Choosing a Medication for the Treatment of Opioid Use Disorder (OUD)

Medication for addiction treatment (MAT) with methadone or buprenorphine is the first line for treatment of OUD during pregnancy. It is important to limit the use of benzodiazepines and other sedating medications to decrease overdose risk.

Is the patient already on a medication for the treatment of opioid use disorder?

YES

Avoid changing medication during pregnancy

- Continue medications that the patient is stable on and optimize the dose.
- The patient may require dose increase as pregnancy advances and dose decrease at 2-4 weeks postpartum.
- If withdrawal symptoms emerge in the third trimester, you may need to increase total daily dose or frequency.

NO

Considerations for initiating medication

- Which medications are readily available?
- Which treatment setting can the patient get to?
- Which medication has the patient done well with before?
- What does the patient prefer?
- For all medication choices, make sure to consider implications for pain management *(see SUD5)* and neonatal withdrawal risk.

First-Line Treatments

	Mechanism	Pros	Cons	Special Considerations in Pregnancy	Lactation
Methadone	Full agonist at the Mu opioid receptor	Administered in structured setting with daily observed treatment Often includes multidisciplinary treatment such as groups and counseling	Must be prescribed through a federally licensed clinic, and clinics are not easy to access Daily observed dosing is not compatible with some work/childcare schedules. Can be sedating at higher doses	Risk of QTc prolongation Rapid metabolism in the third trimester may require dose increase and change from daily to twice daily doses. Pregnant women are eligible for expedited access to a methadone clinic. Multiple drug-drug interactions (e.g., many antiretrovirals, rifampin, phenytoin)	Translactal passage: 1-6 % of the maternal weight adjusted dose Low infant exposure should not preclude breastfeeding. Breastfeeding is encouraged in substance-exposed newborns unless there is active substance use or risk of infection.
Buprenorphine (Suboxone, Subutex, Sublocade)	Partial agonist at Mu opioid receptor High-affinity receptor binding	Office-based treatment; can get a prescription at variable intervals Not usually sedating Low risk for overdose	Must be prescribed by a waivered provider Can complicate pain management in labor (see *SUD5*)	Patient must be in mild withdrawal prior to initiation treatment May require dose increase in third trimester Buprenorphine without naloxone (Subutex) is preferred if available; less-severe neonatal opioid withdrawal	Translactal passage: 1-20 % of the maternal weight adjusted dose (only absorbed sublingually and not orally) Breastfeeding is encouraged in substance-exposed newborns unless active substance use or risk of infection.

Treatments with Less Evidence for Use in Pregnancy

Gradual taper with medication (a.k.a. "detox")	Naltrexone
• Can be done using taper of methadone or buprenorphine • Emerging data for safety in pregnancy but still not standard treatment • High risk of relapse	• Reversible binding of opioid receptor antagonist with efficacy for alcohol and opioid use • Available as oral, daily medication (Revia), and IM monthly injection (Vivitrol) • Very limited and emerging data in pregnancy • Can complicate pain management • Requires 7-10 days of abstinence from all opioids prior to starting naltrexone

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