Taking Action Against Opioid Abuse in Nevada
2/17/2022

Nevada Prescription Monitoring Program (PMP)

- Established in 1997 and co-administered by the Nevada State Board of Pharmacy (BOP) and Nevada Division of Investigation
- Originally designed to identify potential “doctor shoppers”
- Computerized program to track scheduled II-V controlled substance (CS) prescriptions
- Accessible 24/7 through a secure website or via EHR Integration
- Pharmacies, dispensing practitioners transmit data daily (by end of next business day)

Legislation to Take Action Against Opioid Abuse in Nevada

- **Assembly Bill 474** – 2017 Session

The Controlled Substance Abuse Prevention Act

- **Assembly Bill 239** – 2019 Session

Assembly Bill 474 Overview

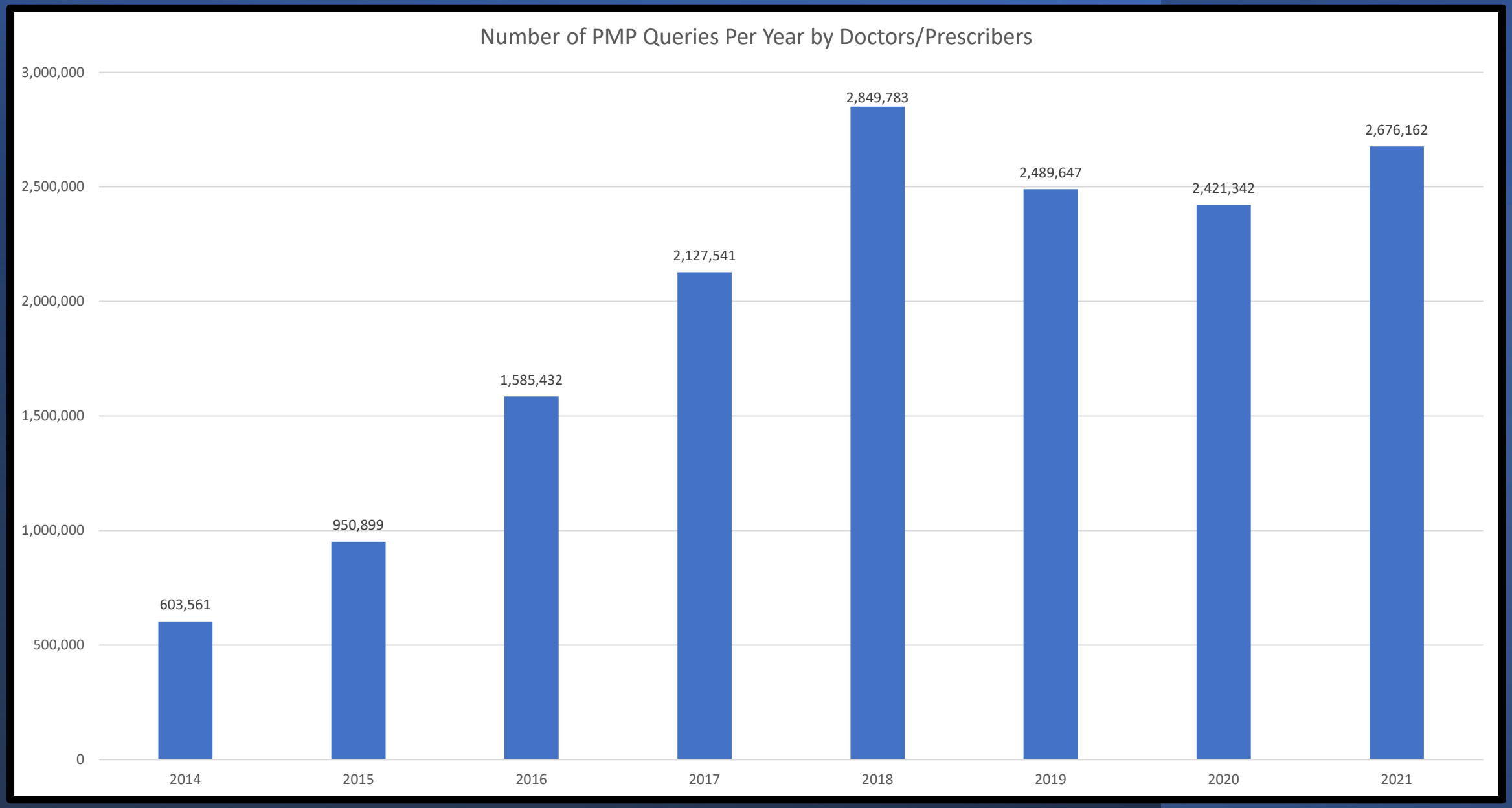
2017 Legislative Session
(Effective January 1, 2018)

- To ensure prescribing a controlled substance (CS) is medically necessary and appropriate.
- To prevent addiction and misuse of CS:
  - Requires a prescriber to review patient's CS prescription history in the PMP database before initial CS prescription and every 90 days during course of treatment.
  - Establishes guidelines for writing an initial CS prescription
    - Initial CS prescription may not exceed 14-day supply or daily 90 MME (opiate naïve patient)
  - Requires informed consent from patient
  - Requires a patient medication agreement if treatment is > 30 days
  - Requires a patient risk assessment if treatment is > 30 days
  - Requires a risk of abuse assessment if treatment is > 90 days

Assembly Bill 239 Overview

2019 Legislative Session
(Effective July 1, 2019)

- Patient risk assessment
  - Medical history limited to the **relevant** medical history of the patient's pain
- Prescribing guidelines for initial CS prescription for the treatment of acute pain
  - Initial prescription may exceed 14-day supply or 90 MME (opiate naïve patient) if deemed medically necessary
- Exemption for hospice, palliative, oncology, and sickle cell CS prescriptions
  - Review patient's CS prescription history in the PMP database as soon as practical and at least once every 90 days
  - Not required to:
    - Perform a patient risk assessment
    - Enter into a patient medication agreement
    - Adhere to initial CS prescriptions days' supply or daily MME
- "Course of Treatment" and "Acute Pain" defined in statute


Number of PMP Queries Per Year by Doctors/Prescribers
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
603,561
950,899
1,585,432
2,127,541
2,849,783
2,489,647
2,421,342
2,676,162
2014
2015
2016
2017
2018
2019
2020
2021

Contact Information

Nevada State Board of Pharmacy

Darla Zarley, PharmD.
Grant & Project Analyst
Nevada State Board of Pharmacy
Email: dzarley@pharmacy.nv.gov

Dave Wuest, RPh.
Executive Secretary
Nevada State Board of Pharmacy
Email: dwuest@pharmacy.nv.gov

Yenh Long, PharmD.
Deputy Executive Secretary
Nevada State Board of Pharmacy
Email: ylong@pharmacy.nv.gov

Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

Opioid Prescribing Patterns and Prescribing Policies within Fee for Service Medicaid

Kyra Morgan, State Biostatistician

Beth Slamowitz, Senior Policy Advisor on Pharmacy

2/17/2022

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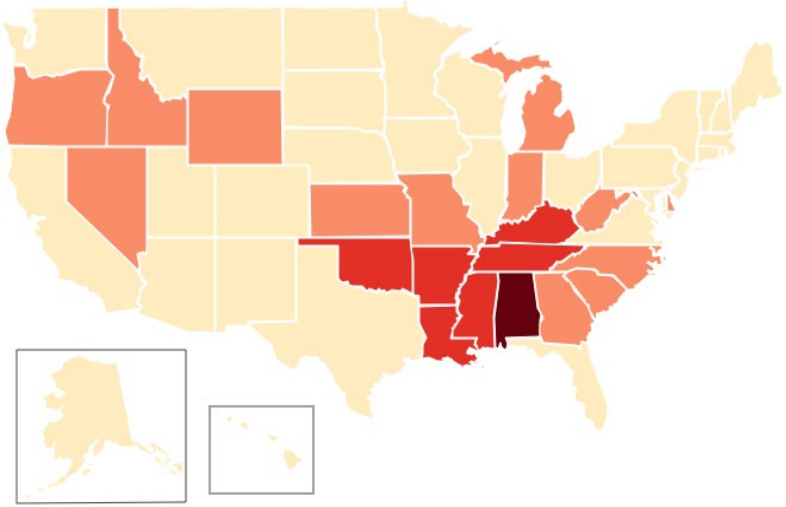
Opioid Prescribing Patterns

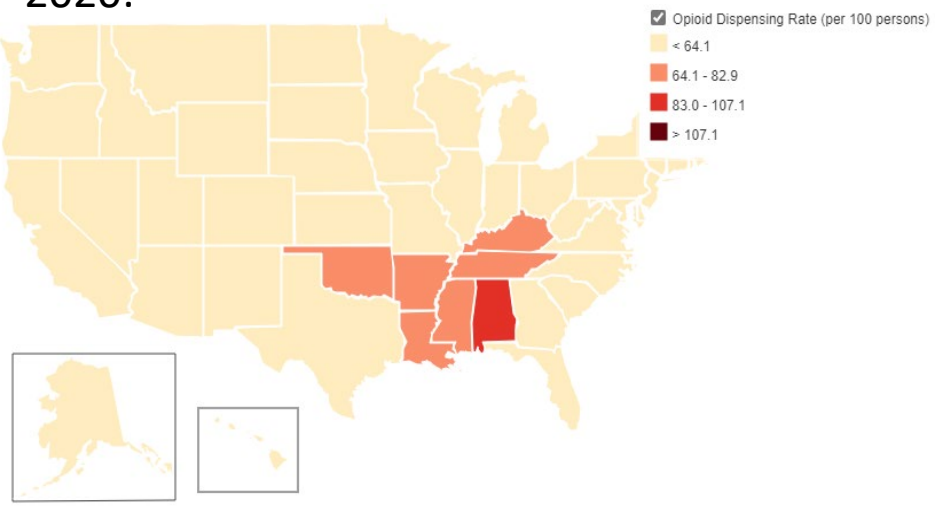
In 2020, Nevada providers wrote 47.4 opioid prescriptions for every 100 persons compared to the average U.S. rate of 43.3 prescriptions.

Although Nevada is still slightly higher than the national average, we have observed a decline from 73 opioid prescriptions for every 100 persons in 2017 (35% decrease).

2017:



2020:



Source: U.S. Opioid Dispensing Rate Maps | Drug Overdose | CDC Injury Center

Data Source

[Nevada Prescription Drug Monitoring Program Dashboard]

Prescription Drug Monitoring Program Nevada 2017-2022

State of Nevada
Department of
Health & Human
Services
Office of Analytics

RX by ICD-10 | RX Trend | RX by MME | Day Supply Groups | Day Supply <15

Nevada Prescription Drug Monitoring Program (PDMP) Dashboard

Data as of 02/07/2022, this dashboard will be updated on the 10th day of each month.
For questions, please contact the DHHS Office of Analytics by emailing data@dhhs.nv.gov.

Opioid analgesic controlled substance prescriptions dispensed including schedule II, III, IV prescription opioids dispensed to patients, as entered into the state prescription drug monitoring program (PDMP) system. Data are total number of prescriptions filled to Nevada residents, this does not capture whether the medications were taken as prescribed or taken by the prescribed patient. A person can be included for more than one prescription and therefore may not be mutually exclusive.

Please use caution when interpreting rates corresponding to small counts.

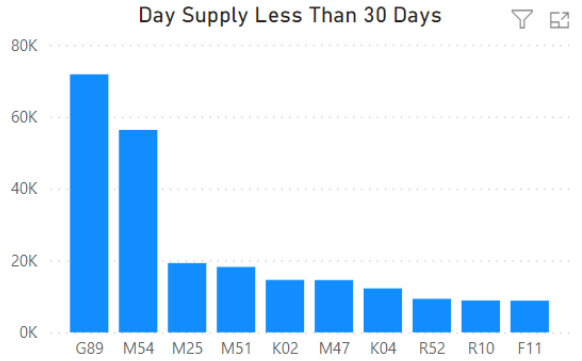
Click on a button above to navigate to the desired information.

Results Filter for Day Supply: <30

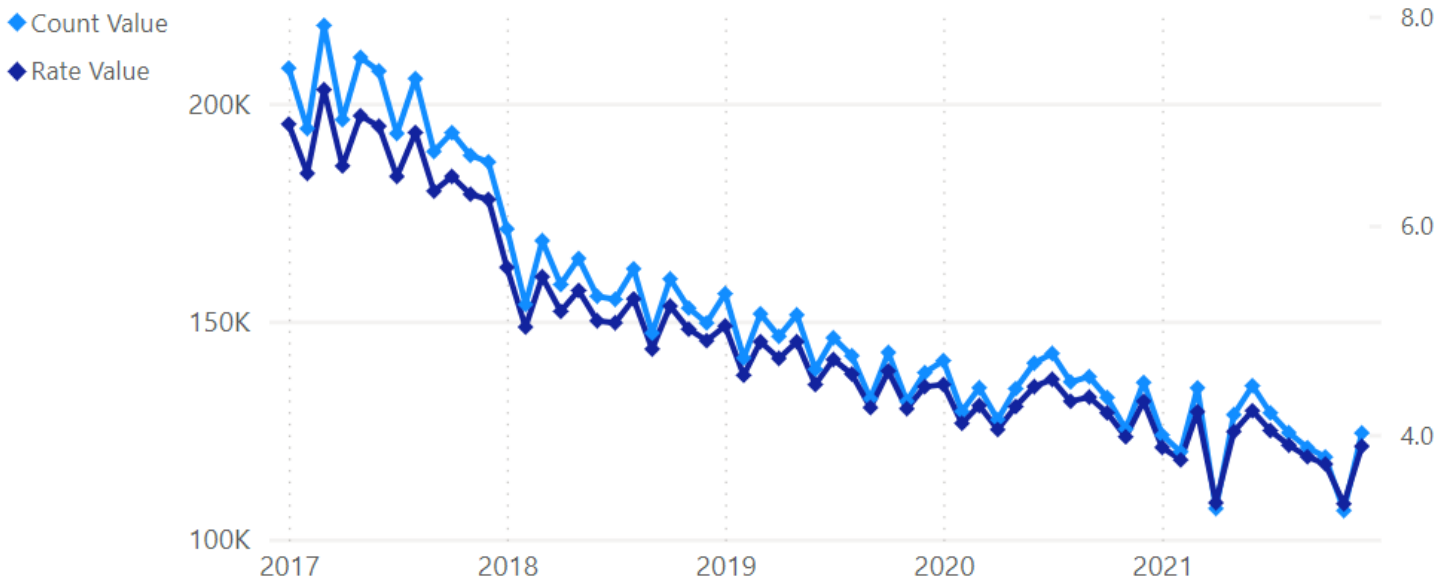
Opioid Prescriptions by Day Supply and Top 10 ICD-10-CM Group, 2021

Diseases of the Nervous System, Pain (ICD-10-CM code G89) was the most common diagnosis code overall, first most common with less than 30 days of supply, third most common diagnosis code on prescriptions with a 30-90 days supply, and fourth most common for prescriptions greater than 90 days of supply.

Top 10 Diagnosis Groups	Code	Prescriptions
Diseases of the Nervous System, Pain, not elsewhere classified	G89	71,797
Dorsalgia	M54	56,327
Other joint disorder, not elsewhere classified	M25	19,292
Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders	M51	18,213
Dental caries	K02	14,596
Spondylosis	M47	14,559
Diseases of pulp and periapical tissues	K04	12,241
Pain, unspecified	R52	9,343
Abdominal and pelvic pain	R10	8,884
Opioid related disorders	F11	8,824



Opioid Prescription Counts & Rates (per 100) by Month 2017 - 2021



From January 2017 to December 2021, there was a 44% decrease in the rate of opioid prescriptions per 100,000 Nevada residents.

The number of individuals who were co-prescribed Opioid and Benzodiazepines during the same month decreased even more significantly, by 68% in Nevada overall.

Opioid Prescription Counts & Rates (per 100) by Days Supply - 2017 & 2021

From January of 2017 to December of 2021, Nevada opioid prescribing rates decreased across all supply volumes.

By Days' Supply:

- < 30 days: 52% decrease
- 30-90 days: 36% decrease
- >90 days: 55% decrease

2017

Year	Month	<30 Count	<30 Rate	30-90 Count	30-90 Rate	>90 Count	>90 Rate	Total Count	Total Rate
2017	January	103,386	3.46	103,941	3.48	824	0.03	208,151	6.97
2017	February	95,607	3.20	97,974	3.28	698	0.02	194,279	6.50
2017	March	107,015	3.58	110,051	3.68	872	0.03	217,938	7.30
2017	April	96,339	3.23	99,161	3.32	794	0.03	196,294	6.57
2017	May	103,605	3.47	106,214	3.56	782	0.03	210,601	7.05
2017	June	102,054	3.42	104,604	3.50	803	0.03	207,461	6.95
2017	July	94,799	3.17	97,535	3.27	803	0.03	193,137	6.47
2017	August	102,445	3.43	102,524	3.43	754	0.03	205,723	6.89
2017	September	93,673	3.14	94,531	3.17	780	0.03	188,984	6.33
2017	October	96,449	3.23	96,108	3.22	757	0.03	193,314	6.47
2017	November	93,395	3.13	94,015	3.15	704	0.02	188,114	6.30
2017	December	90,919	3.04	94,873	3.18	812	0.03	186,604	6.25

2021

Year	Month	<30 Count	<30 Rate	30-90 Count	30-90 Rate	>90 Count	>90 Rate	Total Count	Total Rate
2021	January	49,643	1.55	74,050	2.32	250	0.01	123,943	3.88
2021	February	49,523	1.55	70,344	2.20	216	0.01	120,083	3.76
2021	March	56,649	1.77	77,876	2.44	237	0.01	134,762	4.22
2021	April	45,304	1.42	61,619	1.93	182	0.01	107,105	3.35
2021	May	54,715	1.71	73,656	2.31	247	0.01	128,618	4.03
2021	June	58,318	1.83	76,693	2.40	242	0.01	135,253	4.23
2021	July	54,735	1.71	74,070	2.32	208	0.01	129,013	4.04
2021	August	53,077	1.66	71,176	2.23	228	0.01	124,481	3.90
2021	September	51,373	1.61	69,466	2.17	200	0.01	121,039	3.79
2021	October	50,376	1.58	68,328	2.14	211	0.01	118,915	3.72
2021	November	44,924	1.41	61,482	1.92	191	0.01	106,597	3.34
2021	December	53,209	1.67	70,991	2.22	214	0.01	124,414	3.89

Morphine Milligram Equivalent (MME)

Potency can be compared across the spectrum of opioid drugs using a conversion to a Morphine Milligram Equivalent (MME).

By converting different opioids to a standard unit of measure, a prescriber is more able to assess a patient's potential risk for dose-related adverse events.

Nevada observed decreasing trends across all MMEs from January 2017 to December of 2021.

The largest declines were observed in patients receiving the highest level of MME:

- Patients who received greater than 90 MMEs per month: 53% decrease
- Patients who received 50 to 90 MMEs per month: 49% decrease
- Patients who received less than 50 MMEs per month: 28% decrease

- see data tables on next slide for details -

Opioid Prescription and Patient Counts by MME – 2017 & 2021

Year	County	RX<50	Patients <50	RX 50-90	Patient 50-09	RX >90	Patients >90
2017	Carson City	37,153	31,165	9,011	7,880	7,519	5,861
2017	Churchill	17,585	14,282	5,696	4,871	2,611	2,057
2017	Clark	1,151,418	987,095	298,606	262,806	241,718	185,580
2017	Douglas	31,437	26,523	8,687	7,715	6,576	5,274
2017	Elko	26,839	22,414	5,976	5,331	2,974	2,404
2017	Esmeralda	402	362	96	87	79	68
2017	Eureka	981	821	476	435	237	188
2017	Humboldt	8,400	7,033	1,928	1,659	1,410	1,065
2017	Lander	3,873	3,051	721	625	344	267
2017	Lincoln	3,210	2,717	878	767	612	505
2017	Lyon	43,892	37,083	12,475	10,906	8,371	6,730
2017	Mineral	4,048	3,373	1,104	996	875	708
2017	Nye	43,276	37,230	11,498	10,133	9,391	7,352
2017	Pershing	3,515	2,804	795	701	390	318
2017	Storey	3,753	3,135	1,060	964	753	649
2017	Washoe	247,800	202,944	66,164	58,438	44,562	34,546
2017	White Pine	6,331	4,995	1,668	1,394	1,426	1,079

Year	County	RX<50	Patients <50	RX 50-90	Patient 50-09	RX >90	Patients >90
2021	Carson City	27,711	23,117	4,477	3,951	2,748	2,233
2021	Churchill	10,542	8,916	1,650	1,482	829	662
2021	Clark	777,629	681,159	161,243	144,310	116,734	94,838
2021	Douglas	22,333	19,015	3,654	3,278	2,206	1,843
2021	Elko	16,296	13,853	2,106	1,789	1,341	958
2021	Esmeralda	318	273	60	55	15	15
2021	Eureka	727	641	127	120	35	31
2021	Humboldt	4,433	3,870	749	667	459	298
2021	Lander	1,679	1,492	222	184	157	115
2021	Lincoln	2,433	2,156	623	541	233	187
2021	Lyon	30,814	26,442	5,966	5,361	2,677	2,311
2021	Mineral	2,807	2,334	526	469	388	288
2021	Nye	33,335	29,057	6,693	5,956	4,283	3,382
2021	Pershing	2,425	2,075	307	273	218	155
2021	Storey	1,929	1,670	408	374	242	227
2021	Washoe	169,278	141,550	26,497	23,099	15,861	12,085
2021	White Pine	4,712	3,910	754	628	407	313

Nevada Medicaid Opioid Prescribing Policies

- Chapter 1200 of the Medicaid Services Manual sets guidelines and limitations regarding coverage of prescription drugs. https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/
  - Limitations on early refills for controlled substances (1203.1 D(1))
    - 90% of the controlled substance must be used before a refill is authorized
  - Transdermal Fentanyl (Appendix A (F))
  - Long-Acting Narcotics (Appendix A (Q))
  - Opioids, Opioid Containing Cough Preparations, Opioids Prescribed to Under Age 18 (Appendix A (Z))
    - Prior authorization is not required for initial prescription of 7 days or less, total of 13 seven-day prescriptions in rolling 12-month period, for prescriptions of 60 mg morphine equivalents or less per day, or for chronic pain patients with a prescription in the last 45 days
    - Prior authorization is not required for under age 18 if initial prescription is for 3 days or less
    - Exceptions to policy for cancer related pain, post surgery with > 3 months recovery, palliative care, long term care, HIV/AIDS or in consultation with a pain specialist
    - Must be 18 years or older for opioid containing cough preparation
  - Codeine and Tramadol for Children (Appendix A (TTT))
- When the Opioid policy was implemented in May of 2017, there were 19,349 opioid prescription claims in one month. The average prescription claims per month in 2021 was 11,370. Claim counts have decreased on average 6% year over year.

Contact Information

Kyra Morgan, MS

State Biostatistician

kmorgan@health.nv.gov

Beth Slamowitz, PharmD

Senior Policy Advisor on Pharmacy

bslamowitz@dhcfp.nv.gov

Please send requests for additional data to data@dhhs.nv.gov

Opioid prescribing patterns in Medicaid, following AB474

February 17th, 2022

Sarah A. Friedman, PhD

Assistant Professor, University of Nevada Reno, School of Public Health

Data sources

- Medicaid prescription and professional claims data
- 2015-2019
- Nevada and Colorado
- Study sample of non-cancer, primary care patients aged 18-64

Outcomes among sub-samples

- Dose level (MME > 50 / > 90), among opioid naïve patients
- Days' supply (>7 / >14), among patients with acute conditions
- Opioid and benzodiazepine co-prescribing, among patients with prescriptions for opioids or benzodiazepines
- Immediate release preparations, among opioid naïve patients with chronic conditions
- Physical therapy, among patients with hip/knee osteoarthritis, low back pain, or fibromyalgia diagnoses
- Urine drug testing, among opioid naïve patients

Following the law, in Nevada, we observed:

- Decreases in:
  - Opioid prescriptions over both 50 MME and over 90 MME
  - Opioid prescriptions for 7 days' supply
  - Co-prescribed opioids and benzodiazepines
  - Use of immediate release opioid preparations (against CDC guidelines)

- Increases in:
  - Receipt of urine drug testing
  - Use of physical therapy

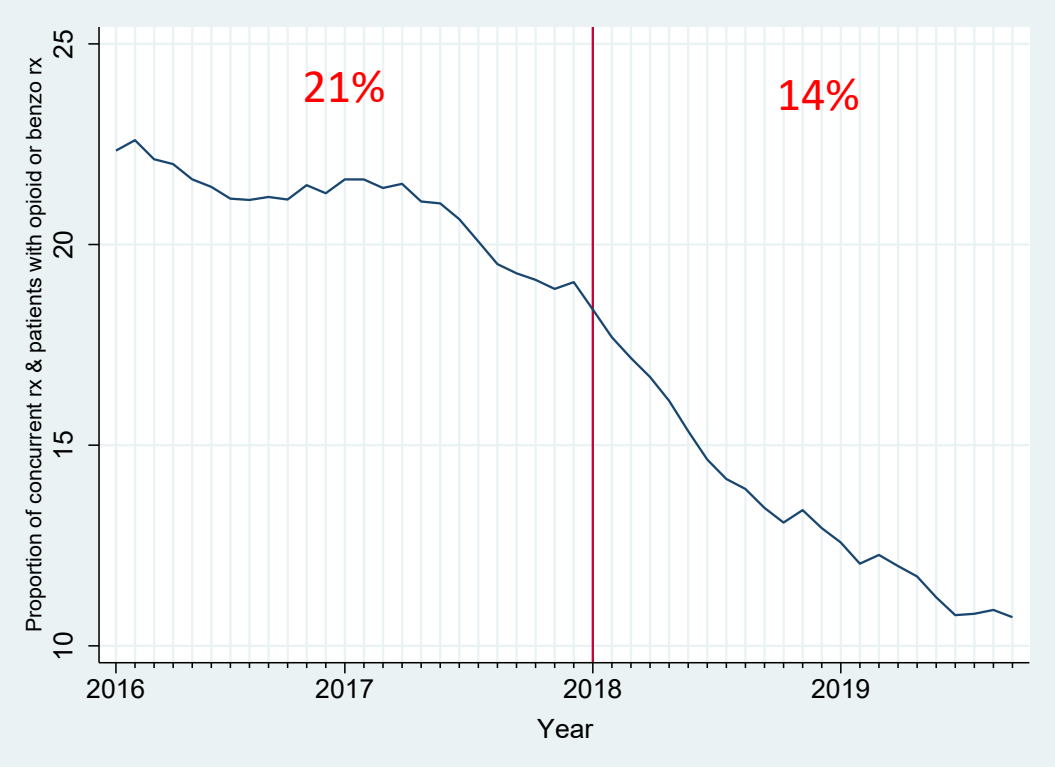
Note: As all data reflect preliminary findings, please do not cite.

MME > 50 in Nevada, among opioid naive

- Immediate and ongoing decrease in MME > 50 in Nevada following law

Note: As all data reflect preliminary findings, please do not cite.

Co-prescribing in Nevada, among patients with opioids or benzodiazepines



- Ongoing decrease in co-prescribing following the law

Note: As all data reflect preliminary findings, please do not cite.

Results from other states

State	Outcomes measured	Select results
North Carolina[1]	The effects of the PDMP (2010), medical state board initiative (2016), and legislative policy (2018).	The 2018 legislative policy evoked the **largest decrease** in: • patients with opioid prescriptions • day supply • mean daily MME compared with the effects of the PDMP and the medical state board initiative.
Florida[2]	The effect of 3-day supply opioid prescribing limit for acute pain	The enactment of House Bill 21 revealed **immediate decreases** in: • amount of new opioid users • use of hydrocodone & non-schedule II opioids • mean day supply
New Jersey[3]	The effect of 5-day opioid prescribing limit in New Jersey (NJ) compared to Pennsylvania (PA), a state without opioid prescribing limit legislation	The NJ state prescribing limit law observed **decreases** in: • number of new opioid prescriptions • quantity and MME/prescription compared to PA.
Massachusetts[4]	The effect of postoperative opioid prescribing limit legislation	The MA prescribing legislation observed: • **Immediate decreases** in opioid prescription quantity filled and day supply
Connecticut[4]	The effect of postoperative opioid prescribing limit legislation	**No change** was observed after policy was passed

1. Maierhofer CN, Ranapurwala SI, DiPrete BL, et al. Association Between Statewide Opioid Prescribing Interventions and Opioid Prescribing Patterns in North Carolina, 2006-2018. *Pain Med*. 2021;22(12):2931-2940. doi:10.1093/pm/pnab181
2. Hincapie-Castillo JM, Goodin A, Possinger MC, Usmani SA, Vouri SM. Changes in Opioid Use After Florida's Restriction Law for Acute Pain Prescriptions. *JAMA Netw Open*. 2020;3(2):e200234. doi:10.1001/jamanetworkopen.2020.0234\
3. Lowenstein M, Hossain E, Yang W, et al. Impact of a State Opioid Prescribing Limit and Electronic Medical Record Alert on Opioid Prescriptions: a Difference-in-Differences Analysis. *J Gen Intern Med*. 2020;35(3):662-671. doi:10.1007/s11606-019-05302-1
4. Cramer JD, Gunaseelan V, Hu HM, Bicket MC, Waljee JF, Brenner MJ. Association of State Opioid Prescription Duration Limits With Changes in Opioid Prescribing for Medicare Beneficiaries. *JAMA Intern Med*. 2021;181(12):1656-1657. doi:10.1001/jamainternmed.2021.4281

Contact

Sarah Friedman, PhD

Assistant Professor

University of Nevada, Reno

School of Public Health

sfriedman@unr.edu

Appendix slides

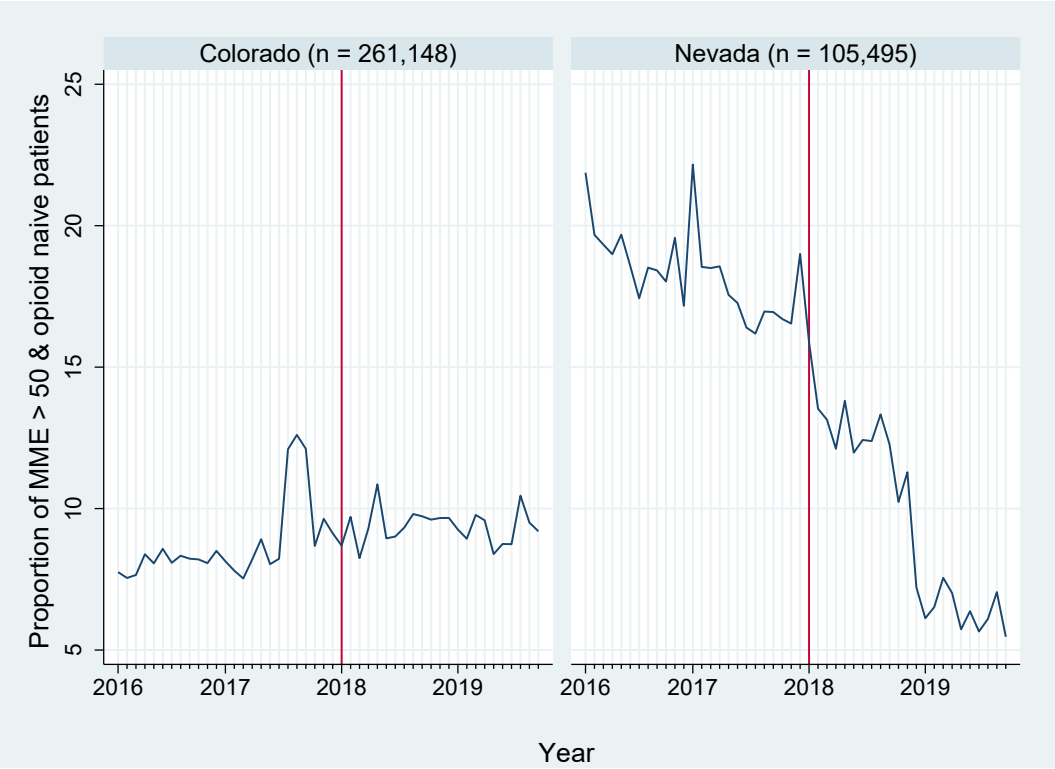
Outcomes in CDC guidelines and in AB474 (part 1)

Outcome	CDC Guideline	Nevada law text
Dose level (50/90 Daily MME)	"**When opioids are started**, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day (recommendation category: A, evidence type: 3)."	"A practitioner, other than a veterinarian, shall not issue an **initial** prescription of a controlled substance listed in schedule II, III or IV for the **treatment of acute pain that prescribes:** (a) An amount of the controlled substance that is intended to be used for more than 14 days; and (b) If the controlled substance is an opioid and a prescription for an opioid has never been issued to the patient or the most recent prescription issued to the patient for an opioid was issued more than nineteen days before the date of the initial prescription for the treatment of acute pain, a dose of the controlled **substance that exceeds 90 morphine milligram equivalents per day**."
Days' supply (7/14 days)	"When opioids are used for **acute pain**, …. Three days or less will often be sufficient; more than 7 days will rarely be needed (recommendation category: A, evidence type: 4)."	
Co-prescribing opioids and benzodiazepines	"Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (recommendation category: A, evidence type: 3)"	"Before prescribing a controlled substance listed in schedule II, III or IV, a practitioner, other than a veterinarian, must consider the following factors, when applicable: 3. Whether there is reason to believe that the patient is using other drugs, including, without limitation, alcohol, controlled substances listed in schedule I or prescription drugs, that: (a) May interact negatively with the controlled substance prescribed by the practitioner; or (b) Have not been prescribed by a practitioner who is treating the patient."
Prescribing immediate release preparations	"When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4)."	Not addressed in law.

Outcomes in CDC guidelines and in AB474 (part 2)

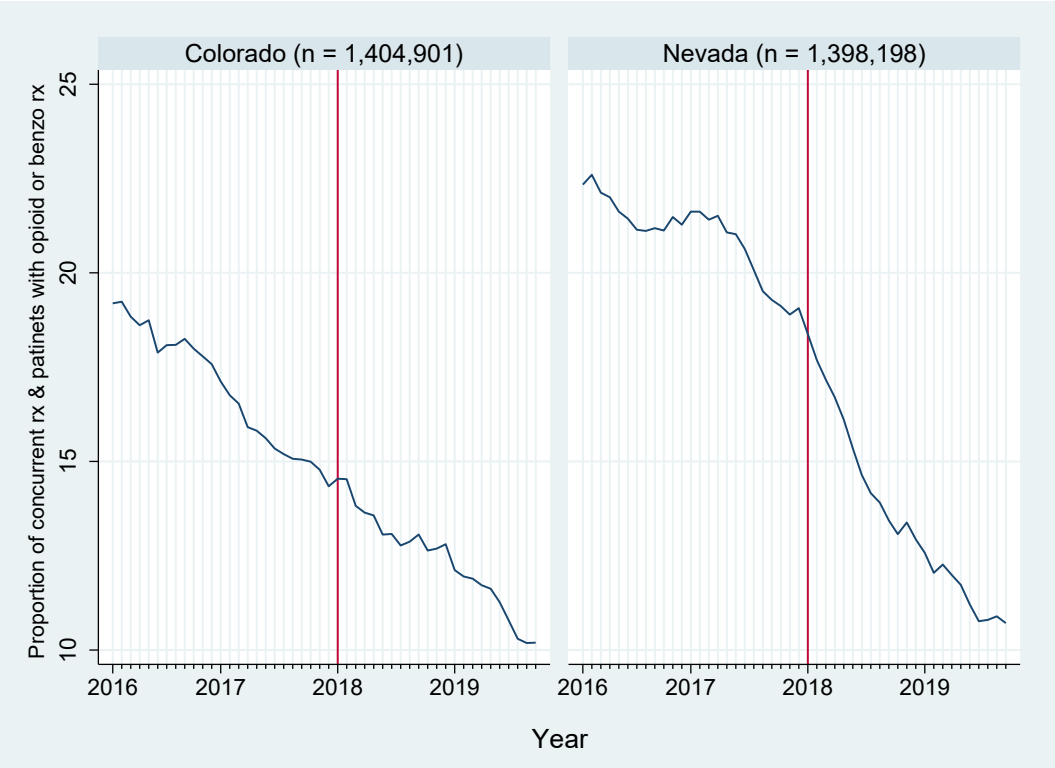
Outcome	CDC Guideline	AB474
Physical Therapy	"Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate"	"Before issuing an initial prescription for a controlled substance listed in schedule II, III or IV for the treatment of pain, a practitioner, other than a veterinarian, must… Document in the medical record of the patient the reasons for prescribing the controlled substance instead of an alternative treatment that does not require the use of a controlled substance" "The informed written consent obtained pursuant to paragraph (e) of subsection 1 of section 53 of this act must include, without limitation, information concerning… Any alternative means of treating the symptoms of the patient and the cause of such symptom"
Urine Drug Testing	"When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs"	Not addressed in law.

MME > 50 in Colorado



Note: As all data reflect preliminary findings, please do not cite.

Co-prescribing* in Colorado



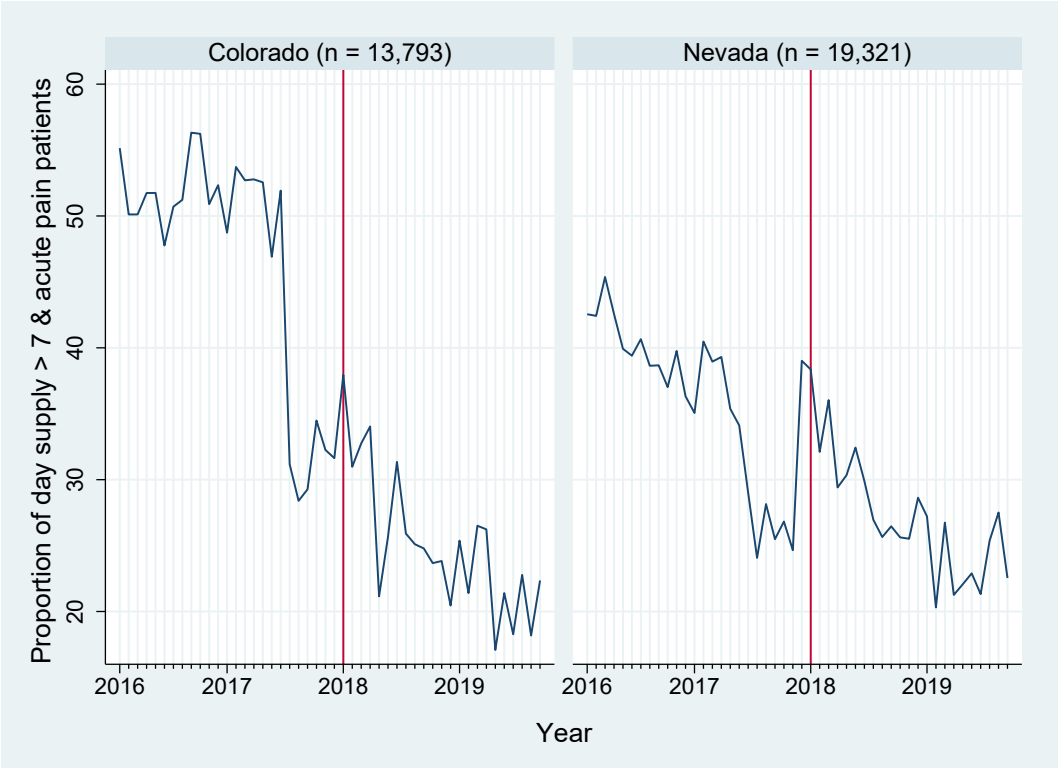
*Opioids and benzodiazepines

Note: As all data reflect preliminary findings, please do not cite.

> 7 Days' supply in Nevada, among acute care patients

Note: As all data reflect preliminary findings, please do not cite.

Days supply in Colorado

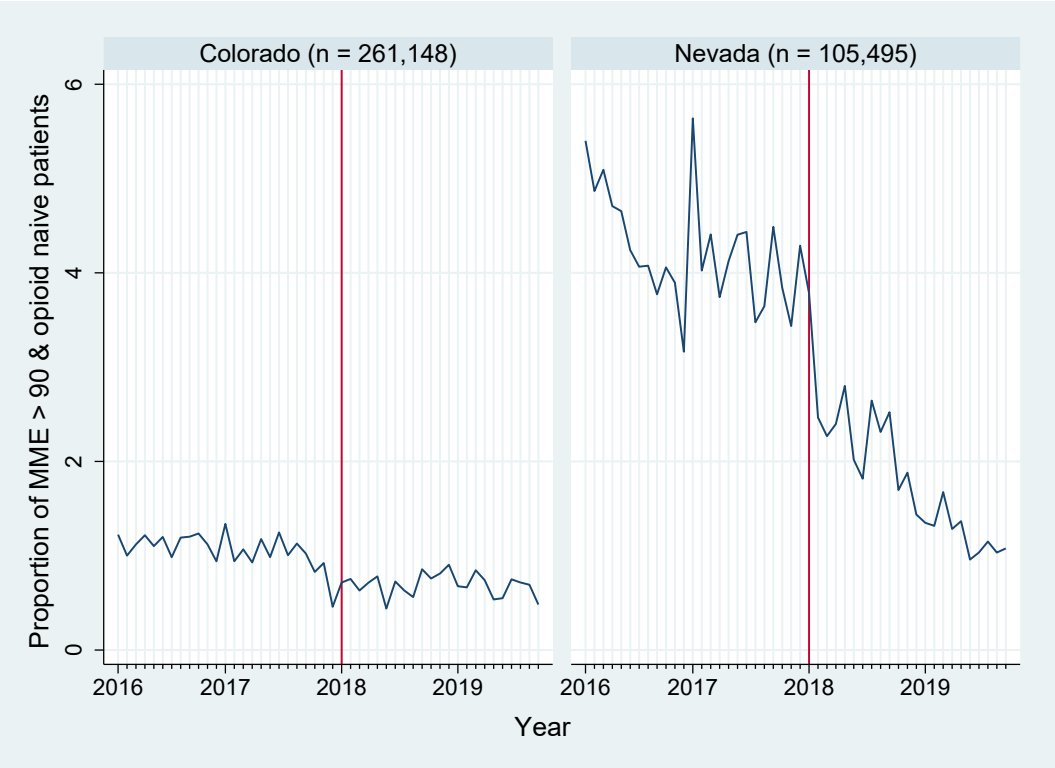


Note: As all data reflect preliminary findings, please do not cite.

MME > 90 in Nevada, among opioid naive

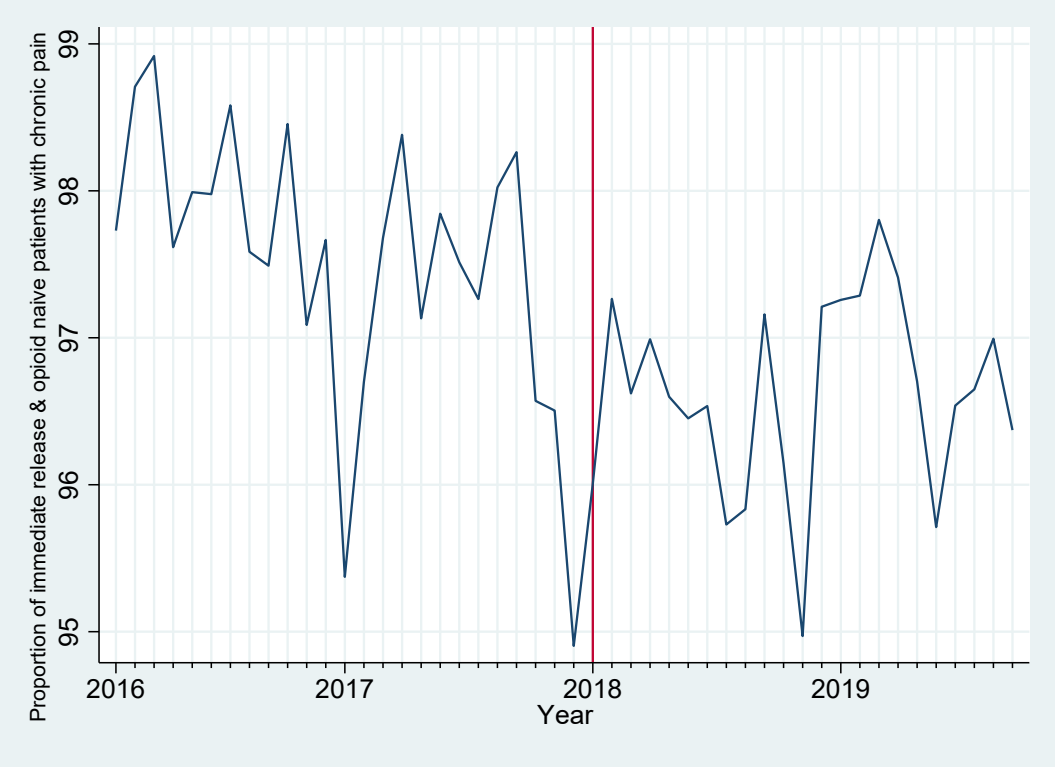
Note: As all data reflect preliminary findings, please do not cite.

MME > 90 in Colorado



Note: As all data reflect preliminary findings, please do not cite.

Immediate release in Nevada, among opioid naïve and chronic pain care patients



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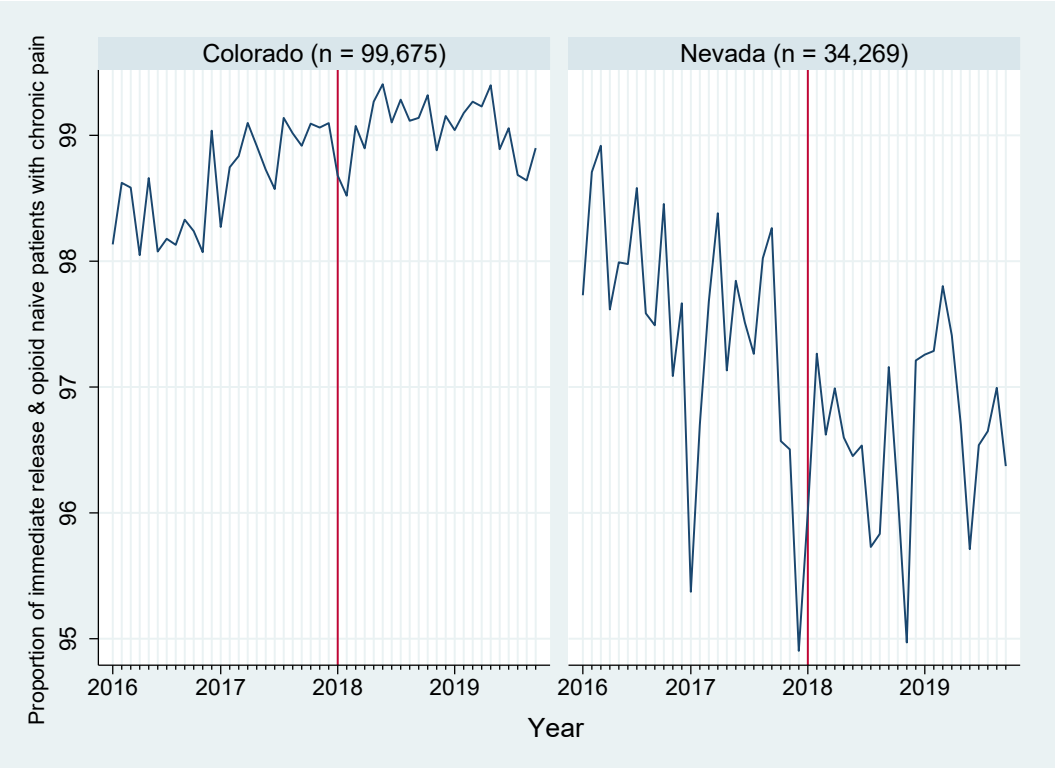
Immediate release in Colorado



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