Checklist of Evidence-Based Recommendations for Caring for Pregnant Women with Opioid Use Disorder
The following checklist intends to support health care teams in providing evidence-based recommendations for treating pregnant and postpartum patients with OUD. The checklist is divided into five sections, sequenced by timing of presentation to care.

At first visit

Screening:

☐ Screen for substance use disorder (SUD) using 4 Ps or CRAFFT (in private). Inquire about ongoing polysubstance use especially nicotine, marijuana, alcohol (T-ACE), and stimulants.

☐ Use DSM-V to determine the presence of opioid use disorder (OUD) among other use disorders.

☐ Initiate buprenorphine based on diagnosis of OUD and patient consent for use during pregnancy. If the patient has had stable access to "street" buprenorphine, consider initiating at stated dose if less than 12 mgs. If induction required, follow this algorithm:

> **Day 1.** Confirm opioid withdrawal using COWS. If score is 13+, prescribe loading dose of 4mg, followed by 2mg every 4-6 hours as needed. If score is 5-12, prescribe loading dose of 2 mg, followed by 2mg every 4-6 hours as needed. No more than 12mg should be administered on Day 1. If score is less than 5, symptoms may be managed adequately with supportive care and clonidine 0.1mg orally every 4-6 hours.
>
> **Day 2.** Total dose from day 1 should be administered as a single morning dose. An additional 2-4 mg of buprenorphine may be administered every 4 to 6 hours as needed, up to 16 mg daily.
>
> **Day 3 and beyond.** Patient should continue on "Day 2" daily dose as one dose in the morning. Incremental daily adjustments can be made, but should typically not exceed 16 mg.

Review and sign:

☐ Related treatment contracts ☐ Expectations around drug screening/pill counts
☐ Mandated notification of substance exposed infants to Maine Office of Child and Family Services
☐ Extended infant hospital stay to monitor (Eat, Sleep, Console) for neonatal abstinence syndrome (min. 5 days).

☐ Screen for social determinant of health needs using the CMS HRSN tool. This screen includes questioning around intimate partner violence, which is common in women with OUD.

☐ Screen for co-occurring mental health disorders using PHQ-9 or other instruments including (CES-D), (MDQ), (EPDS)

☐ Screen for other substance use in home (it is common for partners to be using) and refer for treatment as appropriate.

☐ Review PMP. A reminder that methadone dispensed at facilities that treat OUD is not included in the PMP.

☐ If the patient is physically dependent on alcohol and/or benzodiazepines, consider medically supervised inpatient detox. Consider inpatient hospitalization with ongoing daily use of these substances and/or past history of withdrawal symptoms.

Labs:

☐ HIV ☐ Hepatitis C ☐ Sexually Transmitted Infections

Consider additional testing for TB, Hepatitis A and B depending upon individual risk factors (e.g., history of incarceration, recent history/ongoing intravenous drug use). Consider vaccination as appropriate for Hepatitis A and B.

Prescriptions:

☐ Narcan ☐ Buprenorphine (include diagnosis of pregnancy, OUD (F11.20) and, "Exemption D Chronic" on the prescription).

Either buprenorphine/naloxone or buprenorphine monotherapy can be used safely during pregnancy. The use of monotherapy requires a MaineCare prior authorization; combination therapy does not.

Monitoring at every visit:
☐ Screen for ongoing stability in substance use treatment and manage appropriately. Many pregnant patients require subtle buprenorphine dose increase (2-4 mgs total) during the second trimester. Counsel patients to report changes in withdrawal symptoms and/or cravings.
☐ Obtain drug screen at every appointment. Discuss unexpected results and/or any return to use.
☐ Screen for depression and mental health disorders (PHQ-9), (CES-D), (PCL-C), (MDQ), (EPDS). Monitor for stability if on pharmacologic agent (safest options in pregnancy include sertraline and bupropion) as appropriate. Encourage mental health counseling. Consider psychiatric referral as needed.
☐ Offer CradleME referral to WIC, Maine Families and Public Health Nurses
☐ Screen for intimate partner violence and review OCFS or Child Welfare referral and extended infant hospital stay at least once per trimester.
☐ Discuss postpartum contraception plans at least once per trimester. Long acting reversible contraception is standard of care for all women of childbearing age (Planned parenthood), (ACOG). If permanent sterilization desired, ensure related documents are signed as appropriate.
☐ Anatomy ultrasound at 18-20 weeks followed by monthly growth ultrasound every four weeks thereafter.

Before delivery:
☐ Rescreen Hepatitis C, HIV, and other labs as indicated by patient risk profile (e.g., ongoing drug use, multiple sexual partners). Hepatitis C viral loads are not necessary.

At delivery:
☐ Avoid stadol and nubain. ☐ Avoid fetal scalp electrodes if maternal Hepatitis C or HIV. ☐ Patients should be continued on buprenorphine throughout the delivery hospitalization (including during a planned cesarean section). Pain management options are discussed here (Maine Opioid Response Clinical Advisory Committee Recommendations for Perioperative Pain Management)
☐ Notify Maine Office of Child and Family Services if infant is born substance exposed (State regulations)

Postpartum:
☐ Screen for return to use, changes in mental health status
☐ Combination product should be used after deliver and is compatible with breastfeeding
☐ Discuss contraception
☐ Plan of Safe Care/CradleME
☐ Narcan prescription

Key provider and patient resources are available on the MaineCare MaineMOM Website:
https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/maine-maternal-opioid-model

These recommendations are intended to enhance your care and should not replace your own clinical judgement.
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