Buprenorphine in Pregnancy: FAQs for Obstetricians

This document offers suggestions for obstetricians working with pregnant women who are prescribed buprenorphine by other providers. It does NOT include advice on buprenorphine induction, titration, etc.

1. What is buprenorphine?

- Buprenorphine is a partial opioid agonist that is used as maintenance treatment for opioid dependence. When combined with naloxone, it has been marketed as Suboxone, buprenorphine/naloxone or Zubsolv. There is currently no brand name product for the monoproduct buprenorphine. Both buprenorphine monoproduct and the naloxone combination can be prescribed for opioid dependence by specially trained and waivered medical providers.
- Buprenorphine is increasingly used during pregnancy, but typically without the naloxone component. While both buprenorphine-naloxone and buprenorphine are considered pregnancy category C, there are more data available on the safety of the combined product.

2. Why and when do I need to communicate with my patient's buprenorphine provider?

- Communication should start as early as possible, to improve care coordination and quality of care.
- Communication remains important during and after labor and delivery:
- The labor and delivery team should confirm the patient's buprenorphine dose on admission by calling the buprenorphine provider or pharmacy.
- While the labor and delivery team can order buprenorphine in the inpatient setting, the team will need to coordinate with the outpatient buprenorphine provider to ensure that the patient has a prescription available on discharge.
- If buprenorphine was stopped during the hospitalization *(see item 5, on the next page)*, then the labor and delivery team will need to discuss reinduction timing with the buprenorphine provider.

3. What kind of release of information do I need to communicate with my patient's buprenorphine provider?

- The release of information form signed by the patient needs to specifically authorize the release of information about substance abuse treatment in a way that complies with federal requirements under 42 CFR Part 2. *(For more information, see http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2#sp42.1.2.a)*
- Many standard hospital release forms have a box you can check to specify that this is the information you seek, but it would be wise to verify with your practice or hospital's legal team that this adheres to federal requirements. If it does not, substance use treatment providers will not be able to respond to your request for information.
- The buprenorphine provider may require that the patient have their signed consent form on file so it is best to obtain this early in the course of pregnancy *(for an example of a 42CFR-compliant form, see http://files.hria.org/files/SA3509h.pdf)*.

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4. Should I do urine drug testing for patients with opioid dependence?

- Regular urine drug testing at prenatal visits can be a useful adjunct to the testing done by the patient's buprenorphine provider. This should only be done with consent from the patient.
- A urine drug test should be done for any patient on admission to Labor and Delivery. This should be done with patient consent.
- At a minimum, the drug test(s) that is used should test for opiates, oxycodone, buprenorphine, methadone, benzodiazepines, cocaine and amphetamines. Consider screening for fentanyl use as well.
- Prenatal providers should screen for, and address any alcohol use at least once each trimester. If indicated, ethyl sulfate (ETS) or ethyl glucoronide (ETG) are metabolites of alcohol that may be tested in a urine sample and have a longer half-life than alcohol. If alcohol use is suspected, this should be discussed with the patient's buprenorphine provider. *(See sample screening tool at http://files.hria.org/files/SA3509c.pdf.)*

5. How do I manage pain during and after delivery for a patient who is prescribed buprenorphine?

- In most cases, buprenorphine can be continued during delivery and postpartum, and the following considerations should guide treatment:
- During delivery: Buprenorphine has a high affinity for the opioid receptor, and thus regional analgesia (e.g., an epidural) is particularly useful to provide pain relief in women receiving methadone or buprenorphine who choose to have analgesia for childbirth or require analgesia for cesarean delivery.
- Commonly used opiate agonist/antagonist medications such as nalbuphine (Nubain®) or butorphanol (Stadol®) are contraindicated as opioid withdrawal may be precipitated in the opioid dependent patient.
- Postpartum: NSAIDs (including injectables such as ketorolac) or acetaminophen rather than opioids are recommended for management of mild or moderate pain in buprenorphine-treated patients.
- Dividing the patient's dose of buprenorphine into TID or QID may improve pain control as may increasing the dose of buprenorphine temporarily
- For severe pain, however, women may require pure short-acting opioid agonists, whether IV (such as morphine or hydromorphone) or by mouth (such as oxycodone). Because of buprenorphine's affinity for the opioid receptor, women may require higher doses of opioids, on average 50% more than typically used; women should be monitored closely as the response can vary and be unpredictable. Patient-controlled analgesia (PCA) pumps may be useful.
- In cases where complications cause severe or prolonged pain not relieved by the above measures, consideration can be given to stopping the patient's buprenorphine to allow for better effect of pure opioid agonists. In these situations, patients are typically given a low dose of a long-acting opioid (such as methadone or MS Contin) to address their basal opioid requirement and prevent withdrawal, and then a short acting agent (such as oxycodone) for the pain. After the pain resolves, patients will need reinduction with buprenorphine, typically post-discharge in an out-patient setting. Contacting your patient's buprenorphine provider and/or a local pain or addiction expert for assistance in these cases and coordination of care is recommended.

6. What do I need to do to prepare our pediatric team for care of my patient's baby?

- Many infants born to women taking buprenorphine, but not all, will develop neonatal abstinence syndrome (NAS). Recent studies have shown that infants born to women taking buprenorphine require less pharmacological treatment and have shorter hospitalizations than infants born to women taking methadone. There is no data to suggest that higher doses of buprenorphine are associated

with more severe NAS. Other medications such as benzodiazepines or other sedatives, antidepressants, nicotine, or illicit drugs may contribute to the severity of NAS.

- When mothers are taking buprenorphine, symptoms of NAS typically develop 48 hours or more after birth; babies may need to be monitored for the development of symptoms for as long as 4–5 days. Providers should be cautious about early discharge due to the long half-life of buprenorphine, and the potential for NAS symptoms to occur after discharge.
- To coordinate the care of the mother and infant:
  - Consider arranging a pediatrics and/or neonatal ICU consultation for the patient during her third trimester, to help her learn what to expect and to prepare the pediatrics team for the infant's birth and pediatrics admission.
  - During labor, the pediatrics team should be alerted of an impending delivery, and the infant should be monitored and cared for according to your hospital's NAS protocol.

7. Can patients breastfeed if they are taking buprenorphine?

- Yes. Because of the low levels of buprenorphine in breastmilk, its poor oral bioavailability in infants, and the low drug concentrations found in the serum and urine of breastfed infants, its use is acceptable in nursing mothers, with appropriate monitoring. Moreover, breastfeeding can contribute significantly to mother-infant bonding and non-pharmacological NAS treatment. ***For more safety information, see LactMed (http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT).***
- Breastfeeding may not be advised in women who have continued to use alcohol or other drugs during their pregnancy despite buprenorphine treatment, because of the risk of exposing the baby to other substances. Before making a recommendation to your patient, discuss the status of her recovery, other prescribed medications that may be contraindicated, and review her urine toxicology screens.

8. What can my patient expect regarding the Department of Children and Families (DCF) involvement?

- If you or your patient has questions about DCF involvement, please consult hospital protocols, the hospital social worker, your local DCF office, or ***www.mass.gov/dcf.***

9. Additional resources for providers working with pregnant women who have substance use disorders:

- **The Institute for Health and Recovery** is the central intake for residential treatment services for pregnant women. Call 866–705–2807 or 617–661–3991. (TTY: 617–661–9051)
- **The Massachusetts STATE OBOTB Program** has a hotline to help locate buprenorphine treatment, including for pregnant women. Call 866–414–6926 or 617–414–6926.
- **Massachusetts Substance Abuse Helpline:** The Bureau of Substance Abuse Services at DPH operates a helpline to help individuals with substance use disorders and their families locate services: 1–800–327–5050 or TTY 888–448–8321, or www.helpline-online.com.
- Print resources, including a providers' Toolkit, "*Protecting Women and Babies from Alcohol and Drug Affected Births: Tools and Resources*," are available on the **Massachusetts Clearinghouse**, at https://massclearinghouse.ehs.state.ma.us/category/BSASPREG.html.

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