Prescription Monitoring Program Annual Report

Calendar Year 2023

Required by Title 22 §7250 (8)

Submitted to the Joint Standing Committee on Health and Human Services

Prepared by:
Prescription Drug Monitoring Program
Office of Behavioral Health
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Contents

Section 1: Background and 2023 Activities

1A: Requirements of the Annual PMP Report

Pursuant to P.L. 2017, Ch. 460, the department shall provide to the joint standing committee of the Legislature having jurisdiction over health and human services matters at the beginning of each year, and at such other times as the committee requests the following information:

- Data pertaining to the aggregate number of prescriptions of each drug required to be included in the program [Section 2].
- The number of prescribers participating in the program categorized by specialty [Section 3],
- Historical trends or patterns in prescribing practices within the State.
- Progress in the implementation of information sharing agreements authorized by subsection 4-A [Section 4].
- Information pertaining to the work of the program as requested by the committee that is reasonably available to the department, as long as all information reasonably likely to reveal the patient or the prescriber or other person who is the subject of the information has been removed.

1B: Functions of the PMP

- Database
  - Statewide, internet or electronic health record embedded database of all controlled substances (Schedules II, III, IV) dispensed by pharmacies licensed by the state of Maine.
  - Contains 5 years of prescription history which allows prescribers to assess prescription drug utilization.
- Clinical Tool
  - Promotes informed prescribing and dispensing by providing information about individual patient risk factors.
  - Triggers alerts to prescribers regarding certain prescription decisions.
  - Deters misuse and diversion by maintaining a centralized record of prescriptions.
- Peer Comparison
  - Allows prescribers to view prescribing numbers in comparison to peers.
- Monitoring
  - Develop and tracks metric related to higher risk prescribing practices (i.e. high dose opioids, opioid-benzodiazepine co-prescribing).
  - Monitor PMP data to identify trends, areas of concern, or opportunities for support.
- Reporting Tool
  - Provides data in an analytic platform to facilitate population analysis of prescribers, dispensers, and patients.

1C: Definitions

- Delegate– A staff member authorized by a prescriber to access PMP data on the prescriber's behalf.
- Lorazepam Milligram Equivalents (LME) – The standard value utilized to compare benzodiazepine doses and potency.
- Medications for the treatment of Opioid Use Disorder (MOUD) – The three FDA approved prescription medications for OUD; the PMP tracks only one, buprenorphine, typically in the form of buprenorphine-naloxone.
- Morphine Milligram Equivalents (MME) – The standard value utilized to compare opioid doses and potency; doses greater than 100MME per day require the use of an exemption code in Maine.
- Opioid full agonist – A drug that fully activates the opioid receptors in the brain; the term 'opiate' is frequently used instead of the more comprehensive 'opioid' (some opioid numbers do not include buprenorphine, a partial agonist).
- Opioid partial agonist – A drug that activates the opioid receptors in the brain differently than a full agonist and causes less respiratory depression.
- Patient report **–** A report that displays the controlled substance prescription activity for a specific patient.
- Substance Use Disorder (SUD) – A chronic disease of the brain with specific diagnostic criteria; the medical term addiction is also used.
- Total quantity – The total number of doses for a specific medication (tablets, capsules, patches or kits, not including liquids).

1D: Mapping 2023 PMP Activities to the Maine Opioid Response 2023-2025 Strategic Action Plan

Priority and Strategy	2023 PMP Activity
Priority A: Build a statewide infrastructure to support evidence-based and community-focused actions in response to Maine's opioid crisis	
Strategy #4f: Continue to share key data to inform policy and program design.	• Members of the PMP team meet weekly with the Director of Opioid Response and UMaine research team. • Members of the PMP team work with the Overdose Data to Action (OD2A) grant program. • Members of the PMP team attend and participate in monthly DHHS Opioid Coordinating Council meetings. • The PMP Advisory Committee, comprised of internal and external stakeholders, meets quarterly, and is chaired by Stephanie Nichols, PharmD, faculty at UNE School of Pharmacy and Tufts School of Medicine.
Strategy #6d: Support stigma and discrimination reduction efforts, including continuing education courses for health care providers, first responders, and frontline support staff, emphasizing that mental illness and SUDs are chronic medical conditions	• The PMP team includes messaging about the nature of substance use disorders as chronic diseases and barriers to treatment in Continuing Medical Education programs to prescribers. • Courses also contain discussion around stigma faced by patients with chronic pain on chronic prescribed opioids, particularly when they need a new prescriber. • Members of the PMP team work with the CDC Project to Prevent Prescription Drug/Opioid Overdose-Related Deaths grant which includes anti-stigma efforts.
Priority B: Reduce the percentage of Mainers who develop a substance use disorder	
Strategy #10b: Support the Maine Prevention Network partners in their efforts to educate parents and communities on the risks and impacts of early use of addictive substances.	• The PMP team includes messaging about the harms of controlled substance exposure at ages less than 18 (and 25) in Continuing Medical Education programs to prescribers.
Priority C: Reduce the number of prescribed, illegally trafficked, and unsafely stored opioids	
Strategy #13a: Support clinician adherence to evidence-based guidelines for opioid prescribing through the SUD Learning Community and other academic detailing trainings	• The PMP sponsored a summer webinar series in partnership with the SUD Learning Community and works with the MICIS Academic Detailing program to refer controlled substance prescribers for one-on-one CME on evidence-based pain management strategies. • The PMP also communicates directly with prescribers and delegates regarding the 'Mandatory Use' law and best practices and workflows to check the PMP prior to prescribing opioids and benzodiazepines and every 90 days, if continued.

Strategy #13b: Continue to offer the Controlled Substances Stewardship Program to practices & providers to assist with tapering opioids	• The PMP suggests prescribers who prescribe controlled substances at rates higher than their same specialty peers to contact the Controlled Substances Stewardship Program.
Strategy #13c: Continue to improve the ability of the Prescription Monitoring Program (PMP) to identify and engage high prescribing providers with information and educational opportunities, and where appropriate, referral to relevant licensing boards	• The PMP Higher risk prescribing referral program has identified prescribers who appeared to be prescribing controlled substances at rates higher than their same specialty peers (1.7% of all controlled substance prescribers) and referred them to a voluntary education program and, for those with the highest numbers (less than 0.4% of all controlled substance prescribers), to relevant licensing boards. • The PMP has also completed a lengthy process to receive new CMS funding for the PMP.
Strategy #13d: Support drug take-back days and the availability of secure disposal sites that can be accessed 24/7	• Outreach to prescribers (particularly to acute/procedural prescribers) includes messaging about 'anticipatory guidance' with patients before procedures to include information about risks of opioids as well as safe storage and disposal options. • The PMP team works with the CDC's SPF-Rx and PDO grant teams to increase education and access to primary prevention strategies.
Priority D: Build harm reduction skills and improve public understanding that everyone has a role to play in preventing overdoses and saving lives	
Strategy #18d: Expand the convening of community conversations to listen and share information and educational materials on harm reduction strategies	• Outreach to prescriber and healthcare communities introduces the concept of harm reduction to healthcare providers. • Outreach includes recommendations about prescribing opioid overdose reversal medications and Low Barrier MOUD. • Outreach includes harm reduction strategies for patients on high-dose prescribed opioids and/or combination prescribed opioids and benzodiazepines.
Strategy #19d: Support all hospitals and health centers in implementing best practice system improvements, including Integrated Addiction Teams (IATs) where appropriate and as resources allow	• As part of the Higher Risk Prescribing outreach, the PMP Clinical Advisor reviews best practices with referred clinicians and practices. • The PMP also refers clinicians to the Technical Assistance support offered by the Maine SUD Learning Community and is working with the SUD Learning Community on a webpage dedicated to PMP-related controlled substance prescribing resources for prescribers and health system leaders. • The PMP has had multiple meetings with health system leaders and is developing best practice guidance on utilizing the CMO (Chief Medical Officer) PMP portal, termed 'Organization Management.'

Priority E: Reduce the number of fatal and non-fatal overdoses	
Strategy #21b: Educate health care providers about the opportunities and importance of prescribing naloxone, including co-prescribing naloxone to any patient receiving long-term high dose opioids	• All PMP CME sessions includes information on liberal prescribing of naloxone/overdose reversal agents to many patient groups. • Members of the PMP team work closely with the Overdose to Action grant project manager and initiatives.
Strategy #25c: Continue to provide education and technical assistance support for MOUD providers, through the SUD Learning Community and similar initiatives	• Through the PMP webinar series in summer 2023, the PMP worked in conjunction with the SUD Learning Community to provide education for prescribers of and other providers of controlled substances.
Priority F: Expand the availability of treatment that is local, immediate, affordable, and most appropriate for the patient	
Strategy #26e: Research thresholds for safe prescribing of stimulants	• The PMP team has attended educational programs on stimulant prescribing and met with the New York PMP team to learn more about their stimulant prescribing assessment program.
Priority G: Increase the proportion of persons with SUD/OUD who seek or are in treatment	
Strategy #27a: Promote Treatment Connection, Maine's treatment and recovery tool which will include counseling, group therapy, and peer-to-peer supports, among providers and the public when fully operable and available to the public	• The PMP produced a one-page resource for MOUD patients who need to locate a new buprenorphine prescriber. It is located on the home page of the Office of Behavioral Health.
Strategy #28f: Simplify and integrate the behavioral health, mental health, and substance use disorder systems of care into the general medical care system, with an emphasis on improving patient experience and outcomes	• The PMP assists with providing data on MOUD (buprenorphine prescribing) to inform and measure success of programs within DHHS to increase access to MOUD by increasing the number of prescribers in Maine prescribing buprenorphine. • As of 1/1/23, the Federal requirement to obtain additional certification to prescribe buprenorphine was eliminated.

Section 2: Aggregate Numbers of Prescriptions

Table 1 presents the top 25 controlled prescriptions dispensed (or filled) in Maine throughout 2023. The full list of dispensation data for all medications recorded by the PMP can be found in Appendix A.

Table 1: 25 Most Frequently Prescribed Controlled Medications in Maine, 2023

Rank	Generic Name	Example Brand Name	Drug Class	Prescription Count
1	buprenorphine products	Suboxone™	opioid partial agonist	285,275
2	dextroamphetamine/ amphetamine	Adderall™	stimulant	278,284
3	oxycodone	generic (immediate release), Oxycontin™ (extended release)	opioid full agonist	185,137
4	lorazepam	Ativan™	benzodiazepine	155,315
5	methylphenidate	Concerta™, Ritalin™	stimulant	146,783
6	lisdexamfetamine	Vyvanse™	stimulant	140,298
7	hydrocodone/acetaminophen	Lortab™, Vicodin™	opioid full agonist	127,051
8	clonazepam	Klonopin™	benzodiazepine	111,200
9	tramadol	Ultram™	opioid full agonist	107,723
10	zolpidem	Ambien™	sedative	78,641
11	alprazolam	Xanax™	benzodiazepine	74,000
12	morphine	generic, Avinza™, Kadian™, MS Contin™	opioid full agonist	47,139
13	diazepam	Valium™	benzodiazepine	46,397
14	dexmethylphenidate	Focalin™	Stimulant	45,160
15	pregabalin	Lyrica™	anticonvulsant	42,535
16	oxycodone/acetaminophen	Percocet™	opioid full agonist	32,590
17	testosterone		Hormone	30,337
18	phentermine	Adipex™	Stimulant	22,698
19	hydromorphone	Dilaudid™	opioid full agonist	22,526
20	phenobarbital		barbiturate	13,572

21	Fentanyl	Duragesic™ (patch)	opioid full agonist	12,396
22	acetaminophen with codeine	Tylenol™ #3	opioid full agonist	12,101
23	methadone		opioid full agonist	11,217
24	Eszopiclone	Lunesta™	sedative	10,291
25	temazepam	Restoril™	benzodiazepine	7,326

Source: *Maine Office of Behavioral Health*

Section 3: Number of Prescribers Participating

This section contains information on prescribers registering with and using the PMP. Due to the structure of data collection by the PMP vendor, we are only able to report out on controlled substance prescribers by specialty group for the first six months of 2023.

Table 2: PMP Registrants by Prescriber Type

Prescriber Type	Distinct Users
Physician (MD, DO)	4,324
Nurse Practitioner / Clinical Nurse Specialist	1,796
Physician Assistant	961
Dentist	444
Medical Resident with Prescriptive Authority	339
Veterinarian	285
Midwife with Prescriptive Authority	57
Podiatrist (DPM)	55
Optometrist	5
Total	**8,266**

Source*: Maine Office of Behavioral Health*

Table 3: Active Controlled Substance Prescribers by Specialty Group, January-June 2023

Specialty Grouping	Controlled Substance Prescribers
Medical	2471
Medical	2471
Emergency, Acute Care, Hospitalist	644
Surgical & Obstetric	579
Psychiatry & Neurology	543
Veterinarian	286
Dental	221
Pediatric	206
Orthopedic	168
Hematology & Oncology	121

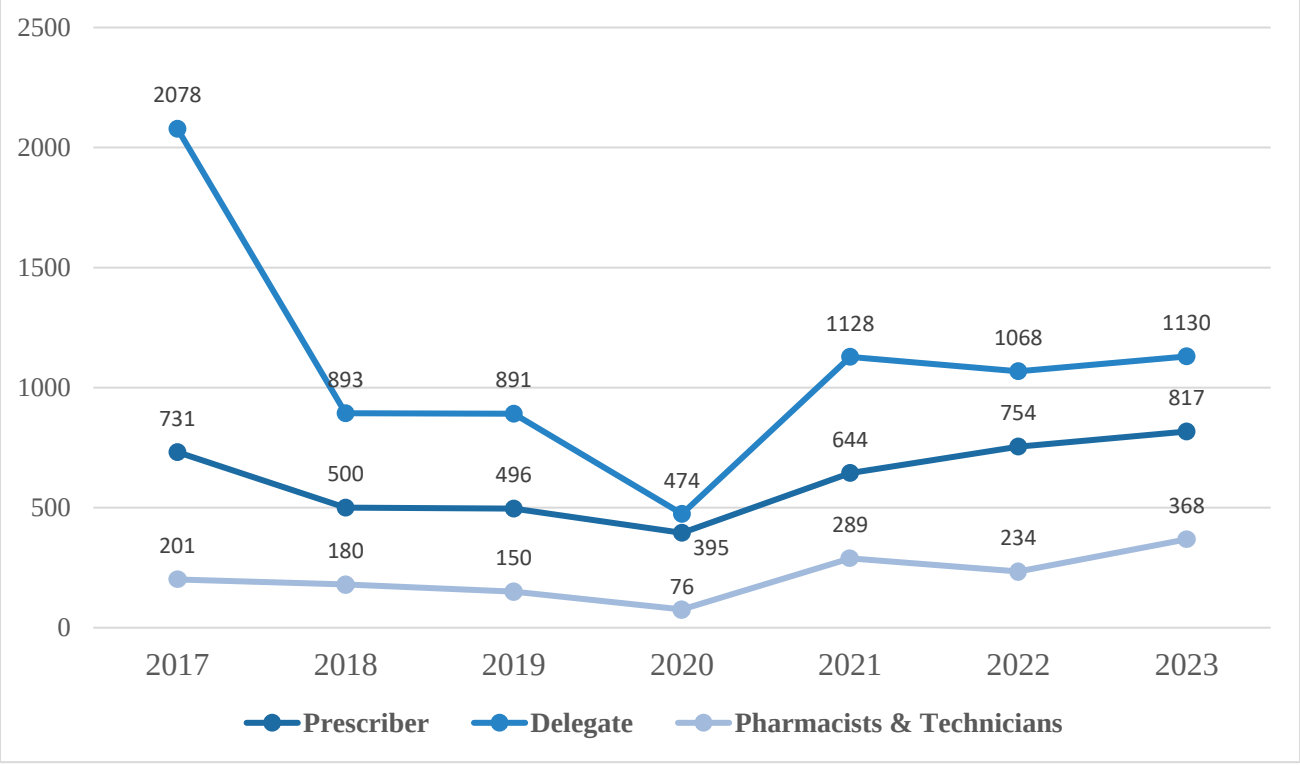
Source: Maine Office of Behavioral Health

Pain & Rehabilitation	82
Addiction	74
Hospice & Palliative Care	67
Podiatry	45
Oral surgery	40
Total	**5,547**

3A: PMP Registrants

New registrations to the PMP vary year over year. The surge of delegate registrations in 2017 is likely to be the result of Chapter 488, passed in mid-2016. This law had multiple opioid prescribing provisions, including 'Mandatory Use,' which requires checking of the PMP upon prescribing and opioid or benzodiazepine and every 90 days if continued. The decreases noted in 2020 are likely artifactual as a transition to a new PMP platform was initiated and subsequently reversed. For several months in 2020, both platforms were operational.

Figure 1: Yearly New PMP Registrants



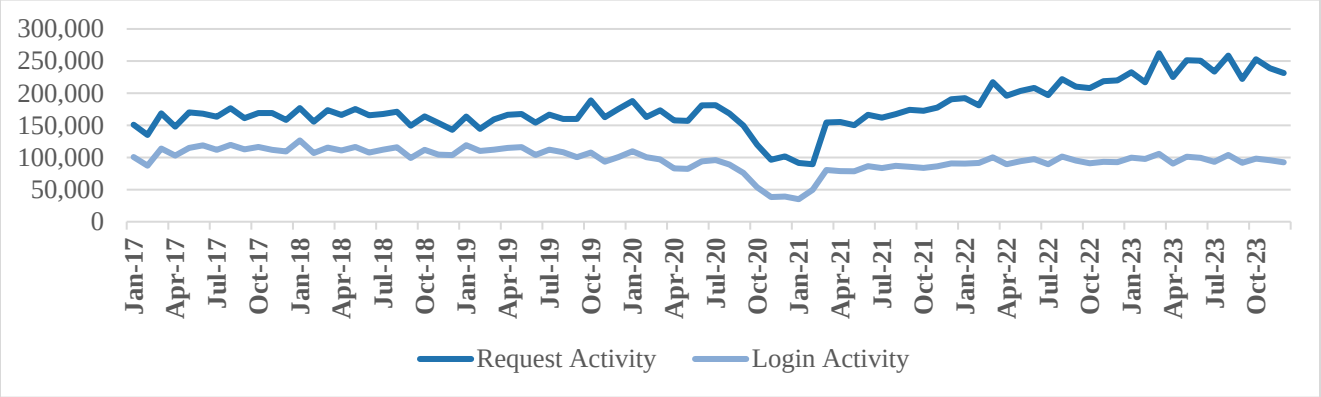
***Source**: Maine Office of Behavioral Health*

3B: Utilization of the PMP

While log in episodes to the PMP have decreased somewhat over the past 7 years, the number of patient reports requested has steadily increased since the end of 2021. In fact, patient report

requests in 2022-2023 increased 36% over the prior two-year period. Additional information on patient report requests from 2012-2023 can be found in Appendix B.

Figure 2: PMP Logins and Patient Report Requests, 2017-2023

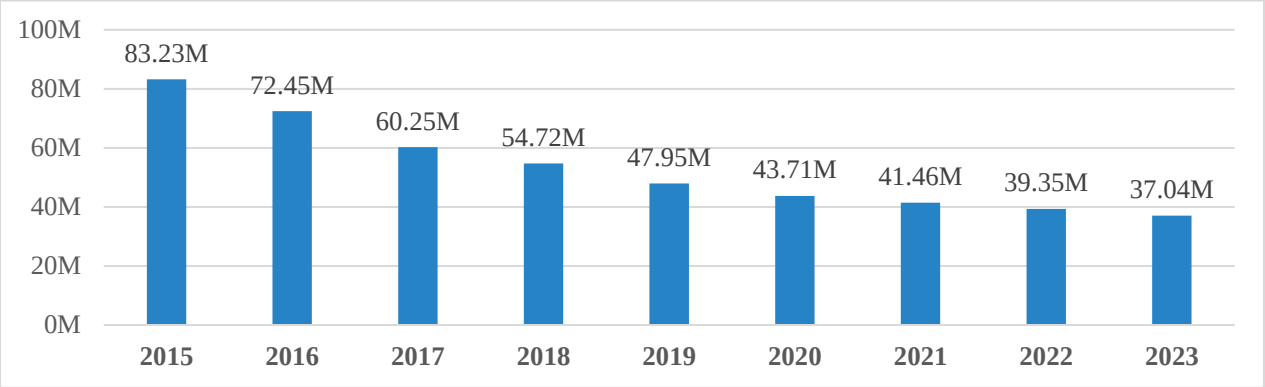


Section 4: Trends and Patterns in Prescribing Practices

4A: Opioids

The quantity of opioid doses dispensed in Maine has continued to decrease over the past 9 years after an all-time high in the four years before 2015. Available data illustrate that between 2018 and 2023, the quantity of opioids dispensed decreased 32% and the amount of opioid, measured in MMEs, decreased 36%. Liquid formulations are excluded due to different units of measurement and their use in excluded settings such as hospice or palliative care. See Appendix C for additional information.

Figure 3: Quantity of Opioid Doses Dispensed, 2015-2023

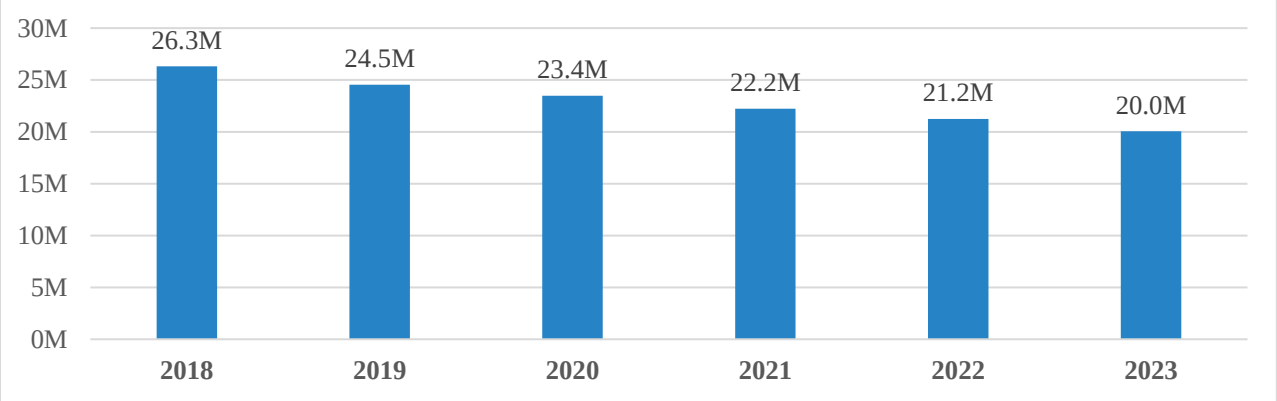


***Source**: Maine Office of Behavioral Health*

4B: Benzodiazepines

The quantities of benzodiazepines dispensed in Maine has decreased each year since 2015. Data available illustrate that between 2018 and 2023, the quantity of benzodiazepine tablets/capsules dispensed decreased 24% while the amount of benzodiazepine, measured in LMEs, decreased 20%. Please see Appendix D for additional information.

Figure 4: Quantity of Benzodiazepine Doses Dispensed, 2015-2023

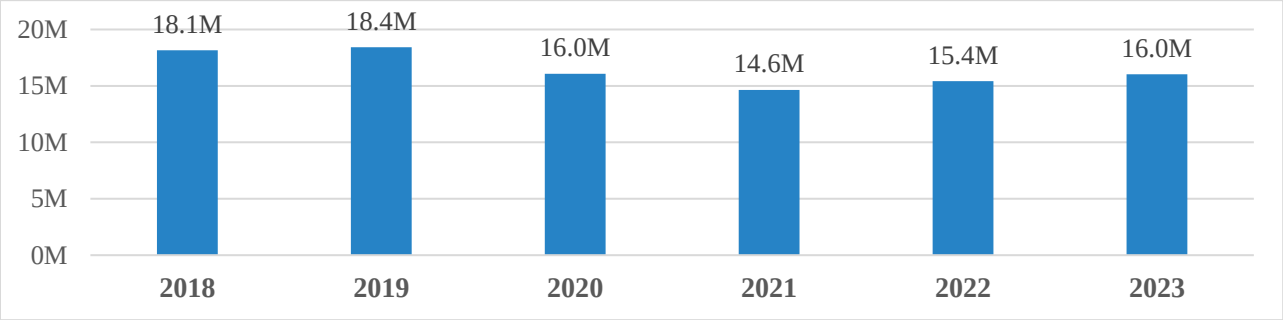


***Source**: Maine Office of Behavioral Health*

4C: Stimulants

The trend related to stimulant dispensations statewide throughout 2023 is less clear than other classes of controlled medications. Since 2021, the number of stimulants dispensed has increased. However, this mirrors a national trend of increased stimulant prescriptions and medication shortages in many states.

Figure 5: Quantity of Stimulant Doses Dispensed, 2015-2023

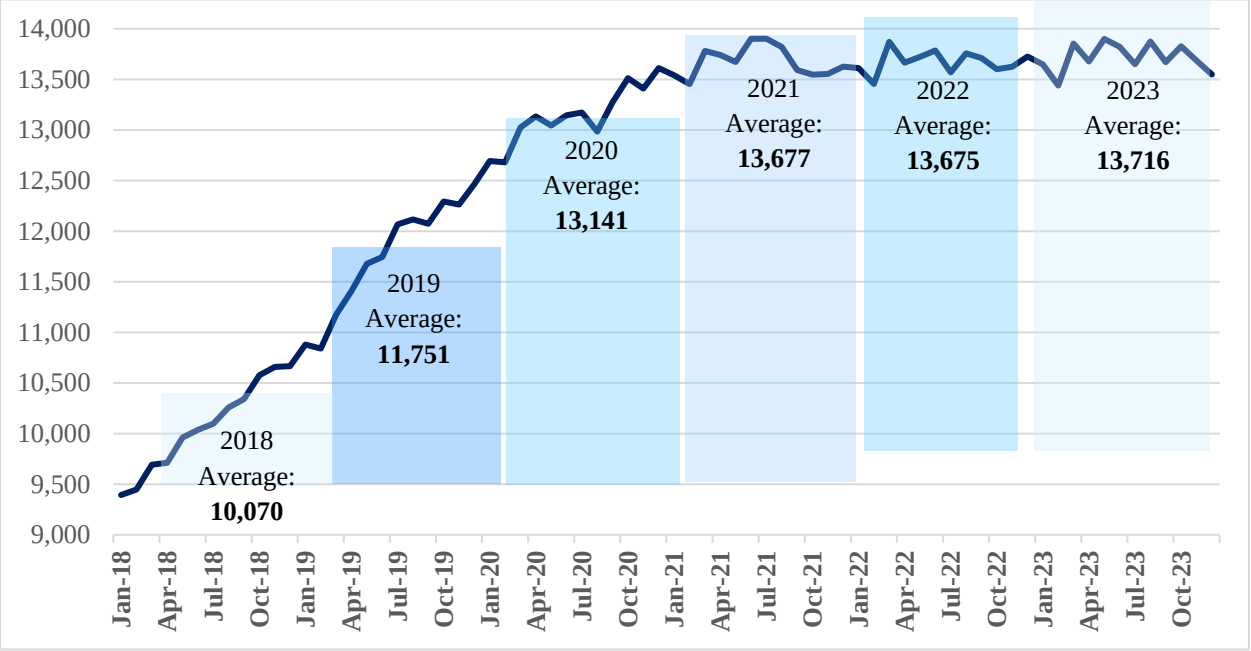


***Source:** Maine Office of Behavioral Health*

4D: Medications for Opioid Use Disorder (MOUD)

While three medications are FDA approved for the treatment of opioid use disorder (OUD), oral/sublingual buprenorphine dispensed by outpatient pharmacies is the only form tracked in the PMP. The number of patients receiving at least one buprenorphine prescription each month in Maine has remained steady over the past three years. To fully explore MOUD utilization in Maine, additional data are required. However, claims data indicates other forms of MOUD have been increasing over the last two years.

Figure 6: Unique Patients Receiving At Least One Buprenorphine Prescription 2018-2023



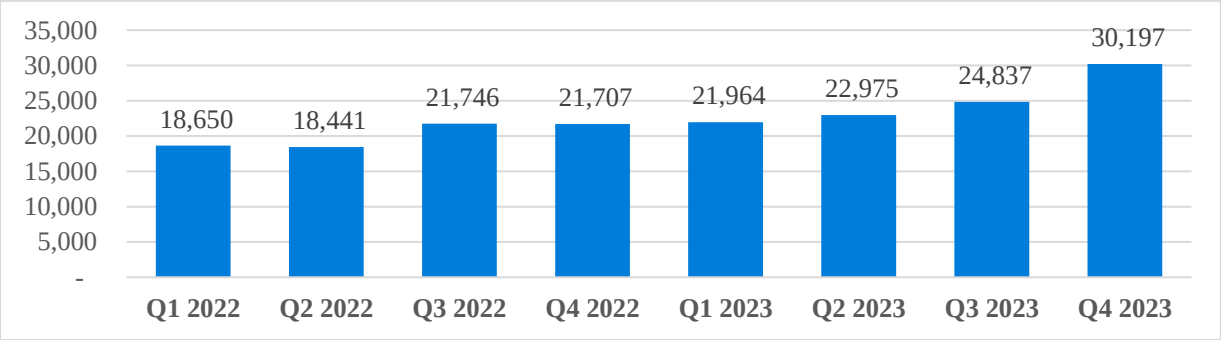
4E: Higher Risk Prescribing Clinical Alerts

When certain types of higher risk prescribing occur, and additional clinical attention may be warranted, Maine's PMP automatically generates alerts on a prescriber's PMP web-based dashboard and subsequent patient reports. The two most common alerts are:

- Prescription of an opioid(s) that exceeds 100 MME/day (high dose alert)
- Co-prescribing of an opioid and benzodiazepine

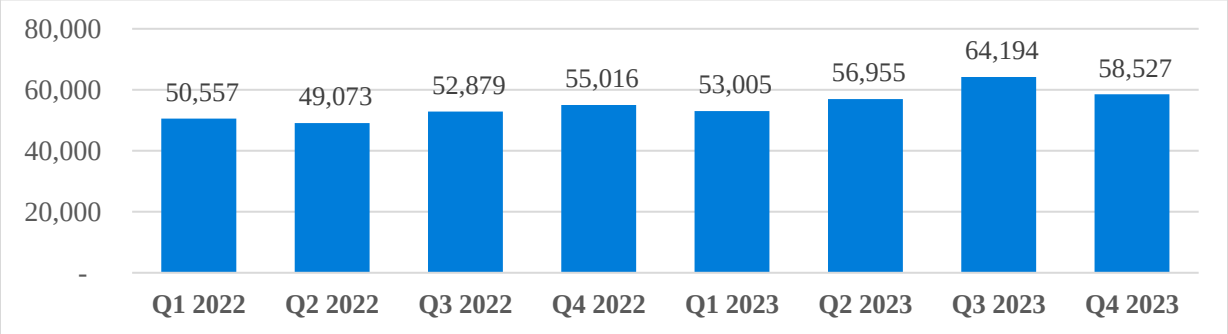
The number of alerts generated for high dose opioid prescribing (greater than 100 MME) have increased from 2022 into 2023. From other data in the PMP, it is known that the number of patients receiving high dose opioids is decreasing. Likewise, while the number of alerts for concurrent opioid-benzodiazepine prescribing has also generally risen, other data indicate that the numbers of patients with overlap has been decreasing. One possible explanation for this increase might be related to team-based care where multiple prescribers are caring for and prescribing for the same patient. The pros and cons of this approach to higher risk prescribing will be discussed in some of the PMP continuing medical education outreach in 2024.

Figure 7: Clinical Alerts for Opioid Prescribing over 100 MME, 2022-2023



Source: *Maine Office of Behavioral Health*

Figure 8: Clinical Alerts for Opioid-Benzodiazepine Co-prescribing, 2022-2023



Source: *Maine Office of Behavioral Health*

4F: High Dose Opioid Prescribing

The 2022 CDC Pain Treatment Guideline both advises against setting absolute limits on opioid doses and recommends in depth, ongoing assessments of risks and benefits of doses greater than 50 MME. Chapter 21 rules issued jointly by the Maine Licensing Boards governing prescribers require that patients on doses of greater than 90 MME, or who are considered high risk, have a thorough review documented every 1-3 months. Patients on high dose and/or long-term opioid treatment should not have doses abruptly decreased or rapidly tapered.

Table 4: Patient Count for Patients Receiving over 100 MMEs by County of Patient Residence, 2018-2023

Patient County	2018	2019	2020	2021	2022	2023
Androscoggin	339	271	202	202	155	132
Aroostook	99	91	89	81	83	64
Cumberland	749	605	532	452	428	375
Franklin	120	98	72	64	51	39
Hancock	125	105	93	76	56	59
Kennebec	393	332	285	273	251	224
Knox	118	83	87	81	67	48
Lincoln	119	83	93	91	71	68
Oxford	192	146	151	159	124	105
Penobscot	465	337	269	262	239	172
Piscataquis	50	40	37	30	29	21
Sagadahoc	84	75	65	55	46	44
Somerset	168	149	124	118	108	87
Waldo	118	83	89	78	71	58
Washington	79	56	55	44	39	40
York	687	568	507	433	376	333
State Total	**3,905**	**3,122**	**2,750**	**2,499**	**2,194**	**1,869**

Note: *Versions of this table in prior annual reports utilized county where the prescription filled instead of county of patient residence, so comparisons with prior years should not be attempted.*
Source: *Maine Office of Behavioral Health*

4G: PMP Outreach to Higher Risk Prescribers

In accordance with Governor Mills' vision of leveraging the Maine PMP as a proactive public health outreach mechanism to improve controlled substance prescribing, the PMP Team began identifying higher-risk prescribers in 2022. Monitoring of high-risk prescribers includes assessment of key metrics including opioid prescription volume, dosage, and co-prescription of other medications known to raise patients' risk of overdose.

Identification of prescribers engaged in higher risk prescribing practices is done through a comparative process utilizing thresholds specific to medical specialty groups. Dispensation information is used to generate a mean and standard deviations for key metrics specific to each specialty group. Each prescriber within the specialty group is then compared to these thresholds to determine if they meet or exceed two standard deviations on any of the key metrics. Data analysis applies the specialty specific threshold to all active prescribers, and those who meet or exceed two standard deviations are then reviewed to determine next steps, this occurs every six months. Additionally, PMP staff review data regularly looking for patterns and trends, or other data that may warrant additional exploration.

If a prescriber is identified as engaging in higher risk prescribing practices determined by threshold comparison or identification of unusual activity, there are two primary responses initiated by PMP staff. First, the prescriber is contacted and invited to pursue an "Education Pathway" voluntarily. The Education Pathway leverages multiple state supported resources to provide continuing education on best practices for controlled substance prescribing, peer-to-peer guidance, and academic detailing support. 1.7% of active controlled substance prescribers have been recommended to pursue an Education Pathway and their PMP data will be re-evaluated one year following notification.

With each phase of notifications, the PMP has adjusted the message and method of delivery resulting in more interaction with prescribers. The PMP team continues to work to balance communication to prescribers about monitoring of controlled substance prescribing with prescribers' concerns about newly assuming care of patients with complex medical histories who have been prescribed controlled substances chronically.

Table 5: Prescribers Referred to Education Pathway for Higher Risk Prescribing Mitigation

Education Pathway Referrals	Number	Responses	Response Rate
Phase I	28	17	61%
Phase II	40	29	73%
Phase III	21	21	100%
Phase IV	14	13	93%

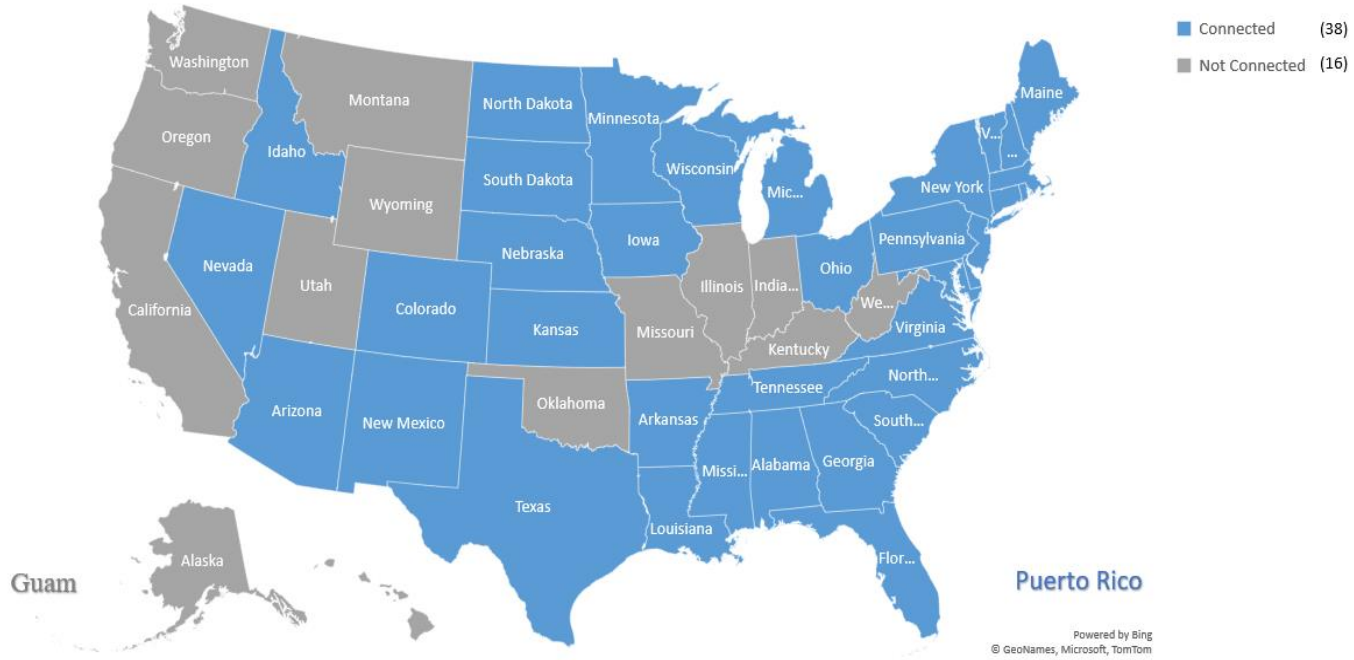
The second response, referring the provider to their licensing board for additional investigation, is pursued in instances where voluntary participation would impact the safety or wellbeing of a larger number of patients. To date, 21 providers, representing 0.4% of active controlled substance prescribers, have been referred to prescriber licensing boards for further evaluation.

Section 5: Information sharing

5A: PMP Data Sharing with Other States

Currently, Maine can share PMP data with 38 states/territories/systems, an increase of 4 from last year. The Military Health System/Veterans Administration maintains its own PDMP which is connected with the Maine PMP (not illustrated below). Interstate PMP connectivity is defined by state statute and regulation, as such Maine delegates are not allowed to make interstate data requests (only prescribers may make interstate requests).

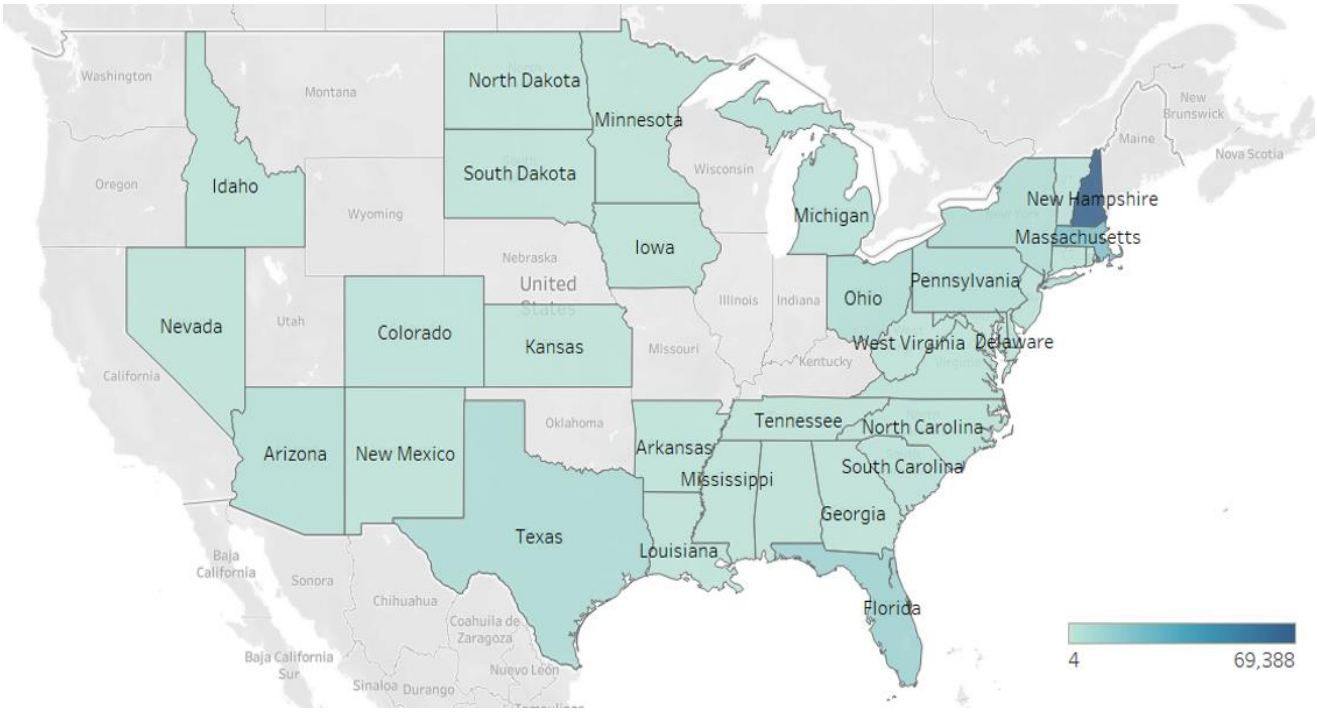
Figure 10: PMP Interstate Connectivity



Source: *Maine Office of Behavioral Health*

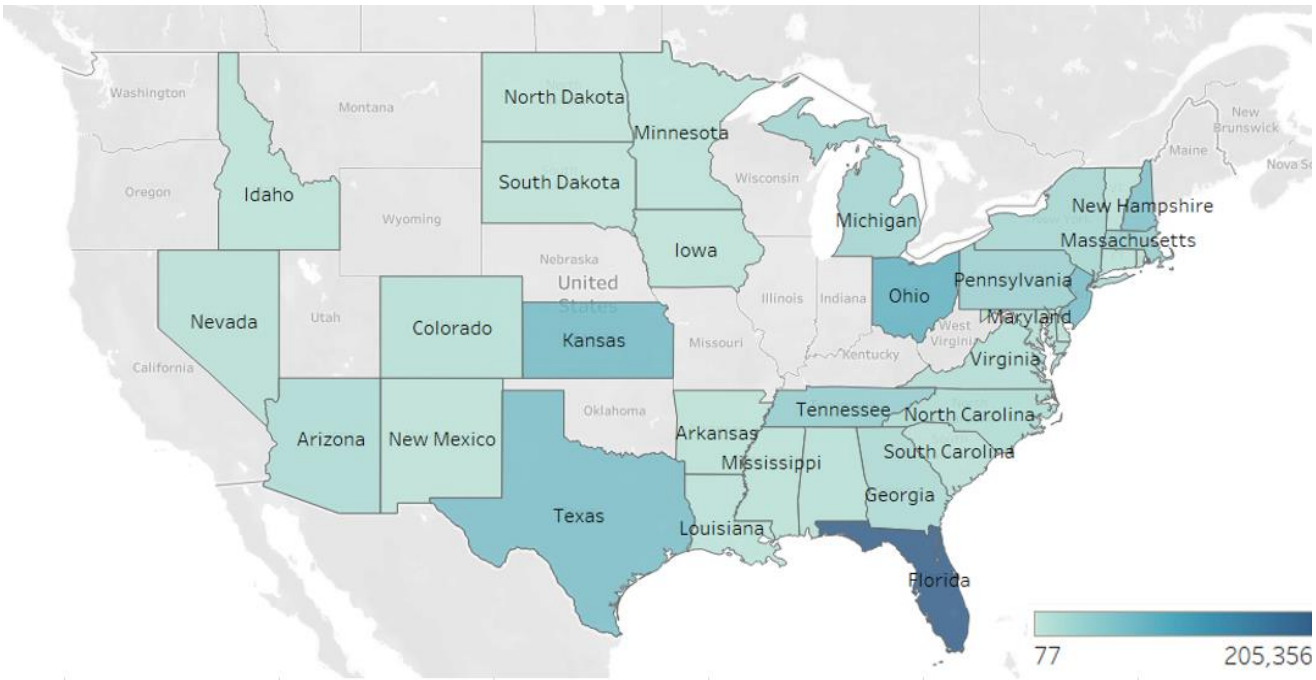
The following two heatmaps show the states with the highest activity of requests for information from Maine and the states most often sharing information with/to Maine. Some states may have interstate data sharing filters automatically turned on for prescribers whereas other states (such as Maine) require prescribers to make selections. Maine prescribers can choose to "turn on" incoming data sharing requests with available states for all patient searches or they may choose to select from available states differently for each patient search.

Figure 11: Heatmap of Interstate Data Sharing Where Other States Request Information from Maine



Source: *Maine Office of Behavioral Health*

Figure 12: Heatmap of Interstate Data Sharing Where Maine Receives Information from Other States



Source: *Maine Office of Behavioral Health*

Appendices

Appendix A: Aggregate Number of Prescriptions of Each Drug Required to be in the PMP

Generic Name	Prescription Count	Patient Count
acetaminophen with codeine phosphate	12,720	5,275
alprazolam	83,294	18,554
amphetamine	177	53
amphetamine sulfate	80	30
armodafinil	2,273	403
buprenorphine	8,053	1,483
buprenorphine HCl	41,521	3,328
buprenorphine HCl/naloxone HCl	261,154	17,136
butalbital/acetaminophen +/- caffeine*	3,579	1,037
butalbital/acetaminophen/caffeine/codeine phosphate*	1,233	248
butalbital/aspirin/caffeine*	1,833	502
butorphanol tartrate	409	46
carisoprodol	4,363	809
chlordiazepoxide HCl*	4,691	1,677
clobazam	3,704	434
clonazepam	120,276	17,470
clorazepate dipotassium	1,101	292
codeine phosphate or sulfate	519	156
codeine phosphate/butalbital/aspirin/caffeine	554	115
daridorexant HCl	275	105
dexmethylphenidate HCl	47,084	6,762
dextroamphetamine plain or sulfate	8,541	1,504
dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate	221,983	28,945
diazepam	51,440	17,847
diethylpropion HCl	69	14
dronabinol	1,396	453
eluxadoline	370	101
esketamine HCl	1,565	114
estazolam	120	32
estrogens,esterified/methyltestosterone	480	112
eszopiclone	11,561	2,287
fentanyl plain or citrate or PF	13,083	1,904
hydrocodone bitartrate	992	130
hydrocodone bitartrate/acetaminophen	132,286	39,120

hydrocodone bitartrate/homatropine methylbromide	1,957	905
hydrocodone polistirex/chlorpheniramine polistirex	3,018	2,162
hydrocodone/ibuprofen	341	80
hydromorphone HCl	24,545	7,929
hydromorphone HCl/PF	496	104
ketamine HCl	4,317	1,449
lemborexant	499	125
lisdexamfetamine dimesylate	148,814	22,155
lorazepam	166,635	49,162
meperidine HCl or /PF	68	11
methadone HCl	12,119	1,144
methylphenidate	877	185
methylphenidate HCl	168,060	23,692
midazolam	1,046	520
midazolam HCl	67	34
midazolam HCl/PF	152	101
modafinil	8,444	1,634
morphine sulfate	49,459	12,302
nandrolone decanoate	46	29
opium tincture	190	36
oxandrolone	25	17
oxazepam	1,011	185
oxycodone HCl	197,662	67,746
oxycodone HCl/acetaminophen	36,260	12,174
oxycodone myristate	3,132	422
oxymorphone HCl	545	55
perampanel	633	81
phendimetrazine tartrate	185	46
Phenobarbital*	14,226	2,789
phenobarbital sodium*	131	73
phentermine HCl	26,218	6,810
phentermine HCl/topiramate	1,255	345
serdexmethylphenidate chloride/dexmethylphenidate HCl	832	234
sodium oxybate	329	41
sodium oxybate/calcium oxybate/magnesium oxybate/pot oxybate	346	47
solriamfetol HCl	501	96
stanozolol micronized	27	15
suvorexant	1,786	469
tapentadol HCl	593	74

temazepam	8,090	1,493
testosterone	12,209	2,796
testosterone cypionate	24,683	5,798
testosterone cypionate, micronized	232	175
testosterone enanthate	1,009	291
testosterone micronized	3,929	1,512
testosterone propionate	68	29
testosterone undecanoate	155	40
tramadol HCl	115,328	34,726
tramadol HCl/acetaminophen or celecoxib	469	108
triazolam	2,639	1,529
zaleplon	1,799	523
zolpidem tartrate	86,511	16,159
total (prescriptions only)	**2,176,747**	**---**

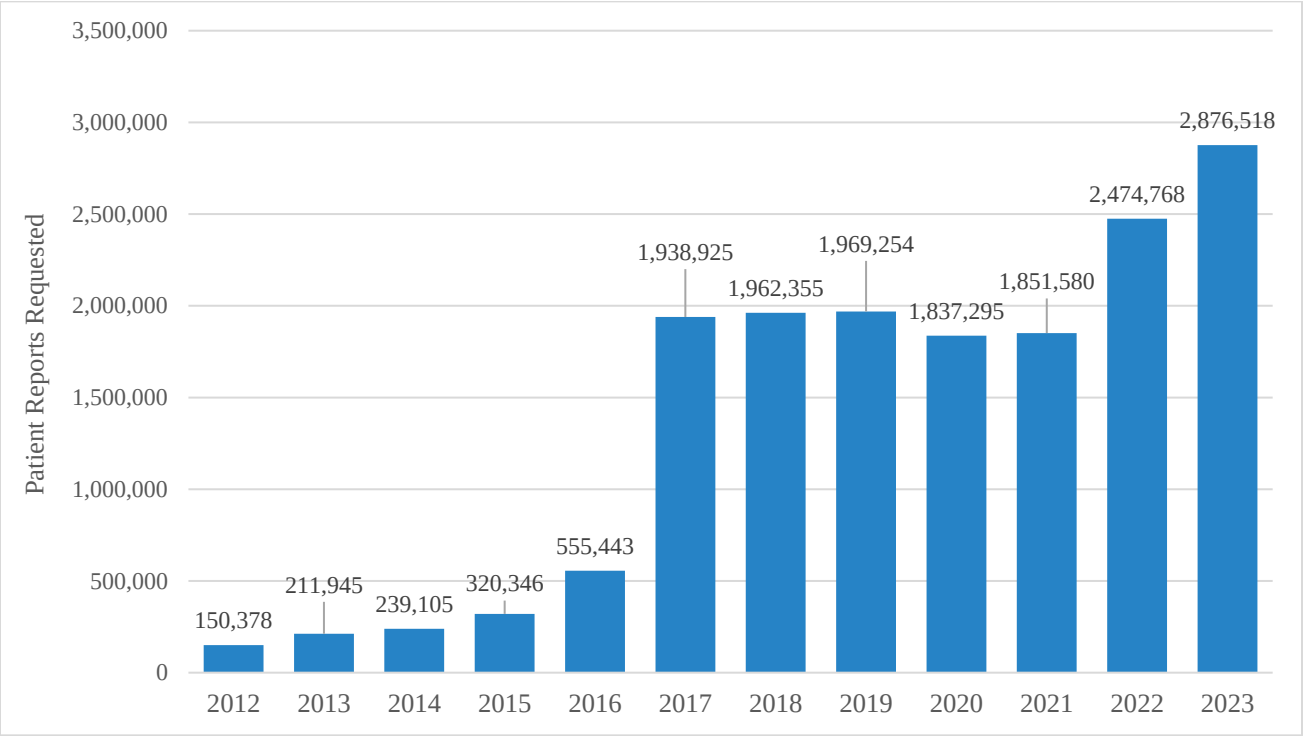
**some versions of combination medications containing these controlled substances are exempt from controlled substance status by the DEA*

Note:*11 medications, representing 0.005% of all controlled substance prescriptions in Maine in 2023, were suppressed/redacted to protect patient identity as they were prescribed to 10 or less patients during the year*

Source: Maine Office of Behavioral Health

Appendix B: Maine PMP Patient Report Requests, 2012-2023

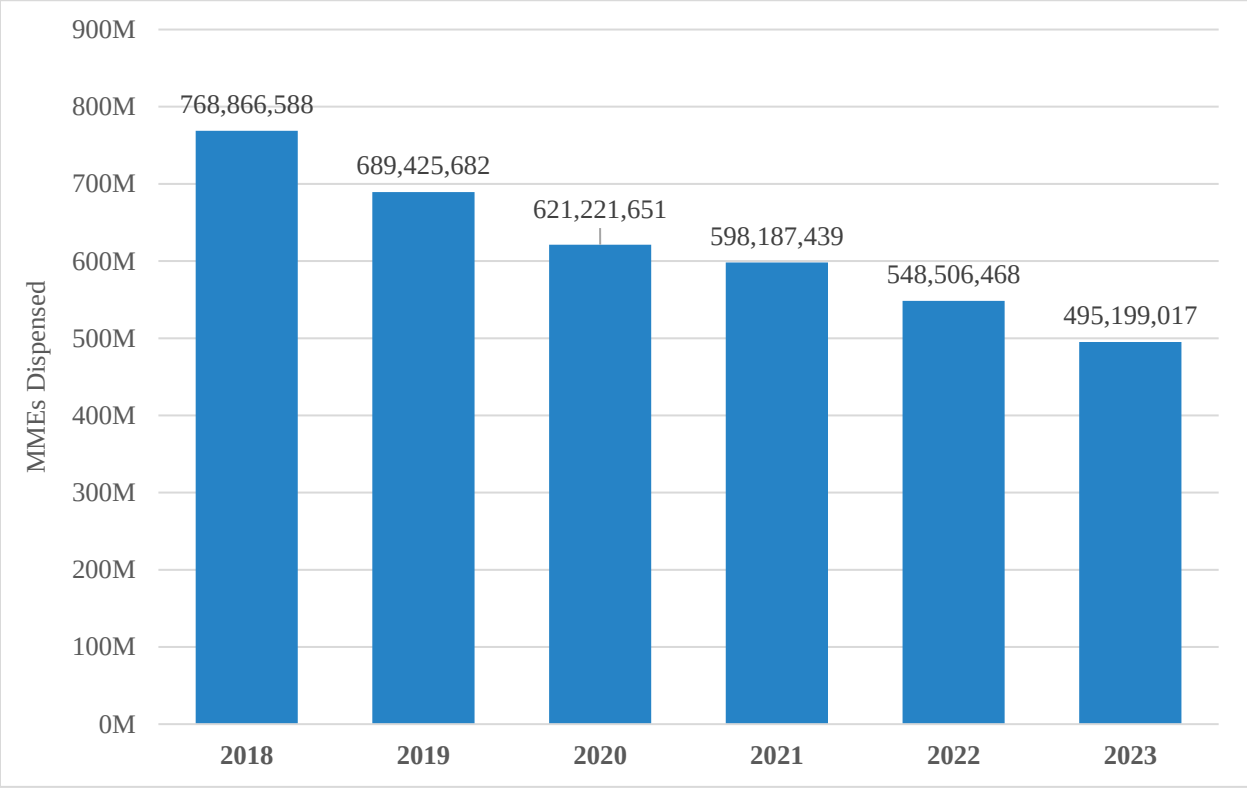
Two substantial increases in PMP patient report requests occurred in the past decade, 2017 and 2022-3. Chapter 488, the law requiring prescribers to check the PMP upon prescribing an opioid or benzodiazepine and every 90 days, was passed in 2016 and fully phased in in 2017. In 2022, the PMP staff added a clinical advisor and initiated increased communication to prescribers regarding the Chapter 488 requirement.



Source: *Maine Office of Behavioral Health*

Appendix C: Morphine Milligram Equivalents (MMEs) Dispensed, 2018-2023

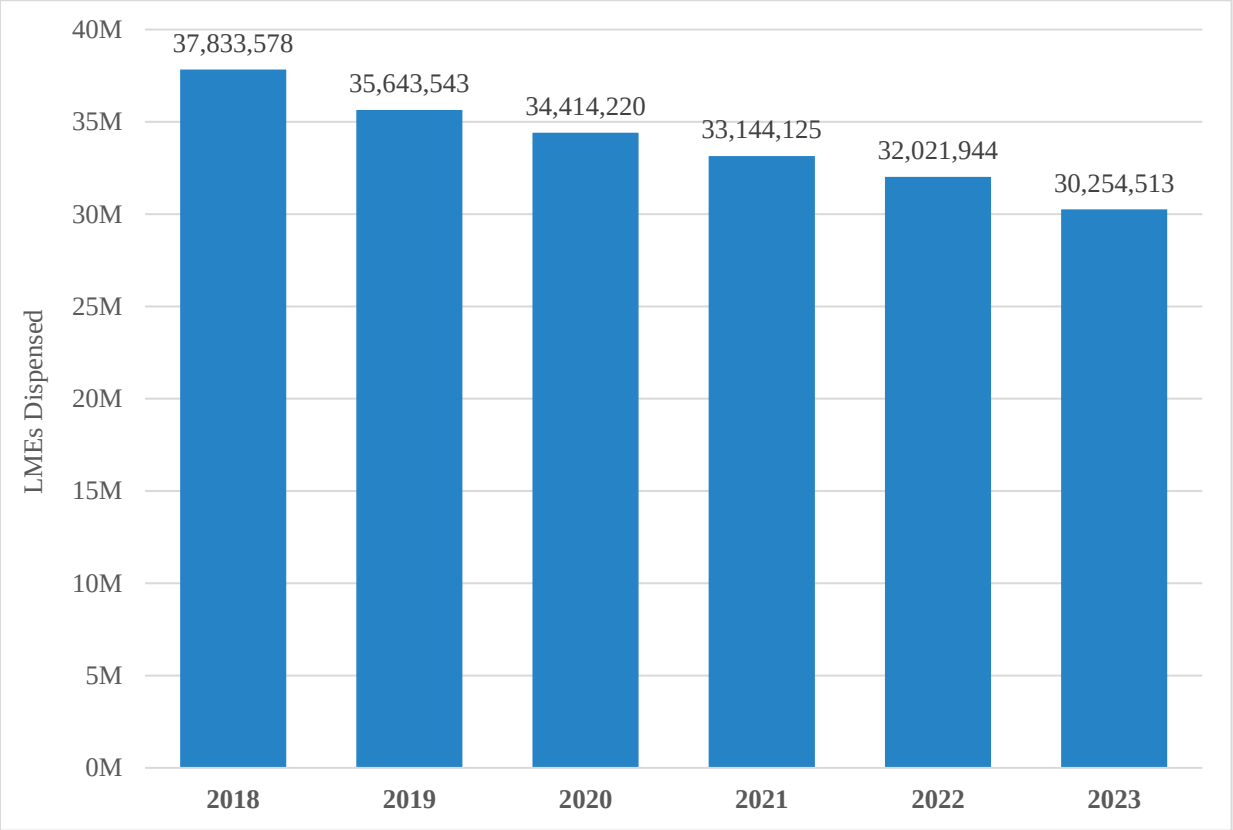
Morphine milligram equivalents (MMEs) are a standardized measurement, equivalent to the amount of morphine in a prescription per day. Usage of higher MMEs is associated with increased risk of nonfatal and fatal accidental overdose as well as other side effects. The height of the dose and the length of time taken are both associated with increased risk of developing opioid use disorder from taking prescription drugs. The number of units dispensed, the number of prescriptions and the amount of opioid have all decreased over the past 6 years.



Note: *Excludes doses dispensed in either milliliter or gram form.*
Source: *Maine Office of Behavioral Health*

Appendix D: Average Lorazepam Milligram Equivalents (LMEs) Dispensed, 2018-2023

Lorazepam milligram equivalents (LMEs) are used to assist in standardizing benzodiazepine doses. The higher the LME, the higher the risk of side effects. Some patients are at risk of developing benzodiazepine use disorder from taking prescription drugs. The number of units dispensed, the number of prescriptions and the amount of benzodiazepine have all decreased over the past 6 years, although they are decreasing at slower rates than the corresponding opioid numbers.



Note: *Excludes doses dispensed in either milliliter or gram form.*
Source: *Maine Office of Behavioral Health*