Methadone Initiation in Pregnancy

Flowchart

Pregnant patient has OUD, wants to start methadone

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Medical or social concerns? (see "Considerations")

— **YES** → **Use OUD in Pregnancy protocol**

↓ **NO**

Give methadone 30 mg PO and treat withdrawal symptoms as needed with adjunct medications

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Does the patient feel like they need more medication?

— **YES** → **Give methadone 10 mg 2 hours after the first dose and continue adjunct medications**

↓ **NO**

Confirm OTP follow up available within 24 hours or dispense methadone to bridge the gap

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Dispensation dose: 30 mg every 12 hours. At 30 mg twice daily, max dispensation dose would be 180 mg.

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Prescribe adjunct medications

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Discharge patient with naloxone, linkage to care within 72 hours, and harm reduction education
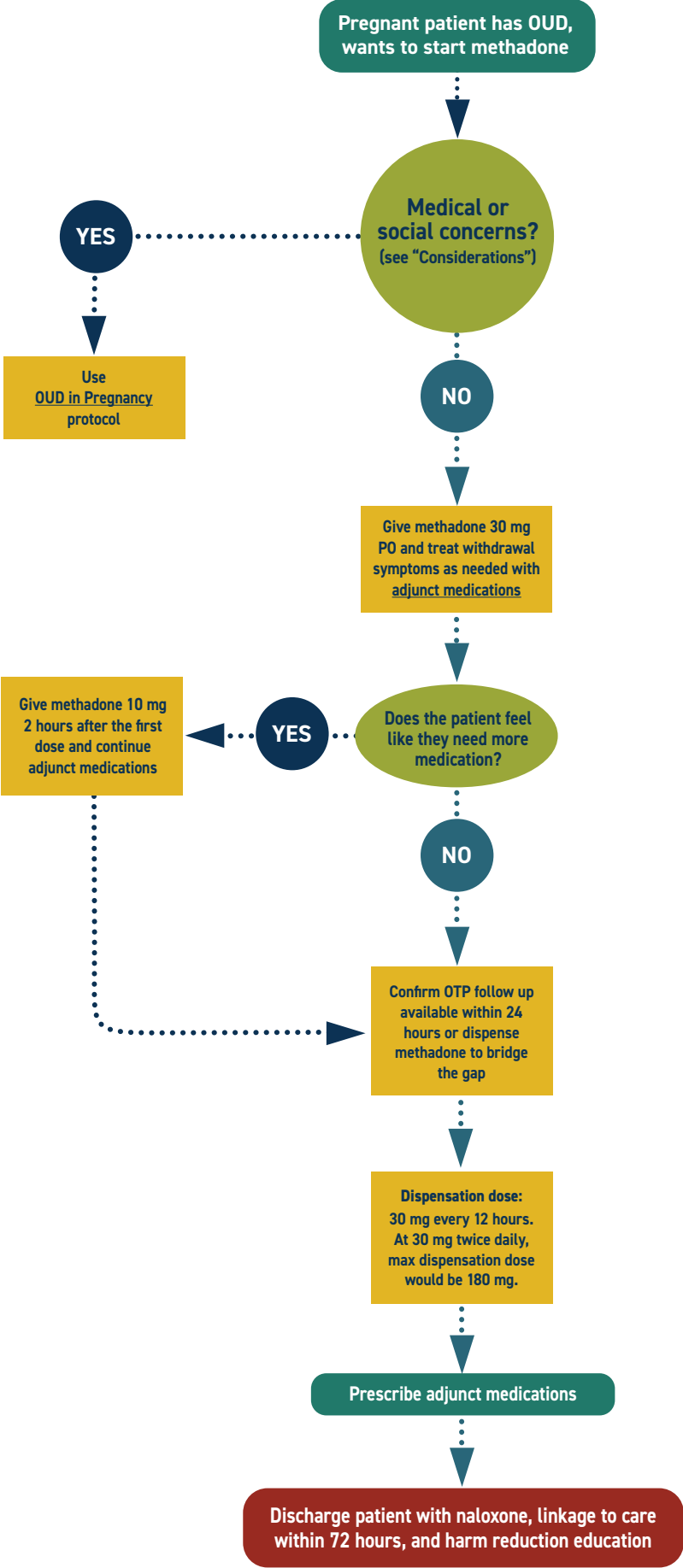
Methadone dispensation

Patient may be dispensed up to a 3-day supply of methadone to bridge the gap between discharge and follow up in accordance with 21 CFR 1306.07(b). Referral to Opioid Treatment Program (OTP) is required.

Considerations

- Severe respiratory compromise
- Concurrent sedative use
- Potential drug-drug interactions

Fentanyl use and fentanyl withdrawal in pregnancy is associated with a high risk of parental overdose death and preterm labor, in addition to other pregnancy and delivery related complications. Transition to MOUD greatly reduces these risks, is safer and more effective than withdrawal management ("detox"), and is recommended by the American College of Obstetricians and Gynecologists (ACOG).

Consider admission for all pregnant patients for the stabilization of high risk pregnancy. The physiological stress of pain and withdrawal is experienced by both the parent and fetus. Stabilization and treatment of withdrawal benefits both members of the dyad. Medicaid pays for medically necessary admissions.

Methadone is metabolized more quickly in pregnancy; patients will need twice daily dosing. Twice daily dosing may also be done postpartum if patient prefers. Methadone is safe for use in breastfeeding.

Check if the patient can reliably connect with an OTP. Consider how far it is, their transportation options, daily dosing requirements, and whether the OTP is accepting new patients. Make sure the patient understands how the OTP works and what to expect.

Don't start methadone unless the OTP can see the patient within 24 hours or there are available appointments or walk-in slots within 72 hours and your hospital has an established process for methadone dispensation.

Communicate with the OTP. At the very least, provide them with records of when and what dose of methadone was given to the patient.

Consider screening for HIV, HCV, STIs, and mental health comorbidities. Link to ongoing care as needed.

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