

Prescription Opioids in Vermont

A DISCUSSION ABOUT LAWS AND
GUIDELINES

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Rule(s) Governing the Prescribing of Opioids for Pain

- KEY
 - rule adopted pursuant to Sections 14(e) and 11(e) of Act 75 (2013) and Sections 2(e) and 2a of Act 173 (2016).
 - CDC guideline
 - Areas of change with stakeholder input
 - Area not changed despite stakeholder input

Rule(s) Governing the Prescribing of Opioids for Pain

- adopted pursuant to Act No. 75 of the Acts of the 2013 Session (8/01/15); adopted pursuant to Sections 14(e) and 11(e) of Act 75 (2013) and Sections 2(e) and 2a of Act 173 (2016). (7/01/17.)
- legal requirements for the appropriate use of opioids in treating pain in order to minimize opportunities for misuse, abuse, and diversion, and optimize prevention of addiction and overdose
- prescription limits for **acute pain only apply to the first prescription written** for a given course of treatment, and **do not apply to refills**. The prescribing limits under this rule do not apply to palliative care, or end of life care.

CDC Guideline

- chronic pain (ie, pain conditions that typically last >3 months or past the time of normal tissue healing) in outpatient settings.
- intended for primary care clinicians (eg, family physicians, internists, nurse practitioners, and physician assistants.) Use in other acute care settings or by other specialists is not the focus of the guideline
- improve communication regarding the benefits and risks of opioids, improve safety and effectiveness of pain treatment, reduce risks associated with long-term opioid therapy

CDC Guideline

- CDC updated a systematic Review sponsored by AHRQ on the effectiveness and risks of long-term opioid treatment of chronic pain
- Controversy about effectiveness of long-term opioids for outcomes at least 1 year later related to pain, function, and quality of life; whether findings on short-term effectiveness can be extrapolated to estimate benefits of long-term therapy for chronic pain
- updated review revealed that evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits, although evidence suggests risk of serious harms that is dose-dependent

4.0 Universal Precautions

- Any opioid, Schedule II, III, or IV, for the first time during a course of treatment to any patient
 - Consider Non-Opioid and Non-Pharmacological Treatment
 - Query the Vermont Prescription Monitoring System (VPMS)
 - Provide Patient Education and Informed Consent

4.0 Universal Precautions

- Consider and Document Non-Opioid and Non-Pharmacological Treatment
- Include but not limited to
 - NSAIDs
 - Acetaminophen
 - Acupuncture
 - OMT
 - Chiropractic
 - PT
 - to document the consideration of alternatives for pain management is unnecessarily burdensome and will not be effective-eliminated

CDC Guideline

- In this article, we summarize benefits and harms of nonopioid therapies found in the clinical literature and harms of opioid therapy, including additional studies not included in the clinical evidence review (eg, studies not restricted to patients with chronic pain)
- Several nonpharmacologic and nonopioid pharmacologic treatments were found to be effective for chronic pain in studies ranging up to 6 months. For example, cognitive behavioral therapy (CBT) had small positive effects on disability and catastrophic thinking. Exercise therapy reduced pain and improved function in chronic low back pain; improved function and reduced pain in osteoarthritis of the knee and hip; and improved well-being, symptoms, and physical function in fibromyalgia. Multimodal and multidisciplinary therapies helped reduce pain and improve function more effectively than single modalities

4.0 Universal Precautions

- Query the Vermont Prescription Monitoring System (VPMS)

4.0 Universal Precautions

- Provide Patient Education and Informed Consent
 - in-person discussion with the patient (parent, guardian, or legal representative) regarding potential side effects, risks of dependence and overdose, alternative treatments, appropriate tapering and safe storage and disposal
 - Prior to prescribing, shall provide the patient with the Department of Health patient education sheet published on the Health Department website, or a written alternative
 - signed informed consent
 - Information on potential for misuse, abuse, diversion, and addiction; risks of life-threatening respiratory depression; fatal overdose from accidental exposure, especially in children; neonatal opioid withdrawal syndrome; and fatal overdose when combining with alcohol and/or other psychoactives (benzodiazepines and barbiturates)

4.0 Universal Precautions

- Provide Patient Education and Informed Consent
 - signed informed consent with no ability to delegate before every opiate prescription for acute pain-denied

Prescribing Opioids for Acute Pain

- Framework smallest doses for the shortest periods of time
- limits found in Figures 1.0 and 2.0 are maximums
- Maximums are averages, not absolute daily limits. This may allow larger doses at the start of the prescription with smaller doses at the end as the patient tapers
- limits apply to patients who are opioid naïve and are receiving their first prescriptions **not administered in a healthcare setting**
 - [decision making required by the rule would be too complicated to manage for medications that would be administered where there is minimal risk of diversion in a hospital]
 - has not used opioids for more than seven consecutive days during the previous 30 days.

CDC Guideline

- KQ5: Effect of Opioid Therapy for Acute Pain on Long-term Use
- Opioid therapy prescribed for acute pain was associated with greater likelihood of long-term use

Prescribing Opioids for Acute Pain

- limits do not prohibit writing a second prescription (or refill prescription) for the patient if necessary
- Figure 1.0 for adults ages 18 years and older
- Figure 2.0 for children ages 0-17 years old
- Four categories in each figure (**patient placed based on the medical judgment of the prescriber**)
 - [prescription limits that were based on categories of procedures and injuries did not allow for the necessary subjective consideration of a patient's pain]

Pain	Average Daily MME (allowing for tapering)	Prescription TOTAL MME based on expected duration of pain	Common average DAILY pill counts	Commonly associated injuries, conditions and surgeries
Minor pain	No Opioids	0 total MME	0 hydrocodone 0 oxycodone 0 hydromorphone	molar removal, sprains, non-specific low back pain, headaches, fibromyalgia, un-diagnosed dental pain
Moderate pain	24 MME/day	0-3 days: 72 MME 1-5 days: 120 MME	4 hydrocodone 5mg or 3 oxycodone 5mg or 3 hydromorphone 2mg	non-compound bone fractures, most soft tissue surgeries, most outpatient laparoscopic surgeries, shoulder arthroscopy
Severe pain	32 MME/day	0-3 days: 96 MME 1-5 days: 160 MME	6 hydrocodone 5mg or 4 oxycodone 5mg or 4 hydromorphone 2mg	many non-laparoscopic surgeries, maxillofacial surgery, total joint replacement, compound fracture repair
For patients with severe pain and extreme circumstance, the provider can make a clinical judgement to prescribe up to 7 days so long as the reason is documented in the medical record.				
Extreme Pain	50 MME/day	7 day MAX: 350 MME	10 hydrocodone 5mg or 6 oxycodone 5mg or 6 hydromorphone 2mg	similar to the severe pain category but with complications or other special circumstances

Pain	Average Daily MME (allowing for tapering)	Prescription TOTAL MME based on expected duration of pain	Common average DAILY pill counts	Commonly associated injuries, conditions and surgeries
Minor pain	No Opioids	0 total MME	0 hydrocodone 0 oxycodone 0 hydromorphone	molar removal, sprains, non-specific low back pain, headaches, fibromyalgia, un-diagnosed dental pain
Moderate to Severe pain	24 MME/day	0-3 days: 72 MME	4 hydrocodone 5mg or 3 oxycodone 5mg or 3 hydromorphone 2mg	non-compound bone fractures, most soft tissue surgeries, most outpatient laparoscopic surgeries, shoulder arthroscopy

CDC Calculator MME

OPIOID (dose=mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Oxycodone	1.5
Morphine	1
Oxymorphone	3

Relative Strengths

Solomon, Arch Int Med '10

- Morphine(MS for Morphine Sulfate)=1
- Hydrocodone=1
- Aspirin=1/360 MEQ
- Codeine, Tramadol=1/10 MEQ
- Oxycodone=1.5-2.0 MEQ
- Hydromorphone=5 MEQ
- Methadone=3-7.5 MEQ (high individual variation)
- Oxymorphone=7 MEQ
- Fentanyl=50-100 MEQ

Prescribing Opioids for Acute Pain

- Long-acting opioids are not indicated for acute pain; reason must be justified in the patient's medical record
- prior to ending care for acute pain, if not primary care provider, ensure a safe transition of care by making a reasonable effort to contact the primary care provider with any relevant clinical information concerning the patient's condition, diagnosis and treatment [a clear discharge summary that includes expectations for ongoing pain treatment shall satisfy this requirement]
- prior to prescribing, shall make a reasonable effort to consult with child's primary care provider

CDC Guideline

- Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
- Three days or less will often be sufficient; more than 7days will rarely be needed
- Clinicians should not prescribe ER/LA opioids for the treatment of acute pain

Exemptions

- Palliative care
- End-of-life and hospice care
- Patients in skilled and intermediate care nursing facilities
- Pain associated with significant or severe trauma
- Pain associated with complex surgery (spinal surgery)
- Pain associated with prolonged inpatient care due to post-operative complications
- Medication-assisted treatment for substance use disorders
- Patients who are not opioid naïve
- Other circumstances as determined by the Commissioner of Health

Prescribing Opioids for Chronic Pain

- Schedule II, III or IV opioids for chronic pain (pain lasting longer than 90 days)
- prescribing for the first time during a course of treatment, the Universal Precautions in Section 4.0 apply

CDC Guideline

- KQ1: Effectiveness and Comparative Effectiveness
- No study of opioid therapy vs placebo, no opioid therapy, or nonopioid therapy for chronic pain evaluated long-term (>1 year) outcomes related to pain, function, or quality of life. Most placebo controlled randomized clinical trials were 6 weeks or shorter

CDC Guideline

- KQ2: Harms and Adverse Events
- Long-term opioid therapy was associated with problematic patterns of opioid use leading to clinically significant impairment or distress. Varying terminology has been used to reflect this pattern, including addiction” (more informally), “opioid abuse and opioid dependence.” Such disorders are manifested by similar criteria, including unsuccessful efforts to reduce or control use and use resulting in social problems and a failure to fulfill major role obligations at work, school, or home.
- Different from tolerance and physical dependence

CDC Guideline

- KQ2: Harms and Adverse Events (cont)
- Long-term opioid therapy was associated with an increased risk of an opioid abuse or dependence diagnosis vs no opioid prescription. In primary care settings, prevalence of opioid dependence (using *DSM-IV* criteria) ranged from 3% to 26%
- Factors associated with increased risk of misuse included history of substance use disorder, younger age, major depression, and use of psychotropic medications. Opioid use was associated with a dose-dependent increased risk of fatal and nonfatal overdose. Other risks associated with opioid use included cardiovascular events, endocrinological harms, and road trauma

CDC Guideline-Recommendation

- Extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury)
- Extensive evidence suggests some benefits of nonpharmacologic and nonopioid pharmacologic therapy, with less harm

Prescribing Opioids for Chronic Pain

- Screening, Evaluation, and Risk Assessment
- Initiating an Opioid Prescription for Chronic Pain
- Referrals and Consultations
- Reevaluation of Treatment
- Exemptions

Screening, Evaluation, and Risk Assessment

- conduct and document a thorough medical evaluation and physical examination
- document supporting diagnoses
- evaluate and document benefits and risks, including the risk for misuse, abuse, diversion, addiction, or overdose including
 - 3.18 “Risk Assessment” for predicting a patient's likelihood of misusing or abusing opioids (SOAPP or “any evidence-based screening tool”)
 - Other examples on VDH website

CDC Guideline

- KQ4: Risk Assessment and Risk Mitigation Strategies
- Evidence on the accuracy of risk assessment instruments for predicting opioid abuse or misuse was inconsistent for the Opioid Risk Tool and limited for other risk assessment instruments.
- No study evaluated the effectiveness of risk mitigation strategies

Initiating an Opioid Prescription for Chronic Pain

- consider and document
 - Non-opioid alternatives up to a maximum recommended by the FDA, including non-pharmacological treatments
 - Trial use of the opioid
 - requirements to query VPMS
 - currently or has recently been dispensed methadone or buprenorphine or prescribed and taken any other controlled substance
 - required by law to disclose this information
 - signed Controlled Substance Treatment Agreement

CDC Guideline

- Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months

CDC Guideline

- Clinicians should not dismiss patients from care based on a urine drug test result. This could have adverse consequences for patient safety, including missed opportunities to facilitate treatment for substance use disorder
- The use of confirmatory testing adds substantial costs and should be based on the need to detect specific opioids that cannot be identified on standard immunoassays or on the presence of unexpected urine drug test results. Clinicians should ask patients whether there might be unexpected results-discuss with Lab and patient

Initiating an Opioid Prescription for Chronic Pain

- Controlled Substance Treatment Agreement
 - functional goals for treatment
 - choice of dispensing pharmacy
 - safe storage and disposal
 - other requirements as determined by the prescriber
 - directly observed urine drug testing and pill counts
- examples of informed consent and Controlled Substance Treatment Agreements will be available on VDH website

Initiating an Opioid Prescription for Chronic Pain

- For the duration of the patient's treatment
 - Schedule and undertake periodic follow-up visits and evaluations at a frequency determined by the patient's risk factors, the medication dose and other clinical indicators
 - stable patients reevaluated at least every 90 days
 - write maximum daily dose or a “not to exceed” on script

CDC Guideline

- Determining When to Initiate or Continue Opioids for Chronic Pain
- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy
- Nonpharmacologic therapy (such as exercise therapy and CBT) should be used to reduce pain and improve function in patients with chronic pain

CDC Guideline

- Opioids should not be considered first-line or routine therapy for chronic pain outside of active cancer, palliative, and end-of-life care, given small to moderate short-term benefits, uncertain long-term benefits, and potential for serious harms
- This does not mean that patients should be required to sequentially “fail” nonpharmacologic and nonopioid pharmacologic therapy before proceeding to opioid therapy
- In some clinical contexts (eg, headache, fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks regardless of previous nonpharmacologic and nonopioid pharmacologic therapies used. In other situations (eg, serious illness in a patient with poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and patient agreement that the overriding goal is patient comfort) it may be appropriate

CDC Guideline

- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals, including realistic goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks
- Continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. There are some clinical circumstances under which reductions in pain without improvement in physical function might be more realistic (eg, diseases with progressive functional impairment or catastrophic injuries such as spinal cord trauma)
- Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain and function
- Depression, anxiety, and other psychological comorbidities should be assessed and treatment optimized

CDC Guideline

- Be explicit and realistic about expected benefits of opioids, explaining that while opioids can reduce pain during short-term use, there is no good evidence that opioids improve pain or function with long-term use and that complete relief of pain is unlikely
- serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder.
- Discuss effects that opioids may have on ability to safely operate a vehicle, particularly when opioids are initiated, when dosages are increased, or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently

CDC Guideline

- Discuss risks to household members and other individuals if opioids are intentionally or unintentionally shared; young children are susceptible to unintentional ingestion. Discuss storage of opioids
- Consider whether cognitive limitations might interfere with management of opioid therapy

Referrals and Consultations

- Consider a referral to a pain specialist or substance abuse specialist
 - not meeting the goals of treatment despite escalating doses
 - high risk for substance misuse, abuse, diversion, addiction, or overdose as determined by history or screening
 - reasonable grounds to believe, or confirms, misuse of opioids or other substances
 - multiple prescribers and/or pharmacies
 - prescribed multiple controlled substances
 - patient request

Reevaluation

- Controlled Substance Treatment Agreements will be reviewed and documented at least yearly in medical record
- Specific rules relative to exceeding 90 MME/day
- Determine and document as part of the reevaluation:
 - Whether to continue opioids or trial alternatives
 - Obtain pain management, substance abuse or pharmacological consult
 - Acknowledgement that a violation of the agreement may result in consequences

Reevaluation

- Specific rules relative to exceeding 90 MME/day
 - in-person discussion regarding increased risk of overdose
 - reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of adherence
 - potential for the use of non-opioid and nonpharmacological alternatives
 - functional examination of the patient
 - review of Controlled Substance Agreement and Informed Consent
 - assessment of co-morbid conditions affected by treatment with opioids
 - other related actions by the patient that may lead prescriber to modify pain management regimen (risk factors)

CDC Guideline

- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to 50 morphine milligram equivalents (MME) or more per day
- Clinicians should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90MME or more per day

CDC Guideline

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently
- Clinicians should work with patients to reduce opioid dosage or to discontinue opioids when possible if clinically meaningful improvements in pain and function are not sustained
- Tapering: A decrease of 10% of the original dose per week is a reasonable starting point, 10% per month if have been on a long time. Rapid tapers and pregnancy may require assistance

CDC Guideline

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. It might be safer and more practical to taper opioids first
- Clinicians should 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

Exemptions

- Chronic pain associated with cancer or cancer treatment
 - Palliative care
 - End-of-life and hospice care
 - Patients in skilled and intermediate care nursing facilities
-
- Pain caused by cancer and acute pain from cancer/cancer care are not exempt from the universal precautions (checking VPMS, informed consent, providing an information sheet) nor from the prescribing limits-denied. Chronic pain may be exempt

Naloxone (Acute or Chronic)

- Co-prescribe for MME>90 or concurrent prescription for benzodiazepines
- Opioid-related overdose risk was dose-dependent, with higher opioid dosages associated with increased overdose risk. 1 to <20MME compared to 50 to <100MME and above
- Disproportionate numbers of overdose deaths associated with methadone; fatal overdose risk associated with co-prescription of opioids and benzodiazepines; and risks associated with sleep-disordered breathing, reduced renal or hepatic function, older age, pregnancy, mental health comorbidities, history of substance use disorder, and history of overdose

Naloxone

- Co-prescribe for MME>90 or concurrent prescription for benzodiazepines
- consider offering naloxone when prescribing opioids to patients at increased risk of overdose including patients at risk of returning to a high dose to which they are no longer tolerant (eg, patients recently released from prison)

Extended Release (Acute or Chronic)

- In addition to the above, ER hydrocodones and oxycodones not manufactured as Abuse-deterrent Opioids require
 - conduct and document a thorough medical and physical examination
 - diagnoses which support the use
 - evaluate and document benefits and risks including Risk Assessment
 - pain severe enough to require daily, around-the-clock, long-term, opioid treatment for which alternative treatment options, including non-pharmacological treatments, are ineffective, not tolerated, or are otherwise inadequate
 - signed Informed Consent
 - signed Controlled Substance Treatment Agreement

CDC Guideline

- KQ3: Dosing Strategies
- Initiation of therapy with an extended-release/long-acting(ER/LA)opioid was associated with greater risk of nonfatal overdose than initiation with an immediate-release opioid in 1 study, with risk greatest in the first 2weeks after initiation of treatment
- Three studies of various ER/LA opioids found no clear differences related to pain or function

CDC Guideline

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
- Clinicians should not initiate opioid treatment with ER/LA opioids and should not prescribe ER/LA opioids for intermittent use.
- avoiding the use of immediate-release opioids in combination with ER/LA opioids is preferable
- Methadone should not be the first choice for an ER/LA opioid. Avoid transdermal fentanyl

Extended Release

- Cont.
 - query VPMS and document
 - review of other prior controlled substances preceding ER
 - query no less frequently than every 120 days for 40 mg or greater of hydrocodone or 30 mg or greater of oxycodone
 - query no less frequently than as described in the Vermont Prescription Monitoring System Rule
 - write a maximum daily dose, or a “not to exceed value”
 - filled within seven (7) days of the date issued and no more than 30-day supply

Extended Release

- Periodic follow-up visits and evaluations at least every 90 days during which the following must be documented
 - whether to continue ER
 - need for a pain management or substance abuse consultation
 - acknowledgement that a violation of the agreement may result in consequences

Additional reading

- http://healthvermont.gov/adap/documents/vpms_annual_data_report_2014.pdf
- <http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>
- Rodgers J, Cunningham K, Fitzgerald K, Finnerty E. Opioid Consumption Following Outpatient Upper Extremity Surgery. *J Hand Surg Am.* 2012;37(4):645-50. doi: 10.1016/j.jhsa.2012.01.035.

Additional reading

- Case A, Deaton A, Rising morbidity and mortality in midlife among white nonHispanic Americans in the 21st century, Proceedings of the National Academy of Sciences, 2015 [epub ahead of print]; www.pnas.org/content/early/2015/10/29/1518393112.full.pdf?sid=9bfb943f75394564aedf9f4bcec9b5f9.
- Azevedo LF, et al. A population based study on chronic pain and the use of opioids in Portugal, Pain, 2013; 154(12):2844–52. doi:10.1016/j.pain.2013.08.022.
- Von Korff M Opioids for chronic musculoskeletal pain: Putting patient safety first, Pain, 2013; 154(12):2583–5.



VERMONT PRESCRIPTION MONITORING SYSTEM

UPDATES AND TIPS

What is VPMS?

The Vermont Prescription Monitoring Program (VPMS) is a statewide electronic database of Schedule II-IV controlled substance prescriptions dispensed from Vermont-licensed pharmacies.

- VPMS is a clinical tool
- Controlled substance data collected from Vermont-licensed pharmacies includes information on the:
 - ▣ Prescribed drug
 - ▣ Recipient of the prescribed drug
 - ▣ Health care provider who wrote the prescription
 - ▣ Pharmacy that dispensed the prescription
- Prescriptions are required to be uploaded to the system within 24 hours or one business day
- Prescriptions dispensed in certain situations are not included:
 - ▣ Emergency Departments, for treatment of pain for 48 hours or less
 - ▣ Veterinarian offices
 - ▣ “Hubs” (OTP)

What is new?

- ▣ **Migration to new platform**

- VPMS migrated to AWAxE platform on June 15th, 2017

- ▣ **Rules, effective July 1st, 2017**

- Includes increased query responsibilities as well as operational information

- ▣ **Quarterly Reports**

- Include county level metrics on prescription information

- ▣ **Ability to query additional states**

- Currently able to query CT, MA, ME, NH, NJ, NY, RI

- ▣ **Increased delegate/supervisor possibilities**

- Many/many relationship – up to 50

What updates are coming?

- **New Interface**
 - Early November

- **Prescriber Insight Reports**
 - Fall 2017
 - Provide metrics on the provider's prescriptions dispensed in comparison with peers within specialty

- **Clinical Alerts**
 - Late 2017
 - Patients with MME over 90, Overlapping Benzo/Opioid Rxs and/or Multiple Provider Episodes will be flagged on prescriber dashboards

- **Annual Reports**
 - *2016 Annual Report* due early 2017, *2017 Annual Report* due shortly thereafter

How do I best use VPMS?

- **Know when to query**
 - Remember “Initial, Re-evaluation, Replacement”

- **Know the limitations of what you are seeing**
 - VT-licensed pharmacies
 - Exact name match on bulk searches and interstate queries
 - No “hub” data
 - VPMS data is *additional* information – it may not be *complete* information

- **Provide wider queries and then narrow down**
 - Use “partial name search” and the minimum amount of information required in order to return the maximum results

- **Use integrated tools**
 - Bulk Patient Upload
 - MyRx

Contact VPMS

- ▣ **Technical Support questions can be directed to:**

[Support Desk Ticketing](#)

or

888-461-8628

- ▣ **Programmatic questions can be directed to the program manager,
Hannah Hauser at:**

Hannah.Hauser@vermont.gov

or

(802) 652-4147