1. **Background**

Opioid use disorder is a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences. Opioid use disorder is a chronic, treatable disease that can be managed successfully by combining medications with behavioral therapy and recovery support, which enables those with opioid use disorder to regain control of their health and their lives.

Opioid use in pregnancy is associated with increased risk of preterm delivery, intrauterine growth restriction, neonatal abstinence syndrome, and sudden infant death syndrome. Pregnant women with opioid addiction are at increased risk for delayed prenatal care and many do not disclose their addiction history. Treatment with an opioid-agonist proves pregnancy outcomes for people with Opioid Use Disorder (OUD). The best perinatal and neonatal outcomes are observed when women are enrolled in a comprehensive treatment program. The overarching goals of therapy for opioid dependence during pregnancy are to provide medical support to prevent withdrawal during pregnancy, minimize fetal exposure to illicit substances, and engage the mother as a leader in her recovery. Such engagement provides her the opportunity to receive both medical and ancillary services which will allow her to successfully parent her child. Adequate doses of MAT are encouraged. The risk of serious adverse effects such as an overdose or treatment dropout is greater if a Customer Owner is undertreated with buprenorphine and continues to self-medicate withdrawal symptoms with opioids, alcohol, or other sedative-hypnotics, in particular benzodiazepines.

Office-based therapy during pregnancy favors the Customer Owner that is highly motivated to recovery and parenting. Many women usually agree to substance abuse counseling and the assistance of community resources to aid in the recovery process. Customer Owners unwilling to engage in these services may still be candidates for MAT office-based therapy using a harm reduction model. Inclusion of substance abuse counseling and wrap around services should be strongly encouraged for all Customer Owners, as medication alone may be insufficient for optimal pregnancy and parenting outcomes. Transition planning of MAT care to a primary care provider for post pregnancy should begin at the time of initiation of perinatal MAT care to aid the transition of care when the Customer Owner is greater than eight weeks postpartum. In selected cases, home induction of buprenorphine may be considered by the provider (see Appendix E for Education Tools).

2. **Screening and Diagnosis**

2.1. **Universal Screening** for substance use should be part of comprehensive obstetric care and should be done at the first prenatal or transfer visit in partnership with the pregnant woman. Routine screening should rely on a validated tool, such as 4Ps Plus and SBIRT. Any positive screen should be referred to the OBGYN BHC for further evaluation of motivation to initiate MAT.

2.2. The diagnosis of OUD should be confirmed by DSM-5 criteria (Appendix B), and by urine drug testing. An in-house substance screen is adequate for initiation while advanced toxicology screen is pending. Opioid dependence may also be documented by the presence of opioid withdrawal symptoms, based on the Clinical Opiate Withdrawal Scale, or COWS.

2.3 Diagnosis of pregnancy with a positive HCG in clinic should be obtained prior to initiation of buprenorphine if not previously obtained. Confirmation of viability is not necessary prior to initiation.
2.4 An inventory of past and current substance use and past OUD treatment should be collected.

2.5 A query of the Alaska Prescription Drug Monitoring Program to assess prescription opioid use is recommended.

2.6 Psychiatric co-morbidities (especially depression, anxiety disorders, and PTSD) are common, and need to be evaluated. An assessment of social and environmental factors by the Behavioral Health Consultant should be conducted to identify facilitators and barriers to addiction treatment, and specifically to pharmacotherapy.

2.7 A physical examination should be completed, with attention to potential sequelae of substance use.

2.8 The following laboratory tests may be obtained: Complete Blood Count, Complete Metabolic Profile, Hepatitis A, B, and C, HIV, Syphilis, Gonorrhea, Chlamydia, Trichomonas, Full High Risk Utox from Millenium Lab and PPD placement.

2.9 Anyone with a substance use disorder or living with someone with a substance use disorder should be prescribed naloxone in case of overdose.

2.10 Supportive pharmacological methods can be prescribed in pregnancy to help with some symptoms associated with withdrawal and Medication Assisted Therapy. The use of these medications concurrently can help the customer owner achieve maintenance on the lowest dose possible. These medications include:

2.10.1 Anxiety/Irritability/Restlessness:
   - Diphenhydramine 50-100 mg po q 4 hours prn (maximum 300 mg daily)
   - Hydroxyzine 25-100 mg po q 6-8 hours prn (maximum 400 mg daily)

2.10.2 Diarrhea:
   - Loperamide 4 mg po then 2 mg po p each loose stool (maximum 16 mg daily)

2.10.3 Nausea/Vomiting:
   - Ondansetron 4-8 mg po or IV every 12 hours as needed (maximum 16 mg daily)
   - Promethazine 25 mg po q 4-6 hours prn (maximum 50 mg po daily)

2.10.4 Insomnia/Pain/Muscle Spasm:
   - Trazadone 25-100 mg po q HS
   - Hydroxyzine 25-100 mg po q HS
   - Zolpidem 5 – 10 mg po q HS

2.10.4 Muscle Aches/Joint Pain/Headache:
   - Acetaminophen 650-1000 mg po q 4-6 hours prn (maximum 4000 mg daily)
2.10.5 Muscle Spasm/Restless Legs:
Cyclobenzaprine 5-10 mg po q 8 hours prn (maximum 30 mg daily)

3. Management of OUD with Buprenorphine-Naloxone

3.2 Initially, Customer Owners should be seen frequently while induction is being completed, from daily to every 2-3 days. Then weekly visits until they are well stabilized. Once well stabilized, frequency will be determined by the provider and Customer Owner.

3.3 Consideration for alternatives to Office-Based Inductions for:

3.3.1 Women with acute medical or surgical illness

3.3.2 Complicated obstetric co-morbidities

3.3.3 Customer Owner requests admission

3.3 Considerations for Buprenorphine

3.3.1 Women with polysubstance abuse may be initiated on buprenorphine if the provider believes that the patient has a good likelihood of abstinence from other substances (ie: alcohol, cocaine, methamphetamine) once on opioid replacement therapy. This is often a subjective decision, which can be based on initial interview, past history and substance abuse review and conversations with substance abuse counselor if already engaged.

3.3.2 It is important to discuss the dangers of using benzodiazepines when taking buprenorphine with Customer Owners. Overdose deaths have occurred when buprenorphine and benzodiazepines were concomitantly abused. The customer owner should also be informed of the risk of using alcohol and buprenorphine.

3.3.3 Chronic active hepatitis with laboratory evidence of significant liver damage is not an absolute contraindication, but the provider may need to consider MAT induction using monoprodut (buprenorphine alone/Subutex) and/or maintenance with the monoprodut at lower doses and with closer monitoring.

3.4 Guidelines for MAT Induction of the Pregnant Customer Owner

3.4.1 Instruct Customer Owner to withhold using any opioids prior to induction day in order to precipitate mild to moderate withdrawal symptoms. This period will vary by Customer Owner based on a number of factors. These include the Customer Owner’s level of tolerance and the dose of substance that they use. In general, this should take 12-16 hours for short-acting opioids (heroin, hydrocodone, oxycodone-immediate release, morphine), 17-24 hours for intermediate-acting opioids (oxycodone-sustained release, oxycontin), and 30-48 hours, or longer, for long-acting opioids such as methadone. The longer one can hold off on giving the first dose of buprenorphine, the easier the induction will be. Consider giving the Customer Owner a copy of the COWS score.

3.4.2 Review and sign INFORMED CONSENT AND TREATMENT AGREEMENT FORM (Appendix C).

3.4.2.1 DAY ONE
3.4.2.1.1 Instruct Customer Owner on how to take a sublingual tablet or film and review the Customer Owner information about induction.

3.4.2.1.2 Assess for signs of opiate withdrawal and obtain COWS score. This COWS assessment can be performed by the RN Case Manager COWS score >8 will indicate mild withdrawal. (Note: Customer Owners with low opioid dependence may never reach COWS score of 8 or higher).

3.4.2.1.3 Administer Customer Owner’s first dose, 2-4 mg of buprenorphine-naloxone sublingual. Withdrawal symptoms may or may not be improved with the first dose, depending on their degree of dependence, and are often not alleviated or improved at all if given 2 mg dose. Significant symptom improvement often does not occur until about 40 minutes following the first dose of the opioid agonist.

3.4.2.1.4 Withdrawal should be assessed every 60 minutes after the first dose with the COWS. If she does not have worsening withdrawal, but still has existing withdrawal symptoms, she should receive an additional 2 or 4 mg SL. Once there are no signs of withdrawal after these doses, then the Customer Owner may leave with an additional 2 or 4 mg dose. Most will respond well with doses of 16 mg or less. The provider will communicate to CO that our daily maximum dose is 24 mg SL daily. If symptoms of withdrawal still exist or the CO has chronic pain requests, consider other settings for MAT including residential, Detox, or methadone outpatient.

3.4.2.1.5 Due to increased metabolic rate in pregnancy, twice a day dosing or “split-dosing” can sometimes be more effective than once a day dosing in pregnant Customer Owners. Use caution to avoid the customer owner from getting a positive response instead of the desired elimination of withdrawal symptoms. Customer Owner should be cautioned about taking buprenorphine-naloxone on an as needed basis which reinforces addiction behavior. Prior to initiating split dosing, increase the daily dose to achieve absence of withdrawal symptoms in the 24-hour period.

3.4.2.2 DAY TWO or THREE

3.4.2.2.1 Assess Customer Owner’s response to first day’s dosing.

3.4.2.2.2 Assess vital signs and signs of withdrawal and obtain COWS score.

3.4.2.2.3 If opioid withdrawal symptoms were fully suppressed and Customer Owner is feeling no withdrawal or cravings between doses, then keep dose at first day’s total dose. Otherwise increase the dose by 2 or 4 mg on day 2.
3.4.2.3 AFTER INDUCTION

3.4.2.3.1 Once the Customer Owner is stable, continue that dose for 3-7 days until steady-state levels are achieved before increasing the dose further. Doses should be decreased by 2 mg at a time if the Customer Owner experiences intoxication (not withdrawal effects).

3.4.3 Post Induction Surveillance

3.4.3.1 After induction, the Customer Owner should be seen at least weekly by both the provider and the BHC.

3.4.3.2 Assess for any illicit substances by the Customer Owner's report and urine drug testing

3.4.3.3 Assess for use of sedative hypnotic drugs (e.g. benzodiazepines) or heavy alcohol

3.4.3.4 Query of the Prescription Drug Monitoring Program (PDMP) reveals no unexplained, unadmitted, or otherwise concerning findings.

3.4.3.5 Assess whether the Customer Owner is taking buprenorphine as directed, with no requests for early refills, lost/stolen prescriptions, etc. and whether drug craving is under reasonable control.

3.5 Maintenance of Medication-Assisted Treatment during Pregnancy

3.5.1 The goals of maintenance are to prevent the emergence of opioid withdrawal symptoms, suppress the Customer Owner's craving for opioids, and greatly attenuate the effect of self-administered opioids in Customer Owners who continue to episodically use illicit opioids.

3.5.2 Maintenance doses can usually be determined by 7 days post induction. Most Customer Owners can be stabilized on a dose between 8 mg and 16 mg/24 hours (in QD or BID dosing). If the customer owner requires a dose higher than 24 mg daily, consider residential treatment or treatment with outpatient methadone. The Addiction Medicine Physician with Four Directions may be consulted with OB providers over the phone as well as accept a referral for continued MAT care. (See Appendix G).

3.5.3 The prescribing provider, BHC, and Customer Owner will agree on frequency of visits to monitor MAT. Initially, the Customer Owner should be seen every 2-3 days for the first two weeks and then weekly if indicated.

3.5.4 At each visit, effective dosing should be assessed and monitored.

3.5.5 Doses should be titrated according to regular review of the following clinical signs/symptoms:

3.5.5.1 Intoxication, withdrawal, and cravings over the past 24 hours
3.5.5.2 Additional drug use and the Customer Owner’s reason for use of illicit street drugs or prescription opioids

3.5.5.3 Side effects or other adverse events

3.5.5.4 Adherence to dosing regimen

3.5.5.5 Customer Owner’s expressed satisfaction

3.5.6 The Community Resource Specialist and the Behavioral Health Consultant will be utilized to see the Customer Owner at each appointment to assess social needs, motivation for recovery, and ongoing support of recovery efforts and plan.

4. Intrapartum and Postpartum Medication-Assisted Treatment

4.1 Methadone, buprenorphine/buprenorphine-naloxone should be continued during antepartum, intrapartum, and postpartum care.

4.2 Be aware of the Customer Owner’s usual dose and schedule and try to maintain. (However, withdrawal is unlikely if the Customer Owner is receiving opioids for pain control.)

4.3 Fentanyl may be used for analgesia, but higher and more frequent dosing may be required.

4.4 Epidurals and nitrous oxide are preferred for pain management.

4.5 Stadol (Butorphanol) should be avoided. It is a partial narcotic antagonist which may precipitate withdrawal.

4.6 Expect decreased Fetal Heart Rate variability and fewer accelerations.

4.7 Naloxone (Narcan) may be used as a life-saving measure in the mother. Opioid withdrawal seizures may occur if used during infant resuscitation.

4.8 A urine drug screen should be ordered to confirm the absence of other drugs that may affect management.

4.9 Maximize non-opioid options such as Ibuprofen, Acetaminophen, non-opioid patches, etc. Use 0.5-4mg buprenorphine q4-8hr for pain, total daily dosing not to exceed 24mg in 24-hour period. Conversion equivalent is 10mg PO morphine to 1mg SL buprenorphine, (ie: 30mg PO morphine equates to 3mg SL buprenorphine). Lortab or Percocet may be used while on buprenorphine with close attention to the acetaminophen cumulative dose. Providers are encouraged to use the smallest amount of narcotics upon discharge and arrange daily follow up contact either in clinic or by phone. Please see SCF MAT Guideline for additional resources.

4.10 Breastfeeding should be encouraged in women who are stable on their opioid agonists, without using illicit drugs for at least 90 days. If they are stable with their treatment without relapse for 30-90 days the recommendation for breastfeeding should be made on a case by case basis factoring in their likelihood for relapse into illicit drug use. The amount of buprenorphine in human milk is small and unlikely to have short-term negative effects on the developing infant. Breastfed infants have less severe NAS and are less likely to require pharmacological
intervention than the formula-fed infants. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.

4.11 The neonate may need to stay at least 72 hours. During the time from the mother’s discharge to the baby’s discharge, the Customer Owner should have their own buprenorphine or methadone to take. Rooming in with newborn is encouraged.

4.12 Access to adequate postpartum psychosocial support services, including substance use disorder treatment and relapse prevention programs, should be made available.

4.14 Contraceptive counseling and access to contraceptive services should be a routine part of substance use disorder treatment among women of reproductive age to minimize the risk of unplanned pregnancy.

References:


American Society of Addiction Medicine. Public policy statement on office-based opioid agonist treatment. [https://www.asam.org/docs/default-source/public-policy-statements/1obot-treatment-7-04.pdf?sfvrsn=6ecf77e3_0](https://www.asam.org/docs/default-source/public-policy-statements/1obot-treatment-7-04.pdf?sfvrsn=6ecf77e3_0)
APPENDIX A

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the Customer Owner’s signs or symptom. Rate on the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the Customer Owner was jogging just prior to assessment, the increased pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Customer Owner’s Name: __________________________</th>
<th>Date and Time <strong>/</strong>/<strong><strong>:</strong></strong>___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for this assessment: ____________________</td>
<td>GI Upset: over last ½ hour</td>
</tr>
<tr>
<td>Resting Pulse Rate: ___ beats/minute</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>Measured after Customer Owner is sitting or lying for one minute</td>
<td></td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>5 Multiple episodes of diarrhea or vomiting</td>
</tr>
<tr>
<td>Sweating: over past ½ hour not accounted for by room temperature or Customer Owner activity.</td>
<td></td>
</tr>
<tr>
<td>0 no report of chills or flushing</td>
<td>Tremor observation of outstretched hands</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>0 No tremor</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td>4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td>Restlessness Observation during assessment</td>
<td></td>
</tr>
<tr>
<td>0 able to sit still</td>
<td>Yawning Observation during assessment</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td>0 no yawning</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>5 Unable to sit still for more than a few seconds</td>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>Pupil size</td>
<td></td>
</tr>
<tr>
<td>0 pupils pinned or normal size for room light</td>
<td>4 yawning several times/minute</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
<td></td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
<td></td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
<td></td>
</tr>
<tr>
<td>Bone or Joint aches If Customer Owner was having pain previously, only the additional component attributed to opiates withdrawal is scored</td>
<td></td>
</tr>
<tr>
<td>0 not present</td>
<td></td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
<td></td>
</tr>
<tr>
<td>2 Customer Owner reports severe diffuse aching of joints/muscles</td>
<td></td>
</tr>
<tr>
<td>4 Customer Owner is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
</tr>
<tr>
<td>Runny nose or tearing Not accounted for by cold symptoms or allergies</td>
<td></td>
</tr>
<tr>
<td>0 not present</td>
<td>Gooseflesh skin</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td>5 prominent piloerection</td>
</tr>
<tr>
<td>Anxiety or Irritability</td>
<td></td>
</tr>
<tr>
<td>0 none</td>
<td></td>
</tr>
<tr>
<td>1 Customer Owner reports increasing irritability or anxiousness</td>
<td></td>
</tr>
<tr>
<td>2 Customer Owner obviously irritable anxious</td>
<td></td>
</tr>
<tr>
<td>4 Customer Owner so irritable or anxious that participation in the assessment is difficult</td>
<td></td>
</tr>
</tbody>
</table>

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Total Score _______

The total score is the sum of all 11 items

Initials of person completing Assessment: ___________
APPENDIX B

DSM-V OPIOID USE DISORDER CRITERIA

Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)

Opioid use disorder is defined as two or more of the following within a 12-month period:

- Using larger amounts of opioids or over a longer period than was intended
- Persistent desire to cut down or unsuccessful efforts to control use
- Great deal of time spent obtaining, using, or recovering from use
- Craving, or a strong desire or urge to use substance
- Failure to fulfill major role obligations at work, school, or home due to recurrent opioid use
- Continued use despite recurrent or persistent social or interpersonal problems caused or exacerbated by opioid use
- Giving up or reducing social, occupational, or recreational activities due to opioid use
- Recurrent opioid use in physically hazardous situations
- Continued opioid use despite physical or psychological problems caused or exacerbated by its use
- Tolerance (marked increase in amount; marked decrease in effect)
- Withdrawal syndrome as manifested by cessation of opioids or use of opioids (or a closely related substance) to relieve or avoid withdrawal symptoms.
- Tolerance and withdrawal criteria are not considered to be met for those taking opioids solely under appropriate medical supervision.
- Severity of opioid use disorder is categorized as mild (presence of 2-3 symptoms), moderate (4-5 symptoms), or severe (6 or more symptoms).
- Remission of opioid use disorder is categorized as:
  - In early remission: where none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception of craving, or a strong desire or urge to use opioids), but full criteria for opioid use disorder were previously met.
  - In sustained remission: where none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception of craving, or a strong desire or urge to use opioids), but full criteria for opioid use disorder were previously met.
APPENDIX C

**Suboxone or Subutex Treatment Agreement**

I, (name of patient) ________________________________, DOB: ______________, have been advised of the risks and benefits of the use of Suboxone or Subutex in the treatment of opioid abuse and dependence. I freely and voluntarily agree to accept this treatment agreement as follows:

1) I agree to keep, and be on time to, all my scheduled appointments with the physician and/or treatment team. I agree to call the OB provider team if I am running late for any reason.

2) I agree to conduct myself in a courteous manner in the treatment setting.

3) I agree not to arrive at the office intoxicated or under the significant influence of drugs or alcohol. If I do, I will not be given a prescription.

4) I agree not to sell, share, give, or steal any medication from another individual. I understand that such mishandling of my medication is a serious violation of this agreement.

5) I agree that my medications (or prescriptions) can be given to me only at my regularly scheduled appointments. Any missed appointments may result in my not being able to receive medications until my next scheduled appointment.

6) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place, especially away from children. I agree that lost or stolen medication will not be replaced regardless of the reasons for such loss.

7) I agree not to obtain any controlled substances from any physician, pharmacy, or other source without informing my OB provider team. I understand that mixing Suboxone or Subutex with other medications, especially benzodiazepines such as diazepam/Valium, lorazepam/Ativan, alprazolam/Xanax, and other drugs of abuse can be lethal. I also understand that a number of deaths have been reported among individuals mixing Suboxone or Subutex with alcohol.

8) I agree to take my medication as the OB provider has instructed and not to alter the way I take my medications without first consulting with my provider.

9) I understand that medication alone is not sufficient treatment for opioid dependence, and I agree to participate in the treatment plan as agreed upon with the treatment team.

10) I agree to abstain from alcohol, opioids, benzodiazepines, marijuana, stimulants such as methamphetamine and cocaine, and other addictive substances (with the exception of nicotine and caffeine only).
11) I agree to return all phone calls as soon as possible, no later than 24 hours from the time that I am called.

12) I agree to complete random urine drug/alcohol screens as requested by the treatment team and within 24 hours of being called.

13) I agree to complete random pill or strip counts as requested by the treatment team and within 24 hours of being called.

14) I understand that if I am unable to consistently work together with the OB provider team to meet the above components of this Treatment Agreement, then I may require increased support such as: more frequent visits or increased peer-support meeting attendance, referral to a higher level of care such as outpatient, intensive outpatient, or residential treatment, referral to a more regimented suboxone program, referral to a methadone program, or other changes in my treatment plan.

Patient signature: _____________________________ Date: ____________
Appendix D

OBGYN MAT Program Diversion Control Plan

1. The Customer Owner will be given an opportunity to review the Treatment Agreement Plan and agree to, and sign outlining appropriate and inappropriate usages of buprenorphine before treatment with buprenorphine will be started.

2. The Customer Owner will have urine drug screens at least every 2 weeks for the first 2 months of treatment and at least monthly thereafter and a urine drug screen specifically testing for norbuprenorphine at least every 3 months.

3. The Customer Owner will not be provided more than 1 week worth of medication at a time for the first month of treatment and no more than 2 weeks’ worth of medication at a time for the next month, then no more than 1 month worth of medication at a time afterward, unless there are extenuating circumstances decided individually by the prescribing physician.

4. The Customer Owner will be required to keep their medication in a secure, locked location as a prerequisite to buprenorphine MAT being initiated.

5. The Alaska PDMP will be checked prior to any new or refilled prescription being given to the Customer Owner to ensure that no other narcotic prescriptions have been given out by any other source. If the Customer Owner violates this rule, the prescribing provider will determine appropriate consequences.

6. If the Customer Owner is found to be distributing, selling, or otherwise taking their medication in an unapproved manner, there will be an escalation in treatment that may include any of the following: turning in all used film wrappers, observed dosings, increased frequency of visits, shorter prescriptions, increase in random UDS/film/pill counts, increase in psychosocial treatment requirements, referral to a higher level of care.

7. The Customer Owner will not routinely be given any early refills for “lost”, “stolen” or otherwise missing medication.

8. The Customer Owner will be subject to random medication counts and random call backs for medication counts and/or urine drug screens at the discretion of the prescribing provider at any time during their treatment. If repetitively found in violation, see #6 above for change in treatment options.

9. Any leftover medication resulting from changes in dosing or discontinuation of treatment shall be promptly brought by the Customer Owner directly to the clinic for appropriate disposal in provided medication disposal bags.
If you develop worsening symptoms while starting buprenorphine before your next scheduled outpatient
DO NOT mix buprenorphine with alcohol, anticholinergics – such as Xanax, Valium or Valium – or other sedatives.

Step 1
Take the first dose.

Step 2
Wait 2 hours after the first dose.

Step 3
Wait 2 hours.

Step 4
Stop

Most people feel better the first day after 8.75 mg
Dosage depends on how early on the first day you start

4.75 mg of buprenorphine

Day 1

Day 2

Day 3

Day 4

Most people feel better after 72 hours.

Dosage needs to be adjusted to start the medication.

Talk to your provider if feeling 4.7 mg when you should be taking 8.75 mg.

2 hours after you swallow these pills:

2 hours after you used buprenorphine:

You should feel at least:

Customer-Delivered Guide for Beginning Buprenorphine Treatment

Before you begin you want to feel very sick from your withdrawal symptoms:

It should be at least:

APPENDIX E
Education Tools for Home Inductions

06/2020

ANMC OB/GYN Service Medication Assisted Treatment in Pregnancy and Postpartum Initiation and Management Guidelines
Suboxone® (buprenorphine/naloxone) – Beginning Treatment

DAY ONE:

WAIT at least 12 hours since using heroin or pain pills
WAIT at least 48 hours since using methadone

Before taking Suboxone, you need to feel lousy from your withdrawal symptoms. Very lousy.

You should have at least 3 of the following feelings:

- Twitching, tremors, shaking
- Joint and bone aches
- Chills or sweating
- Anxious or irritable
- Goose bumps/goose pimples
- Very restless, can’t sit still
- Heavy yawning
- Enlarged pupils
- Runny nose, tears in eyes
- Stomach cramps, nausea, vomiting, diarrhea

Wait as long as you can. The worse you feel when you begin the medication, the better it will make you feel and the more satisfied you will be with the whole experience.

FIRST DOSE: 4 mg of Suboxone under the tongue.

Keep it there. If you swallow the films, they will not work. The medication is best absorbed through the thin skin on the bottom of your tongue.

ALWAYS check dose on your strip package to make sure taking correct amount

IF it is an 8 mg strip, cut in half to get 4 mg.

IF it is a 2 mg strip, take two, to get 4 mg.

plus

It takes 20-45 minutes to start working. Feel better? Good, the medicine is working. Still feel lousy after 45 minutes? Don’t worry, you just need more medication.
Suboxone® (buprenorphine/naloxone) – Beginning Treatment

DAY ONE (Continued)

At 1-3 hours (60-180 minutes), see how you feel.

If you feel fine, \(\text{WAIT,} \) don’t take anymore.

If you feel withdrawal feelings, \(\text{take another } \frac{1}{4} \text{ mg dose under your tongue.}\)

At 6-12 hours, see how you feel again.

If you feel fine, \(\text{WAIT,} \) don’t take anymore.

If you feel withdrawal feelings, \(\text{take another } \frac{1}{4} \text{ mg dose under your tongue.}\)

Most people feel better after the 4-12 mg on the first day. **DO NOT TAKE MORE THAN 12 mg of SUBOXONE ON THE FIRST DAY,** unless directed by your provider.

If you still feel bad, like a bad withdrawal, call your provider right away. \(\text{Call anytime you are having difficulty.}\)

It’s important to track your doses, you will need this information for Day Two.

<table>
<thead>
<tr>
<th>Day One Summary</th>
<th>Time ⏰</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Dose</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>2nd Dose (if needed)</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>3rd Dose (if needed)</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>Total mg taken on Day One =</td>
<td></td>
<td>mg</td>
</tr>
</tbody>
</table>
DAY TWO:
The right dose depends on how you felt on Day One.

When you wake up, see how you’re feeling.

If you feel fine, take the total mg taken on Day One (see previous page). This will be your new daily dose.

If you feel withdrawal feelings, take an additional ¼ mg dose under your tongue.

At 1-3 hours (60-180 minutes), see how you feel.

If you feel fine, WAIT, don’t take anymore.

If you feel withdrawal feelings, take another ¼ mg dose under your tongue.

If you still feel bad, like a bad withdrawal, call your provider right away. Call anytime you are having difficulty.

It’s important to track your doses, you will need this information for Day Three.

<table>
<thead>
<tr>
<th>Day Two Summary</th>
<th>Time</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Dose</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>2nd Dose (if needed)</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>Total mg taken on Day Two=</td>
<td></td>
<td>mg</td>
</tr>
</tbody>
</table>
**Suboxone® (buprenorphine/naloxone) – Beginning Treatment**

**DAY THREE:**

The right dose depends on how you felt on Day Two.

When you wake up, see how you’re feeling.

If you feel fine, take the total mg taken on Day Two (see previous page). This will be your new daily dose.

If you feel groggy or sedated, take 2 to 4 mg less than yesterday.

If you feel withdrawal feelings, take the total mg taken on Day Two (see previous page). WAIT 1-3 hours to see how you feel.

At 1-3 hours (60-180 minutes), see how you feel.

If you feel fine, WAIT, don’t take anymore.

If you feel withdrawal feelings, take another 4 mg dose under your tongue.

If you still feel bad, like a bad withdrawal, call your provider right away. Call anytime you are having difficulty.

It’s important to track your doses, you will need this information for Day Three.

<table>
<thead>
<tr>
<th>Day Three Summary</th>
<th>Time</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Dose</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>2nd Dose (if needed)</td>
<td></td>
<td>mg</td>
</tr>
<tr>
<td>Total mg taken on Day Three =</td>
<td></td>
<td>mg</td>
</tr>
</tbody>
</table>

← This your new daily dose.

**Day Four and Beyond**

On Day Four and beyond, take the same mg dose as you took on Day Three. You can take more or less mg depending on how you feel overall. Discuss any dose adjustments with your provider.

** NEVER take more than 24 mg of buprenorphine in one day **

** Come back to your next clinic appointment. **
Buprenorphine/Naloxone Home Dosage Schedule: Films or Tablets

Name: ___________________________ Date: ___________________________

Procedure for taking buprenorphine:
- Let the medication dissolve under your tongue for at least 10 minutes. Do not suck on it.*
- Do not eat, drink, or smoke cigarettes for 30 minutes after you take your medication.
- Wait 2 hours between each dose.

The maximum dose is 16 mg/4 mg. If you reach this dose, you cannot increase further without calling the office first.
The office phone number is ___________________________ [insert phone number].

Day 1 Induction Day (In Office): You have taken a total dose of _____ mg.

Day 2 in the Morning: Take the total dose you took on Day 1 = _____ mg.
- If you experience withdrawal 2 hours later, you may take one 2 mg/0.5 mg film or tablet.
- Record your withdrawal symptoms:
- If you continue to experience withdrawal 2 hours later, you may take one more 2 mg/0.5 mg film or tablet.
- Record your withdrawal symptoms:
Your total dose on Day 2 cannot exceed _____ mg. Record your total dose on Day 2: _____ mg.

Day 3 in the Morning: Take the total dose you took on Day 2 = _____ mg.
- If you experience withdrawal 2 hours later, you may take one more 2 mg/0.5 mg film or tablet.
- Record your withdrawal symptoms:
- If you continue to experience withdrawal 2 hours later, you may take one more 2 mg/0.5 mg film or tablet.
- Record your withdrawal symptoms:
Your total dose on Day 3 cannot exceed _____ mg. Record your total dose on Day 3: _____ mg.

Day 4 in the Morning: Take the total dose you took on Day 3 = _____ mg.
- If you experience withdrawal 2 hours later, you may take one more 2 mg/0.5 mg film or tablet.
- Record your withdrawal symptoms:
- If you continue to experience withdrawal 2 hours later, you may take one more 2 mg/0.5 mg film or tablet.
- Record your withdrawal symptoms:
Your total dose on Day 4 cannot exceed _____ mg. Record your total dose on Day 4: _____ mg.

Day 5 to next visit: In the morning, take the total dose you took on Day 4 = _____ mg.

General Rules
- The maximum dose is 16 mg/4 mg. If you reach this dose, you cannot increase further without calling the office first.
The office phone number is ___________________________ [insert phone number].
- Please call if you have any questions. There are no “stupid” questions.
- Call us if you feel sleepy after your dose.
- Please bring this record to your next visit.
- It’s okay to take Tylenol (acetaminophen) or Motrin (ibuprofen) for aches/pains.

BRING THIS WITH YOU TO YOUR NEXT APPOINTMENT, scheduled for ___________________________ [insert date and time].

Notes:

*If prescribing the buccal film, ensure the patient understands that the buccal film is placed on the inner cheek (buccal mucosa) rather than sublingually (under the tongue).
FREQUENTLY ASKED QUESTIONS – CUSTOMER-OWNERS

SUBOXONE® (buprenorphine/naloxone) Sublingual Film

1. Why do I have to feel sick to start the medication for it to work best?

When you take your first dose of SUBOXONE, if you already have high levels of another opioid in your system, the SUBOXONE will compete with those opioid molecules and replace them at the receptor sites. Because SUBOXONE has milder opioid effects than full agonist opioids, you may go into a rapid opioid withdrawal and feel sick, a condition which is called “precipitated withdrawal.”

By already being in mild to moderate withdrawal when you take your first dose of SUBOXONE, the medication will make you feel noticeably better, not worse.

2. How does SUBOXONE work?

SUBOXONE binds to the same receptors as other opioid drugs. It mimics the effects of other opioids by alleviating cravings and withdrawal symptoms. This allows you to address the psychosocial reasons behind your opioid use.

3. When will I start to feel better?

Most customer-owners feel a measurable improvement by 30 minutes, with the full effects clearly noticeable after about 1 hour.

4. How long will SUBOXONE last?

After the first hour, many people say they feel pretty good for most of the day. Responses to SUBOXONE will vary based on factors such as tolerance and metabolism, so each customer-owners dosing is individualized. Your provider may increase your dose of SUBOXONE during the first week to help you from feeling sick.

5. Is it important to take my medication at the same time each day?

In order to make sure that you do not get sick, it is important to take your medication at the same time every day.

6. If I have more than one sublingual film, do I need to take them together at the same time?

Yes and no – you do need to take your dose at one “sitting,” but you do not necessarily need to fit all sublingual films under your tongue simultaneously. Some people prefer to take their sublingual film this way because it’s faster, but this may not be what works best for you. The most important thing is to be
sure to take the full daily dose you were prescribed, so that your body maintains constant levels of SUBOXONE.

7. Why does SUBOXONE need to be placed under the tongue?

There are two large veins under your tongue (you can see them in the mirror). Placing the medication under your tongue allows SUBOXONE to be absorbed quickly and safely through these veins as the sublingual film dissolves. If you chew or swallow your medication, it will not be correctly absorbed as it is extensively metabolized by the liver. Similarly, if the medication is not allowed to dissolve completely, you won’t receive the full effect.

8. Why can’t I talk while the medication is dissolving under my tongue?

When you talk, you move your tongue, which lets the undissolved SUBOXONE “leak” out from underneath, thereby preventing it from being absorbed by the two veins. Entertaining yourself by reading or watching television while your medication dissolves can help the time to pass more quickly.

9. Why does it sometimes only take 5 minutes for SUBOXONE to dissolve and other times it takes much longer?

It takes 5 to 10 minutes for a sublingual film to completely dissolve. However, other factors (e.g. the moisture of your mouth) can affect that time. Drinking something before taking your medication is a good way to help the sublingual film dissolve more quickly.

10. If I forget to take my SUBOXONE for a day, will I feel sick?

SUBOXONE works best when taken every 24 hours, however, it may last longer than 24 hours, so you may not get sick. If you miss your dose, try to take it as soon as possible, unless it is nearing time for your next dose. If it is nearing time for your next dose, just skip the dose you forgot, and take the next dose as prescribed. Do not take two doses at once unless directed to do so by your provider.

11. What happens if I still feel sick after taking SUBOXONE for a while?

There are some reasons why you may feel sick. You may not be taking the medication correctly or the dose may not be right for you. It is important to tell your provider if you still feel sick.

12. What happens if I take drugs and then take SUBOXONE?

You will feel very sick and experience what is called a “precipitated withdrawal.”

13. What happens if I take SUBOXONE and then take drugs?

If SUBOXONE is in your body, it will significantly reduce the effects of any other opioids used, because SUBOXONE will dominate the receptor sites and block other opioids from producing any effect.
14. What are the side effects of this medication?

Most side effects seen with SUBOXONE appear during the first week or two of treatment, and then generally subside.

Adverse Reactions:

Abdomen pain, chills, fever, headache, infection, withdrawal syndrome, flu syndrome, decrease in blood pressure, dizziness, constipation, diarrhea, heartburn, nausea, vomiting, hepatitis, insomnia, sedation, anxiety, depression, runny nose, cough, pharyngitis, and sweating

Allergic Reactions:

Most common – Rash, hives, itchiness
Less common – Trouble breathing, swelling around the eyes

Operation of Machinery:

Operating a car or hazardous machinery should not be performed until certain buprenorphine therapy will not adversely affect ability to do so.

Overdose:

Customer-owner may experience overdose and death if buprenorphine is taken with benzodiazepines, sedatives, tranquilizers, antidepressants and alcohol.

Symptoms of overdose:

Small pupils, sedation, decreased blood pressure/dizziness, respiratory depression, and potentially death.

Emergency:

In the event of an emergency be sure ER treatment team is aware of opioid dependence and that the customer-owner is on buprenorphine.

If you are experiencing any side effects, be sure to talk about it with your provider, as they can often treat those symptoms effectively until they abate on their own.
APPENDIX G – 4 DIRECTIONS REFERRAL FORM

OBGYN 4D MAT Referral Checklist

Customer Owner: __________________________________________________________

Medical Record Number: _________________________________________________

Date of Birth: ___________________________________________________________

Contact Number: _________________________________________________________

Address: __________________________________________________________________

Referring Physician: _______________________________________________________

Referring Clinician: _______________________________________________________

Check List: Attach the following information to this MAT referral face sheet

☐ Summary of treatment (H&P, most recent progress note, current medications including current buprenorphine dosing)

☐ Lab studies—(CBC, CMP, TSH, Chronic Hepatitis Panel (A,B,C), HIV, Syphilis Screen, PPD, Urine Drug Screen, GC/Chlamydia, Urine HCG, consider full high risk Utox from Millennium Lab), PPD. Ensure PPD & urine HCG results are entered in Cerner results section.

   o Ensure that the customer-owner is up to date on all immunizations.

   o Consider Hepatitis A and Hepatitis B vaccinations if at risk.

☐ Psychosocial Assessment

☐ SBIRT

☐ ASAM - arrange while in house if possible (not required for referral)

☐ Medication Agreement

☐ ROI (specific to substance use disorder and treatment)

ON DISCHARGE OR FROM CLINIC, ENSURE ATTENDING PRESCRIBER PROVIDES ENOUGH BUPRENORPHINE TO BRIDGE THE PATIENT TO THE END OF THE DAY OF INTAKE TO 4D MAT.

INFORMATION TO INCLUDE IN EVALUATION NOTE:

☐ Medical Problems (list – see H&P)

☐ If female, is the customer owner pregnant?

☐ Frequent Hospitalizations or chronic medical condition limiting ability to make appointments?

☐ Psychiatric History

   o Stable vs Unstable – does the customer owner’s psychiatric condition limit their ability to make appointments?

☐ Does the customer owner have uncontrolled pain issues?

   o Who is managing chronic pain?
How is chronic pain being managed?

☐ Does the customer owner have reliable transportation to get to and from appointments?
  ☐ Has a vehicle / ride / access to public transport?

☐ Does the customer owner have a cell phone with voicemail?
  ☐ Home Phone with voice mail
  ☐ Other way to reach customer owner or leave a message?

☐ Is the customer owner domiciled?
  ☐ Does the customer owner live in Anchorage?
  ☐ Is there anyone else in the household an opioid or other substance abuser?

  ▪ **Document any concerns for diversion**

  ☐ Can customer owner keep the medication safe and secure?
    ☐ Are there children in the home? Discuss importance! One strip can be lethal to a child
    ☐ How will they keep the medication secure?

  ☐ Does the customer owner have other substance related use issues?
    ☐ Is Opioid Use disorder the customer owner’s primary addiction?
    ☐ What other substances is the customer owner know to use/abuse
    ☐ Does the customer owner meet criteria for another substance use disorder?

☐ Has the customer owner have documented history of remission from substances for more than one year?

☐ Is the customer owner willing to give up all substances if using more than just opioids?

☐ Has the customer owner engaged in substance use treatment in the past?
  ☐ If yes, how many times, where, when, what medications were used in the past?
  ☐ Has the customer owner ever been in a residential treatment facility?
  ☐ Has the customer owner had a trial of buprenorphine / suboxone in the past?
    ▪ If yes, consider Methadone Maintenance
  ☐ Has the customer owner relapsed while taking on an opioid agonist medication?

☐ Is the customer owner prescribed benzodiazipines?

☐ Does the customer owner have documented suicidal or homicidal ideation?

☐ Is customer-owner able to meet program requirements? A commitment to stay in Anchorage for at four least months of treatments is preferred.
  ▪ Coordinate an initial meeting with BHC and/or Pharmacy, if available.
  ▪ Pharmacy offers training on naloxone, vivitrol, medication management.

☐ Beneficiary or Non-beneficiary?