

# Dr. Robert Ben Mitchell, D.O.

Office-Based Opioid Treatment Program  
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**Buprenorphine (Subutex) treatment is not currently FDA approved for pregnant or nursing women, so its using during pregnancy is an off-label treatment. Therefore, your obstetrician must sign this form in order for Dr. Mitchell to treat you for Opioid Dependence (ICD# 304.00) with buprenorphine (Subutex).**

Dr. Mitchell,

I will be the obstetrician for \_\_\_\_\_ (DOB: \_\_\_/\_\_\_/\_\_\_) during her pregnancy, and **I have discussed all of the following with this patient:**

1. Buprenorphine (Subutex) treatment is **not currently medically approved by the FDA** for treating opioid dependence in pregnant or nursing women. Only methadone is FDA approved for such treatment.
2. There can be possible adverse affects when starting, continuing, or stopping buprenorphine (Subutex) during pregnancy, including **fetal and/or newborn withdrawal syndrome.**
3. Buprenorphine (Subutex) blocks other opioids, so patients must stop their buprenorphine (Subutex) for **at least 24 hours prior to using any opioid pain medications, including tramadol (Ultram/Ultracet).**
4. The **benefits currently outweigh the risks** of buprenorphine (Subutex) treatment for this patient.
5. As the obstetrician for this patient, **I will notify Dr. Mitchell immediately** of any changes in her condition which would warrant discontinuation of her buprenorphine (Subutex) treatment.

As this patient's obstetrician, I understand that if this patient is not already being treated by Dr. Mitchell, then **she must be in full withdrawals (stop all opioids for at least 24 hours)** prior to her first visit, so that she can take a 2 (two) mg test dose of buprenorphine as Subutex in Dr. Mitchell's office during her first office visit there. **I find no indications that this 24 hour withdrawal period will be of any harm to this patient or her fetus.**

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Doctor (sign): \_\_\_\_\_

Doctor (print): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

FOR DR. MITCHELL'S OFFICE USE ONLY:
Phone confirmation done :
_____/_____/____ : ____
With: _____
Notes: _____
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