MOMs +

(Maternal Overdose Matters)

Inpatient OB Comfort Order Set

Patient Declines to Continue MOUD Post-Discharge

CLINICAL PEARLS

Regulations

- **ED may administer** methadone for **3 days** in a row. If a patient is hospitalized, administer throughout their **hospitalization**.
- Methadone **cannot be prescribed at discharge** for the treatment of **OUD**.
- Hospitals can **dispense a 72 hour supply** of methadone to help patients connect to a clinic.
- OTPs can **only** provide methadone if patients **are over age 18.** Treating a patient under 18 with methadone requires approval from the State Opioid Treatment Authorities (SOTA). Buprenorphine is FDA approved for adolescents.

The goal is to keep patients comfortable, so they stay in the hospital and receive care. It is important to maintain tolerance to reduce the risk of overdose after discharge.

Buprenorphine should not be given to patients who are currently taking **methadone**, as this would **cause withdrawal**. Please coordinate with patient's methadone clinic provider if patient has been receiving methadone treatment and desires to change to buprenorphine.

Methadone may be a **good option** for patients who are **struggling to initiate buprenorphine**, have been **unsuccessful with buprenorphine** treatment in the past, or **prefer methadone** due to not having to experience opioid withdrawal prior to initiation.

Both methadone and buprenorphine are **recommended** medications for treatment of **opioid use disorder in pregnancy**, and one is not better than the other.

MEDICATIONS FOR OPIOID USE DISORDER

Start Time:
As soon as possible to get ahead of withdrawal, unless patient acutely intoxicated

☑ **Methadone 30 mg**
Supplied in formulation carried by hospital
Administer 30 mg orally q24h

Reassess in 4-6 hours, if no sedation give:

☐ **Methadone 10 mg**
Supplied in formulation carried by hospital
Administer 10 mg orally once.
Total daily dose not to exceed 40mg

Opioid Agonists

May use in addition to methadone if methadone dosing insufficient to alleviate symptoms. If using alone (without methadone), it is reasonable to increase doses higher than written below.

☐ **Hydromorphone 4-6 mg orally q 4-6 h PRN COWS >8**
or
☐ **Oxycodone 10-15 mg orally q4-6 h PRN COWS >8**

+/-

☐ **Morphine Extended-Release 15-30 mg orally TID**

NALOXONE INPATIENT ORDERS

☑ **Naloxone 0.4 mg Injection Solution**
Administer 0.4 mg IV as needed for respiratory depression, and notify provider
☑ **Naloxone 4 mg Nasal Spray**
Administer 4 mg nasally as needed for respiratory depression if no IV access, and notify provider

ADJUNCT TREATMENTS (+/-)

☐ Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
☐ Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
☐ Ondansetron 4 mg orally q6h PRN nausea
☐ Dicyclomine 10 mg orally TID PRN abdominal cramping
☐ Trazodone 50-100 mg orally qHS PRN insomnia
☐ Acetaminophen 500-1000 mg orally q6h PRN headache, pain
☐ Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
☐ Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondansetron, or not having success with ondansetron)

Complicating Factors:

- **RR<10** or **sedated**
- Low opioid tolerance
- **Allergy** to methadone
- **Known QTc >450** (do not need to check EKG to start methadone routinely)
- **>450 but <500**: begin methadone, but monitor EKG for 30 day
- **>500**: do not start methadone without **cardiology consult. Check TSH, Mag, Phos and patients home medication list.**
- Recent use of **benzodiazepines, alcohol** or other **sedatives**
- **Severe liver** disease
- Medically **unstable**

Methadone and buprenorphine are safe in pregnancy and breastfeeding!

In cases of **high tolerance**, including **fentanyl use**, may need **additional dose of full opioid agonists**, in addition to methadone, to control withdrawal; only while patient is in the hospital:

Sedation from methadone **peaks at 3-4 hours after** each dose, patients experiencing sedation should **not receive additional dose**

Recommend timing any antenatal monitoring (NSTs, BPPs) outside peak window (3-4 hours after receiving methadone) to prevent False-positive NSTs. Guidelines do not recommend continuous fetal monitoring while treating opioid withdrawal or initiating MOUD.

The Half-life of methadone is **more than 24 hours**, so **doses can stack** and sedation can occur after multiple days at the same dose.

Buprenorphine should not be given to patients who are currently taking methadone, as this would cause precipitated **withdrawal.**

Methadone has many **significant medication interactions**. Before starting new medications, **always check** the effect on methadone levels to avoid over-sedation or withdrawal.

LABORATORY (IN ADDITION TO STANDARD OB LABORATORY ORDERS)

- ☐ HIV
- ☐ Hepatitis B Antigen and Antibody
- ☐ Hepatitis C Antibody with reflex RNA
- ☐ RPR/Treponema
- ☐ Urine screen for Chlamydia/Gonorrhea, Trichomonas
- ☐ CBC and CMP (if not part of standard OB admission order set)

INFECTIOUS DISEASE CONSIDERATIONS

- ☐ Treat/ refer for treatment of sexually transmitted infections
- ☐ Offer PrEP for patients with injection use, partners with injection use and/or transactional sex/ sex work

CONSULTS

- ☐ Pain Management/Anesthesia
  Consider Exparel, On Q, Scheduled ketorolac/NSAID or acetaminophen for post-cesarean pain management
- ☐ NICU Team
- ☐ Nursery/Pediatrics
- ☑ Case Management/ Social Work
- ☑ Peer Support Specialist
- ☑ Education on naloxone take home kit (Nursing/Pharmacy)
- ☑ Education to encourage Methadone MOUD (Nursing/Pharmacy)

AFTERCARE

- ☑ Outpatient SUD Provider- consider outpatient MOUD
- ☑ Outpatient Behavioral Health Services
- ☑ Navigation Team
- ☑ Harm Reduction Services
- ☑ Peer Support Services
- ☐ Outpatient Prenatal Care/Postpartum Care
- ☐ Outpatient Pediatric/Family Medicine
- ☑ **Naloxone 4 mg Nasal Spray- Take Home Kit**
  Administer 4 mg nasally as needed for opioid overdose
  Dispense at Discharge

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