



Indiana Guidelines *for* Opioid Prescribing *in the* Emergency Department

The Indiana Guidelines for Opioid Prescribing in the Emergency Department do not supplant or supersede the clinical judgment of prescribers. All individuals who present to the ED are required to be provided an appropriate medical screening examination to determine if an emergency medical condition exists. These guidelines are intended to provide a general approach to prescribing opioids and other controlled substances in the ED and are intended to complement the Indiana Chronic Pain Management Rules and any other laws governing prescribing practices or patient treatment.

*More information
on the ongoing
efforts across the
state can be found
at:*

[Indiana Next Level
Recovery](#)

[Indiana State Medical
Association – Controlled
Substance Prescribing](#)

[Indiana State Department
of Health](#)

[Indiana Board of Pharmacy
Prescription Drug
Monitoring Program
\(INSPECT\)](#)

[Attorney General's
Prescription Drug Abuse
Prevention Task Force](#)

1. Emergency medical clinicians should not routinely provide:
 - a) Replacement prescriptions for opioids and other controlled substances that were lost, destroyed or stolen.*
 - b) Replacement doses of Suboxone, Subutex or Methadone for patients in an addiction treatment program.*
 - c) Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches and methadone).*
2. Opioids and other controlled substances should be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.
 - a) Prescriptions for chronic pain should not typically be provided if it is known that the patient has either previously presented with the same problem or received a prescription for opioids and/or other controlled substances from another provider within the last month.*
 - b) Doses of opioids and other controlled substances for routine chronic pain or acute exacerbations of chronic pain should not typically be given in injection (IM or IV) form.*
 - c) IV Demerol (Meperidine) for acute or chronic pain is discouraged.*
 - d) Providers should consider risk factors for respiratory depression when prescribing to patients currently taking benzodiazepines and/or other opioids and other controlled substances.*
3. When an ED provider is considering prescribing or administering opioids and other controlled substances, the emergency clinician:
 - a) Should consider a search of the Indiana Board of Pharmacy's Prescription Drug Monitoring Program (INSPECT) or other prescription monitoring programs that incorporate INSPECT data.*
 - b) Should exercise caution when considering prescribing opioids and other controlled substances for ED patients in situations in which the identity of the individual cannot be verified.*
 - c) Has the right to perform a urine drug screen or other drug screening.*
4. Except in rare circumstances, emergency clinicians should limit ED prescriptions for opioids and other controlled substances to no more than a five-day supply. Continued pain needs referral to the primary care provider or appropriate specialist for re-evaluation.



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5. Prior to making a final determination regarding whether a patient will be provided a prescription for opioids and other controlled substances, the emergency clinician may consider the following options:
 - a) *Contact the patient's routine provider who usually prescribes their opioids and other controlled substances.*
 - b) *Request a consultation from their hospital's palliative or pain service (if available) or an appropriate sub-specialty service.*
 - c) *Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.*
 - d) *Request medical and prescription records from other hospitals, provider's offices, etc.*
6. The ED facility should coordinate the care of patients who frequently visit the ED to establish a patient-specific policy/treatment plan, which should include treatment referrals for patients with suspected prescription drug abuse problems.
7. Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed.
8. Following the medical screening, emergency/acute care facilities should consider providing a patient handout that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.

NOTE: It is recommended that these guidelines not be posted in the ED waiting rooms or treatment areas. CMS has expressed concern that the posting of signs and/or distribution of brochures in an ED emphasizing that certain types of pain medications will not be prescribed may place a hospital at risk of noncompliance with the Emergency Medical Treatment and Labor Act (EMTALA).

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