine* 89 (2025): 209-215. https://doi.org/10.1016/j.ajem.2024.12.059.

- **Telehealth:** Patients can start methadone and buprenorphine treatment using telehealth. However, the rules are stricter for methadone than buprenorphine. Patients must be evaluated using video telehealth services to initiate methadone, whereas buprenorphine can be intiated with audio-only communication.[17] Phone evaluations for methadone initiation are only allowed if video services are unavailable and the patient is meeting with a prescribing medical provider.[18]

Many States Have Stricter Regulations than Federal Policies

States and localities, as well as OTPs themselves, may have stricter rules than the federal policies currently in place.[19] A study conducted in 2021 found that nearly half of all states required patients to attend counseling in order to receive treatment,*** despite evidence showing that MOUD are just as effective without counseling and requirements being removed from federal regulations.[20, 21] Over half of all states required patients to submit to more than the eight annual drug tests mandated by federal regulations for methadone treatment, requiring patients to sacrifice more time and privacy.[22]

Strict state and local policies make it even harder to access methadone. While SAMHSA may promote loosened policies, local governments and OTPs do not have to comply. For instance, although federal policy allows more take-home access, there are still patients across the country who are required to travel daily to an OTP to receive methadone.[23] Daily OTP visits are especially challenging for people in rural areas where clinics are scarce and longer travel is often required.[24] In addition, OTPs are still not equally accessible for people in every state or region of the nation. For example, as of June 2025, there are no OTPs in Wyoming and only one in South Dakota.[25]

Health Insurance Limits Access to MOUD

Many public and private health insurance companies must give prior authorization before they cover the cost of MOUD. These requirements can delay access to treatment and cause patients to fall out of care. In 2021, 64% of state Medicaid plans required prior authorization for at least one form of buprenorphine.[26] Other insurance requirements like "fail first" policies require that patients try different medications or non-medication treatments before MOUD can be covered.[27, 28] Many insurance companies also require patients to attend counseling even if the medications are working without it.[29, 30]

MOUD is Limited in Correctional Facilities

Offering MOUD during incarceration leads to better health outcomes and fewer interactions with the criminal legal system.[31] In Rhode Island, providing MOUD in jails and prisons dramatically reduced overdose deaths after reentry.[32] However, most people do not receive any treatment or counseling while incarcerated.[33] Fewer than 30% of jails and 10% of state prisons offer all three forms of MOUD.[34] Most of these facilities only provide MOUD to people who were already taking it before they were incarcerated.

Failing to provide or limiting access to MOUD in correctional facilities likely violates the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973.[35]

The ADA protects people with disabilities from discrimination by state and local governments. The Rehabilitation Act prohibits federally-funded agencies, facilities, and programs from discriminating against people with disabilities. OUD and the use of MOUD are generally recognized as protected under these laws.[36] Correctional facilities or criminal justice agencies likely violate these anti-discrimination laws when they deny or limit access to MOUD without offering reasonable alternatives.[37]

*** OTPs must provide "adequate substance use disorder counseling and psychoeducation to each patient as clinically necessary and mutually agreed-upon, including harm reduction education and recovery-oriented counseling." 42 CFR § 8.12(f)(5)(i).

Stigma Deters Patients and Providers

Drug policies that demonize people who use drugs contribute to healthcare providers' reluctance to prescribe MOUD and leads to the perception that patients with OUD are too complex or difficult to manage.[38] This is especially true with methadone. Even with the removal of barriers that previously applied to prescribing buprenorphine, the stigma associated with the medication means there are not enough buprenorphine prescribers to meet the need.[39]

Policies that severely restrict access often reinforce abstinence-only approaches, sending the message that MOUD is dangerous or undesirable. These negative perceptions, along with rigid dispensing requirements, discourage patients from seeing MOUD as valid and effective treatment options. As a result, some may turn to alternatives to manage withdrawal, including secondhand MOUD or illicit opioids like fentanyl, which significantly increase the risk of overdose.[40]

Racial Inequities Influence Availability

Structural racism, like residential segregation, affects MOUD prescribing. White people are more likely to receive buprenorphine than people of color.[41] Buprenorphine prescribers tend to be located in mostly white communities. In contrast, methadone providers are more often located in communities with higher Black and/or Latino populations.[42] OTPs were intentionally concentrated in communities of color due to the war on drugs' emphasis on strict regulation and social control.[43] Racial disparities persist,[44] with Black people more likely to have access to the tightly controlled and surveilled medication (methadone) and white people with greater access to the less strictly regulated medication (buprenorphine).

Training and Support for Healthcare Providers Is Insufficient

Many healthcare providers outside of OTPs do not feel that they have adequate training or support to prescribe MOUD or care for people with OUD.[45] This is consistent with the fact that only a handful of medical education curriculums include substance use disorder treatment as a core competency.[46]

RECOMMENDATIONS TO INCREASE MOUD ACCESS

Policymakers must prioritize the following actions at all levels to increase MOUD access.

FEDERAL POLICIES

- **Remove burdensome OTP restrictions:** Federal regulations should expand access to methadone beyond OTPs and treat methadone more like buprenorphine. Patients should be able to access methadone from their primary care provider, community clinic and pharmacy, and in other office-based settings. Eliminating OTP requirements would reduce transportation issues and improve patient choice in providers.[47]
- **Expand telehealth access to methadone:** Federal regulations should be updated to allow providers to use audio-only telehealth to prescribe methadone, standardizing telehealth access with buprenorphine.[48] These changes would reduce barriers to care for people without access to a smartphone, reliable internet, or in-person care.[49]

STATE POLICIES

- **Align state OTP policies with federal standards:** States should repeal any laws that impose more stringent burdens than required by federal law. States could follow Alaska[50] and Idaho's[51] example by enacting laws that tie their OTP standards to federal law. State law should be updated to regularly align with changes to federal law.[52]
- **States should prohibit prior authorizations:** As of 2021, seven states prohibit public and/or private insurance companies from imposing prior authorizations for at least some forms of MOUD.[53] Removing prior authorization reduces barriers for both patients and providers, helping patients receive care faster.

CRIMINAL LEGAL SYSTEM SETTINGS

- **MOUD treatment options should be available to people involved with the criminal legal system:** In accordance with the ADA and Rehabilitation Act, all three forms of MOUD should be available to people involved in all federal, state, and local criminal legal systems, including in jails and prisons, on probation, parole, or other community supervision, and in drug courts. This gives people with OUD the best chance of staying healthy and maintaining their recovery.

PROVIDER-LEVEL IMPROVEMENTS

- **Expand provider training:** Addiction medicine should be a core component of medical education for all healthcare professionals. Providers also need greater access to ongoing support, including remote clinical consultation services that connect them with addiction medicine experts. Programs like the National Clinical Consultation Center's National Substance Use Warmline should be expanded to reach providers in rural and medically underserved communities.[54]
- **Diversify the addiction healthcare workforce:** Health systems and institutions should provide addiction medicine training to people from marginalized communities and those with lived experience. This can include training and mentorship for a range of roles, including pharmacists, care navigators, outreach workers, and peer support specialists. Diversifying the addiction medicine workforce not only increases capacity but also builds trust—especially when patients feel their providers understand their lived experience.
- **Increase MOUD access points:** MOUD should be offered in locations where people already receive services. This includes community clinics, emergency departments, pharmacies, and harm reduction programs such as syringe service programs. Mobile MOUD units should be expanded to reach underserved areas.

URGENT ACTION IS NEEDED TO INCREASE ACCESS TO MOUD

Sweeping actions are needed to address the major public health crisis of opioid overdose deaths. Without prompt action, hundreds of thousands of people will continue to die from opioid overdoses. Policymakers must increase access to lifesaving MOUD now.

END NOTES

1. Christopher M. Jones et al., "Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021," *JAMA Network* Open 6, no. 8 (2023): e2327488, https://doi.org/10.1001/jamanetworkopen.2023.27488; Deborah Dowell et al., "Treatment for Opioid Use Disorder: Population Estimates — United States, 2022," *MMWR Morbidity and Mortality Weekly Report* 73, no. 25 (2024): 567–74, https://doi.org/10.15585/mmwr.mm7325a1.
2. Hedegaard, Holly, Arialdi M. Miniño, and Margaret Warner. Drug Overdose Deaths in the United States, 1999–2018. NCHS Data Brief, no. 356. Hyattsville, MD: National Center for Health Statistics, 2020.
3. Farida B. Ahmad et al., *Provisional Drug Overdose Death Counts* (Centers for Disease Control and Prevention (U.S.), 2025), https://doi.org/10.15620/cdc/20250305008.
4. 21 U.S.C. § 812(Schedule II)(b)(11).
5. 21 C.F.R. § 1308.13(e)(2)(i).
6. Committee on Medication-Assisted Treatment for Opioid Use Disorder et al., *Medications for Opioid Use Disorder Save Lives*, ed. Alan I. Leshner and Michelle Mancher (National Academies Press, 2019), 25310, https://doi.org/10.17226/25310.
7. Ibid.
8. Ibid.
9. Ibid.
10. Christopher M. Jones et al., "Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021," *JAMA Network Open* 6, no. 8 (2023): e2327488, https://doi.org/10.1001/jamanetworkopen.2023.27488; Dowell et al., "Treatment for Opioid Use Disorder."

END NOTES

11. 42 C.F.R. § 8.11(e). (2025); 21 C.F.R § 1306.07(b). (2025); Samantha Huo et al., "Emergency Department Utilization of the Methadone 72-Hour Rule' to Bridge or Initiate and Link to Outpatient Treatment," *The American Journal of Emergency Medicine* 89 (March 2025): 209–15, https://doi.org/10.1016/j.ajem.2024.12.059.

12. 42 C.F.R. § 8.11(e). (2025)

13. David Frank et al., "'It's like 'Liquid Handcuffs': The Effects of Take-Home Dosing Policies on Methadone Maintenance Treatment (MMT) Patients' Lives," *Harm Reduction Journal* 18, no. 1 (2021), https://doi.org/10.1186/s12954-021-00535-y.

14. 42 C.F.R. § 8.12(f) (2025).

15. Ibid.

16. Kellen Russoniello et al., "State-Specific Barriers to Methadone for Opioid Use Disorder Treatment," *Journal of Law, Medicine & Ethics* 51, no. 2 (2023): 403–12, https://doi.org/10.1017/jme.2023.73.

17. 21 CFR § 1306.51.

18. 42 CFR § 8.12(f)(2)(v)(A) (2025).

19. Corey S. Davis and Derek H. Carr, "Legal and Policy Changes Urgently Needed to Increase Access to Opioid Agonist Therapy in the United States," *The International Journal on Drug Policy* 73 (November 2019): 42–48, https://doi.org/10.1016/j.drugpo.2019.07.006.

20. Committee on Medication-Assisted Treatment for Opioid Use Disorder et al., *Medications for Opioid Use Disorder Save Lives*.

21. Niki Miller, *Medicaid Coverage for MAT 50 State Review Comprehensive Update on State Medicaid Coverage of Medication-Assisted Treatments and Substance Use Disorder Services*, Advocates for Human Potential, 2018, https://doi.org/10.13140/RG.2.2.18316.16000.

22. Pew Charitable Trusts, "Overview of Opioid Treatment Program Regulations by State," September 19, 2022, https://pew.org/3Qw8g8c.

23. Beth E. Meyerson et al., "Nothing Really Changed: Arizona Patient Experience of Methadone and Buprenorphine Access during COVID," *PLOS ONE* 17, no. 10 (2022): e0274094, https://doi.org/10.1371/journal.pone.0274094.

24. Paul J. Joudrey et al., "Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States," *JAMA* 322, no. 13 (2019): 1310–12, https://doi.org/10.1001/jama.2019.12562.

25. Substance Abuse and Mental Health Services Administration, "Opioid Treatment Program Directory," accessed February 10, 2021, https://dpt2.samhsa.gov/treatment/directory.aspx.

26. Max Jordan Nguemeni Tiako et al., "Thematic Analysis of State Medicaid Buprenorphine Prior Authorization Requirements," *JAMA Network Open* 6, no. 6 (2023): e2318487, https://doi.org/10.1001/jamanetworkopen.2023.18487.

27. Committee on Medication-Assisted Treatment for Opioid Use Disorder, *Medications for Opioid Use Disorder Save Lives*.

28. Davis and Carr, "Legal and Policy Changes Urgently Needed to Increase Access to Opioid Agonist Therapy in the United States."

29. Committee on Medication-Assisted Treatment for Opioid Use Disorder et al., *Medications for Opioid Use Disorder Save Lives*.

30. Niki Miller, *Medicaid Coverage for MAT 50 State Review Comprehensive Update on State Medicaid Coverage of Medication-Assisted Treatments and Substance Use Disorder Services*, Advocates for Human Potential, 2018, https://doi.org/10.13140/RG.2.2.18316.16000.

31. Miriam Delphin, Sherry McKee, & Lindsay Oberleitner, "Yale study: Methadone treatment in prison improves inmates' behavior, likelihood of staying clean post-release," *Yale School of Medicine*, January 23, 2018, https://medicine.yale.edu/ysm/news-article/16631/.

32. Traci C. Green, et al., Post-incarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System, 75 *JAMA PSYCHIATRY* 405 (Apr. 2018), https://doi.org/10.1001/jamapsychiatry.2017.4614.

33. Prison Policy Initiative, "Addicted to Punishment: Jails and Prisons Punish Drug Use Far More than They Treat It," https://www.prisonpolicy.org/blog/2024/01/30/punishing-drug-use/.

34. Elizabeth Flanagan Balawajder et al., "Barriers to Universal Availability of Medications for Opioid Use Disorder in US Jails," *JAMA Network Open* 8, no. 4 (2025): e255340, https://doi.org/10.1001/jamanetworkopen.2025.5340; Christy K. Scott et al., "The Impact of the Opioid Crisis on U.S. State Prison Systems," *Health & Justice* 9 (July 2021): 17, https://doi.org/10.1186/s40352-021-00143-9.

35. Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice Syste*m (2011), https://www.lac.org/assets/files/MAT_Report_FINAL_12-1-2011.pdf.

36. 42 U.S.C § 12102 (1990); 29 U.S.C. § 701

37. Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System*.

38. Benjamin Lai et al., "Buprenorphine Waiver Attitudes Among Primary Care Providers," *Journal of Primary Care & Community Health* 13 (January 2022): 21501319221112272, https://doi.org/10.1177/21501319221112272; Richard Bottner Stefanko Christopher Moriates, Matthew, "Stigma Is Killing People with Substance Use Disorders. Health Care Providers Need to Rid Themselves of It," *STAT*, October 2, 2020, https://www.statnews.com/2020/10/02/stigma-is-killing-people-with-substance-use-disorders-health-care-providers-need-to-rid-themselves-of-it/.

39. Sarah Leitz, "Buprenorphine saves lives. Why can't more patients get it?" *Kaiser Permanente*, Sept. 11, 2024. https://about.kaiserpermanente.org/news/buprenorphine-saves-lives-why-cant-more-patients-get-it.

40. Frank et al., "'It's like 'Liquid Handcuffs."

41. Pooja A. Lagisetty et al., "Buprenorphine Treatment Divide by Race/Ethnicity and Payment," *JAMA Psychiatry* 76, no. 9 (2019): 979, https://doi.org/10.1001/jamapsychiatry.2019.0876.

42. William C. Goedel et al., "Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States," *JAMA Network Open* 3, no. 4 (2020): e203711, https://doi.org/10.1001/jamanetworkopen.2020.3711; Helena Hansen et al., "Buprenorphine and Methadone Treatment for Opioid Dependence by Income, Ethnicity and Race of Neighborhoods in New York City," *Drug and Alcohol Dependence* 164 (July 2016): 14–21, https://doi.org/10.1016/j.drugalcdep.2016.03.028; Megan S. Schuler et al., "Growing Racial/Ethnic Disparities in Buprenorphine Distribution in the United States, 2007-2017," *Drug and Alcohol Dependence* 223 (June 2021): 108710, https://doi.org/10.1016/j.drugalcdep.2021.108710.

END NOTES

43. Roberts, Samuel K. "The Politics of Stigma and Racialization in the Early Years of Methadone Maintenance Regulation." In *Methadone Treatment for Opioid Use Disorder: Improving Access Through Regulatory and Legal Change: Proceedings of a Workshop*, edited by Clare Stroud, Sheena M. Posey Norris, and Lisa Bain, Appendix C. Washington, DC: National Academies of Sciences, Engineering, and Medicine, 2022. https://www.ncbi.nlm.nih.gov/books/NBK585212/.

44. Pew Charitable Trusts, *Improved Opioid Treatment Programs Would Expand Access to Quality Care*, Issue Brief (2022), https://pew.org/3GL39fD; Goedel et al., "Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States"; Institute of Medicine (US) Committee on *Federal Regulation of Methadone Treatment* et al., "Federal Regulation of Methadone Treatment," in Federal Regulation of Methadone Treatment (National Academies Press (US), 1995), https://www.ncbi.nlm.nih.gov/books/NBK232105/; Mical Raz, "Treating Addiction or Reducing Crime? Methadone Maintenance and Drug Policy Under the Nixon Administration," *Journal of Policy History* 29, no. 1 (2017): 58–86, https://doi.org/10.1017/S089803061600035X.

45. Emma E. McGinty et al., "Medication for Opioid Use Disorder: A National Survey of Primary Care Physicians," *Annals of Internal Medicine* 173, no. 2 (2020): 160–62, https://doi.org/10.7326/M19-3975.

46. Lai et al., "Buprenorphine Waiver Attitudes Among Primary Care Providers."

47. National Coalition to Liberate Methadone, *Liberating Methadone: A Roadmap for Change Conference Proceedings and Recommendations* (2024).

48. Ibid.

49. Ibid.

50. Alaska Admin. Code tit. 7, § 70.125(a)(1).

51. Idaho Admin. Code r. 16.07.17.415(2

52. Russoniello et al., "State-Specific Barriers to Methadone for Opioid Use Disorder Treatment."

53. "Removing Prior Authorization for MAT Results in More Patient Care," American Medical Association, February 5, 2020, https://www.ama-assn.org/practice-management/prior-authorization/removing-prior-authorization-mat-results-more-patient-care.

54. Nicholas LeFevre et al., "The End of the X-Waiver: Excitement, Apprehension, and Opportunity," *The Journal of the American Board of Family Medicine* 36, no. 5 (2023): 867, https://doi.org/10.3122/jabfm.2023.230048R1.