

# Maine Medical

## PARTNERS

### Women's Health

*A department of Maine Medical Center*

## NARCOTIC PRESCRIBING GUIDELINES IN PREGNANCY

### Introduction:

The widespread use of narcotics with increasing maternal and fetal dependence issues has resulted in a need for stricter guidelines for opiate prescribing in pregnancy.

The basic tenet is that “clinicians should counsel women about risks in pregnancy and encourage minimal or no use of chronic opioid therapy unless potential benefits outweigh risks.” Acute limited use for specific indications (post surgical for example) would be considered reasonable, whereas chronic narcotic prescribing for chronic conditions is to be discouraged. The smallest necessary dose and the least potent effective medication should be prescribed.

### Guidelines:

1. Acute pain can be managed with narcotics if non-opioid alternatives are inadequate for pain management
  - Least potent, smallest effective dose
  - 5-7 day maximum supply
2. Chronic pain conditions/ long-term therapy (>7 days) to be managed and medications prescribed by pain-care specialists or patient's long-term non-obstetrical provider (e.g. primary care provider).
3. For patients on long term non-medically prescribed narcotics, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal. These patients should be medically managed by a physician licensed to prescribe buprenorphine, buprenorphine-naloxone, or methadone therapy.
4. The Prescription Monitoring Program database record for the patient must be reviewed prior to providing any narcotic prescription.
5. In the event that long-term prescribing of narcotics is required:
  - Approval by the Division Director, Chair or Designee is required.
  - Appropriate subspecialty (e.g. neurology for headaches and urology for kidney stones) consultation required.

- Risks, benefits, and alternatives to opioid use need to be discussed. The discussion should include the risk of becoming dependent on opioids and the possibility of neonatal abstinence therapy syndrome. Practice goals should include alternative pain therapies, such as physical therapy, behavioral approaches, and non-opioid pharmacologic treatments, to minimize the use of opioids.
- Drug contract must be signed.
- Prescriptions for longer than seven days duration should not be provided. If needed for a longer duration, renew on a weekly basis. The physician initiating treatment assumes responsibility for the patient's pain management plan including, but not limited to, continued narcotic prescribing consistent with good medical practice. (Maine Board of Medicine, Rules and Statutes, Ch 21 :Use of controlled substances for the control of pain.  
<https://www.maine.gov/md/licensure/prescribing-resources>

6. With long term narcotic use:

- Testing for STIs, HIV, hepatitis B and C, and tuberculosis should be considered. Hep B vaccination if HBsAg neg but at high risk of hep B infection
- Screening for depression and other behavioral health disorders
- First trimester, “rule out anomalies”, and monthly growth ultrasounds
- Consultation with maternal fetal medicine, social services, nutrition, etc in addition to addiction and pain management specialists as needed
- Neonatal consultation for NAS discussion
- Breastfeeding encouraged in women not using illicit drugs
- Screening for use of other substances, particularly tobacco use, and discussion with cessation services

[Additional resource:](#)

“Snuggle Me” Guidelines Tools for Caring for Women with Addictions and Their Babies” 2<sup>nd</sup> edition. <https://www.maine.gov/dhhs/SnuggleME/documents/SnuggleME-2018-GuidelinesFINAL.pdf>

[Reference:](#)

ACOG Committee Opinion No. 711. Opioid abuse, dependence, and addiction in pregnancy. August 2017 (reaffirmed 2019).