

Appendix A: Management of Opioid Use in Pregnancy

1. **Background:** Women of childbearing age may be taking opioids in a variety of circumstances, including:
 - By prescription for the treatment of pain,
 - Through medication-assisted therapy (either methadone or buprenorphine) for the management of opioid dependence,
 - Misuse of prescription medications (taking medications other than how they were prescribed, including medications that were prescribed for another person or that were obtained illegally), and/or
 - Using heroin or other illegal opioids.

People who take opioids, whether by prescription or illicitly, may have one or both of the following responses:

- **Physical dependence:** the person will experience unpleasant physical withdrawal symptoms if the opioid is abruptly discontinued.
- **Opioid use disorder/addiction:** the person is using opioids for the purpose of getting high and/or for their perceived impact on pain, stress, anxiety, depression or other conditions.

Pregnant patients on opioid therapy for chronic pain management or medication-assisted treatment (MAT) for opioid dependence should not be advised to discontinue treatment due to high risk of relapse and pregnancy complications associated with withdrawal (Kaltenback et al, 1998). Patients taking opioids illicitly should be referred for MAT, either to an opioid treatment program (for methadone or buprenorphine) or to a physician who has DEA approval to prescribe buprenorphine.

Patients who request opioid detoxification during pregnancy should be referred to an experienced consultant. No standard protocols exist for opioid detoxification in pregnancy. The American Society of Addiction Medicine recommends detoxification in the second trimester, if it is to be undertaken at all. For patients who choose this option, prenatal visits should include screening for relapse (patient report and urine drug screening), ongoing support, and willingness to revisit the use of MAT if the detoxification plan is not successful.

2. **Guidance for working with all patients taking opioids during pregnancy:**
 - a. Provide education about the possibility of neonatal abstinence syndrome and its management.
 - b. Encourage to share their concerns with their prenatal care provider and opioid prescriber. Patients on opioid therapy may require more access to their provider to address their concerns about fetal opioid exposure.
 - c. Schedule more frequent prenatal visits.
 - d. Refer the patient to the pediatric team at the intended delivery facility during the third trimester to discuss the plan for neonatal assessment and management of neonatal abstinence symptoms, if present.
 - e. Work with the patient and the delivery facility to establish a plan for pain management during labor and delivery.

- f. Provide education about the value of breastfeeding for infants exposed to opioids during pregnancy. For more information, refer to the Academy of Breastfeeding Medicine Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman, available at:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2989871/>

3. Management of patients who are currently receiving medication-assisted treatment for opioid use disorder:

- a. Patients on MAT for opioid use disorder should continue this treatment during pregnancy (ACOG 2012); doses may need to be adjusted due to metabolic changes of pregnancy. MAT medications should be managed by the current prescribing provider.
 - i. The prenatal care provider should obtain a thorough history of how long the patient has been on medication-assisted therapy, the dose, its effectiveness, her relationship with the treatment provider, and whether the treatment provider is aware of the pregnancy.
 - ii. Patients already stable on methadone treatment should not be encouraged to switch to buprenorphine during pregnancy.
- b. If current treatment is not meeting the patient's needs, work with the pregnancy care manager, LME/MCO, and/or the treatment provider as applicable to explore alternative treatment options.

4. Management of patients in chronic pain treatment who are taking prescribed opioid medications: The prenatal care provider should work collaboratively with the prescriber of the pain management regimen and other members of the care team (behavioral health, physical therapy, etc.) and should take the following steps (Meyer 2014):

- a. Obtain release of information so all members of the team may share clinical information.
- b. Work with the care team to determine if the patient will continue chronic opioid therapy during the pregnancy. Ensure that all care team members are aware of risks associated with withdrawal during pregnancy.
- c. For patients who will be continuing opioid treatment during pregnancy:
 - i. Establish who will prescribe the pain regimen during pregnancy, including dose and duration (e.g., limiting to 30-day supply).
 - ii. Establish which provider will check the Controlled Substances Reporting System (see Appendix D) for duplicate prescriptions or medications that increase risk when on opioid therapy (e.g., benzodiazepines, sedative hypnotics).
 - iii. The opioid prescriber should take responsibility for performing urine drug screening. (See Appendix B for UDS considerations.)
 - iv. Develop a plan for postpartum evaluation and treatment.
 - v. Ensure safe storage of opioid medications, including use of a lockbox if there are children present in the home.
 - vi. If the pain prescriber is not comfortable managing opioid therapy during pregnancy, the prenatal care provider may continue the current regimen, with

the understanding that the pain provider will reassume care following the pregnancy. The prenatal care provider should take the following steps:

1. Obtain records to confirm diagnosis, current medications and doses, and treatment history.
 2. If available, obtain a pain medicine consult to review the goals of chronic opioid therapy for pain management and to assess alternative medications or treatment modalities.
 3. Complete a work-up as appropriate for the pain disorder (e.g., renal ultrasound, x-ray, etc.).
 4. Treat with minimal opioids and investigate alternatives, such as lidocaine patches, cyclobenzaprine, gabapentin, acupuncture, trigger point injections, or physical therapy.
 5. Emphasize sleep hygiene.
 6. Refer for behavioral health consultation as appropriate.
 7. Consider written/verbal pain agreement (see Appendix C).
- d. For patients who will not be continuing opioid therapy for pain management during pregnancy:
- i. Determine who will manage the patient's discontinuation of treatment.
 - ii. Taper 10% of initial dose every 4-7 days
 - iii. Assess for physical withdrawal symptoms and for pain control.
 - iv. Emphasize alternative therapy, including behavioral health, and coping skills
 - v. Seek ongoing input from pain medicine for exacerbations.

5. Management of patients in need of acute treatment for opioid use disorder: Pregnant patients at risk for acute withdrawal due to discontinuation of opioid use may be managed in the inpatient or outpatient setting. Some patients admitted to the hospital in the antepartum period for other reasons may need management to address opioid withdrawal.

- a. Outpatient management for patients who accept MAT:
 1. Make a referral to a MAT provider that serves the patient's community. Instruct the patient to abstain from narcotics for 24 hours prior to intake, or follow guidance from the treatment provider.
 2. Prescribe as needed to cover the patient until the intake MAT appointment.
 3. Practices with a high volume of patients with opioid use disorder should consider having a provider within the practice become licensed to prescribe buprenorphine to facilitate access to treatment for pregnant patients (see Appendix L for more information on becoming a buprenorphine prescriber).
- b. Outpatient management for patients who do not accept MAT:
 1. Follow harm reduction guidance in Section 3.e.v of the Management of Substance Use in Pregnancy pathway, above.
 2. Assess the patient's willingness to be referred to a behavioral health provider for a substance abuse assessment (Section 4 in pathway, above).
 3. See the patient for more frequent prenatal visits and assess readiness for treatment at each visit.

- ii. For patients with chronic pain treatment needs, see Section 3, above.
- c. Inpatient management:
 - i. Consider referral to a state-operated Alcohol and Drug Abuse Treatment Center (ADATC). The three state ADATCs, operated by the NC Division of State Operated Healthcare Facilities, accept pregnant women from their catchment areas. Pregnant women are a priority population.
 1. The Julian F. Keith ADATC serves patients in the western counties of the state, and the R.J. Blackley ADATC covers the central part of the state.
 2. In addition to serving women in eastern Carolina, Walter B. Jones ADATC in Greenville, NC accepts pregnant women statewide, including those with high-risk pregnancies, and is able to provide medication-assisted therapy for opioid use disorder on site.
 3. To refer to an ADATC, complete the Regional Referral Form available on the Department of State-Operated Healthcare Facilities (DSOHF) website:
<http://www.ncdhhs.gov/dsohf/professionals/admissioncriteria-adatc.htm>.
 4. Fax the form to the number listed on the website for the ADATC to which the referral is being made, then follow up with a phone call to the Admissions Coordinator, whose number is also posted on the DSOHF website.
 - ii. Admit locally for stabilization while arranging follow-up with a MAT program. Seek expert consultation for assistance with methadone or buprenorphine induction, if needed.
- g. Utilize the NC Perinatal Substance Use Coordinator for assistance identifying a program or managing the referral process, including to an ADATC. The Coordinator can be reached through the Alcohol/Drug Council of North Carolina at 1-800-688-4232. See Appendix K for more information.
- h. Refer the patient for pregnancy care management if she does not already have a pregnancy care manager.

Appendix A. References

- American College of Obstetricians and Gynecologists: Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No.524. *Obstet Gynecol* 2012; 119: 1070-6
- Jones HE, Martin PR, Heil SH, Kaltenbach K, Shelby P, Coyle MG, et al.: Treatment of opioid-dependent pregnant women: clinical and research issues. *J Substance Abuse Treatment* 2008; 35(3):245-259
- Kandall SR, Albin S, Lowinson J, Berle B, Eidelman AI, Gartner LM: Differential effects of maternal heroin and methadone use on birthweight. *Pediatrics* 1976; 58(5): 681-6
- Kaltenbach K, Berghella V, Finnegan L: Opioid dependence during pregnancy: Effects and management. *Obstet Gynecol Clin N Am* 1998; 25 (1):139-151
- Meyer M. The Perils of Opioid Prescribing During Pregnancy. *Obstet Gynecol Clin N Am* 2014; 41:297-306