COMPARISON OF CDC GUIDELINES TO INDIANA PRESCRIBING RULE

	CDC RECOMMENDATIONS	INDIANA RULE REQUIREMENTS IF PRESCRIBING REACHES A CERTAIN THRESHOLD*
OPIOID AVOIDANCE	The use of nonpharmacologic therapy and nonopioid therapy are preferred for chronic pain – only consider opioid therapy if expected benefits for pain and function will outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic and nonopioid therapy, as appropriate.	Where medically appropriate, use non-opioid options instead of or in addition to prescribing opioids.
TREATMENT PLAN	Before starting opioid therapy, establish treatment goals and consider how therapy will be discontinued if benefits don't outweigh risks. Continue therapy only if there is a clinically meaningful improvement in pain and function that outweighs risks to patient safety.	After completing an initial patient evaluation, establish a working diagnosis and tailor a treatment plan to meaningful and functional goals with the patient, reviewing them from time to time. In the written Treatment Agreement about the patient, state the reasons that opioid therapy may be changed or discontinued by the physician. There is nothing that specifically addresses discontinuation of therapy if the risks outweigh the benefits.
RISKS AND BENEFITS	Before starting and periodically during opioid therapy, discuss with patients the known risks and realistic benefits of opioid therapy and clinician responsibilities for managing therapy.	The physician must discuss with the patient the potential risks and benefits of opioid treatment as well as expectations related to prescription requests and proper medication use.
DELIVERY MECHANISM	When starting therapy, prescribe immediate-release opioids instead of extended release/ long-acting opioids.	Not specifically addressed.

DOSE ESCALATION	Prescribe the lowest effective dose when beginning therapy. Use caution when prescribing at any dosage, and carefully reassess evidence of individual benefits and risks when increasing dose to ≥ 50 morphine milligram equivalents (MME) per day. Avoid increasing to ≥ 90 MME/day or carefully justify the decision to titrate the dose to ≥ 90 MME/day.	No requirement to prescribe the lowest effective dose when beginning therapy. For a morphine equivalent dose (MED) of > 60 mg/day, physician must have a face-to-face review of the treatment plan and patient evaluation must be scheduled, including consideration of referral to a specialist. If the physician decides to continue with a MED of > 60 mg/day, physician must develop a revised assessment and treatment program for ongoing treatment, which must be documented in the patient's chart, and includes an assessment of increased risk for adverse outcomes, including death.
DURATION	Long-term opioid use often begins with treatment of acute pain. When prescribing opioid for acute pain, prescribe the lowest-effective dose of immediate-release opioids and no greater quantity than needed. Three days or fewer will often be sufficient; more than 7 days will rarely be needed.	With the exception of hydrocodone-only extended release medication not in an abuse-deterrent form, the Indiana rule applies to treatment extending beyond 3 consecutive months.
PATIENT EVALUATION FREQUENCY	Evaluate benefits and harms within 1-4 weeks of starting therapy or dose escalation and again at every 3 months or more frequently. If benefits do not outweigh harm of continued therapy, optimize other therapies and work with patients to taper opioids to lower dosage or taper and discontinue the opioids.	Physicians must see patients with a stable medication regimen and treatment plan at least every 4 months. For patients requiring changes to the medication and treatment plan, the visits must be at least every 2 months. During these visits the physician must evaluate patient progress and compliance with the treatment plan and set clear expectations along the way, such as attending PT, counseling or other treatment options.
RISK MANAGEMENT	Evaluate risk factors for opioid-related harms before starting and when continuing opioid therapy. Incorporate into the management plan risk strategies to mitigate risk, including considering offering naloxone when there are factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, dosages ≥ 50 MME/day, or concurrent benzodiazepine use.	The physician must perform his/her own evaluation and risk stratification by performing an initial evaluation, which includes, among other things, assessing the patient's mental health status and risk for substance abuse using available validated screening tools. There is no requirement to have a plan to mitigate risk, which might include offering naloxone.

PDMP USE	Review the patient's history of controlled substances prescriptions using the state prescription drug monitoring program (PDMP) to determine whether the patient is receiving opioid dosages or dangerous combinations that put the patient at risk for overdose. Review the PDMP data when beginning opioid therapy and periodically during therapy, ranging from every prescription to every 3 months.	Review INSPECT at the outset of opioid therapy, and at least once a year after that. The physician must document whether the INSPECT report is consistent with the physician's knowledge of the patient's controlled substance use history.
DRUG TESTING	Use urine drug testing before starting opioid therapy and consider using urine drug testing at least annually to assess for prescribed medications as well as other controlled prescriptions and illicit drugs.	Any time the physician deems it medically necessary, whether at the beginning of therapy or any time thereafter, the physician must perform or order a drug monitoring test, including confirmatory testing. There are a number of factors for the physician to consider when determining whether a drug test is medically necessary, including whether there is reason to believe that the patient is diverting the opioids, patient attempts early refills, when the patient has a history of substance misuse, etc.
POLY-PHARMACY	Avoid prescribing opioids and benzodiazepines whenever possible.	Not specifically addressed.
OPIOID USE DISORDER	Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.	Not specifically addressed.

* Trigger for the Indiana requirements:

- 60 opioid-containing pills a month for more than 3 consecutive months; A MED of > 15 mg/day, for more than 3 consecutive months;
- Any dose of transdermal opioid patch for more than 3 consecutive months; A Tramadol MED of > 60 mg/day for more than 3 consecutive months; or
- Any dose of a hydrocodone-only extended release medication that is not in an abuse deterrent form.

Note: This comparison lists each of the CDC recommendations and compares each recommendation to Indiana's Opioid Prescribing Rules; the comparison does not list all of the requirements of Indiana's Opioid Prescribing Rules.

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