MEDICATION FOR OPIOID USE DISORDER

MOUD and Pregnancy: A Guide for Providers

mosaic GROUP

As a primary care provider, you may see a pregnant patient with Opioid Use Disorder (OUD). Here, we offer essential information to support decision-making for maternal and fetal health with the use of Medications for Opioid Use Disorder (MOUD).

Recommendations for MOUD in Pregnancy

The American College of Obstetricians and Gynecologists (ACOG) and the Substance Abuse and Mental Health Services Administration (SAMHSA) recommend MOUD over supervised withdrawal during pregnancy, as it offers better health outcomes and reduces the risk of return to opioid use.[1] Abrupt discontinuation or tapering of opioids during pregnancy can lead to severe complications, including preterm labor, fetal distress, and maternal and fetal mortality. Informing patients about these risks is essential.

Benefits and Considerations for MOUD in Pregnancy

MOUD, such as buprenorphine or methadone, provides unique benefits for pregnant patients, including:

- Increased engagement in prenatal care
- Stabilization of opioid use, minimizing withdrawal risks for both mother and fetus
- Lowered return-to-use rates, promoting maternal health and pregnancy stability
- Potentially reducing Child Protective Services (CPS) involvement through a well-coordinated care plan and evidence-based prenatal care (consult hospital, state, and local policies on CPS involvement as needed)

Key Considerations for Providers

Pregnancy and Medication Considerations

CONSIDERATIONS	BUPRENORPHINE
Starting Dose	4-8 mgs with presence of withdrawal symptoms.
Target Dose	16 mgs is the most common daily dosage; however, an optimal target dose will be individually determined by regular assessment of the individual and their response to treatment.
Dose Increase Interval During Initiation	Daily, with presence of withdrawal symptoms, after patient assessment.
Need for Periodic Dose Adjustment	Dose stability is critical for maternal and fetal health. Discuss possible dose increases needed in 2nd and 3rd trimesters due to metabolism and blood volume increase.

It is important to note that many patients struggle with the suggestion to increase their medication dosage through pregnancy, so it's helpful to have educational conversations about this directly.

Educate patients about the potential need for adjustments dosage or frequency during the second and third trimesters, as increased blood volume can affect medication levels. Emphasize the importance of these adjustments in preventing withdrawal symptoms and cravings to help address any concerns about dose changes.

Providers may consider both increasing the dose as well as adjusting the frequency of dosing. Patients should be made aware that increased dose does not increase the likelihood of Neonatal Opioid Withdrawal Syndrome (NOWS). Dose stability is corollary to maternal and fetus wellbeing. MOUD should be maintained throughout and following delivery.

Neonatal Opioid Withdrawal Syndrome (NOWS) Considerations

Approximately 50% of neonates exposed to opioids require treatment for Neonatal Opioid Withdrawal Syndrome (NOWS), meaning there is a significant possibility that the newborn may not experience NOWS at all. Furthermore, when NOWS occurs, it is generally milder in cases where the mother was treated with buprenorphine compared to full mu-opioid agonists, such as most opioid analgesics and methadone.

It is recommended to discuss NOWS with patients to set realistic expectations. Educate patients on the importance of understanding the NOWS protocols at the delivering hospital, including the possibility of a precautionary observation period of 5-7 days for neonates exposed to opioids or MOUD.

NOWS symptoms, such as irritability and poor feeding, can vary based on opioid type, exposure duration, and additional factors. Evidence shows that non-pharmacologic methods like rooming-in and skin-to-skin contact can significantly decrease NOWS severity. Additionally, breastfeeding can help, as low levels of buprenorphine or methadone in breast milk can provide a gradual taper for the newborn, shortening hospital stays and fostering bonding.

Discussing MOUD with Pregnant Patients

When discussing MOUD with opioid-using pregnant patients, primary care providers should adopt a compassionate, trauma-informed approach that focuses on patient empowerment and evidence-based care. It's essential to explain that MOUD is a highly effective treatment that improves maternal and fetal outcomes by way of harm reduction, significantly reducing the risk for overdose and withdrawal, as well as lowering the likelihood of return to use during pregnancy.

Providers should also emphasize that untreated withdrawal during pregnancy may increase the risk of miscarriage. Ongoing illicit opioid use can lead to additional adverse outcomes, including miscarriage, complications from infectious diseases and maternal overdose. A clear, nonjudgmental explanation of these risks, combined with support for harm reduction strategies, can help patients make informed and confident decisions.

It is highly likely that there will be child protective services (CPS) involvement once the child is born. When discussing potential CPS involvement, providers should adopt a transparent, compassionate, and supportive approach. Start by acknowledging the patient's concerns and explaining that CPS involvement varies by jurisdiction and often depends on whether the parent demonstrates active engagement in prenatal care and substance use treatment, such as MOUD. It is critical to emphasize that being on buprenorphine under medical supervision is considered a best-practice treatment for opioid use disorder during pregnancy and can be viewed favorably by CPS as part of a responsible plan to ensure maternal and fetal health. Providers should reassure patients that maintaining treatment and participating in additional supportive services, such as counseling or prenatal care, can significantly reduce the risk of adverse outcomes, including negative perceptions by CPS. Open, nonjudgmental communication about the patient's rights, the role of CPS, and the provider's advocacy for the patient's well-being can help build trust and empower the patient to remain engaged in care.

Developing Collaborative Relationships

Establishing strong, collaborative partnerships with a patient's prenatal healthcare provider is critical for enhancing care and support for pregnant patients receiving MOUD. Effective coordination ensures continuity and quality of care across healthcare settings. Optimal care is delivered by a multidisciplinary team, including OB/GYNs, substance use disorder (SUD) specialists, case managers, and peer recovery coaches, working together to address the comprehensive needs of the patient. If a patient is not yet connected with an OB/GYN or fetal medicine specialist, consultation and a warm handoff is recommended. Additionally, behavioral interventions may need to be adjusted or intensified to mitigate the risk of return to use. Referring patients to counseling or SUD specialty care, in conjunction with MOUD, fosters adherence to treatment, builds coping mechanisms, and reduces the likelihood of substance use recurrence during pregnancy.

Return to Use During Pregnancy

Given that return to use is a common occurrence with OUD, especially early in treatment when medication is being stabilized, doing so should not be viewed as a setback or failure, but as an indication of the need to reassess the patient and adjust the treatment plan.

A pregnant patient who returns to opioid use should have the effectiveness of the medication reevaluated. A medication taper is not recommended after returning to use, and MOUD should not be interrupted. Instead, an increase in dose may be warranted to relieve cravings and possible withdrawal symptoms. Additionally, it might be beneficial to refer to a higher level of care, up to and including residential treatment (if MOUD is continued) to provide increased support and accountability.

Clinical Complexity and Referral to a Higher Level of Care

When determining whether to continue prescribing buprenorphine to a pregnant patient or refer to a higher level of care, primary care providers should assess several factors including:

- Patient's stability in treatment
- Adherence to prescribed medication
- Engagement in recommended behavioral health or prenatal services

If the patient demonstrates consistent attendance, adherence to treatment, and an ability to manage their recovery effectively, the provider may feel confident keeping them on their caseload. However, signs of clinical complexity, such as polysubstance use, significant psychosocial stressors, unmanaged psychiatric comorbidities, or frequent relapses, may indicate the need for a referral to a higher level of care, including an Opioid Treatment Program or Residential Care.

Labor and Delivery

MOUD providers should deliver patient education around pain management during labor and following delivery in anticipation of both vaginal and cesarean section deliveries. Additionally, the patient can be encouraged to have an anesthesia consult to discuss options should a vaginal birth be contra-indicated. Modalities of pain management reviewed should include both pharmacological and non-pharmacological options including:

- Oral, intravenous or intramuscular opioids
- OTC non-opioid analgesics
- Spinal analgesia
- Nitrous oxide
- Massage
- Hydrotherapy
- Ice/heat
- TENS and breathing techniques.

RESOURCES

American College of Obstetricians and Gynecologists. (2017). *Opioid use and opioid use disorder in pregnancy* (Committee Opinion No. 711). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

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