**Introduction:**

The widespread use of narcotics noted recently with increasing maternal and fetal dependence issues has resulted in a number of organizations calling 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, where as chronic narcotic prescribing for chronic conditions is to be discouraged.

Opioids are to be given for acute pain management. The smallest necessary dose and the least potent effective medication are encouraged.

**Guidelines:**

1. Acute pain can be managed with narcotics if required.
   - 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 patients long-term non-obstetrical provider (e.g. primary care provider).

3. Patients on long-term non medically prescribed narcotics should be referred to addiction specialists for methadone or subutex therapy.

4. 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.
   - Drug contract must be signed.
   - Weekly Scripts required. 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.*
5. With long-term narcotic use:
   a. Neonatal referral for NAS
   b. Breastfeeding encouraged
   c. Monthly growth ultrasounds

Reference: