Emergency Department Methadone Initiation in Pregnancy

Additional Clinical Guidance

- Opioid use disorder (OUD) is a treatable health condition. It is best treated with methadone or buprenorphine.
- Buprenorphine and methadone are life-saving medications for OUD that reduce the risk of all-cause mortality and overdose death by over 50%.
- Recovery often requires multiple treatment attempts. A repeat encounter is not a treatment failure, but an opportunity to reinitiate potentially life-saving medication.
- If patients continue to use other opioids while on methadone or buprenorphine, a higher dose may be needed to manage their symptoms. Therapeutic dosing should be guided by adequate management of withdrawal and cravings.
- Opioid withdrawal is excruciating. Without swift and adequate intervention, patients may self-direct discharge and be at risk for overdose, pregnancy or delivery complications, harm to the fetus/newborn, and disruptions to the family system.
- The primary goal is to provide evidence-based, patient-centered care to perinatal patients with OUD, ensuring the safety and well-being of both patient and fetus/newborn. Medications for opioid use disorder (MOUD) enable stability, facilitate bonding, and support parental and infant health.
- Pregnant and parenting patients with OUD are highly stigmatized. Stigma prevents people from seeking care and worsens health outcomes. Providers should challenge biases to provide compassionate, evidence-based care.

Assessment

- Consider screening for sexually transmitted infections, including HIV, hepatitis C virus, syphilis, gonorrhea, and chlamydia. Consider linkage to PrEP as indicated.
- Consider screening for mental health comorbidities, including anxiety, depression, and post-traumatic stress disorder.

Labs

- Drug testing is not necessary to initiate treatment of OUD.
- If drug testing is performed for clinical reasons, obtain informed consent.
- In Washington State, drug use alone does not constitute a mandatory report to Child Protective Services (CPS).

Pharmacotherapy

- Methadone is safe and effective for MOUD during pregnancy and lactation.
- Dosing should be individualized based on the patient's needs and history of opioid use.
- Methadone can have significant drug-drug interactions, which should be reviewed prior to initiation.
- Later pregnancy and postpartum:
  - Methadone metabolizes faster later in pregnancy, requiring dose adjustments. Twice daily dosing is most effective during this time, and patients are likely to need higher doses.
  - Twice daily dosing may be beneficial postpartum as well, especially for the first several weeks. There is significant variability in when methadone metabolism returns to pre-pregnancy levels, typically over 2-12 weeks. There is no limit on the duration of split dosing. Encourage patients to talk to their OTP providers to determine the best dosing regimen for them.
- Monitor patients closely and adjust doses as needed to maintain therapeutic levels.
- Because methadone is a long-acting opioid with cumulative effects, dosing should begin low and be gradually up-titrated over days or weeks until an adequate dose is achieved. Patients commonly experience withdrawal and craving during this time and often benefit from adjunct medications.
- Patients may continue to use other opioids prior to reaching a therapeutic dose of methadone. Neither providers nor patients should judge the efficacy of methadone treatment until after the up-titration period.

Pathophysiology

- Methadone metabolizes faster later in pregnancy, requiring dose adjustments (e.g., increased dose, twice daily dosing).
- Patients with OUD have increased opioid tolerance and require higher doses of opioids for effective pain management when needed (e.g., during labor and delivery and postpartum).
- Perinatal patients with OUD are at increased risk for opioid overdose, particularly in the postpartum period, due to changes in opioid tolerance.
- Neonatal opioid withdrawal syndrome (NOWS), previously called neonatal abstinence syndrome (NAS), is an expected and treatable potential outcome for neonates exposed to opioids in utero. The risk of NOWS should not discourage MOUD. Higher doses do not increase the risk of neonatal opioid withdrawal.

Special populations

Patients under age 18 must have written parental consent to start methadone for OUD and should initiate at an opioid treatment program.

Polysubstance use

- Polysubstance use is never a contraindication for initiating methadone or buprenorphine.

Discharge planning

- Help the patient schedule a follow-up appointment with an OTP. Hospitals enrolled in ScalaNW can call the 24/7 appointment scheduling line and receive a confirmed date, time, and location for MOUD follow up appointment during the 10-minute phone call.
  - For hospitals not enrolled in ScalaNW, reference the **Washington State Opioid Treatment Program Guide** for OTP locations and contact information.
  - Ask the patient if they have previously been established with an OTP and where they would like to receive ongoing care.
  - Educate the patient on the expectation for daily dosing at an OTP. After some time, they will start to receive take-home doses. Ensure they understand methadone can only be obtained from an OTP and that they have a plan for how to attend appointments.
- Provide the OTP with documentation of the patient's methadone dose, including the date, time, and dosing regimen, if possible. Also give the patient a copy of this information to bring to their OTP appointment.
- **21 CFR 1306.07(b)** allows hospitals to discharge a patient with up to a 3-day supply of methadone to bridge the gap between discharge and outpatient care if they are referred to an OTP.
- Many patients need adjunct medications to control withdrawal symptoms until they stabilize on methadone. If needed, provide prescriptions for adjunct withdrawal management medications to cover at least 7 days.
- In Washington, emergency departments are required to dispense naloxone to patients with OUD or others who are at risk of opioid overdose, in compliance with SB5195. Ensure the patient is discharged with naloxone in hand.
- When possible, connect patients with supports such as social workers, care navigators, or peers to improve patient experience and strengthen linkage to care.

Patient Education

Educate the patient about:

- The need to slowly increase methadone dose. Advise patients not to judge its effectiveness until the appropriate dose has been reached.
- Adjunct medications may be required to control withdrawal symptoms. Remind patients that they will not be turned away from the OTP. Even if they use other drugs before their appointment, they can still attend and receive their scheduled dose of methadone.
- Methadone can cause respiratory depression when taken at high doses or combined with other sedatives. Instruct patients not to increase the use of other sedatives and not to drink more than their usual amount of alcohol while starting methadone.
- The importance of avoiding driving or operating machinery until they are accustomed to their medication. Provide work notes if needed.
- Breastfeeding is safe and encouraged when taking methadone, but discouraged with active, unregulated opioid use.
- Overdose prevention strategies. Ensure the patient and their support system understand when and how to use naloxone.
- The risks of change in use patterns, which can alter tolerance and increase risk of opioid overdose.