Opioid Law Changes:

Wyoming Opioid Legislation

BY NATALIE WINTER, MD

Since the opioid epidemic started in 1999, more than 700,000 Americans have died of a drug overdose. On average, 130 Americans die every day from an opioid overdose. As the deaths reached epidemic proportions, lawmakers have been working on legislation to combat the epidemic. Massachusetts was the first state to pass opioid legislation in 2016. Since that time, most states have passed laws restricting opioid prescribing for acute pain. At this time, there is limited data on whether these laws mediate opioid-related morbidity and mortality or whether they are associated with negative unintended outcomes.

In Wyoming, opioid legislation was passed in 2019. The major changes took effect 7/1/19.

The laws state as follows:

- No practitioner shall prescribe nor shall any person dispense any opioid or combination of opioids for acute pain to an opioid naive patient for more than a seven (7) day supply in a seven (7) day period. The board shall by rule establish reasonable exceptions to this section, in consultation with other professional licensing boards that license practitioners, including exceptions for chronic pain, cancer treatment, palliative care and other clinically appropriate exceptions. As used in this subsection:
  - (i) "Opioid" means an opium-like compound that binds to one (1) or more of the major opioid receptors in the body;
  - (ii) "Opioid naive patient" means a patient who has not had an active opioid prescription in the preceding forty five (45) day period.
- Except as otherwise provided in this subsection, when a practitioner, other than a veterinarian, prescribes a schedule II, III, IV or V controlled substance, the practitioner or his delegate shall search the prescription tracking program for prior prescriptions issued to the patient before first issuing the prescription and shall repeat the search every three (3) months thereafter for as long as the controlled substance remains a part of the patient's treatment. A practitioner who prescribes a schedule V controlled substance shall only be required to search the program as otherwise provided in this subsection if the substance is an opioid.
- The board shall require three (3) hours of continuing education related to the responsible prescribing of controlled substances every two (2) years.
- On and after January 1, 2021, except when dispensed directly by a practitioner other than a

> pharmacy to an ultimate user, no controlled substance included in any schedule shall be dispensed without the electronic prescription of a practitioner.

Most states now have laws restricting amounts of opioids prescribed for acute pain. There is data in the literature to support this as we now know that patients can become opioid dependent in just three days. There is also evidence that the greater amount of initial opioid exposure (higher total dose, longer duration prescription) is associated with a higher risk of long-term use, misuse, and overdose. In addition to this, most who abuse opioids obtain them first from diversion—many from a family member or friend for free. There is a lot of evidence in the literature that patients receive more medication than they actually take, such as after surgery, and there is risk then that these excess pills may not be taken as prescribed.

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Wyoming has had a prescription drug monitoring program (PDMP) since 2004. The database provides information on all controlled substances prescribed to a patient in the state of Wyoming. Over the last few months, the database also gives information on other states through Interconnect. This information is helpful in identifying patients who may be doctor shopping as well as patients that are at increased risk for an opioid related complication—those that are on another sedating medication which may interfere with opioid therapy. In 2015, 23% of people that died of an opioid overdose tested positive for benzodiazepines as well. A study in North Carolina showed that a patient prescribed both opioids and benzodiazepines had a tenfold increased risk of overdose related death. Another reason to check the database is to find out exactly how much opioid medication a patient has truly received. It gives information on the dose, amount, and date of fill. Patients who are opioid naïve are at higher risk of complications related to opioids, and even if a patient has been on a high dose in the past, restarting at these doses could result in a fatality if they have not been on opioids recently.

In terms of best practices for opioid prescribing, there are many recommendations. Most notable is the CDC recommendations for managing chronic pain which was released in 2016. These recommendations focused on ways to improve safety and effectiveness of pain management as well as decrease risks associated with long-term opioid therapy. First, opioids should not be first-line treatment for chronic pain. Other treatments are likely to be more effective in long-term management of chronic pain. If, however, these other treatments are not effective or there are limited options, opioid therapy may be considered but only after a thorough discussion takes place between practitioner and patient on the risks with opioid therapy and the goals for treatment efficacy. Immediate-release opioids are safer and should be used first at the lowest dose for the shortest amount of time possible. Providers should caution increasing the dose above 50mg morphine equivalents (MME) and should avoid going above 90 MME without a significant reason. At this dosage, patients have a higher risk of overdose and death. At 50 MME, the risk doubles for overdose death; at 90 MME, the risk increases tenfold. For acute pain, clinicians again should use the lowest dose for the shortest amount of time, and no more than the amount needed should be prescribed. Three days is often enough, and more than 7 days is rarely needed. This is in line with the new legislation limiting initial prescription in the opioid naïve to 7 days.

In addition, there are recommendations for monitoring including evaluating patients within 1-4 weeks of initiation of opioid therapy for chronic pain or with any dose changes. On continued therapy, clinicians should be reevaluating the benefits and harms every 3 months or more frequently. If benefits do not outweigh the risks, then opioid therapy should be tapered. This does not mean forcing patients off of opioids completely. This should be an ongoing evaluation and decision.

The CDC recommendations also include checking the PDMP at least at 3 month intervals, urine drug testing before initiating long-term opioid therapy and then again at least annually, avoiding concomitant benzodiazepine use, recognizing patients with an opioid use disorder so they can receive appropriate treatment (possibly medication assisted treatment such as suboxone in combination with behavioral therapy).

The new state legislation and the CDC guidelines both require a lot of time and consideration, but as we have seen since 1999, this is necessary to avoid more unnecessary deaths. Opioid related death is preventable, and with responsible prescribing, more deaths may be avoided.