Despite the efforts of physicians, the public health community and elected officials, the opioid overdose and death epidemic continues in Alabama and across the nation. This toolbox contains important information and resources for physicians and health care professionals across the state.

**OPIOID RELATED MORTALITY IN ALABAMA 2012-2016**

Source: U.S. Centers for Disease Control and Prevention

**OPIOID PRESCRIPTIONS - ALABAMA**

Source: IQVIA

**PRESCRIPTIONS FOR:**
Buprenophine, Buprenophine/Naloxone, Methadone, Naloxone, Naltrexone.
TAKING RESPONSIBILITY
Reversing the Opioid Epidemic in Alabama

TREATING THE PATIENT’S PAIN WITH CARE AND COMPASSION

CHECK the state prescription drug monitoring program (PDMP) to ensure you have the information you need about your patient’s prescription history.

AVOID initiating opioids for new patients with chronic non-cancer pain unless the expected benefits are anticipated to outweigh the risks. Non-pharmacologic therapy and non-opioid therapies are preferred.

LIMIT the amount of opioids prescribed for post-operative and acute care. It is recommended that patients only receive the lowest effective dose for the shortest possible duration.

WHAT DO ALABAMA BOARD OF MEDICAL EXAMINERS REQUIRE?
For controlled substance Rxs totaling 30 MME/day or less, physicians are expected to use the PDMP in a manner consistent with good clinical practice.

For controlled substance Rxs totaling more than 30 MME/day, physicians shall review the patient’s Rx history in the PDMP at least two times per year.

For controlled substances more than 90 MME/day, physicians shall query the PDMP to review a patient’s Rx history on the same day the Rx is written.

ALABAMA LAW ALLOWS:
A licensed physician approved by the ADPH who has authority to prescribe, dispense, or administer controlled substances may designate up to two employees who may access the PDMP on the physician’s behalf.

MORPHINE MILLIGRAM EQUIVALENT REFERENCE GUIDE

<table>
<thead>
<tr>
<th>OPIOID (Doses in mg/day except where noted)</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl trans-dermal (mcg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
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<tr>
<td>41-60 mg/day</td>
<td>10</td>
</tr>
<tr>
<td>≥ 61-80 mg/day</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
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<tr>
<td>Oxymorphone</td>
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</table>

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

**DETERMINE** the total daily amount of each opioid the patient takes.

**CONVERT** each to MMEs - multiply the dose for each opioid by the conversion factor (see table below)

**ADD** them together.

CALCULATING MORPHINE MILLIGRAM EQUIVALENTS (MME)

1. **DETERMINE** the total daily amount of each opioid the patient takes.
2. **CONVERT** each to MMEs - multiply the dose for each opioid by the conversion factor (see table below).
3. **ADD** them together.

MORPHINE MILLIGRAM EQUIVALENT REFERENCE GUIDE

<table>
<thead>
<tr>
<th>OPIOID</th>
<th>DOSE PER DAY</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
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<td>13.5</td>
<td>18</td>
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<tr>
<td>Codeine 60**</td>
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<td>18</td>
<td>27</td>
<td>36</td>
<td>45</td>
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<td>15</td>
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<td>25</td>
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<tr>
<td>Hydrocodone 7.5</td>
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<td>15</td>
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<td>30</td>
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<td>80</td>
<td>120</td>
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</tbody>
</table>

Codeine 30* = Tylenol 3  Codeine 60** = Tylenol 4
GREY - check PDMP twice a year.
GREEN - check every prescription.
MME Calculations determined using OpioidCalc

CAUTION: Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION: Methadone – the conversion factor increases at higher doses. Fentanyl – dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors.

RESOURCES:
- Alabama Smart and Safe program: www.smartsandsafeal.org
- Alabama Prescription Drug Monitoring Program: www.adph.org/pdmp
- Providers’ Clinical Support System: https://pcssnow.org/education-training/treating-chronic-pain-core-curriculum/
- CDC Guidelines for Prescribing Opioids for Chronic Pain: www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

CONTACT US
MA TASK FORCE TO REDUCE OPIOID ABUSE RECOMMENDATION ON NALOXONE

CO-PRESCRIBING NALOXONE MAY HELP SAVE A PATIENT'S LIFE.

Several factors may be helpful in determining whether to co-prescribe naloxone to a patient, to a family member or to a close friend of the patient, including:

- Is my patient on a high dose of opioids?
- Does my patient also have a concomitant benzodiazepine prescription?
- Does my patient have a history of substance use disorder?
- Does my patient have an underlying mental health condition that might make him or her more susceptible to overdose?
- Does my patient have a medical condition, such as a respiratory disease or other co-morbidities, that might make him or her susceptible to opioid toxicity, respiratory distress or overdose?
- Might my patient be in a position to aid someone who is at risk of opioid overdose?

Click here to view Prescribe to Prevent's Naloxone Product Chart

WHAT DOES ALABAMA LAW AUTHORIZE?

Alabama law (Section 20–2–280) authorizes physicians acting in good faith to directly or by standing order prescribe naloxone to:

An individual at risk of experiencing an opiate-related overdose.

A family member, friend, or other individual, including law enforcement, in a position to assist an individual at risk of experiencing an opiate-related overdose.

PROMOTE SAFE STORAGE AND DISPOSAL OF OPIOIDS AND ALL MEDICATIONS

1 TALK TO YOUR PATIENTS! More than 70% of people misusing opioid analgesics are getting them from family and friends – sharing opioids is illegal and may be deadly

2 REMIND YOUR PATIENTS! Store medicines out of reach from children and never share prescriptions with anyone.

3 URGE YOUR PATIENTS TO SAFELY DISPOSE OF EXPIRED, UNWANTED AND UNUSED MEDICATIONS! Recommend patients use pharmacy and law enforcement “take back” resources whenever possible.

FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use.

Click here to learn Where and How to Dispose of Unused Medicines
Click here to search for a disposal location near you
"Patients in pain and patients with a substance use disorder need comprehensive treatment — not judgment. Just as a patient with heart disease or diabetes, a patient with a substance use disorder can be successfully treated and enjoy long-term recovery."

- Patrice A. Harris
  MD, MA, Chair, AMA Task Force to Reduce Opioid Abuse

**TREATMENT, CONSULTATION, AND TRAINING RESOURCES**

- **Physician Locator for Substance Use Disorder Treatment (SAMHSA)**
  [Click here to learn more](#)

- **SAMHSA MAT Pocket Guide**
  - order it for free
  [Click here to learn more](#)

- **Treatment Near You**
  [Click here to learn more](#)

- **Safe Medicine Disposal**
  [Click here to learn more](#)

**Stop the stigma of substance use disorder.**
Enhance access to treatment.

- Become trained to provide in-office buprenorphine (PCSS)
  [Click here to learn more](#)

- ASAM National Practice Treatment Guideline (PCSS-MAT)
  [Click here to learn more](#)

- Providers’ Clinical Support System for Medication Assisted Treatment
  [Click here to learn more](#)

- Opioid Treatment Program Directory
  [Click here to learn more](#)

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