

# Buprenorphine (Bup) Quick Start in Pregnancy

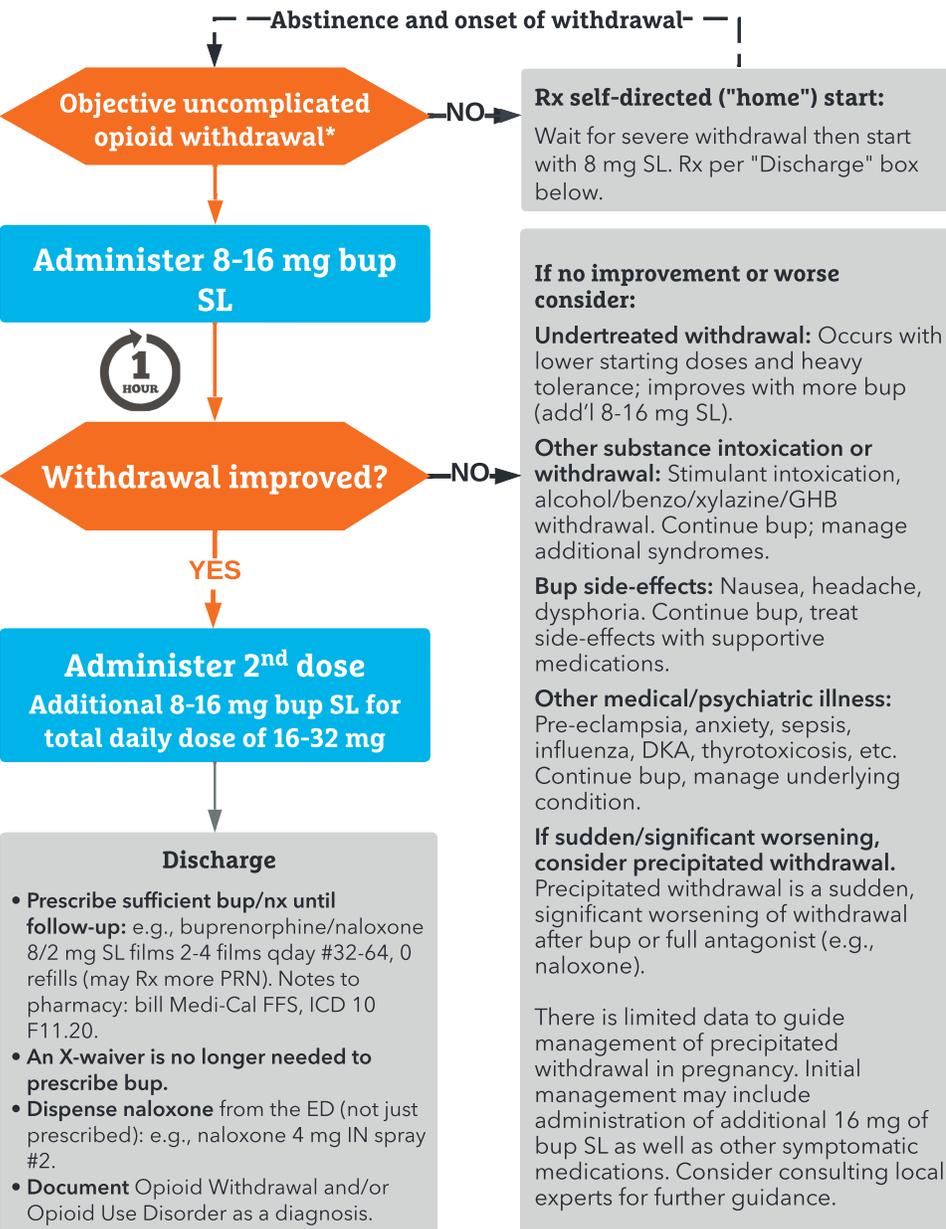


This guidance is for the emergency department (ED). We advocate for continuation & initiation of bup in inpatient and outpatient settings. Algorithms vary based on clinical scenario.

## Medication for Addiction Treatment in Pregnancy

- Any prescriber can order bup in the ED/hospital. It can also be prescribed as medication for opioid use disorder by any prescriber with an active Drug Enforcement Agency license that includes schedule III medications.
- Fetal monitoring is not required to start bup in normal pregnancy, regardless of gestational age.
- Admission for observation is NOT required for bup starts.
- Bup monoproduct or bup/naloxone (nx) is OK in pregnancy.
- Bup is a high-affinity partial agonist opioid that is SAFE in pregnancy and highly effective for treating opioid use disorder.
- Split dosing and an increase in total bup dose is often necessary, esp. in later trimesters.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

We encourage shared decision making with patients for dosing.



## Peripartum (for planned C-Section and/or labor, or acute pain):

- Continue patient's normal bup dose in combination with multimodal analgesia that may include regional anesthesia and opioids.
- Bup is safe for breastfeeding.
- Bup reduces neonatal abstinence syndrome (NAS) severity. Dose does not correlate to NAS severity.

## Postpartum:

Bup dose reduction should be gradual and per patient cravings.

## Ethical Considerations:

- MAT alone is not justification for contacting Child Protective Services.
- Consent is required for urine drug testing.
- Pregnant patients have the right to determine their treatment plan.
- Delivering quality care is an essential component of **reducing mortality for Black birthing people.**

## \* Opioid Withdrawal:

**At least one clear objective sign (prefer ≥ 2):**

Tachycardia, mydriasis, yawning, rhinorrhea, vomiting, diarrhea, piloerection. **Ask the patient if they are in bad withdrawal** and if they feel ready to start bup. If they feel their withdrawal is mild, it is too soon.

**If unsure, use COWS (clinical opioid withdrawal scale).** Start if COWS ≥ 8 AND objective signs.

**Typical withdrawal onset** >12 hours after last short acting opioid use (excluding fentanyl); variable after last use of fentanyl or methadone (may be >72 hours).

**Start protocol may vary for complicating factors:**

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma, or planned large surgery
- Organ failure or other severe medical illness (decompensated heart failure, respiratory distress, hemodynamically unstable, etc.)
- Recent methadone use
- Minimal opioid tolerance (consider lower dosing)

Most people who use fentanyl do well with starts following this guide. For fentanyl specific initiation questions, see [Fentanyl FAQ](#).

**If patient has already completed withdrawal (no longer symptomatic withdrawal, often >72 hrs from last use of opioids) and wants to start bup:** give bup 8 mg SL q6h PRN cravings, usual dose 16-32mg/day. After first day, consolidate dosing to daily.

## Additional Resources:

- [Prevent & Treat Opioid Withdrawal in Your Baby](#)
- [Opioid Use and Opioid Use Disorder in Pregnancy](#)
- [Pregnancy and Substance Use: A Harm Reduction Toolkit](#)

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## CORRESPONDING AUTHOR

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