

Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council

2016 Recommendations

The Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council was created pursuant to a revision to the Pain Relief Act in 2012. The Council, which is administratively attached to the Department of Health, is charged with reviewing the current status of prescription drug misuse and overdose prevention and current pain management practices in New Mexico, and national prescription drug misuse and overdose prevention and pain management standards, as well as educational efforts for both consumers and professionals. The council is also charged with recommending pain management and clinical guidelines.

New Mexico's drug overdose death rate has been significantly higher than the national rate for many years. However, New Mexico experienced a downturn in the drug overdose death rate, and an improvement in its national ranking for overdose death in 2015. New Mexico's overdose death rate decreased approximately 7.5% from 2014 to 2015; as the number of deaths decreased from 540 to 493, the death rate declined from 26.8 per 100,000 population to 24.8 per 100,000 population, and its ranking among the states improved from 49th in the nation to 43rd. During this period, drug overdose death rates declined in nearly two thirds of New Mexico counties. Overdose deaths in the New Mexico county with the highest death rate (Rio Arriba) declined by 40%. However, New Mexico's rate continues to remain substantially higher than the most recently announced national rate, which was 16.3 deaths per 100,000 population reported for 2015.

Several factors contributed to the improvement from 2014 to 2015. One factor is improved prescribing. Between the third quarter of 2014 and the third quarter of 2016, the number of patients with overlapping prescriptions of opioids and benzodiazepines for at least 10 days decreased by 13%, and the number of patients with overlapping prescriptions of opioids from different prescribers for at least 10 days decreased by 25%. The number of opioid prescriptions that provided 90 or more morphine milligram equivalents (MME) decreased by 13%. The number of practitioner requests for Prescription Monitoring Program (PMP) reports increased by 78% in that period. The number of patients receiving buprenorphine/naloxone for at least 10 days increased by 24% in the same period. Also, hydrocodone was rescheduled by the DEA from Schedule III to Schedule II, effective October 6, 2014. Refills of prescriptions are allowed for Schedule III drugs, but not for schedule II drugs, so prescriptions for hydrocodone written after October 6, 2014 cannot be refilled. The total amount of hydrocodone dispensed by New Mexico pharmacies (measured in MME) declined by 8.9% between 2014 and 2015, and the number of patients prescribed hydrocodone declined by 5.7% in that period.

In a 2016 report, the National Safety Council found that New Mexico is one of only four states to merit a rating of "Making Progress" for reducing overdose deaths, based on "careful evaluation of key indicators". Those four states were found to be making progress in all of the areas of "mandatory prescriber education, opioid prescribing guidelines, eliminating pill mills, prescription drug monitoring programs, increased access to naloxone, and availability of opioid use disorder treatment." Two important laws went into effect during the past year. The first law, effective January 1, 2017, requires practitioners to check the

PMP database when prescribing opioids. The second law has resulted in increased availability of naloxone—a medication that reverses opioid overdoses.

The 2016 Recommendations of the Governor’s Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council are intended to solidify and expand on work that has been accomplished to date. The recommendations are below.

1. Practitioners should avoid prescribing opioid pain medications and benzodiazepines concurrently whenever possible.
2. Practitioners should adhere to the summary of the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain (CDC Guideline), published in the New England Journal of Medicine, and the complete CDC Guideline, in addition to the one-page summary document. Providers should not use the Guideline to override a provider’s judgement regarding a specific patient, but rather to guide skillful and appropriate pain management.
3. The medical provider licensing boards should not use the CDC Guideline to set strict policy or to enforce practice standards.
4. Licensing entities should promulgate rules requiring practitioners to limit an initial opioid prescription for acute pain to no more than a 10-day supply for a single prescription.
5. Congress should amend the Comprehensive Addiction and Recovery Act to include Clinical Nurse Midwives, Clinical Nurse Specialists, and Pharmacist Clinicians in the definition of “qualifying other practitioner.”. (At this time, only appropriately trained physicians, nurse practitioners, and physician assistants qualify as medical care providers to provide office-based opioid addiction treatment with buprenorphine. Passing this amendment would increase the number of medical care providers who could provide this treatment.)
6. New Mexico’s health insurers and Managed Care Organizations should:
 - Provide coverage for at least two naloxone products at the member’s lowest-tier copay;
 - Provide coverage for naloxone products dispensed even if the insured member is not the ultimate user of the naloxone product;
 - Reimburse pharmacies for overdose prevention and naloxone administration education provided by pharmacists;
 - Create alprazolam prior authorization requirements for new start patients receiving more than a two-week supply;
 - Provide coverage for all combination buprenorphine/naloxone products and buprenorphine monoproducts for treatment of opioid use disorder or opioid withdrawal management;
 - Provide coverage for extended-release injectable naltrexone for patients enrolled in psychosocial treatment services;

- Create prior authorization requirements when initially prescribing methadone for treatment of chronic pain to include: necessity of use rationale, overdose risk assessment, overdose prevention education, and co-prescription of naloxone;
- Create prior authorization requirements when initiating benzodiazepine therapy for more than two months for patients currently on chronic opioid therapy; and,
- Create prior authorization requirements when initiating opioid therapy for more than seven days for patients currently on chronic benzodiazepine therapy. Patients already on concurrent therapy should be safely tapered to avoid serious risk associated with benzodiazepine withdrawal.