# Best Practices for Prescribing Controlled Substances

Maine Independent Clinical Information Service

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## Practice Level

- Develop a protocol for controlled substance prescribing which is followed by all prescribers and staff
- Highlight portions of the protocol on a regular basis and expect consistent adherence
- Maintain a registry of all patients on controlled substances and assign a staff member to assess compliance with best practices on a monthly basis
- Use standard patient-provider agreements (PPA) including informed consent documents which are reviewed by the PRESCRIBER with the patient yearly
- Check the PMP regularly, especially when required; have a standard workflow
- Create a workflow or standing order to automatically prescribe naloxone at least once a year to anyone prescribed opioids or diagnosed with a drug use disorder
- Consider medication counts as a potential, but not mandated, tool on a case by case basis rather than as a strict practice.

## Prescriber Level

- Think:lowest dose, lowest number of pills, lowest number of days
- Avoid multiple classes of controlled substances for the same patient
- Use a 28 day supply for chronic prescriptions
- Monitor for and document functional improvement; if none, change treatment plan
- Use toxicology screening according to regulation and your protocol; share results with patients
- Use a standardized screening tool to assess for the development of use disorders, including alcohol and marijuana, for all patients prescribed controlled substances, at a minimum once a year
- Address “non-reassuring” behaviors immediately; ask the patient open-ended questions
- Treat use disorders with evidence-based treatments; refer if necessary
- Never abruptly discontinue chronic opioid or benzodiazepine therapy; reserve rapid tapering for extenuating circumstance

## Patient Education Points

### For acute pain

- Opioids can reduce acute pain but are unlikely to completely remove it
- Taking acetaminophen and ibuprofen/naproxen at the same time is often more effective for acute pain (give written instructions)
- Avoid using opioids except when needed for severe pain (‘as needed’ on the bottle means only take if absolutely necessary)
- Take the lowest dose for the least possible time
- Stop taking opioids as soon as possible

### For both acute and chronic pain

- Opioids can cause confusion, falls and decreased breathing, even in the short term
- Store opioids in a safe location, preferably locked
- Safely dispose of opioids within a week-check if your pharmacy or local law enforcement agency has a permanent take back box, use activated charcoal disposal bags, mix with coffee grounds or kitty litter and water and dispose in trash

## Additional Resources

- MME and Tapering Calculators amdg.wa.gov
- MICIS Resources micismaine.org/education-topics/clinical-toolkit
- Chronic pain toolkit for patients and prescribers www.oregonpainguidance.org/paineducationtoolkitforclinicians

**Disclaimer**

These are general recommendations only; specific clinical decisions should be made by the treating healthcare provider based on an individual patient’s clinical condition. This document presents general information regarding prescribing regulations in the state of Maine and does not substitue for legal counsel.

**FMI:** Maine Independent Clinical Information Service (MICIS) c/o Maine Medical Association, MICISMaine.org, 207.622.3374

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# General Overview of Maine Opioid Prescribing Laws and Rules

## Maine's Opioid Prescribing Law (Chapter 488, 2015) requirements:

1. Mandatory check of PMP for any initial opioid or benzodiazepine prescription and every 90 days thereafter (for prescriptions that are filled at retail/online pharmacies for self-administration)
2. Limit on opioid prescription duration: acute 7 days, chronic 30 days (*note 28 day supply is a best practice)
3. High opioid doses (>100 MME/day) require exemption codes on the script
4. Mandatory electronic prescribing of opioids (unless waiver approved by PMP)
5. Mandatory Opioid CME (requirements vary by licensing board, generally 3 hours every 2 years)

## Joint Rule (Chapter 21, Section 4) of licensing board requirements

*(each licensing board has the same rule, specific subsections in parentheses)*:

1. Utilize universal precautions before prescribing opioids: full history and physical, risk assessment (2)
2. Documented treatment plan to include functional assessment (2B1)
3. Re-evaluate harms and benefits within 28 days of first script (2B2c)
4. Follow Chapter 488 dosing limits and exemptions (2B2d)
5. Consider prescribing naloxone for high-risk patients (2B2g)
6. Avoid concurrent opioid and benzodiazepine prescription whenever possible (2B2h)
7. Perform periodic review of treatment efficacy; if high risk (dose greater than 90MME, concomitant opioid-benzodiazepine use), document thorough review every 1-3 months (2B3)
8. Consult or refer for additional evaluation or treatment as necessary (2B4)
9. Coordinate care with other treating clinicians (2B6
10. Taper if opioid therapy is to be discontinued (2B7)
11. Document informed consent and patient-provider treatment agreement (2C)
12. Perform urine drug screens prior to initiating opioids and at random intervals--at a minimum, annually (2F)
13. Refer to section 2G for a list of elements to include in the medical record (2G)
14. Utilize caution in the prescribing of methadone for pain (4B)
15. Prescribers "must be aware of and follow" the CDC Opioid Guideline (5)

## Text to Include on Opioid Prescriptions

1. 'Acute' or 'Chronic'
2. Exemption code if >100 MME
3. ICD-10 code for Code B (may also be required by some insurers)

## >100 MME Exemption Codes

**A** Pain associated with active & aftercare cancer treatment

**B** Palliative Care in conjunction with a serious illness (must include ICD-10 code)

**C** End-of-life and hospice care

**D** Medication-Assisted Treatment for substance use disorder (PMP no longer lists MMEs for MAT)

**E** A pregnant individual with a pre-existing prescription >100 MME

**F** Acute pain for an individual with an existing chronic opioid prescription (when new combination is >100 MME)

**G** Individuals pursuing an active taper of opioid medications (6 month limit)

**H** Individuals prescribed a second opioid after proving unable to tolerate a first opioid (if additive MME is >100)

**I** Sickle cell disease (for possible future use)

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