THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
Part 2640: Prescribing, Administering and Dispensing
Summary

PMP Usage Requirements:

- Pain Management Providers/Practices must review a PMP before a Rx for a controlled substance is authorized *[Rule 1.3 and Rule 1.14(J)]*.
- All licensees must review the PMP at each encounter wherein an opioid is prescribed for acute or chronic non-cancer/non-terminal pain *[Rule 1.3]*.
- All licensees must review the PMP before prescribing a benzodiazepine for non-cancer/non-terminal, chronic medical or psychiatric conditions *[Rule 1.7(L)]*. Essentially, if you prescribe a benzodiazepine, you must check the PMP first *[Rule 1.10(H)]*.
- All non-pain provider/practice licensees must review the PMP upon initial contact with new patients and every 3 months thereafter before prescribing controlled substances other than opioids *[Rule 1.3]*. This rule pertains to those patients treated for chronic conditions requiring controlled substances who are seen outside a registered pain practice setting.
- Documentation evidencing a licensee has run the PMP as required must be recorded in the patient record *[Rule 1.3]*. An example of this would be printing a copy of the PMP and placing it into the record. Simply making a note it was reviewed and was appropriate (or inappropriate) satisfies this requirement as well.
- PMP review is not required when issuing prescriptions for Lomotil, Lyrica, Testosterone, Pseudoephedrine, or Amphetamines prescribed to pediatric patients under 16 for the treatment of ADHD *[Rule 1.3]*.
- PMP use is not required when treating patients in an inpatient setting. However, PMP review is required before a patient is discharged if the decision is made to issue a prescription for a controlled substance *[Rule 1.3]*.

Controlled Substance Prescribing Requirements (Opioids)

- Licensees are discouraged from prescribing or dispensing more than a three (3) day supply of opioids for acute non-cancer/non-terminal pain, and must not provider greater than a ten (10) day supply for acute non-cancer/non-terminal pain. Licensees may issue an additional ten (10) day supply if clinically necessary, but said supply must be issued in accordance with Federal law (i.e., the prescription must be dated the date of issuance with ‘do not fill until’ noting the date at which the prescription may be filled). The need for this additional ten (10) day supply must be documented in the chart to evidence that no other alternative was appropriate or sufficient to abate the acute pain. Addition ten (10) day supplies, with one (1) refill, may be issued if deemed medically necessary and only if supported by additional clinic evaluation *[Rule 1.7(H)]*.

- When prescribing opioids for acute pain, licensees must prescribe the lowest effective dose of immediate release opioids *[Rule 1.7(H)]*.

- It is a relative contraindication to prescribe opioids in concert with benzodiazepines and/or Soma (Carisoprodol). However, opioids may be prescribed on a very short term basis when an acute injury requiring opioids occurs. The need must be documented in the chart. Caution and care should be taken to prescribe the lowest effective dose of each medication if unable to discontinue one or the other completely. Caution and care should be taken to prescribe the lowest effective dose of each medication if unable to discontinue one or the other completely. Clinicians involved in managing a patient's care should document communication regarding the patient's needs, goals, risks and coordination of care. Prescribing of opioids concurrently with benzodiazepines and/or Soma may be allowed only under very limited circumstances in which the combination is used to treat very specific chronic medical conditions for which there is no other treatment modality available *[Rule 1.7(J)]*.

- Use of Methadone to treat acute non-cancer/non-terminal pain is prohibited *[Rule 1.7(M)].*

- Use of Methadone to treat chronic non-cancer/non-terminal pain is permissible within a registered pain management practice or when resulting from a referral to a certified pain specialist. It may only be prescribed by a physician *[Rule 1.7(M)]*. In other words, and for example, a Family Practice provider could prescribe Methadone for chronic pain if a certified pain specialist placed the patient on that medication previously via referral.

- Prior to the issuance of an opioid or benzodiazepine for the treatment of chronic non-cancer/non-terminal pain, each patient in a pain management practice must have an in-person evaluation by a registered pain management physician *[Rule 1.14(M)].*

- Opioid prescriptions are now reviewed against the daily Milligrams of Morphine Equivalence (mEq) scale. Licensees are largely expected to keep mEq under 50mg. Licensees must avoid dosages greater than 90mg mEq and must provide significant justification for exceeding this ceiling. Greater than 100mg mEq requires referral to a pain specialist *[Rule 1.7(G)].*

- While patients prescribed greater than 100mg mEq must be referred to a pain specialist, not all patients will need to remain with said pain specialist long term. In this sense, 'referral' should be treated more as 'consult', as a pain specialist may concur with treatment, or even modify treatment, then return the patient under the new, agreed upon, treatment plan for management by the referring physician *[Rule 1.7(G)]*.

Controlled Substance Prescribing Requirements (Benzodiazepines)

- Prescriptions for a benzodiazepine are limited to a 1-month supply with 2 refills, or a 90-day supply with no refills *[Rule 1.10(H)].*

Urine Drug Screening Requirements

- Point of service drug testing must be done at least three (3) times per year when a Schedule II medication is written to treat chronic non-cancer/non-terminal pain *[Rule 1.7(L)]*.
- Point of service drug testing must be done at least three (3) times per year for patients prescribed benzodiazepines for chronic medical and/or psychiatric conditions that are non-cancer/non-terminal *[Rule 1.7(L)].*
- Point of service drug testing must test (at a minimum) for opioids, benzodiazepines, amphetamines, cocaine, and cannabis *[Rule 1.7(L)].*
- Inpatient and hospice treatment are exempt from point of service drug testing requirements *[Rule 1.7(L)].*
- Patients prescribed Tramadol will not test positive on standard UDS, as it is a synthetic opioid analgesic. This means a confirmatory test would be necessary to accurately measure this level. As Tramadol is a C-IV, prescribing would only require PMP review, not a UDS. However, physicians should test for Tramadol if the capability is present and if it is normal to do so in the usual course of their practice (e.g., in a pain practice setting).