



## Joint Statement on the Prescribing of Opioid Antagonists Minnesota Boards of Medical Practice, Nursing, and Pharmacy

Opioid prescription drug abuse is a significant issue in healthcare today. Between 2000 and 2015, more than half a million people died in the United States from opioid related drug overdoses (Rudd, 2016). The following statistics are staggering ([National Association of State Alcohol and Drug Abuse Directors, 2015](#)):

- approximately 1.5 million Americans over the age of 12 years used opioid pain relievers for a non-medical use,
- fifty-three percent of Americans who misuse opioids received it from a friend or relative for free, or from a doctor,
- admission for treatment of opioid dependence has increased by 500%,
- nearly 17, 000 Americans died from opioid overdose, and
- the United States population accounts for 80% of the prescriptions for opioid consumption worldwide and 99% of the hydrocodone consumption.

In Minnesota, there were 395 opioid overdose deaths in 2016, 194 that involved prescription opioids, and 150 overdose deaths that involved heroin. (MDH, 2017). Opioid misuse, abuse and overdose has been declared at an epidemic level by the US Department of Health and Human Services ([US DHHS](#)).

The [MDH Opioid Dashboard](#) data reports that nonfatal overdoses, analyzed from the Minnesota Hospital Discharge Database, continue to rise in Minnesota. In the first three quarters of 2016 there were 2,074 hospital treated opioid overdoses and 1,109 emergency room visits for opioids.

The Minnesota Tri-Regulatory Collaborative, comprised of the Boards of Medical Practice, Nursing, and Pharmacy (Boards) have addressed growing concerns on the opioid epidemic. An increasingly interprofessional based healthcare delivery system requires collaborative guidance from the regulatory boards. The Joint Statement is meant to offer guidance to healthcare providers in the use of opioid antagonists, such as naloxone, and is not intended to set a standard of care or replace state and federal statutes.

Opioid antagonists, such as naloxone, can save lives and are a valuable tool in the fight against opioid overdose deaths. Naloxone is a pure opioid antagonist that reverses

opioid overdose when administered correctly. Naloxone may be delivered by injection or as a nasal spray. Naloxone may be prescribed by a licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) to an individual who has been prescribed opioids, a family member, friend, or care giver of the individual. A number of Minnesota statutes have provided for broader prescribing, dispensing, and administration of naloxone to help prevent opioid-related overdose deaths.

Minn. Stats. §151.37, subd. 12 provides for the administration of naloxone by emergency medical responders, peace officers, and staff of community-based health disease prevention or social service programs if a licensed physician, PA, or APRN has issued a standing order or entered into a protocol with the individual. The individual must have had training in the recognition of signs of opioid overdose and the use of opioid antagonists as part of the emergency response to opioid overdose. Minn. Stats. §604A.04, subd. 2, provides civil and criminal immunity for an individual who is *not* a health care provider if that person administers an opioid antagonist in good faith. Minn. Stats. §604A.04, subd. 3 releases health care professionals from civil and criminal liability when prescribing, dispensing, distributing, or administering an opioid antagonist if the antagonist is given by someone other than the person prescribed or to someone other than the individual prescribed the antagonist.

The Minnesota Board of Pharmacy has developed an [Opioid Antagonist Protocol](#) (authorized under Minn. Stats. § 151.37, subd. 13) which can be used by pharmacist who is working with the medical consultant of a community health board or with a physician employed by the Minnesota Department of Health. The protocol was developed in collaboration with the Boards of Medical Practice and Nursing, other state agencies, and professional associations. It allows the pharmacist to issue a legally valid prescription for naloxone and then to dispense it. The medical consultant or physician, PA or APRN is considered to be the official prescriber. Pharmacists can also work with other physicians, or with PA or APRN, to develop their own naloxone protocol, rather than using the protocol developed by the Board of Pharmacy (as authorized under Minn. Stats. §151.01, subd. 27(6)).

The [Minnesota Opioid Prescribing Guidelines](#), published April 26, 2018, states that co-prescribing naloxone to patients, their family, friend or caregiver is an important part of care to prevent opioid-related overdose deaths. McDonald (2016) conducted a systematic review of 22 observational studies which showed moderate quality level of evidence that take home naloxone programs are effective in improving overdose survival and decreasing mortality. The [Guidelines](#) recommend prescribers of opioid consider prescribing naloxone to individuals at high risk of opioid overdose or to their families, friends or caregivers.

The Minnesota Tri-Regulatory Collaborative Boards of Medical Practice, Nursing, and Pharmacy supports the prescribing of opioid antagonists to individuals at high risk of overdose, their families, friends or caregivers and the use of pharmacist protocols to

expand the availability of naloxone to prevent opioid and opioid-related overdose deaths. The Boards also encourage prescribers of opioids and all health-related licensees to become involved in the campaign against opioid misuse, abuse and the prevention of opioid overdoses. Information on safe opioid prescribing and use may be found on the Minnesota Board of Nursing website [Safe Opioid Prescribing and Use Practice Resources](https://mn.gov/boards/nursing/practice/opioid-practice-resources/) webpage (<https://mn.gov/boards/nursing/practice/opioid-practice-resources/>).

## Resources

McDonald, R., Strang, J. Are take-home naloxone programmes effective? Systematic review utilizing application of Bradford Hill criteria. *Addiction*. 2016; 111:1177-87.

Minnesota Department of Health, Injury and violence prevention unit. Total opioid overdose deaths, 2000-2016. 2017. Available at <http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/index.html>

National Association of State Alcohol and Drug Abuse Directors. (February, 2015). *NASADAD Fact Sheet: Opioids*. Retrieved from <http://nasadad.wpengine.com/wp-content/uploads/2015/05/Opioids-Final.pdf>.

Rudd, R.A., Seth, P., David, F. et al. Increases in drug and opioid-involved overdose deaths- United States, 2010-2015. *MMWR Morbidity Mortality Weekly Report*. 2016; 65: 1445-52.

US Department of Health and Human Services. About the U.S. Opioid Epidemic. Available at <https://www.hhs.gov/opioids/about-the-epidemic/index.html#data>.