impact of this intervention on her baby's risk for NAS and on her lactation options and should be educated about the risks and benefits of using or not using this pharmacotherapy to treat her condition.

- A pregnant woman with opioid use disorder who uses other substances should be informed of the impact (1) illicit substances, (2) misuse of licit substances, (3) tobacco, (4) alcohol, (5) benzodiazepines, (6) amphetamines, and (7) SSRIs has/have on the severity of NAS and other effects on the infant.
- A pregnant woman with opioid use disorder and untreated comorbid mental health conditions should be informed about the possible impact of her condition on NAS.
- A pregnant woman with opioid use disorder and comorbid (1) depression and (2) anxiety treated with an SSRI should be informed that this pharmacotherapy is independently associated with NAS and may worsen her baby's NAS.
- A pregnant woman with opioid use disorder should be started on (1) methadone or (2) buprenorphine.
- A woman on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder who states the intention to become pregnant should be advised of the likelihood of her newborn's experiencing NAS if the woman conceives and gives birth while taking buprenorphine or methadone.
- A woman on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder who states the intention to become pregnant should be advised that there are no known increased risks of birth defects associated with buprenorphine or methadone at this time[2].
- A pregnant woman with opioid use disorder should be encouraged to stop smoking.

Dose Adjustment or Change of Medications During Pregnancy

- A pregnant woman previously stable on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder should be assessed for a dose increase if she complains of (1) withdrawal symptoms or (2) cravings and (3) should receive additional behavioral interventions.
- A pregnant woman stable on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder who wants to decrease her dose so her baby will have less withdrawal at birth should be advised that the mother's dose of buprenorphine or methadone is not associated with the intensity of NAS and should be told about other evidence-based strategies for minimizing NAS.

[2] These indications were rated and supporting literature was provided based on data available at the time of the RAM meeting. The research papers used for the RAM process were selected according to a methodology outlined in Chapter II. Other federal agencies and offices apply different methodologies to the evidence or research used to support their decision-making. The clinical guide to be developed based on recommendations in this report will have greater latitude to include additional relevant source material.

- A pregnant woman stable on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder who wants to decrease her dose so her baby has less withdrawal should be advised (1) that smoking cessation may reduce opioid withdrawal her baby may experience, (2) that cessation of other substance use may reduce opioid withdrawal her baby may experience, (3) that breast-feeding may reduce opioid withdrawal her baby may experience, and (4) that nonpharmacologic interventions for the infant may reduce opioid withdrawal her baby may experience.
- A pregnant woman stable on methadone who wants to switch to buprenorphine so her baby will have milder or shorter neonatal opioid withdrawal should not be switched to buprenorphine.

Medically Supervised Withdrawal[3]

- A pregnant woman with opioid use disorder should be advised that detoxification (defined as medically supervised withdrawal) is associated with high rates of relapse and is not the recommended course of treatment.
- A pregnant woman stable on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder who wishes to be withdrawn from medication should be advised that medically supervised withdrawal from medication-assisted treatment is not advisable during pregnancy due to the stress on the fetus and risk of relapse.
- A pregnant woman with opioid use disorder who refuses medication-assisted treatment may undergo detoxification (medically supervised withdrawal) during the second trimester if the benefits outweigh the risk.

Treatment for Pregnant Women Who Relapse to Substance Use

- A pregnant woman, previously stable on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder, who relapses to opioid use (1) should have her dose assessed for effectiveness, (2) should receive additional behavioral interventions, and (3) should be referred for a higher level of care.
- A pregnant woman on buprenorphine (or buprenorphine/naloxone) or methadone for opioid use disorder who has concurrent ongoing other substance use (e.g., alcohol, tobacco, illicit substances) (1) should receive behavioral interventions for these substance use disorders, (2) should receive pharmacologic interventions for these substance use disorders, and (3) should be referred for a higher level of care.
- A woman who discontinues naltrexone after becoming pregnant and relapses to opioid use should begin use of buprenorphine or methadone.

[3] Medically supervised withdrawal is an area of intense research. These recommendations are based on the ratings of the expert panel using the evidence identified in the methodology described in Chapter II. The clinical guide to be developed based on recommendations in this report will have greater latitude to include additional relevant source material.