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MOUD Treatment Basics for Perinatal Patients

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Key Abbreviations

OUD = opioid use disorder

MOUD = medications for opioid use disorder

SUD = substance use disorder

NOWS = neonatal opioid withdrawal syndrome

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Objectives

1. Discuss how to utilize methadone and buprenorphine to treat OUD in perinatal patients
2. Review clinical pathways and resources to support providers in MOUD
3. Apply MOUD knowledge and tools to perinatal patient cases

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Withdrawal Management

Opioids

Prepare by asking patients:
What is your first symptom?
What is your worst symptom?

Intoxication	Withdrawal
Sedation	Flu-like symptoms
Decreased respiratory rate	Nausea, vomiting, diarrhea
Pinpoint pupils	Anxiety & agitation
	Elevated vitals (BP, HR)
	Sweating & chills
	Insomnia
	Aches & pains

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Clinical Opioid Withdrawal Scale (COWS)

Treatment usually begins once patients are in moderate withdrawal

(COWS of 13)

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Inpatient OB Comfort Order Set

Patient Declines to Continue MOUD Post-Discharge

Start Time:
As soon as possible to get ahead of withdrawal, unless patient acutely intoxicated

☑ **Methadone 30 mg**

Supplied in formulation carried by hospital

Administer 30 mg orally q24h

Reassess in 4-6 hours, if no sedation give:

☐ **Methadone 10 mg**

Supplied in formulation carried by hospital

Administer 10 mg orally once.

Total daily dose not to exceed 40mg

Opioid Agonists

May use in addition to methadone if methadone dosing insufficient to alleviate symptoms. If using alone (without methadone), it is reasonable to increase doses higher than written below.

☐ **Hydromorphone 4-6 mg orally q 4-6 h PRN COWS >8**

or

☐ **Oxycodone 10-15 mg orally q4-6 h PRN COWS >8**

+/-

☐ **Morphine Extended-Release 15-30 mg orally TID**

ADJUNCT TREATMENTS (+/-)

☐ Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
☐ Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
☐ Ondansetron 4 mg orally q6h PRN nausea
☐ Dicyclomine 10 mg orally TID PRN abdominal cramping
☐ Trazodone 50-100 mg orally qHS PRN insomnia
☐ Acetaminophen 500-1000 mg orally q6h PRN headache, pain
☐ Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
☐ Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondansetron, or not having success with ondansetron)

The goal is to keep patients comfortable, so they stay in the hospital and receive care. It is important to maintain tolerance to reduce the risk of overdose after discharge.

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Meds First

- Withdrawal from fentanyl occurs sooner after last use compared to heroin (about 3-4 hours)
- Relieving withdrawal symptoms promptly makes everyone feel better
- While it is important to gather more information about obstetric history, substance use history, psychosocial context, etc., the information you obtain when a person has had their opioid withdrawal symptoms relieved is likely to be higher yield
- Ethical Concern?
  - Iatrogenic opioid withdrawal in the hospital setting is a vulnerable state, and there is increasing concern about patient's risk for coercion when being asked to make medical decisions in acute, untreated opioid withdrawal
- Leaving the hospital AMA due to untreated w/d is an incredibly high-risk and high liability situation

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Treatment

Literature Supports MOUD

Buprenorphine Versus Methadone for Opioid Dependence in Pregnancy

Arezo Noormohammadi, PharmD, Alicia Forinash, PharmD, [...], and Jaye Shyken, MD +3 View all authors and affiliations

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The American College of Obstetricians and Gynecologists WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711 • August 2017 (Replaces Committee Opinion Number 524, May 2012)

Committee on Obstetric Practice
American Society of Addiction Medicine

The Society of Maternal-Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Macaulo, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.

Opioid Use and Opioid Use Disorder in Pregnancy

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Special Report

smfm.org

Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine

Check for updates

Jeffrey Ecker, MD; Alfred Abuhamad, MD; Washington Hill, MD; Jennifer Bailit, MD; Brian T. Bateman, MD; Vincenzo Berghella, MD; Tiffany Blake-Lamb, MD; Constance Guille, MD; Ruth Landau, MD; Howard Minkoff, MD; Malavika Prabhu, MD; Emily Rosenthal, MD; Mishka Terplan, MD; Tricia E. Wright, MD; Kimberly A. Yonkers, MD

The American College of Obstetricians and Gynecologists supports the value of this clinical document as an educational tool, March 2019.

Recent trends in treatment admissions for prescription opioid abuse during pregnancy

Caitlin E Martin [1], Nyaradzo Longinaker [2], Mishka Terplan [3]

Affiliations + expand

PMID: 25151440 PMCID: PMC4648237 DOI: 10.1016/j.jsat.2014.07.007

Free PMC article

A Public Health Response to Opioid Use in Pregnancy

Stephen W. Patrick, MD, MPH, MS, FAAP,[a,b,c,d,e] Davida M. Schiff, MD, FAAP,[f] COMMITTEE ON SUBSTANCE USE AND PREVENTION

Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: a systematic review and meta-analysis of safety in the mother, fetus and child

Barbara K Zedler [1], Ashley L Mann [1], Mimi M Kim [2], Halle R Amick [1], Andrew R Joyce [1], E Lenn Murrelle [1], Hendrée E Jones [3] [4]

Affiliations + expand

PMID: 27223595 PMCID: PMC5129590 DOI: 10.1111/add.13462

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Harm Reduction for Mom & Baby

The American College of Obstetrics and Gynecologists & The American Society of Addiction Medicine support both methadone and buprenorphine treatment as best practice for OUD during pregnancy.

Treatment with methadone or buprenorphine improves infant outcomes by:

- Stabilizing fetal opioid levels, reducing repeated prenatal withdrawal
- Providing opportunity for treatment of infectious diseases and better prenatal care

Compared to untreated pregnant women, those on MOUD had:

- Lower risks associated with Neonatal Opioid Withdrawal Syndrome (NOWS)
- Greater weight, head circumference and gestational age at birth

SMFM Special Report

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

Pregnancy as a window of opportunity for treatment

Pregnancy is a window of opportunity for the treatment of chronic diseases, which includes substance use disorders. During this time, women have access to health insurance and often are motivated toward positive health behaviors in an effort to invest in the health and well-being of their future children.[70] Similar to the treatment of other perinatal chronic diseases (eg, diabetes mellitus, hypertension, connective tissue disease), obstetricians have an opportunity to provide care for substance use disorders during pregnancy that will reduce maternal, obstetric, fetal, and newborn infant morbidity and mortality rates and potentially decrease generational transmission of this chronic condition.[71–74] High-quality, evidence-based treatment interventions during this time have the potential to improve maternal and child health and have far-reaching health benefits for future generations.[75]

SMFM Special Reprot: Substance Use Disorders in Pregnancy: Clincial, Ethical and Research Imperatives fo the Opioid Epidemic Published march 2019

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NIDA. 2017, July 1. Treating Opioid Use Disorder During Pregnancy. Retrieved from http://nida.nih.gov/publications/treating-opioid-use-disorder-during-pregnancy on 2023, March 30

Breastfeeding is Safe and Recommended!

Breastfeeding should be encouraged for women who are stable on methadone or buprenorphine, do not have other active substance use, and who have no contraindications.

Breastfeeding in women receiving methadone or buprenorphine treatment has been associated with:

- Decreased severity and lower need for pharmacotherapy to treat NOWS
- Shorter hospital stays for the infant
- Improved attachment between mom and baby
- Increased immunity provided to the infant

Breastfeeding is recommended regardless of the maternal dose of buprenorphine or methadone due to the minimal transfer into breast milk.

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Sachs HC. The transfer of drugs and therapeutics into human breast milk: an update on selected topics. Committee on Drugs. Pediatrics 2013;132:e796–809.

Choice of Medication: Patient-Centered Approach

- Neither medication shows association with birth defects
- Neither medication shows a statistically significant difference in Neonatal Opioid Withdrawal Syndrome (NOWS) risk, when compared to the other

Full agonist:
generates effect

Partial agonist:
generates limited effect

Balance availability, prescribing logistics and risk vs benefit to determine what is best for each individual patient

In studies, buprenorphine was associated with:

- Lower risk of preterm birth
- Less risk of low birth weight
- Lower risk of a decreased head circumference
- No greater harm than methadone
- Greater accessibility and ease of prescribing

In studies, methadone was associated with:

- Reduced pregnancy complications
- Decreased fetal mortality rate
- Better adherence to treatment and prenatal care
- Greater success than buprenorphine with transition from high doses of non-medical opioids
- Need for more frequent dose titration due physiologic changes in pregnancy

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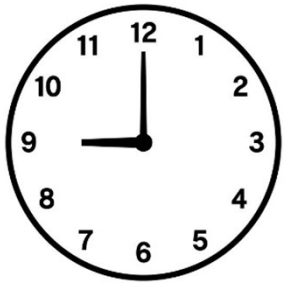
Timing of Initiation



Methadone: start as soon as possible to get ahead of withdrawal, unless acutely (independent of time of last use)

Buprenorphine:

- Fentanyl use: initiate once COWS >13 and 24-36 hours has elapsed since last use
- Short-Acting Opioid Use (heroin, oxycodone, tramadol, kratom*, etc): initiate once COWS>13 and 12-24 hours has elapsed since last use of short acting opioid
- From Methadone to Bupe: initiate once COWS>13 and 36 hours has elapsed since last methadone OR **consider low-dose bupe cross titration**

If initiating full agonist opioids in combination with low dose buprenorphine, there is no need to wait

Kratom now has a "long-acting" form called 7-OH. Consider waiting 24-36 hrs

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Methadone Inpatient OB Order Set

Patient Desires to Continue MOUD Post-Discharge

MEDICATIONS FOR OPIOID USE DISORDER

Day 1:

☑ **Methadone 30 mg**
Supplied in formulation carried by hospital
Administer 30 mg orally once
Reassess in 4 hours, if no sedation give:

☐ **Methadone 10 mg**
Supplied in formulation carried by hospital
Administer 10 mg orally once
Reassess in 4 hours, if no sedation give:

☐ **Methadone 10 mg**
Supplied in formulation carried by hospital
Administer 10 mg orally once
****permissible to give up to 50 mg total on day 1**

Start Time:
As soon as possible to get ahead of withdrawal, unless acutely intoxicated

Day 2:

☑ **Methadone 40 mg-50 mg** (give previous days total dose)
Supplied in formulation carried by hospital
Administer 40-50 mg orally once 24 hours after previous dose
Reassess in 4 hours, if no sedation give:

☐ **Methadone 10 mg**
Supplied in formulation carried by hospital
Administer 10 mg orally once

Day 3:

☑ **Methadone 50 mg-60 mg** (give previous days total dose)
Supplied in formulation carried by hospital
Administer 50-60 mg orally once 24 hours after initial day 2 dose
Reassess in 4 hours, if no sedation give:

☐ **Methadone 10 mg**
Supplied in formulation carried by hospital
Administer 10 mg orally once

Day 4 and Beyond:

☑ **Methadone 60-70 mg** (give previous days total dose)
Supplied in formulation carried by hospital
Administer 60-70 mg orally once every 24 hours

May increase daily dose by 10 mg every 3-5 days as needed to control symptoms
May consider adding short acting opioid if methadone alone does not control symptoms

ADJUNCT TREATMENTS (+/-)

☐ Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
☐ Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
☐ Ondansetron 4 mg orally q6h PRN nausea
☐ Dicyclomine 10 mg orally TID PRN abdominal cramping
☐ Trazodone 50-100 mg orally qHS PRN insomnia
☐ Acetaminophen 500-1000 mg orally q6h PRN headache or pain
☐ Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
☐ Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondansetron, or not having success with ondansetron)

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Buprenorphine Standard Induction Inpatient OB Order Set

Patient desires to continue MOUD post-discharge

MEDICATIONS FOR OPIOID USE DISORDER

☑ **Buprenorphine-Naloxone 2mg-0.5mg Sublingual Film**
May substitute comparable buprenorphine product on formulary
Administer 4 mg (2 films) SL TID (12 mg daily)

Start Time:
Fentanyl Use: Initiate once COWS >13 and 24-36 hours has elapsed since last reported or suspected use of fentanyl

---

Short-Acting Opioid Use (heroin, oxycodone, tramadol, kratom, etc): Initiate once COWS > 13 and 12-18 hours has elapsed since last reported or suspected use of a short acting opioid

---

Methadone Use: Initiate once COWS >13 and 36 hours has elapsed since last reported or suspected use of methadone

**If initiating full agonist opioids in combination with low dose buprenorphine, there is no need to wait

If withdrawal has improved, continue with current dosing

IF NOT:

☐ **Buprenorphine-Naloxone 2mg-0.5mg Sublingual Film**
Administer 4 mg (2 films) SL Once
Change order to:
☐ **Buprenorphine-Naloxone 8mg-2mg Sublingual Film**
Administer 8 mg SL TID (24 mg daily)
Reassess in 1 hour after administration of first dose

If withdrawal has improved, continue with current dosing

IF NOT:

☐ **Buprenorphine-Naloxone 8mg-2mg Sublingual Film**
Administer 8 mg SL Once
Change order to:
☐ **Buprenorphine-Naloxone 8mg-2mg Sublingual Film**
Administer 16 mg (2 films) SL BID (32 mg daily)
Reassess in 1 hour after administration of first dose

If withdrawal has improved, continue with current dosing

If withdrawal has NOT improved, consult addiction specialist

ADJUNCT TREATMENTS (+/-)

☐ Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
☐ Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
☐ Ondansetron 4 mg orally q6h PRN nausea
☐ Dicyclomine 10 mg orally TID PRN abdominal cramping
☐ Trazodone 50-100 mg orally qHS PRN insomnia
☐ Acetaminophen 500-1000 mg orally q6h PRN headache, pain
☐ Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
☐ Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondanset

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Buprenorphine Low-Dose Induction Outpatient OB Order Set

Rationale for Use: Due to the unique pharmacodynamics of fentanyl being highly lipophilic, transition to buprenorphine has a higher risk for precipitated withdrawal. In order to avoid precipitating withdrawal, low-dose ('microdose") protocols have been developed. The key is that buprenorphine is initiated at low, increasing doses while the patient continues to use fentanyl, until up to 8mg-2mg two-three times daily on buprenorphine, then stop fentanyl use. When done properly, this protocol may reduce the risk of precipitated withdrawal and make ongoing buprenorphine treatment more successful.

Buprenorphine should not be given to patients who are currently taking **methadone,** as this would **cause withdrawal.** Please coordinate with patient's methadone clinic provider if patient has been receiving methadone treatment and desires to change to buprenorphine.

ADJUNCT TREATMENTS (+/-)

- ☐ Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
- ☐ Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
- ☐ Ondansetron 4 mg orally q6h PRN nausea
- ☐ Dicyclomine 10 mg orally TID PRN abdominal cramping
- ☐ Trazodone 50-100 mg orally qHS PRN insomnia
- ☐ Acetaminophen 500-1000 mg orally q6h PRN headache or pain
- ☐ Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
- ☐ Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondansetron, or not having success with ondansetron)

MEDICATIONS FOR OPIOID USE DISORDER

☑ **Buprenorphine-Naloxone 2mg-0.5mg Sublingual Film**
May substitute buprenorphine 2 mg SL tablet, if patient cannot take film
Initial Quantity: 9 films written for 3 day supply

☑ **Buprenorphine-Naloxone 8mg-2mg Sublingual Film**
May substitute buprenorphine 8 mg SL tablet, if patient cannot take film
Initial Quantity: 21 films written for 7 day supply

May initate at any time, without gap in current use

Day 1
Take 0.5 mg (one quarter 2 mg film) SL once

Day 2
Take 0.5 mg (one quarter 2 mg film) SL twice daily

Day 3
Take 1 mg (one half 2 mg film) SL twice daily

Day 4
Take 2 mg (one 2 mg film) SL twice daily

Day 5
Take 4 mg (use 2 mg or 8 mg films) SL twice daily

Day 6
Take 8 mg (one 8 mg films) SL twice daily

Day 7
Take 8 mg (one 8 mg films) SL up to three times daily

DISCONTINUE OTHER OPIOIDS THIS DAY

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Laws & Regulations

Methadone in hospitals is special

- When in the hospital or ED setting, it is permissible to give any opioid, including methadone, to treat opioid withdrawal
- When a patient is in the hospital and receives methadone for treatment of opioid withdrawal, this dose may be split, titrated, etc
- For a person to continue methadone treatment after discharge from hospital, they will need to be enrolled in an OTP (opioid treatment program)
  - **Ideally this intake/enrollment should occur prior to discharge from hospital
- Patients can now receive 72 hours of methadone medication upon discharge from hospital setting to allow for linkage to care with OTP (from hospital, not sent to a pharmacy)

Go to momsplus.us to find our "Legal and Regulatory Considerations for Hospital Treatment of OUD" handout

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Updates to Federal Guidelines - 4/2024

1. **Day 1= 50 mg:** First day total dose can now be 50 mg
2. **Telehealth:** A methadone intake can now happen via telehealth. This means that a patient in a rural area (or a hospital?) (accessing care in a methadone van, for example) can enroll in methadone without an in-person exam. Must be a screen/visual appointment; telephone intakes are NOT allowed.
3. **Take homes doses:** People can now get up to 7 days of take homes on their first day of OTP enrollment
4. **Jails, prisons, long term care facilitates** can dispense methadone without becoming an OTP
5. **Year OUD criteria:** Got rid of the rule that people had to meet OUD criteria for a full year before they could receive methadone
6. **Split dosing:** Now the OTP clinician just needs to document why split dosing is needed (i.e., pregnancy, pain dx, rapid metabolizer, on meds that speed up methadone metabolism)

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Cases

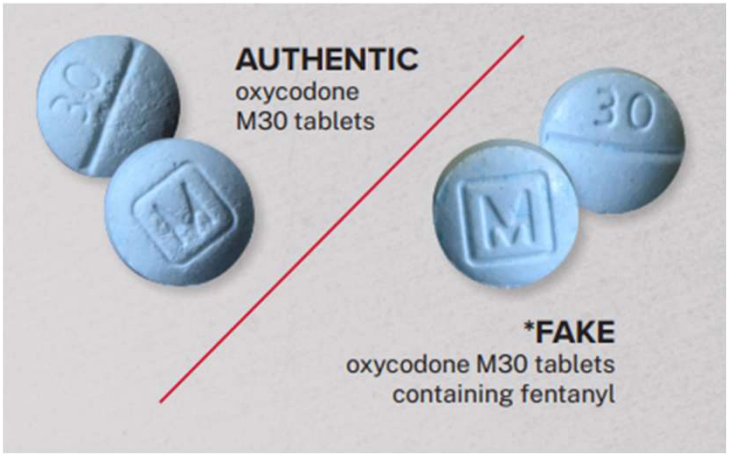
Case #1: Fentanyl to Methadone (inpatient)

Case #2: Fentanyl to Buprenorphine (outpatient)

Case # 3: Fentanyl to Buprenorphine (inpatient)

Patient Case AB

- Pt is 25 yo G3P1011 at 26 weeks who presents to OBED with concern for contractions
- RN uses 5Ps to screen patient, who admits to using 20-25 “blues” per day, last use 8-10 hours ago
- She has been trying to “detox” at home, but started having contractions and got scared
- Comprehension check:
  - What are “blues”?
  - What are next steps?
  - Who would you call?



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Patient Case AB: Day 1

- Methadone 30 mg x1 now
  - Reassess in 4 hours. If no sedation and/or continued withdrawal, give another 10 mg.
  - Reassess in 4 hours. If no sedation and/or continued withdrawal, give another 10 mg.
- Ask, "What withdrawal symptoms bother you the most?"
  - N/V: ondansetron, promethazine
  - Belly cramps, diarrhea: dicyclomine, loperamide
  - Anxiety, restlessness: clonidine, hydroxyzine, gabapentin
  - Insomnia: hydroxyzine, trazodone
- Offer additional opioids
  - Oxycodone, hydromorphone

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Patient Case AB: Day 2

- Methadone 50 mg x1
  - Reassess in 4 hours and give another 10 mg if needed
- Additional opioids/adjuvants PRN
- Discuss plans for medication
  - Comfort and maintenance of tolerance while in hospital?
  - Continue treatment and need enrollment in OTP
- Additional labs, resources, social work consult, PoSC, connection to OTP
- Take-home naloxone kit for discharge

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Patient Case AB: Day 3

- Methadone 60 mg x1
  - Reassess in 4 hours and give another 10 mg if needed
- Connect patient to OTP
  - Same- or next- day intake?
- Does patient need emergency supply of methadone on discharge?
- Don't panic! All of this information is available 24/7 on MOMs+ website
- Call the CO PROSPER line for support
  - 888.910.0153

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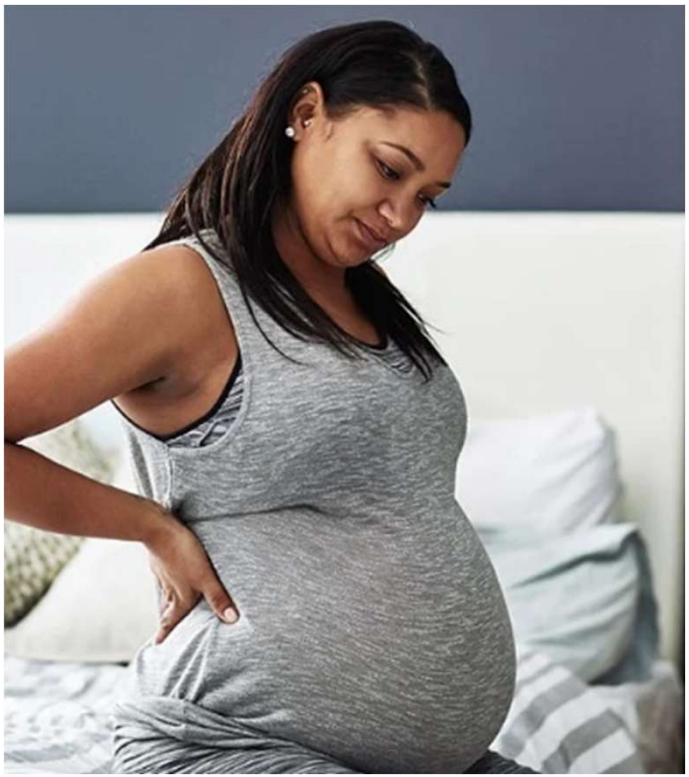
Patient Case CD

- Pt is 25 yo G3P1011 at 26 weeks who comes to see you for new OB visit in outpatient clinic.
- Pt reports fentanyl use daily and would like to start buprenorphine treatment.
- Previous experience with methadone but did not feel well, missed doses frequently due to work schedule.
- Has tried to start buprenorphine at her own, but ended up with precipitated withdrawal, so nervous about trying again.
- How do you start buprenorphine in the outpatient setting?



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Patient Case CD: Buprenorphine Outpatient

- Cannot prescribe full agonist opioids for opioid withdrawal in outpatient setting.
- Can prescribe non-opioid adjuvant meds.
- Utilize low dose buprenorphine protocol with *continued fentanyl use for several days while titrating bupe dose*.

This is not promoting ongoing fentanyl use, this is recognizing the pharmacologic reality of the substance, and how to work with what we've got to get to mutual goal of stabilizing on buprenorphine quickly, comfortably, and safely.

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Patient Case CD: Buprenorphine Outpatien

- Establish a baseline: “How many pills/powder do you need to use per day to just not be sick?”. Once established, continue that amount daily while starting buprenorphine.
- Agree no alcohol, benzodiazepine, and minimize stimulant use as much as possible
- Many people use (more) cannabis during this week, readdress once stabilized on buprenorphine.
- Clarify that pt does not need to wait to be in withdrawal to start buprenorphine.
- Give instructions about when and how to take any adjuvants you also prescribe.
- Always prescribe naloxone and review overdose prevention.
- Not required, but nice if there is another person who can help support and monitor pt at home.

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Buprenorphine Low-Dose Induction Outpatient OB Order Set

Rationale for Use: Due to the unique pharmacodynamics of fentanyl being highly lipophilic, transition to buprenorphine has a higher risk for precipitated withdrawal. In order to avoid precipitating withdrawal, low-dose ('microdose") protocols have been developed. The key is that buprenorphine is initiated at low, increasing doses while the patient continues to use fentanyl, until up to 8mg-2mg two-three times daily on buprenorphine, then stop fentanyl use. When done properly, this protocol may reduce the risk of precipitated withdrawal and make ongoing buprenorphine treatment more successful.

Buprenorphine should not be given to patients who are currently taking **methadone,** as this would **cause withdrawal.** Please coordinate with patient's methadone clinic provider if patient has been receiving methadone treatment and desires to change to buprenorphine.

ADJUNCT TREATMENTS (+/-)

- ☐ Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
- ☐ Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
- ☐ Ondansetron 4 mg orally q6h PRN nausea
- ☐ Dicyclomine 10 mg orally TID PRN abdominal cramping
- ☐ Trazodone 50-100 mg orally qHS PRN insomnia
- ☐ Acetaminophen 500-1000 mg orally q6h PRN headache or pain
- ☐ Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
- ☐ Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondansetron, or not having success with ondansetron)

MEDICATIONS FOR OPIOID USE DISORDER

☑ **Buprenorphine-Naloxone 2mg-0.5mg Sublingual Film**
May substitute buprenorphine 2 mg SL tablet, if patient cannot take film
Initial Quantity: 9 films written for 3 day supply

☑ **Buprenorphine-Naloxone 8mg-2mg Sublingual Film**
May substitute buprenorphine 8 mg SL tablet, if patient cannot take film
Initial Quantity: 21 films written for 7 day supply

May initate at any time, without gap in current use

Day 1
Take 0.5 mg (one quarter 2 mg film) SL once

Day 2
Take 0.5 mg (one quarter 2 mg film) SL twice daily

Day 3
Take 1 mg (one half 2 mg film) SL twice daily

Day 4
Take 2 mg (one 2 mg film) SL twice daily

Day 5
Take 4 mg (use 2 mg or 8 mg films) SL twice daily

Day 6
Take 8 mg (one 8 mg films) SL twice daily

Day 7
Take 8 mg (one 8 mg films) SL up to three times daily

DISCONTINUE OTHER OPIOIDS THIS DAY

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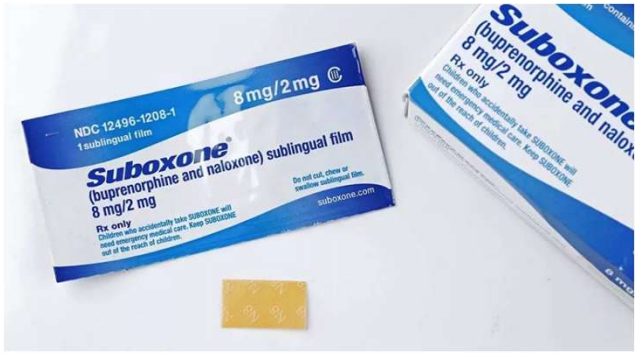
CONNECTION, TREATMENT & COMMUNITY

Patient Case CD: Buprenorphine Outpatient



A bit more rapid approach (5 days to goal buprenorphine dose):

- Prescribe 2mg and 8mg tablets or films

Sig for 2mg tabs/films:

"Day 1: take ¼ tablet under tongue every 6 hours. Day 2: Take ½ tablet under tongue every 6 hrs. Day 3: Take 1 tablet under tongue every 6 hours" #8 tabs (one extra in case of crumbling)

Sig for 8mg tab/film:

"Day 4: take ½ tab under tongue every 6 hrs. Day 5: Take full tab under tongue 4 times per day. *Stop other opioids this day* # 28 tabs (for a 7 day follow up, or however much pt will need until follow up, assuming 24-32mg per day)

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Patient Case CD: Buprenorphine Outpatient

- Give clear patient instructions (dotphrase for AVS recommended)
- Include how and when to take adjuvant meds

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- Include clinic contact info, ED precautions, and follow up visit time/date.
- Naloxone provision and overdose prevention education

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Patient Case EF: Buprenorphine Inpatie

25 yo G3P1011 at 26w, admitted to hospital, with abdominal discomfort, N/V, and history of OUD.
Current use includes fentanyl 20-25 pills or fentanyl powder per day, last use 10 hours ago. Pt currently reporting nausea, chills, HR 115.

Next steps?

- Opioid withdrawal most common cause of symptoms described, and, should be a diagnosis of exclusion (don't fall into premature closure trap!)
- Pt expresses strong preference for buprenorphine treatment
- How do you start buprenorphine from fentanyl use?

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Patient Case EF: Buprenorphine Inpatient

Pt expresses significant fear of withdrawal

- How do you address the "opioid deficit" of withdrawal to buy yourself time to start buprenorphine?

3-part medication plan:

- Full agonist
- Low-dose buprenorphine titration
- Adjuvant meds for specific symptom relief

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Patient Case EF: Buprenorphine Inpatient

Part One: Full agonist

Compared to outpatient setting in which patient will continue use of full agonist (fentanyl) themselves in order to successfully follow low-dose buprenorphine titration, when patient is in the hospital and no longer using fentanyl, it must be replaced in order to successfully utilize low-dose buprenorphine protocol.

- Methadone
- Hydromorphone
- Oxycodone
- MS Contin
- Fentanyl - Hard to do as short acting

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Patient Case EF: Buprenorphine Inpatie

Part Two: Low Dose Buprenorphine Titration

Continue the full agonist(s)!

- Day 1: 0.5 mg SL buprenorphine q 6 hr
- Day 2: 1 mg SL buprenorphine q 6 hr
- Day 3: 2 mg SL buprenorphine q6 hr
- Day 4: 4 mg SL buprenorphine q 6 hr
- Day 5: 8 mg SL buprenorphine TID to QID (*stop full agonist*)

Can go quicker in the hospital, since can always give additional full agonist opioids, adjuvant meds, etc to treat through any mild precipitated withdrawal

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Patient Case EF: Buprenorphine Inpatient

Part Three: Adjuvant meds

- Will not mask moderate to severe opioid withdrawal
- Will help support pts with specific symptoms (nausea, muscle cramps, pain, sleep, etc)
- Not a substitute for full agonist opioid initiation (methadone) or deficit management (buprenorphine)
- Pitfall: polypharmacy
  - Some providers will end up giving multiple different adjuvants, all with their own and synergistic side effects, in an attempt to avoid/minimize giving full agonist opioids
  - Don't fall for this trick! Opioid withdrawal is treated with opioids, adjuvants are just that: add-ons to the main therapy, not a stand-alone treatment

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Patient Case EF: Buprenorphine Inpatient

Day 5: patient stabilized on 8 mg SL TID, ready to go home!

- Ideally have been able to use time in hospital to explore and connect with additional treatment plans and recovery resources:
  - Residential, IOP, sober living, community groups
  - Peer Support Specialist/Peer Recovery Doula
  - Nicotine cessation plan (if applicable)
- Clear plan for follow up for prenatal care, with appt scheduled
- Clear plan for follow up for buprenorphine prescription
  - With prenatal care provider? Other?
  - Ensure very clear who they are to call, for what, if not same person/clinic – and always with appt scheduled!
- Naloxone provision and overdose prevention education

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Q&A

Discussion, Concerns, Barriers

Leading Your Community

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How can your hospital, clinic, YOU lead the surrounding community in welcoming and providing treatment and perinatal care to pregnant and parenting patients and families affected by substance use?

IMPACT BEHAVIORAL HEALTH