Buprenorphine (Bup) Quick Start in Pregnancy

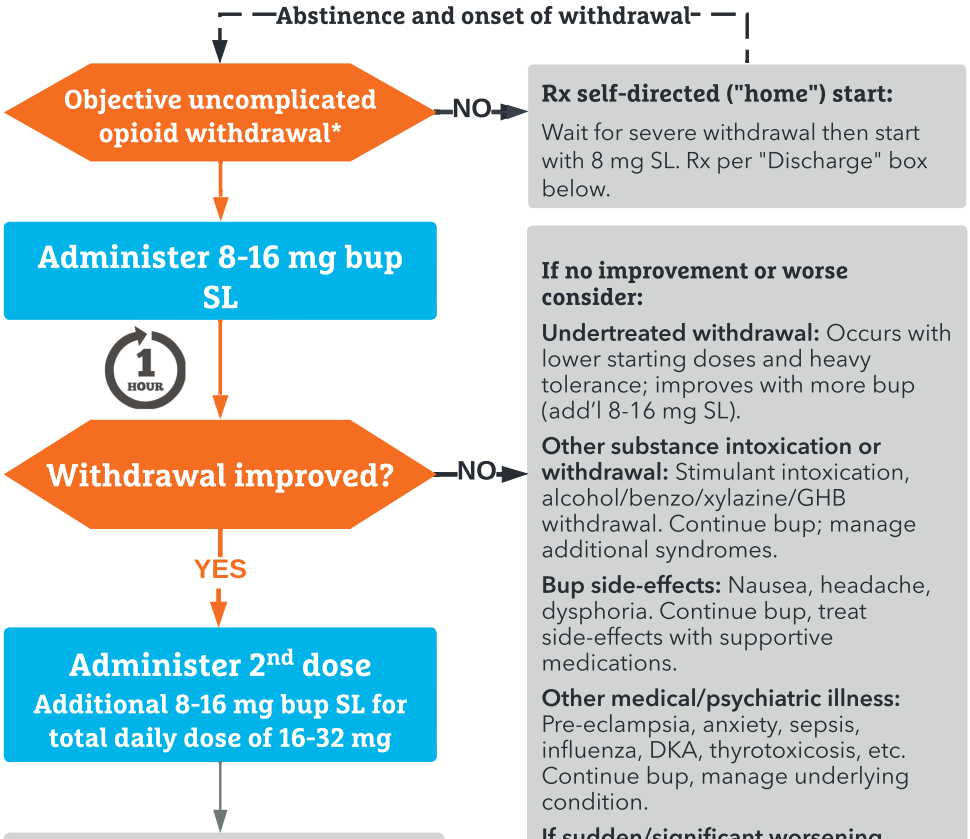
This guidance is for the emergency department (ED). We advocate for continuation & initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.

CA BRIDGE

Medication for Addiction Treatment in Pregnancy

- Any prescriber can order bup in the ED/hospital. It can also be prescribed as medication for opioid use disorder by any prescriber with an active Drug Enforcement Agency license that includes schedule III medications.
- Fetal monitoring is not required to start bup in normal pregnancy, regardless of gestational age.
- Admission for observation is NOT required for bup starts.
- Bup monoproduct or bup/naloxone (nx) is OK in pregnancy.
- Bup is a high-affinity partial agonist opioid that is SAFE in pregnancy and highly effective for treating opioid use disorder.
- Split dosing and an increase in total bup dose is often necessary, esp. in later trimesters.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

We encourage shared decision making with patients for dosing.



Discharge

- **Prescribe sufficient bup/nx until follow-up:** e.g., buprenorphine/naloxone 8/2 mg SL films 2-4 films qday #32-64, 0 refills (may Rx more PRN). Notes to pharmacy: bill Medi-Cal FFS, ICD 10 F11.20.
- **An X-waiver is no longer needed to prescribe bup.**
- **Dispense naloxone** from the ED (not just prescribed): e.g., naloxone 4 mg IN spray #2.
- **Document** Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.

Peripartum (for planned C-Section and/or labor, or acute pain):

- Continue patient's normal bup dose in combination with multimodal analgesia that may include regional anesthesia and opioids.
- Bup is safe for breastfeeding.
- Bup reduces neonatal abstinence syndrome (NAS) severity. Dose does not correlate to NAS severity.

Postpartum:

Bup dose reduction should be gradual and per patient cravings.

Ethical Considerations:

- MAT alone is not justification for contacting Child Protective Services.
- Consent is required for urine drug testing.
- Pregnant patients have the right to determine their treatment plan.
- Delivering quality care is an essential component of reducing mortality for Black birthing people.

* Opioid Withdrawal:

At least one clear objective sign (prefer ≥ 2): Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND objective signs.

Typical withdrawal onset >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours).

Start protocol may vary for complicating factors:

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma, or planned large surgery
- Organ failure or other severe medical illness (decompensated heart failure, respiratory distress, hemodynamically unstable, etc.)
- Recent methadone use
- Minimal opioid tolerance (consider lower dosing)

Most people who use fentanyl do well with starts following this guide. For fentanyl specific initiation questions, see Fentanyl FAQ.

If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup: give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

Additional Resources:

- Prevent & Treat Opioid Withdrawal in Your Baby
- Opioid Use and Opioid Use Disorder in Pregnancy
- Pregnancy and Substance Use: A Harm Reduction Toolkit

April 2023

PROVIDER RESOURCES

California Substance Use Line
CA Only (24/7)
1-844-326-2626

UCSF Substance Use Warmline
National (M-F 6am-5pm; Voicemail 24/7)
1-855-300-3595