Opioid Use Disorder Treatment During Pregnancy

- Clinicians should advise their patients to avoid abrupt discontinuation of opioids, including buprenorphine (BUP) or methadone, during pregnancy because of the risks posed by withdrawal or resumption of unhealthy use (i.e., heroin) following abstinence. (B2)
- When offering pregnant patients BUP treatment or referral to an opioid treatment program (OTP) for methadone treatment, clinicians should discuss the maternal and fetal risks and benefits of both medications (see Table 1); the treatment choice should be based on patient preference whenever possible. (A3)
- Clinicians should educate patients who take opioids, BUP, or methadone during pregnancy about the risk of neonatal opioid withdrawal syndrome (NOWS), an expected and treatable outcome. (A3)
- Clinicians should inform patients that breastfeeding while taking BUP or methadone is safe and may reduce the risk of NOWS. (A2)
- Clinicians should not recommend naltrexone initiation, which requires withdrawal from opioids, for a pregnant patient who is actively using opioids. (A2)
  - If a pregnant patient is abstinent from opioids and requests treatment with naltrexone, clinicians should discuss naltrexone as an alternative treatment and inform the patient of the associated risks and benefits. (A3)
  - Clinicians should inform patients who become pregnant while taking naltrexone of the risks and benefits and preferred pharmacologic treatment options (see Table 2 in full guideline). (B3)
    - See the NYSDOH AI guideline *Treatment of Opioid Use Disorder > Implementing Opioid Use Disorder Treatment*
- Before initiating BUP in a pregnant patient with OUD, clinicians should confirm that the patient is experiencing at least mild opioid withdrawal symptoms (B3) and should consult with an experienced substance use treatment provider regarding the risk of precipitated withdrawal. (A3)
- Clinicians should advise patients who initiate BUP or methadone during pregnancy, and those who become pregnant while taking BUP or methadone, to continue treatment throughout pregnancy, labor, delivery, postpartum, and breastfeeding. (A2)

- At each visit, clinicians should monitor pregnant patients taking BUP for opioid cravings and withdrawal symptoms and, if present, increase the dose as appropriate for the individual and reassess at the next visit; any dose increase should be maintained until treatment goals can be evaluated postpartum. (A3)
  - If taking a dose of 32 mg BUP mg daily does not allow the patient to meet treatment goals, clinicians should recommend methadone treatment. (A3)
- If a pregnant patient is considering a change from methadone to BUP, the clinician should consult an experienced substance use treatment provider because of the risk of precipitated withdrawal. (A3)

Neonatal Opioid Withdrawal Syndrome

- Clinicians should provide patient education about NOWS that addresses the risk of NOWS, harm reduction strategies, typical symptoms and duration, and pharmacologic and nonpharmacologic treatment options. (A3)
- When an infant is at risk of NOWS, the clinician should recommend postpartum contact, including breastfeeding, rooming-in, and skin-to-skin contact. (A2)

Alcohol Use and Alcohol Use Disorder Treatment During Pregnancy

- Clinicians should recommend inpatient alcohol withdrawal management for pregnant patients with or at risk for moderate, severe, or complicated alcohol withdrawal [Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar) scores ≥10], and consult with an OB/GYN. (A3)
- Clinicians should use caution when prescribing a benzodiazepine medication for pregnant patients. (B3)
- Clinicians should advise pregnant patients who use alcohol to abstain from or minimize use during pregnancy and minimize use during breastfeeding to prevent harm to the developing fetus or infant. (A2)
- Clinicians should provide harm reduction counseling to help minimize the effects of alcohol on the patient and the fetus. (A3)
- If a pregnant individual cannot decrease or cease alcohol use, the clinician should discuss pharmacotherapy for alcohol use disorder (AUD) as a harm reduction approach and engage the patient in shared decision-making regarding its use. (B3)

Alcohol Use and Alcohol Use Disorder Treatment During Pregnancy, *continued*

- If a patient becomes pregnant while taking pharmacologic medication for AUD or requests medication during pregnancy, clinicians should inform them of the risks and benefits of preferred agents during pregnancy and breastfeeding. (A3)
- Clinicians should identify and inform patients with AUD and risky alcohol use about available support or behavioral treatment options and provide these options or refer as indicated. (A3)

Tobacco Use Disorder Treatment During Pregnancy

- For pregnant patients with tobacco use disorder, clinicians should:
  - Advise patients to abstain from or minimize use during pregnancy to prevent harm to themselves and the fetus. (A2)
  - Offer nicotine replacement therapy (NRT) with or without bupropion after discussing the risks and benefits. (A2)
  - Perform or refer to psychosocial counseling and support. (A1)

Treatment of Other Substance Use Disorders During Pregnancy

- Clinicians should advise pregnant patients who use any substances to abstain from or minimize use during pregnancy to prevent adverse maternal and neonatal effects. (A3)
- Clinicians should identify and inform patients about all available treatment options and resources for support and provide appropriate interventions or referrals as needed. (A3)

← Use this code with your phone's QR code reader to go directly to a mobile-friendly version of the guideline.

This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline *Substance Use Disorder Treatment in Pregnant Adults* The full guideline is available at www.hivguidelines.org.

HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

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SUBSTANCE USE DISORDER TREATMENT IN PREGNANT ADULTS

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE JULY 2021

GOALS OF SUBSTANCE USE DISORDER TREATMENT DURING PREGNANCY

Goals of substance use disorder (SUD) treatment may include the following for pregnant adults:

- Abstaining from or reducing substance use
- Preventing adverse effects of substance use or withdrawal for the pregnant individual and fetus
- Staying in care, which can also facilitate prevention, diagnosis, and treatment of other conditions
- Reducing high-risk behaviors, such as injection drug use and use or reuse of unsterile equipment and sharing injection equipment, and reducing related complications, such as infection and overdose
- Improving the quality of life and other social conditions, such as employment, stable housing, and risk of incarceration

KEY POINTS

- Healthcare providers who have a conscious or unconscious bias against pregnant patients who use drugs or alcohol may be reluctant to provide care or may make erroneous judgments about a patient's fitness as a parent.
- Discrimination and prejudice impede engagement in care, including prenatal care, and can impair parental and neonatal health outcomes.
- Opioid overdose during pregnancy is an increasing cause of and contributor to maternal mortality.
- Naloxone is the standard of care for overdose prevention in pregnant Individuals.

Table 1: Considerations in Choosing Methadone or Buprenorphine for OUD Treatment During Pregnancy [a]

Factor	Buprenorphine	Methadone
Setting	· Available through office-based prescription or a specialty OTP	· Available only through a specialty OTP · Pregnant individuals receive priority access
Initiation requirement	· Mild opioid withdrawal required before treatment can be initiated [b] · Cautious, slow, and low-dose induction advised [c]	· Withdrawal not required
Safety and effectiveness	· Safe throughout pregnancy, labor, delivery, and postpartum · Dose can be increased to control cravings and prevent withdrawal. · Dose increase may be required later in pregnancy to maintain the appropriate effect.	
Treatment duration	Continue treatment throughout pregnancy, labor, delivery, and postpartum.	
Can the regimen be changed?	· Switch to methadone is possible if needed to control cravings and avoid opioid withdrawal.	· Switch to BUP is not advised because of the potential for precipitated opioid withdrawal symptoms.
Effect on opioid use	Equally effective in reducing opioid use during pregnancy	
Effect on infant	· Duration, severity, and dose of medication required for NOWS may be reduced. · No known effects on growth or cognitive or psychological development	· No known effects on growth or cognitive or psychological development
Pain management	Nonopioid and opioid analgesic agents are used in addition to the maintenance OUD treatment dose of methadone or BUP [ASAM 2020b]. The addition of a short-acting full-agonist opioid can be considered for managing moderate to severe acute pain. When adding a full-agonist opioid analgesic, patients will likely need a higher dose than opioid-naive patients to achieve adequate analgesia.	
Breastfeeding	Breastfeeding, breastmilk, and skin-to-skin contact all reduce the severity and duration of NOWS.	

Abbreviations: BUP, buprenorphine; NOWS, neonatal opioid withdrawal syndrome; OTP, opioid treatment program; OUD, opioid use disorder.

a. For adverse events associated with each medication, see package inserts for SUBUTEX (buprenorphine sublingual tablets) and DISKETS® Dispersible Tablets CII (Methadone Hydrochloride Tablets for Oral Suspension, USP).

b. See the Clinical Opiate Withdrawal Scale and the Subjective Opiate Withdrawal Scale.

c. Slow, low-dose induction: Initiate treatment with 2 mg of BUP, followed 30 to 60 minutes later by an additional 2 mg. The pattern of increasing BUP in 2 mg increments and waiting 30 to 60 minutes before the next increase continues until the dose is sufficient to control opioid cravings and prevent withdrawal.

Table 2: Benefits and Risks of Continuing or Discontinuing Naltrexone During Pregnancy [a]

Continuing Naltrexone	Discontinuing Naltrexone
· **Benefits:** Ongoing blockade of the mu-opioid receptor decreases opioid cravings; no risk of NOWS in the neonate · **Risks:** Insufficient data regarding teratogenicity or effects on milk production or infants exposed through breastfeeding	· **Benefits:** No fetal in utero exposure · **Risks:** Reduced opioid tolerance that could result in overdose if opioid use is resumed, risk of NOWS increased if the patient uses opioids

a. See package insert for Vivitrol (naltrexone for extended-release injectable suspension).