UTAH DEPARTMENT OF HEALTH
Violence & Injury Prevention Program

Co-prescription Guidelines

LEGISLATIVE REPORT

Legislative Report
Utah Code 26-55-108

During the 2017 General Session, the Utah State Legislature passed Senate Bill 258 Addiction Recovery Amendments which amended the Opiate Overdose Response Act requiring the Utah Department of Health (UDOH) to establish a scientifically based guidelines for controlled substance prescribers to co-prescribe an opiate antagonist to a patient.

According to Utah Code 26-55-108 the UDOH shall report to the Health and Human Services Interim Committee before October 30, 2017, regarding the co-prescribing guidelines established. The report shall include:

- Established rules regarding the co-prescription of an opiate antagonist to a patient and an analysis of:
  - the application of the rules, and
  - the impact of the rules.

Co-prescribing naloxone, an opiate antagonist, provides an opportunity for healthcare providers to initiate difficult conversations with their patients about patients about the risks of opioids, signs of an opioid overdose, and treatment options for substance use disorder.
Research shows that:

- Co-prescribing naloxone reduced emergency department visits.[1]
- Both patients and healthcare providers find the offer of a naloxone prescription acceptable.[2,3]
- Co-prescribing naloxone does not increase liability risk. [4]

Rulemaking

The UDOH Violence and Injury Prevention Program (VIPP) filed a rule with the Utah Department of Administrative Services (DAS) to establish co-prescription guidelines pursuant to Title 26, Chapter 55 for the UDOH by November 1, 2017. The rule will now undergo a 30-day public comment period.

Co-prescribing Guideline Development

Over the last six months, the UDOH VIPP worked with key stakeholders to draft the co-prescription guidelines rule. The co-prescribing guidelines were based on scientifically-based recommendations including the U.S. Centers for Disease Control and Prevention Guideline for Prescribing Opioids, American Medical Association Opioid Task Force, and the Utah Clinical Guidelines on Prescribing Opioids. The following stakeholders were provided an opportunity for input and feedback prior to submission of the rule for public comment as per 26-55-108: Physicians Licensing Board, Osteopathic Physician and Surgeon's Licensing Board, and the Division of Occupational and Professional Licensing. In addition, the Utah Department of Health, the Utah Medical Association, the Utah Coalition for Opioid Overdose Prevention Provider Training and Patient Education Workgroup,the Intermountain Healthcare Opioid Community Collaborative Provider Workgroup, health insurance agencies, and pharmacists.

There has not been sufficient time to conduct an analysis of the application and impact of the rules. However in the future, VIPP will develop and implement a policy evaluation plan to conduct this analysis over time.

References

1. Coffin, Behar et al, "Nonrandomized intervention of Naloxone Co-prescription for Primary Care Patients Receiving Long Term Opioid Therapy for Pain", Annals of Internal Medicine, 20 August 2016. For patients who received a prescription for naloxone, there was a reduction in emergency department visits by 47 percent after 6 months and 63 percent after one year.
2. Behar, Rowe et al, "Primary Care Patient Experience with Naloxone Prescription", Annals of Family Medicine, September 2016.
3. Behar, Rowe et al, "Acceptability of Naloxone Co-Prescription Among Primary Care Providers Treating Patients on Long-Term Opioid Therapy for Pain", Journal of General Internal Medicine, November 2016.
4. Davis, Burris et al, "Co-prescribing Naloxone Does Not Increase Liability Risk", Journal of Substance Abuse, October 2016.