OKLAHOMA OPIOID PRESCRIBING GUIDELINES

TREATING PREGNANT PATIENTS WITH OPIOID USE DISORDER

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, and mental and public health officials.[1,2,3,4,5] Although the recommendations do not include language on Oklahoma's opioid-related laws, it is imperative that providers maintain compliance.

During pregnancy:

1. All patients should receive early screening for substance use disorder. When indicated, patients should receive in-practice intervention and be referred to appropriate treatment for a full, individualized assessment to determine the intensity and duration of care.

2. Medication-assisted treatment (MAT) is the recommended standard of care for women with opioid use disorder. Either methadone or buprenorphine may be used. Referral should be made to an MAT provider for initiation in pregnant patients who have the diagnosis of opioid use disorder and desire to transition to MAT.
   - MAT should be provided in conjunction with behavioral therapies.
   - Due to the current lack of safety data on naloxone in pregnancy, buprenorphine alone remains the preferred agent in pregnancy rather than the combination product of buprenorphine plus naloxone.

3. Medically-supervised withdrawal is NOT recommended during pregnancy or shortly after delivery.

4. For patients receiving chronic opioid therapy, maintain pre-pregnancy dose or transition to methadone or buprenorphine to treat pain and avoid opioid withdrawal symptoms.

5. In patients who require additional pain medication during pregnancy for an acute event, opioid prescribing by the obstetric care provider should be carefully coordinated with the MAT provider and be for the shortest duration possible.

6. For patients who are already receiving MAT, buprenorphine or methadone should be continued on the patient's current dose during pregnancy.

7. Pregnant women may develop symptoms of withdrawal as pregnancy progresses and may require dose increases to address physiologic changes due to pregnancy.

Intrapartum and postpartum pain management:

1. It is essential to provide adequate pain management during labor and in the postpartum period, and patients on MAT frequently have higher analgesia needs compared to those who are not receiving chronic opioid therapy.

2. Buprenorphine or methadone should be continued at the patient's current dose throughout the intrapartum and postpartum course, unless otherwise advised by the patient's MAT provider.

3. Health care providers are encouraged to provide pain management in conjunction with an addiction specialist.

4. Intrapartum:
   - Continue regular dose of buprenorphine or methadone.
   - Offer epidural or spinal analgesia where appropriate.
   - Opioid agonist-antagonists such as butorphanol and nalbuphine should be avoided, as they may precipitate acute withdrawal in patients on MAT.

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5. Following vaginal birth:

- Continue regular dose of buprenorphine or methadone, unless otherwise advised by the patient's MAT provider.
- Nonopioid therapies such as non-steroidal anti-inflammatory drugs (NSAIDs) and acetaminophen should be prescribed on a schedule for a short duration for mild to moderate pain.
- An immediate-release opioid medication may be added as needed.
- No additional opioid pain medication beyond MAT should be prescribed after discharge. There may be occasional exceptions, for example in patients with a third- or fourth-degree perineal laceration, and these should be determined on a case-by-case basis in conjunction with the patient's MAT provider.

6. Following cesarean birth:

- Continue regular dose of buprenorphine or methadone, unless otherwise advised by the patient's MAT provider.
- Nonopioid therapies such as non-steroidal anti-inflammatory drugs (NSAIDs) and acetaminophen should be prescribed on a schedule for a short duration for mild to moderate pain.
- If opioids beyond the patient's usual MAT dose are needed upon hospital discharge, they should be provided in coordination with the patient's MAT provider.

7. If opioids are deemed necessary for severe pain, such as with cesarean birth or perineal laceration, providers should use the lowest effective dose of immediate-release opioids, for no more than 3-7 days duration. Long-acting or extended-release opioids are rarely indicated and should be avoided.

8. Breastfeeding should be encouraged in mothers maintained on methadone or buprenorphine with the following exceptions: urine drug screens positive for illicit drugs, HIV-positive status, and/or the existence of other medical and/or psychiatric contraindications.

9. Prior to discharge, discuss contraceptive options with patients as appropriate.

10. Patients may be at an increased risk of an overdose during the postpartum period. Therefore, consider co-prescribing naloxone.

1. Pennsylvania Department of Health. (2016). Prescribing Guidelines for Pennsylvania, Use of Addiction Treatment Medications in the Treatment of Pregnancy Patients with Opioid Use Disorder. Retrieved from https://www.health.pa.gov/topics/Documents/Opioids/Use%20of%20Addiction%20Treatment%20Medications%20in%20the%20Treatment%20of%20Pregnant%20Patients%20with%20Opioid%20Use%20Disorder%20(FINAL).pdf. Accessed December 12, 2018.
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5. Centers for Disease Control and Prevention. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain. Retrieved from https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed December 12, 2018.

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