Frequently Asked Questions

Medications for Addiction Treatment: Pregnancy

Is buprenorphine (or buprenorphine/naloxone) safe during pregnancy?

Yes! It is safe to take either buprenorphine monoproduct or the buprenorphine/naloxone combo product during pregnancy.[1, 2, 3]

Is methadone safe during pregnancy?

Yes, methadone is a great option for treatment for opioid use disorder (OUD) in pregnant patients. Similarly to buprenorphine, patients may need to increase their maintenance methadone dose and frequency of dosing due to the increase in metabolism. Methadone has been used for more years and has higher retention in treatment, buprenorphine has less severe neonatal abstenance syndrome. Both are good options.[1, 2, 3]

Is detox (medical withdrawal) recommended for pregnant patients with OUD?

Detox, or medical withdrawal, is not recommended during pregnancy as recurrence rates are high and it is associated with worse outcomes.[1, 4, 5, 6]

Should I switch my pregnant patient from methadone to buprenorphine?

If your patient is stable and doing well on methadone, it is not recommended to switch to buprenorphine. There is increased risk of withdrawal and recurrence during the transition.[1]

Do pregnant patients need fetal monitoring or inpatient admission for a buprenorphine start?

Fetal monitoring or admission to the hospital are not required to start buprenorphine in a normal pregnancy regardless of gestational age.[1]

How do you dose buprenorphine during pregnancy?

Many patients will need to increase their dose of buprenorphine as they progress through their pregnancy due to increased metabolism and increased plasma volume. They may also need to split the dosing to BID, TID, or QID to help control cravings. The buprenorphine dose does not correlate to the severity or risk of neonatal abstinence syndrome (NAS), ie. higher buprenorphine doses do not increase risk or severity of NAS.[1]

How will buprenorphine affect the fetus?

Compared to methadone, buprenorphine will decrease neonatal abstinence syndrome (NAS), preterm delivery rate, increase birth weight and increase head circumference.[2, 3] Although this is favorable, methadone still has lower rates of preterm birth, increased birth weights, and increased head circumference when compared to no treatment for OUD and is therefore still a good option.[1]

How do you manage pain during labor/C-section?

You can use a multimodal approach to pain and make sure to have a plan with the patient during an antenatal visit to decrease stress and to address any concerns. Continue the patient's maintenance dose of buprenorphine. You can also utilize non-opioid analgesics, epidural, spinal anesthesia, etc. You can always add on full opioid agonists to help control their

pain in addition to their maintenance buprenorphine. Adding on full agonists to those already on buprenorphine will not precipitate withdrawal. Additionally, there is evidence that there is no interference with opioid requirements and no difference in postoperative complications or length of hospital stay for those taking buprenorphine for MOUD compared to methadone.7 You may notice needing higher doses of full agonists for patients on medications for opioid use disorder (MOUD) due to an increase in tolerance, but there is no increase in morbidity or mortality when compared to patients not on MOUD receiving full opioid agonists. Avoid using partial agonist/antagonist medications such as butorphanol, nalbuphine and pentazocine as it can precipitate withdrawal in patients on buprenorphine.[1,8,9]

Can patients breastfeed while taking buprenorphine or methadone?

Yes! It is safe for patients to breastfeed while taking buprenorphine, buprenorphine/naloxone, or methadone. Only negligible amounts are transmitted through breast milk and patients should be encouraged to breastfeed if there are no other contraindications.[1, 6, 10]

After delivery, when should patients go back to their pre-pregnancy dose of buprenorphine?

A gradual reduction postpartum should be based on the patient's cravings and side effects. It should not be rushed as there is a large range and variation (days versus months) of when patients need to return to their pre-pregnancy dose.[1]

What else should I think about postpartum?

There should be frequent check-ins with the patient as the risk of overdose and recurrence significantly increases postpartum. Patients should also be offered reliable contraception if they desire it and they should be screened for postpartum depression.[1,11]

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