LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

March 2, 2021

Delegate Shane E. Pendergrass, Chairperson
Health and Government Operations Committee
Room 241
House Office Building
Annapolis, Maryland 21401

Re: HOUSE BILL 1125 ("Prescription Drug Monitoring Program – Prescribers of Opioids – Notification"); informational only.

Madam Chair Pendergrass,

The Legislative Analysis and Public Policy Association (LAPPA) offers this written informational testimony about Maryland House Bill (HB) 1125.

LAPPA's understanding is that the general purpose of HB 1125 is to require prescribers who prescribe or dispense an opioid to a patient in a dosage of 50 morphine milligram equivalents (MME) or more to note in the Maryland Prescription Drug Monitoring Program (PDMP) if the prescriber: (1) discussed with the patient the risks of opioids; (2) discussed with the patient the availability of naloxone; and (3) prescribed naloxone to the patient. The present language of HB 1125—specifically lines 20-24 of page 2—seems to provide that the notation will be made where the prescriber (and not the patient) receives education or is made aware of opioid antagonists. Accordingly, the text of HB 1125 should be rewritten to make clear that the intent is for the prescriber to educate the patient about these items.

The Centers for Disease Control's (CDC's) 2016 guidelines for prescribing opioids for chronic pain recommend that "[c]linicians should incorporate into the [patient's] management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present."[1] Current Maryland law is largely consistent with this recommendation.[2]

Allowing for naloxone co-prescriptions when prescribing an opioid does not potentially save as many lives as would a requirement for co-prescription. Stated differently, the CDC's recommendation that co-prescribing be "considered" is not the current "gold standard" for naloxone co-prescribing. Recent studies show that requiring naloxone co-prescribing to certain patients results in more naloxone being dispensed to citizens,[3] which in turn can result in additional lives saved.[4] Thus, the laws of many states are trending towards this requirement. As

of today, through recent legislation or regulation, ten states now require prescribers to offer naloxone co-prescriptions in certain circumstances:[5] Arizona,[6] California,[7] Florida,[8] Indiana,[9] New Mexico,[10] Ohio,[11] Rhode Island,[12] Vermont,[13] Virginia,[14] and Washington.[15] In addition, New Jersey issued an administrative order in May 2020 requiring the co-prescribing of naloxone with an opioid for the duration of the COVID-19 public health emergency.[16] Moreover, through the first two months of 2021 legislative sessions, there is similar pending legislation in eight states.[17]

Enacting HB 1125 would not allow Maryland to reach the gold standard. The best way to do that would be to change Md. Code Regs. 10.13.03.03 to require co-prescribing in certain situations. Short of making that revision, should Maryland wish to further encourage naloxone co-prescribing, it must develop novel approaches. HB 1125 (if amended as suggested above), seeks to take a step in the right direction through a novel approach by requiring a prescriber to affirmatively note in the PDMP whether or not he or she discusses naloxone with a patient receiving an opioid prescription. Through this proposed requirement, the prescriber is implicitly encouraged to have those conversations and may be more likely to co-prescribe naloxone.[18]

Sincerely,

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[1] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1 (quoting Guideline 8).

[2] Md. Code Regs. 10.13.03.03 ("When determined appropriate by the prescribing licensed health care provider, targeted patient populations [as defined] may be co-prescribed an opioid overdose reversal drug, if the individual is at an elevated risk of experiencing an opioid overdose by virtue of belonging to one or more categories of the targeted patient population."). *See also* Md. Code Ann., Health – Gen. § 13-3502.

[3] Guy GP Jr., Haegerich TM, Evans ME, Losby JL, Young R, Jones CM. Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018. MMWR Morb Mortal Wkly Rep 2019;68:679–686. DOI: http://dx.doi.org/10.15585/mmwr.mm6831e1 ("The highest county-level naloxone dispensing rates were observed in some of the states hit hardest by opioid overdose mortality (*e.g.,* Florida and Massachusetts) and in states that have implemented requirements for naloxone co-prescribing (*e.g.*, Arizona and Virginia).").

[4] Sohn M, Talbert JC, Huang Z, Lofwall MR, Freeman PR. Association of Naloxone Co-prescription Laws With Naloxone Prescription Dispensing in the United States. JAMA Netw Open. 2019;2(6):e196215. doi:10.1001/jamanetworkopen.2019.6215 ("These study findings suggest that legally mandated naloxone prescription for those at risk for opioid overdose may be associated with substantial increases in naloxone dispensing and further reduction in opioid-related harm.").

[5] Legislative Analysis and Public Policy Association, Naloxone Access: Summary of State Laws 10 (September 2020), available at http://legislativeanalysis.org/wp-content/uploads/2020/10/Naloxone-summary-of-state-laws-FINAL-9.25.2020.pdf (last accessed March 2, 2021).

[6] Ariz. Rev. Stat. § 32-3248.01(D) ("If a patient is prescribed more than ninety morphine milligram equivalents per day pursuant to subsection B or C of this section, the prescribing health professional shall also prescribe for the patient naloxone hydrochloride or any other opioid antagonist that is approved by the United States food and drug administration for the treatment of opioid-related overdoses.").

[7] Cal. Bus. & Prof. Code § 741(a) ("Notwithstanding any other law, when prescribing an opioid or benzodiazepine medication to a patient, a prescriber shall do the following: (1) Offer the patient a prescription for naloxone hydrochloride or another drug approved by the [FDA] for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present . . . .").

[8] Fla. Stat. Ann. § 456.44(6) ("For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance . . . must concurrently prescribe an emergency opioid antagonist, as defined in [Fla. Stat. Ann.] 381.887(1).").

[9] Ind. Code Ann. § 12-23-20-2(c) ("A health care provider that prescribes for a patient in an office based opioid treatment setting shall do and document the following: . . . (11) Prescribe an overdose intervention drug and education on how to fill the prescription when buprenorphine is initiated on the patient.").

[10] N. M. Stat. Ann. § 24-2D-7(B)("A health care provider who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply.")

[11] Ohio Admin. Code 4731-11-14(B)(7) ("The physician shall offer a prescription for naloxone to the patient receiving an opioid analgesic prescription under any of the following circumstances: (a) The patient has a history of prior opioid overdose; (b) The dosage prescribed exceeds a daily average of eighty MED or at lower doses if the patient is co-prescribed a benzodiazepine, sedative hypnotic drug, carisprodol, tramadol, or gabapentin; or (c) The patient has a concurrent substance use disorder.").

[12] 216 R.I. Code R. § 20-20-4.4(M) ("A prescriber must co-prescribe naloxone when: 1. Prescribing an opioid which individually or in aggregate with other medications is more than or equal to fifty (50) MMEs per day, or document in the medical record why this is not appropriate for the patient. 2. Prescribing any dose of an opioid when a benzodiazepine has been prescribed in the past thirty (30) days, or will be prescribed at the visit. . . . 3. Prescribing any dose of an opioid to a patient with a prior history of opioid use disorder or overdose. Prescribers must note medical necessity of prescribing of the opioid and explain why the benefit outweighs the risk given the patient's previous history.").

[13] 12-5-53 Vt. Code R. § 7.0 ("Prescribers shall co-prescribe naloxone or document in the medical record that a patient has a valid prescription for or states they are in possession of naloxone for: 7.1.1 All patients who receive one or more opioid prescriptions totaling a Morphine Milligram Equivalent Daily Dose of 90 or more. 7.1.2 All patients receiving a prescription that results in concurrent use of an opioid and benzodiazepines.").

[14] 18 Va. Admin. Code § 85-21-70(B) ("In initiating and treating with an opioid, the practitioner shall: . . . 3. Prescribe naloxone for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME per day, or concomitant benzodiazepine are present.").

[15] Wash. Admin. Code § 246-919-980 ("The opioid prescribing physician shall confirm or provide a current prescription for naloxone when opioids are prescribed to a high-risk patient.").

[16] "Naloxone prescribing by health care practitioners," Admin. ord., Dept. of Law and Public Safety, Div. of

Consumer Affairs, issued May 21, 2020, last accessed March 2, 2021, https://www.njconsumeraffairs.gov/Documents/Naloxone%20rule%20adoption.pdf.

[17] H.B. 474, 156th Gen. Assembly, Reg. Sess. (Ga. 2021); H.B 348, 102nd Gen. Assembly, Reg. Sess. (Ill. 2021); H.B 3454, 102nd Gen. Assembly, Reg. Sess. (Ill. 2021); S.B. 277, 2021 Reg. Sess. (Ky. 2021); H.D. 3835, 192nd Gen. Court, Reg. Sess. (Mass. 2021); S.D. 578, 192nd Gen. Court, Reg. Sess. (Mass. 2021); H.F. 18, 92nd Legis. (Minn. 2021); S.F. 53, 92nd Legis. (Minn. 2021); S.B. 2323, 219th Legis. (N.J. 2020); A.B. 336, 2021-22 Reg. Sess. (N.Y. 2021); S.B. 2966, 2021-22 Reg. Sess. (N.Y. 2021); H.B. 93, 2021 Sess. (N.C. 2021); H.B. 3366, 124th Gen. Assembly (S.C. 2021); S.B. 571, 124th Gen. Assembly (S.C. 2021).

[18] It should be noted that adding one (or three) data fields to the PDMP may require revisions to the PDMP operating system, which may come with computer programing cost, either via internal Maryland state programmers or an outside vendor.