Maryland Board of Physicians

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Board Guidance

In light of the opioid epidemic, the Maryland State Board of Physicians has adopted the following guidance for Maryland physicians and physician assistants to consider when determining whether and how to prescribe opioids.

For full consideration, visit the CDC website (https://www.cdc.gov/drugoverdose/prescribing/guideline.html)

1. Before Opioid Prescribing

- Assess and evaluate patient pain (https://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf).
- Consider non-opioid therapies (https://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf).
- Evaluate and inform patient of the risks and benefits (https://www.cdc.gov/drugoverdose/pdf/assessing_benefits_harms_of_opioid_therapy-a.pdf) of opioid use.
- Establish treatment plan and only continue prescribing opioids if the pain and functionality improvement outweighs the risks.
- Screen for Substance Use Disorder (https://bha.health.maryland.gov/Pages/SBIRT.aspx).
- Consider red flags indicating potential abuse, misuse, and diversion. (See #4 below)
- Check the Prescription Drug Monitoring Program (PDMP) (https://bha.health.maryland.gov/pdmp/Pages/Home.aspx) to review patient medical history of Controlled Dangerous Substances prescriptions.
- Perform patient urine screening to confirm presence of prescribed medication and for undisclosed prescription drug or illicit substance use.
- Schedule follow-up appointment 1-4 weeks after initial prescribing.

2. When Prescribing (Dosages, Duration, Formulations, Contraindication etc.)

- Start low and go slow – start by prescribing lowest effective dosages with immediate release (IR) formulation for the shortest possible duration.
- Avoid prescribing opioids and benzodiazepines concurrently.
- Calculate the morphine equivalent (MME) dosages (https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf).
    - If prescribing > 50 MME increase appointment follow-up frequency and offer naloxone (https://bha.health.maryland.gov/NALOXONE/Pages/Naloxone.aspx) for overdose risk.
    - Avoid prescribing > 90 MME if possible, carefully consider and justify such doses, and consider referring patient to pain management specialist.
- Consider new Medicaid Prior Authorization Information (https://mmcp.dhmh.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/pa-information.aspx) requirements for patients receiving > 90 MME and consider other guidance (https://mmcp.dhmh.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/healthchoice-opioid-response.aspx) from Medicaid for Medicaid patients.
- For Acute care:
    - Prescribe for expected duration of pain; often < 3 days; rarely > 7 days.
    - Consider using immediate release (IR) dosages rather than extended release/long-acting (ER/LA).

3. Continued Treatment using Opioids

- Assess treatment goals and determine if opioids continue to be the best option.
- Consider reassessments no less frequent than every three months.
- Consider whether there are clinically meaningful improvements in pain and function that outweigh the risks or harms of opioid prescribing.
- Consider whether any new red flags (see #4 below) of Substance Use Disorder or diversion are present.
- Perform periodic urine toxicology screenings.
- If over-sedation or increased overdose risk, taper opioid prescribing (https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf) while considering patient’s psychosocial support. Consider a 10% decrease in original dose per week or month, as appropriate.

- If tapering (https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf), monitor for withdrawal symptoms.

4. Red Flags to Consider when Prescribing

Consider the following risk factors of harm, misuse, substance use, or diversion:

- Patient's self-reported medical history is not verifiable
- Patient fails to comply with non-opioid treatments or referrals
- Patient has a history of:
  - overdoses
  - opioid dependence or substance use disorder
  - illegal drug use
  - prescription drug use for non-medical reasons
  - mental illness
  - sleep-disordered breathing
- Patient takes more pills than prescribed
- Patient is from out-of-state
- Patient fails urine or toxicology screens
- Patient requests:
  - medications with high street value
  - medications by name
  - increased quantity or strength of opioid
  - early refills
- Patient pays cash payments for medications
- Patient reports lost or stolen prescriptions
- More than one family member receives the same opioid prescription
- More than one person at the same address receives the same opioid prescription
- Patient reports financial stressors

5. Substance Use Disorder (Addiction) and Overdose

For those with Substance Use Disorder:

- Refer for substance use treatment.
- Consider referring to pain management specialist.
- Consider treating with medication-assisted treatment (MAT) (https://www.samhsa.gov/medication-assisted-treatment) such as buprenorphine, methadone, and naltrexone in combination with behavioral therapies. such as buprenorphine, methadone, and naltrexone in combination with behavioral therapies. List of Maryland treatment centers (https://dpt2.samhsa.gov/treatment/directory.aspx).
- Consider offering naloxone (https://bha.health.maryland.gov/NALOXONE/Pages/Naloxone.aspx) for those with high risk of overdose (https://store.samhsa.gov/shin/content/SMA16-4742/InformationforPrescribers.pdf) such as > 50 MME opioids per day, concurrent benzodiazepine use, history of overdose or substance use disorder.

Note: *The information and links provided are for information purposes only and are not intended to provide standards of practice. The guidance on this website is a resource and has no legal binding effect on licensees. It should not be considered to be a statement of general application and does not govern the practice of medicine before the Board.*

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