



Prescription Monitoring Program Annual Report

2025 Annual Report

01/01/25 to 12/31/25

Required by:

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Prescription Drug Monitoring Program

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Section 1: Background and 2025 Activities

1A: Requirements of the Annual Prescription Monitoring Program (PMP) Report

Pursuant to 22 M.R.S. §7250(8) the department shall provide to the joint standing committee of the Legislature having jurisdiction over health and human services matters at the beginning of each year and at such other times as the committee requests the following information:

- The aggregate number of prescriptions of each drug required to be included in the program [Section 2 and Appendix A],
- The number of prescribers participating in the program categorized by specialty [Section 3],
- Historical trends or patterns in prescribing practices within the State [Section 4],
- Progress in the implementation of information-sharing agreements authorized by subsection 4-A [Section 5], and
- Additional information, as requested by the committee.

1B: Functions of the PMP

The PMP utilizes a vendor-operated database platform that supports a wide range of activities, tools, and features to support the Maine PMP in achieving its goals and objectives.

Database	Provides a statewide database of all controlled substances (schedule II-V) dispensed to individuals in Maine by licensed pharmacies.
	Available via an online portal or embedded directly into electronic health records.
	Contains 5 years of controlled substance dispensation/prescription history.
Clinical Tool	Provides information about individual patient risk factors to support informed decision-making by prescribers.
	Generates alerts for prescribers about medication combinations or higher-risk prescribing practices.
	Deters misuse and diversion by maintaining a centralized record of prescriptions.
Peer Comparison	Allows prescribers to view their prescribing practices relative to peers in the same specialty through a Prescriber Report.
Monitoring	Enables the development and monitoring of key metrics related to higher risk prescribing patterns (i.e., high dose opioid prescriptions, high total quantity of opioids or benzodiazepines, certain drug combinations), trends over time, areas of concern, and opportunities for support.
Reporting Tool	Supports reporting and information sharing through its analytic platform to facilitate population analysis of prescribers, dispensers, and patients.

1C: Definitions

- Delegate: A staff member authorized by a prescriber or pharmacist to access PMP data on their behalf.
- Lorazepam Milligram Equivalents (LME): A standardized value that compares benzodiazepine doses and potency.
- Medications for the Treatment of Opioid Use Disorder (MOUD): The three FDA-approved prescription medications for OUD; the PMP tracks only one, buprenorphine, typically in the form of buprenorphine-naloxone given by mouth.
- Morphine Milligram Equivalents (MME): A standardized value utilized to compare opioid doses and potency; doses greater than 100 MME per day require the use of an exemption code in Maine.
- Opioid Full Agonist: A drug that fully activates the opioid receptors in the brain; the term 'opiate' is frequently used instead of the more comprehensive 'opioid' (some opioid numbers do not include buprenorphine, a partial agonist).
- Opioid Partial Agonist: A drug, such as buprenorphine, that activates the opioid receptors in the brain differently than a full agonist and causes less respiratory depression.
- Patient Report: A report that displays a specific patient's controlled substance prescription history.
- Substance Use Disorder (SUD): A chronic disease of the brain with specific diagnostic criteria; also called addiction in medical settings.
- Total Quantity: The total number of doses for a specific medication (tablets, capsules, patches, or kits, not including liquids).

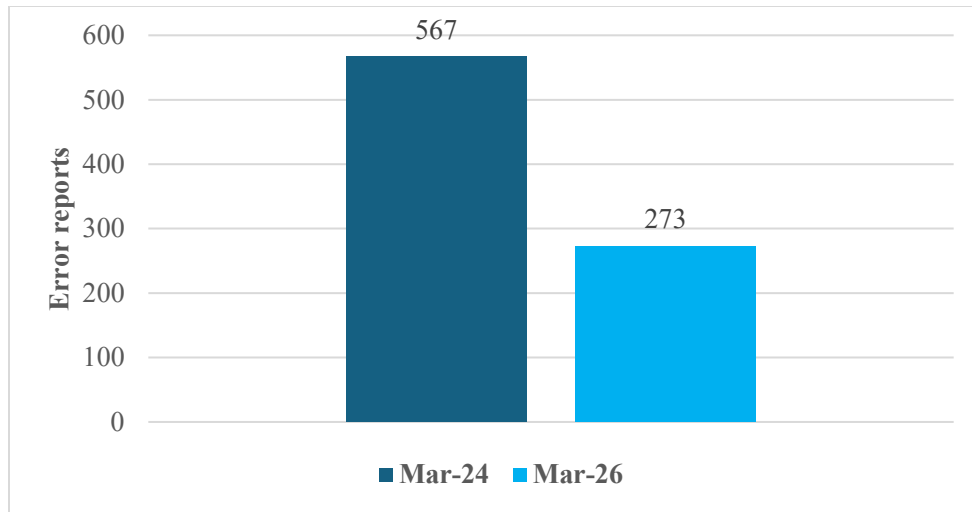
1D: PMP 2025 Focus Areas - Pharmacy Data Integrity

With additional funding approved by the Legislature in 2024, the PMP hired a new staff member to oversee data compliance and provider outreach. Having a dedicated person focused on improving the quality of data submitted to the PMP has led to several improvements. For example, the number of outstanding errors due to incomplete data uploads to the Prescription Monitoring Program (PMP) Clearinghouse decreased significantly from 567 in March 2024 to 273 in March 2026, representing a 52 percent reduction.

The nature of data errors has also shifted over time. In March 2024, the most common issue was missing prescriber DEA numbers, which accounted for 27 percent of all errors. By March 2026, the most frequent error had changed to “Sold at [date] must be later than filled at [date],” representing 33 percent of errors. This shift indicates that earlier data quality challenges have been successfully addressed and that ongoing efforts can now focus on improving the accuracy of date-related reporting.

Together, these improvements demonstrate the impact of targeted staffing and outreach in strengthening data integrity and supporting the PMP’s role in clinical care, compliance, and public health monitoring.

Figure 1: Outstanding Pharmacy Data Submission Error Reports



Higher Risk Prescribing

Aligned with Governor Janet Mills’s vision, the (PMP) continues to expand its outreach and engagement with the prescribing community as a proactive public health strategy to support safe, evidence-based controlled substance prescribing.

A core component of this work is the systematic review of prescribing patterns to identify signals that may indicate elevated patient safety risk and opportunities to provide additional support, education, or clinical resources.

The PMP operates as a public health surveillance and early warning system. Identifying potential risks and connecting prescribers with information and resources to support safe patient care, consistent with its authority under the Maine Revised Statutes, Title 22, Chapter 1603.

The PMP conducts routine statewide analyses of controlled substance prescribing data to identify patterns that may warrant additional review. These analyses incorporate multiple indicators associated with elevated risk, including:

Table 1. Higher Risk Prescribing Indicators

Metric	Description
1	The number of patients who are prescribed an opioid
2	The number of prescriptions issued for more than 90 MME
3	The total MMEs prescribed
4	The number of patients who are prescribed a benzodiazepine
5	The total LMEs prescribed

In 2025, the PMP implemented a refined identification process to improve the precision and clinical relevance of these analyses. As a result of these improvements, a threshold is established for each indicator, and PMP data are reviewed quarterly to identify individuals whose practices are among the top 0.5 percent of prescribers within their specialty. This process recognizes that variation in prescribing may be appropriate and influenced by clinical context, geographic

factors, and patient population needs. Accordingly, identification through this process does **not** constitute a determination of inappropriate prescribing.

Enhancements to the process focus on improving accuracy and reducing unnecessary flagging by:

- **Incorporating clinical context into risk signals**, allowing the PMP to better distinguish between clinically appropriate prescribing (e.g., cancer treatment, or palliative care) and patterns that may indicate increased risk.
- **Using multiple, targeted indicators over time rather than single thresholds**, enabling a more nuanced understanding of prescribing patterns.
- **Eventually, breaking down composite risk indicators into discrete, measurable components** (e.g., overlapping prescriptions, early refill patterns, or dose escalation), which improves transparency, auditability, and consistency.

Together, these refinements allow the PMP to generate more meaningful signals, improve provider trust, and better target outreach where it may have the greatest impact.

Prescriber Engagement and Support

When potential risk patterns are identified, the PMP engages prescribers through direct, individualized communication focused on education, best-practice guidance, and connection to additional resources, many of which are supported by the State. The PMP's primary approach is education and support. This intentional gradual engagement, typically over 6 to 12 months, allows prescribers time to review their data and, where appropriate, adjust without disrupting continuity of care. This approach enables the implementation of safer prescribing practices and patient safety.

If, after this period of engagement, prescribing patterns continue to raise potential patient safety concerns, the PMP may escalate them through appropriate clinical leadership channels (e.g., Chief Medical Officers). In limited circumstances, and consistent with statutory authority, the PMP may refer cases to the relevant professional licensing board when there is a significant concern for patient safety and voluntary engagement has not been sufficient to mitigate risk.

Prescribers who designate a specialty of Hospice or Oncology in their PMP registration are excluded from this process in recognition of the distinct clinical considerations associated with those fields.

1E: PMP 2025 Activities Aligning with State Opioid Response Strategic Action Plan

Priority	2025 PMP Activity & Strategy
Priority A: Build a statewide infrastructure to support evidence-based and community-focused actions in response to Maine's opioid crisis	Strategy 1
	- Ensured regular representation at meetings throughout DHHS, including but not limited to DHHS Opioid Coordinating Council, Opioid Data Sharing Committee, Director of Opioid Response Data Meetings, MaineCare MOUD Utilization, health leadership meetings, and others as requested. - Participated in quarterly meetings with the PMP Advisory Council, sharing information and soliciting feedback from external healthcare leaders, pharmacists, veterinarians, state staff, and other key partners. - Continued enhancing systems to ensure resource availability and access for individuals with substance use disorder through strategic and coordinated response efforts, collaboration among state offices, and regular feedback solicitation from community partners. - Developed and analyzed the annual PMP end user survey which featured a 3-6% response rate from each of the prescriber groups: physician, nurse practitioner, physician assistant, dentist, veterinarian.
	Strategy 4
	- Continued to implement a program for systematically reviewing pharmacy data to ensure timeliness and accuracy. - Ensured the PMP remains a robust and secure data system by cross checking licensing status of new registrants and revising data access protocols. - Completed the required Annual Report and presented findings to internal and external stakeholders, including at the Governor's Opioid Summit webinar series, November 2025.
Priority B: Reduce the percentage of Mainers who develop a substance use disorder	Strategy 11
	Presented to the SPF Rx (Strategic Prevention Framework for Prescription Drug Overdose) CDC grant's community organization 'mini grantees' on the risks of controlled substance medications beyond opioids.

Priority C: Reduce the number of prescribed, illegally trafficked, and unsafely stored opioids	Strategy 13a - Facilitated a webinar series on topics related to and adjacent to controlled substance prescribing in partnership and harm reduction with the SUD Learning Community. - Invited prescribers to academic detailing and technical support for professional development to align with evidence-based practice guidelines.
	Strategy 13b Continued to collaborate with staff at the Controlled Substances Stewardship Program to offer support to appropriate prescribers and practices.
	Strategy 13c - Completed a process to update the algorithm to identify <u>higher risk prescribing</u> behaviors. - Developed a tool to support longitudinal monitoring of higher risk prescribing. - Met with each of the prescriber licensing board staffs to share information about PMP resources and priorities. - Engaged with peers, other state leaders, and national partners through participation in national PMP committees such as the National Association of State Controlled Substance Authorities and the Prescription Monitoring Information eXchange. - Participated in professional development and networking by attending workgroups of the New England state PMP coordinators and the National Association of State Controlled Substance Authorities conference. - Participated in activities of the national Prescription Drug Monitoring Program Technology and Transfer Center (PDMP TTAC, a program funded by the Bureau of Justice Administration). - Prepared a presentation on gabapentin (not currently monitored by the PMP but known to increase the risk of overdose when used in combination with opioids) for internal and external stakeholders.
	Strategy 15 Proposed and saw enacted PL 2025, Chapter 37, §3 (LD765) which made several updates to the PMP statute in preparation for future rulemaking.

Priority D: Build harm reduction skills and improve public understanding that everyone has a role to play in preventing overdoses and saving lives	Strategy 18
	- Engaged in outreach to prescribers and healthcare communities to share information and increase awareness of strategies to lower patient risk, opioid overdose reversal medications, the dangers of co-prescribing opioid and benzodiazepines, and strategies to safely reduce high-dose opioids. - Gained valuable insights on pharmacy disruption responses at an ASTHO (Association of State and Territorial Health Officials) Opioid Rapid Response Convening. - Analyzed data and prepared reports for the Office Director in instances where prescribers of controlled substances suddenly left practice or when medical offices were facing closure.
Priority E: Reduce the number of fatal and non-fatal overdoses	Strategy 21
	- Created and published decision trees to assist <u>prescribers</u> and <u>pharmacists</u> in knowing when they are required to check the PMP (to review patient records for drug-drug interactions that may increase the risk of overdose) - With PMP Advisory Council input, rearranged the order of information presented to prescribers on web-based patient reports to prioritize certain prescription history at the top of the report - Provided information and consultation to the Maine Naloxone Distribution Initiative Program and the Maine Naloxone Steering Committee. - Fulfilled data requests, in accordance with statute and rule, for the Office of the Chief Medical Examiner. - Reviewed the 2025 ASAM (American Society of Addiction Medicine) Benzodiazepine Tapering Guidelines and promoted key messages through the SUD Learning Community and academic detailing.
Priority F: Expand the availability of treatment that is local, immediate, affordable, and most appropriate for the patient	Strategy 25
	Shared aggregate data on volume of patients prescribed buprenorphine per prescriber with key partners.

Section 2: Aggregate Numbers of Prescriptions

Table 2 presents the top 25 controlled medications received by patients in Maine during 2025. In prior years, the number of *prescriptions* was reported, but a shift to the number of *persons* prescribed a medication better demonstrates utilization and community exposure.

Table 2: Most Frequent Controlled Medications Received by Patients in Maine, 2025

Rank	Generic Name	Example Brand Name	Drug Class	Patient Count
1	oxycodone products	Generics, Percocet™, Oxycontin™ (extended-release)	opioid full agonist	85,688
2	lorazepam	Ativan™	benzodiazepine	50,416
3	dextroamphetamine-amphetamine	Adderall™	stimulant	35,866
4	hydrocodone products	Lortab™, Vicodin™	opioid full agonist	35,699
5	tramadol products	Ultram™	opioid full agonist	33,254
6	lisdexamfetamine	Vyvanse™	stimulant	24,904
7	methylphenidate	Concerta™, Ritalin™	stimulant	24,844
8	buprenorphine-naloxone or buprenorphine	Suboxone™	opioid partial agonist	20,861
9	alprazolam	Xanax™	benzodiazepine	17,856
10	diazepam	Valium™	benzodiazepine	17,708
11	pregabalin	Lyrica™	anticonvulsant	16,855
12	clonazepam	Klonopin™	benzodiazepine	16,581
13	testosterone products	Depo-Testosterone™	anabolic steroid	15,933
14	zolpidem	Ambien™	sedative	14,877
15	morphine	Generics, MS Contin™	opioid full agonist	12,323
16	phentermine	Adipex™	stimulant	9,749
17	hydromorphone	Dilaudid™	opioid full agonist	7,505
18	dexmethylphenidate	Focalin™	stimulant	6,109
19	codeine cough medications	Robitussin AC™	opioid full agonist	4,590
20	codeine analgesic products	Tylenol™ #3	opioid full agonist	4,082
21	phenobarbital	Luminal™	barbiturate-sedative	3,016
22	eszopiclone	Lunesta™	sedative	2,386
23	fentanyl (prescription)	Duragesic™ (patch)	opioid full agonist	1,984
24	diphenoxylate-atropine	Lomotil™	opioid full agonist	1,975
25	modafinil	Provigil™	stimulant	1,844

Source: Maine Office of Behavioral Health

Section 3: Number of Prescribers Participating

3A: PMP Registration Numbers

This section contains information on prescribers registered with the Maine PMP and the number of prescribers prescribing controlled substances by specialty.

Table 3: PMP Registrants by Prescriber Type, 2025

Prescriber Type	Distinct Registrants
Physician (DO, MD)	3,767
Nurse Practitioner	1,905
Physician Assistant	956
Resident Physician	489
Dentist	355
Veterinarian	346
Midwife with Prescriptive Authority	44
Podiatrist	43
Optometrist	5
Total	7,910

Source: Maine Office of Behavioral Health

Table 4: Active Controlled Substance Prescribers by Specialty Group, July-December 2025

Specialty Group	Controlled Substance Prescribers
Medical (primary or subspecialty care) & NOS*	2,683
Emergency, Acute Care, Hospitalist	678
Psychiatry & Neurology	637
Surgical & Obstetric	552
Veterinary	291
Pediatric	191
Dental	180
Orthopedic	153
Hematology & Oncology	145
Addiction	107
Pain & Rehabilitation	80
Hospice & Palliative Care	79
Oral Surgery	40
Podiatry	39
Total	5,855

Source: Maine Office of Behavioral Health

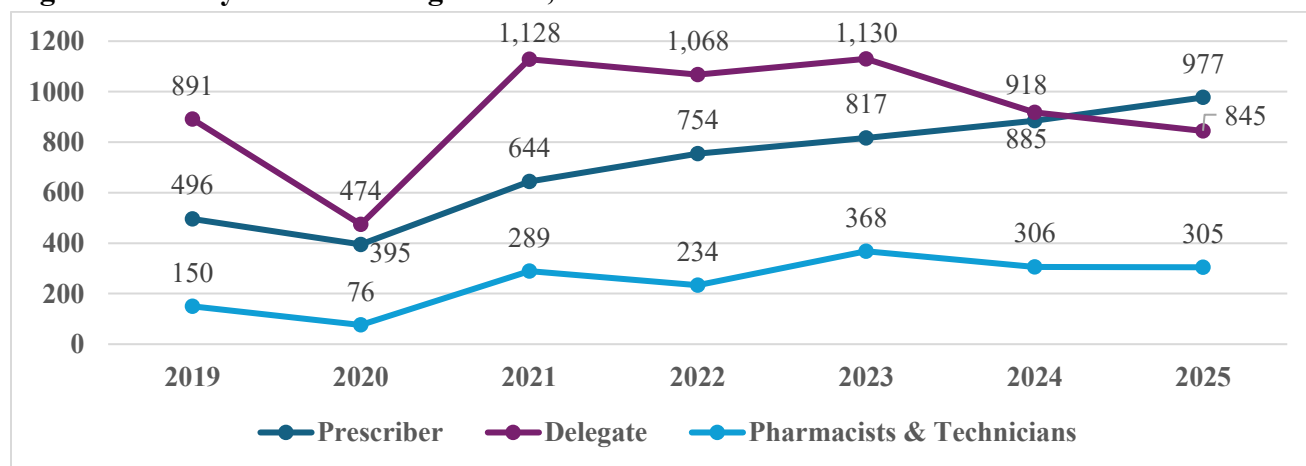
*NOS=Not otherwise specified, many NPs and PAs do not indicate a specialty

In 2025, 26 percent of prescriber registrants did not prescribe a controlled substance, likely reflecting continued education about appropriate PMP use, reducing unnecessary access. Additionally, due to the format of reports provided by our vendor, prescriber specialty group information is currently available in six-month intervals.

3B: New PMP Registrants

While PMP registrations vary annually, there has been an overall increase in prescribers, possibly influenced by expanded telehealth. The decrease in delegates may reflect increased EHR integration, allowing direct access to PMP data.

Figure 2: Yearly New PMP Registrants, 2019-2025

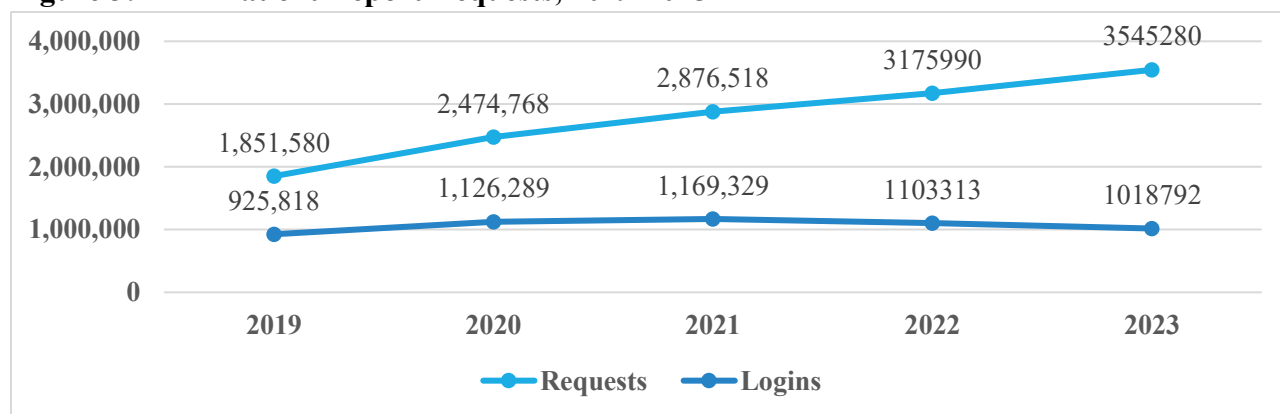


Source: Maine Office of Behavioral Health

3C: Utilization of the PMP

Patient report requests have continued to increase from 2019-2025. Additional patient report request data is in Appendix B.

Figure 3: PMP Patient Report Requests, 2019-2025



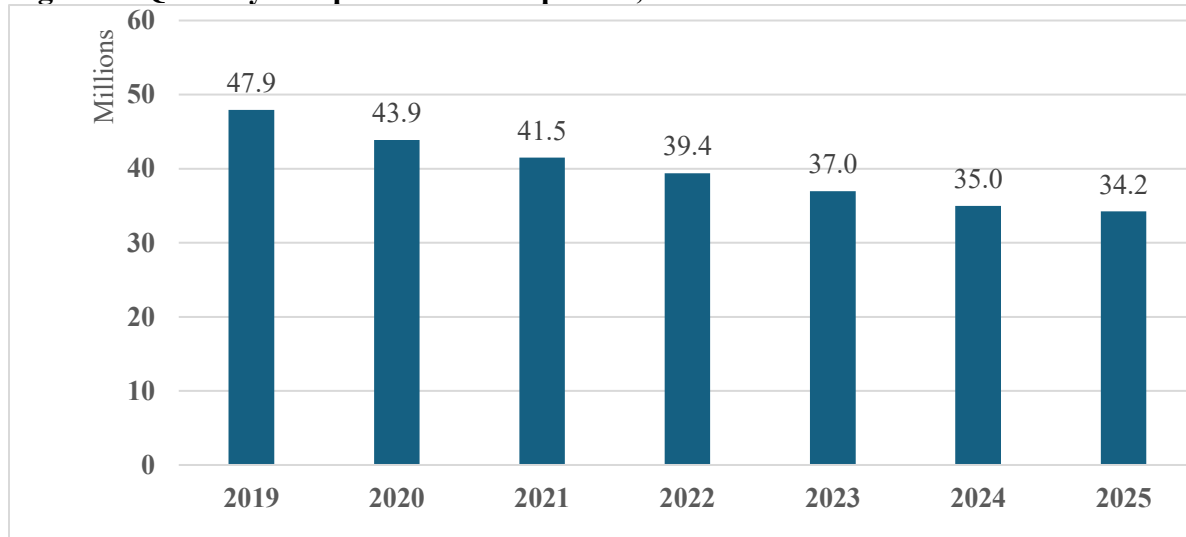
Source: Maine Office of Behavioral Health

Section 4: Trends and Patterns in Prescribing Practices

4A: Opioids

The quantity of opioids dispensed has decreased slightly in the past five years (see Appendix C). Opportunities to educate patients and prescribers about safe and effective non-opioid pain treatments continue to exist.

Figure 4: Quantity of Opioid Doses Dispensed, 2019-2025

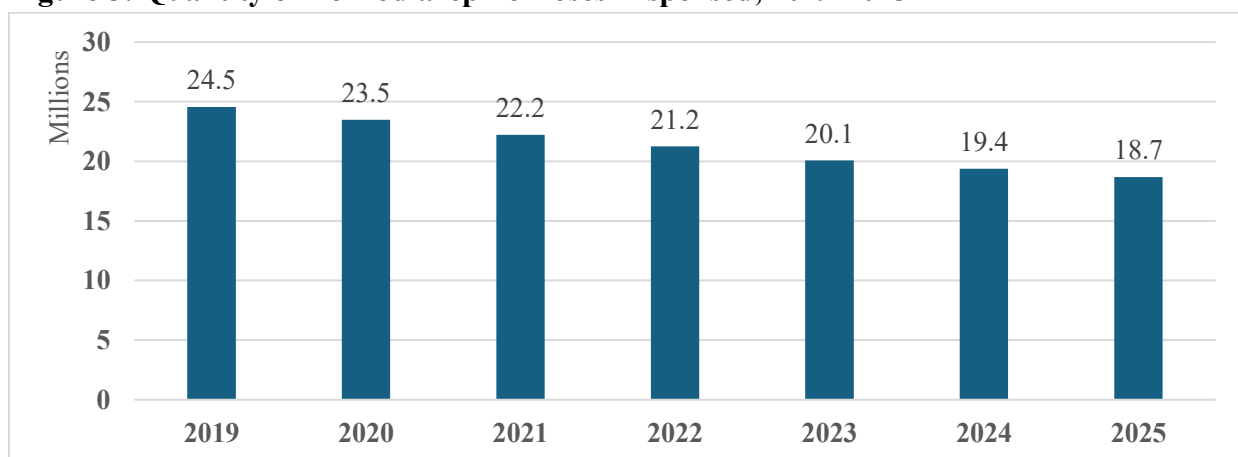


Source: Maine Office of Behavioral Health

4B: Benzodiazepines

The quantity of benzodiazepines dispensed has continued to decline, with a 20 percent decrease observed between 2019 and 2025. (see also: Appendix D).

Figure 5: Quantity of Benzodiazepine Doses Dispensed, 2019-2025

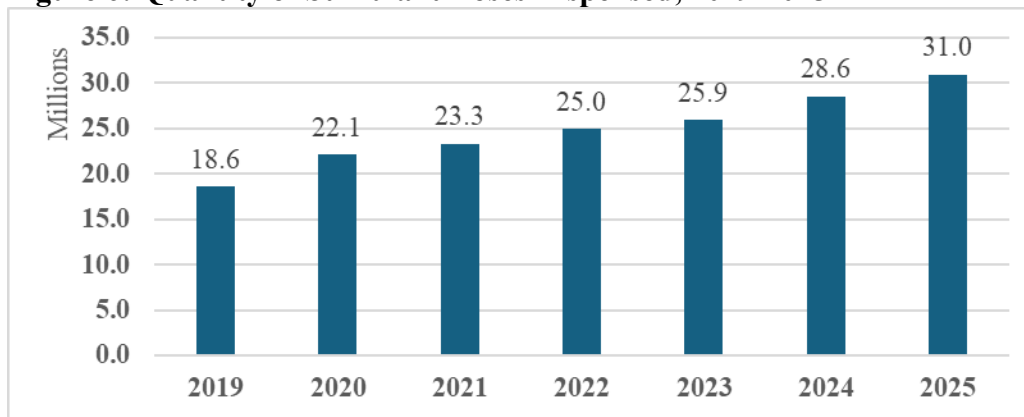


Source: Maine Office of Behavioral Health

4C: Stimulants

The quantity of stimulant doses dispensed has been increasing in the past 5 years. This is consistent with national trends and likely influenced by changes in telehealth prescribing rules since 2020.

Figure 6: Quantity of Stimulant Doses Dispensed, 2019-2025



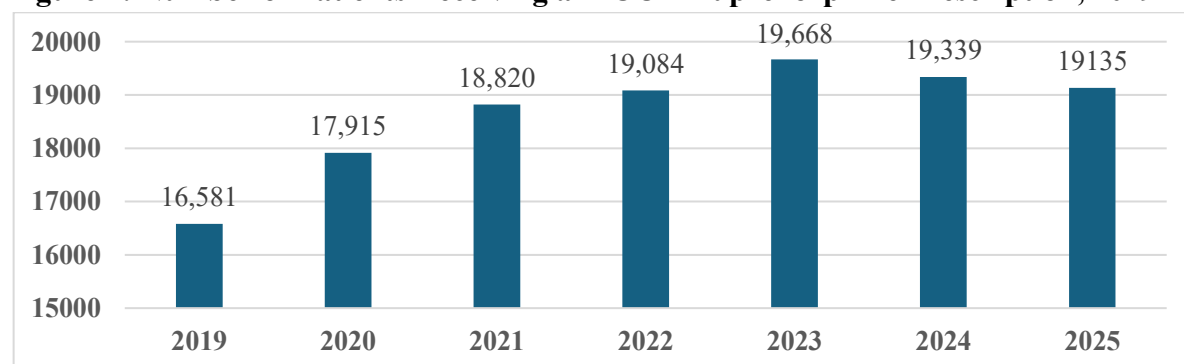
Source: Maine Office of Behavioral Health

Note: Due to changes in system functionality in 2024, these data should not be compared to reports prior to the 2024 PMP Annual Report.

4D: Medications for Opioid Use Disorder (MOUD)-Buprenorphine

Oral forms of buprenorphine are required to be reported to the PMP while injectable form reporting is voluntary. The decrease in PMP patient numbers since 2023 may be related to the increasing utilization of injectable buprenorphine in instances that are not reported to the PMP.

Figure 7: Number of Patients Receiving a MOUD Buprenorphine Prescription, 2019-2025



Source: Maine Office of Behavioral Health

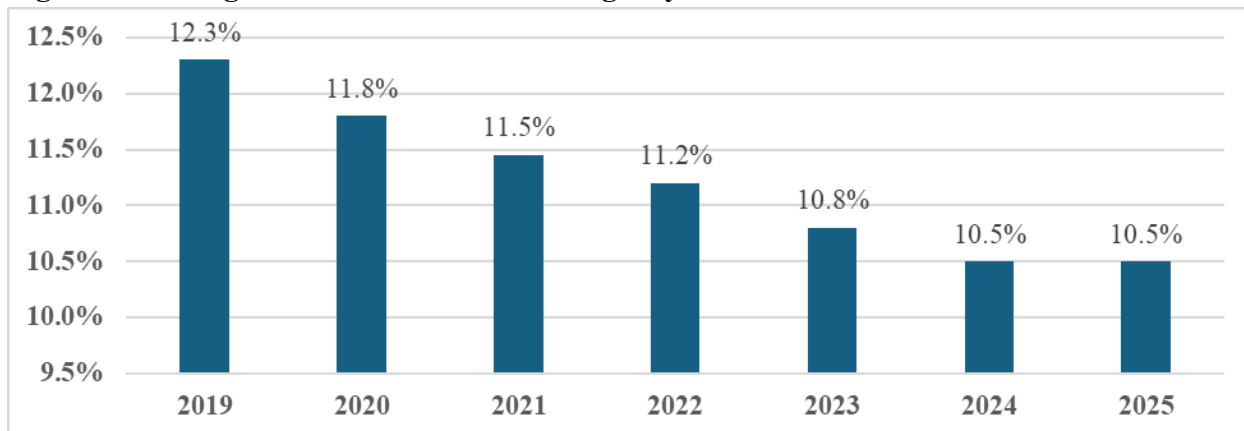
4E: Combination Opioid-Benzodiazepine Prescribing

Patients who are prescribed both opioids and benzodiazepines are at a substantially increased risk of unintentional overdose compared to those who take opioids without benzodiazepines. As such, understanding the number of days an individual patient is prescribed both an opioid and a benzodiazepine assists in the assessment of this higher-risk practice.

One method to assess this risky practice is to evaluate the percentage of the time that a patient is prescribed both medications compared to those where they are prescribed only one (an opioid or a benzodiazepine).

Figure 8 below illustrates the average number of days each year when a patient was prescribed both an opioid and a benzodiazepine. As illustrated, co-prescribing in Maine has been steadily decreasing after reaching a high of 12 percent in 2019.

Figure 8: Average Percent of Co-Prescribing Days in Maine 2019-2025



Source: Maine Office of Behavioral Health

4F: High Dose Opioid Prescribing

Higher doses of prescription opioids (greater than 90-100 MME) are associated with greater risks of side effects, particularly unintentional overdose and the development of opioid use disorder. Given this risk, Maine state licensing boards have specific rules regarding the factors that should be assessed on a regular basis for patients on high opioid doses. The 2022 CDC Opioid Prescribing Guideline advises against setting absolute limits on opioid doses and recommends ongoing individual assessments of the risks and benefits of doses greater than 50 MME. In addition, the height of the opioid dose and the length of time taken are both associated with an increased risk of developing opioid use disorder originating from the use of prescription opioids. Patients on high-dose and/or long-term opioid treatment should not have doses abruptly decreased or rapidly tapered.

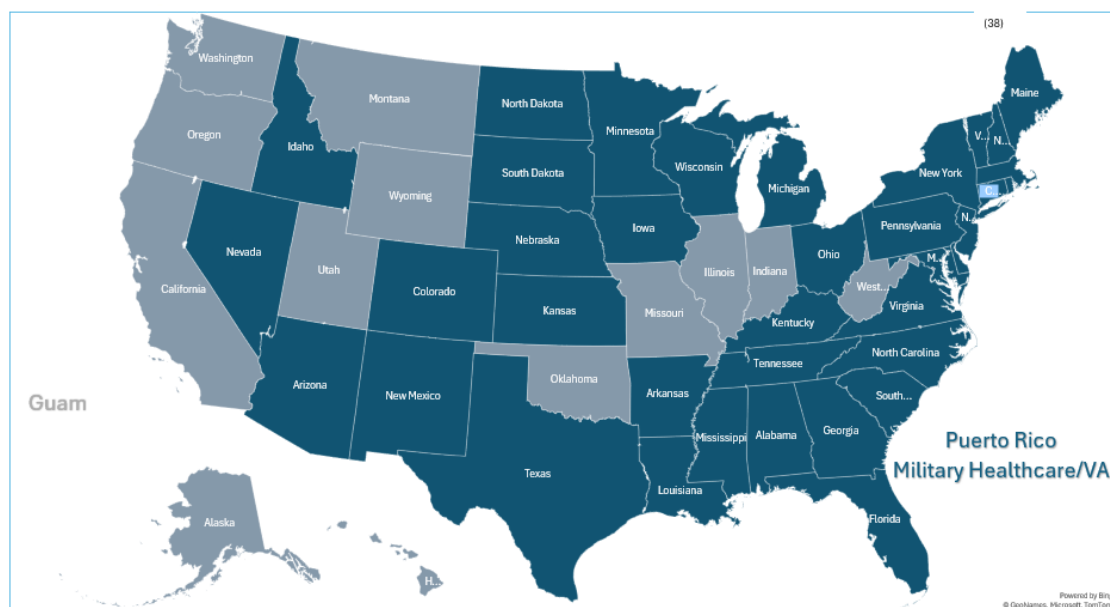
Table 5: Count of Patients Receiving over 100 MMEs by County of Patient Residence, 2019-2025

Patient County	2019	2020	2021	2022	2023	2024	2025
Androscoggin	296	207	213	168	171	168	144
Aroostook	95	96	83	79	70	59	65
Cumberland	646	577	484	441	464	467	437
Franklin	110	75	69	51	41	44	27
Hancock	123	105	85	63	73	52	43
Kennebec	327	290	275	246	248	217	191
Knox	80	91	87	66	47	54	54
Lincoln	95	102	102	77	84	88	89
Oxford	163	156	162	121	112	108	101
Penobscot	350	288	272	246	198	187	172
Piscataquis	41	36	27	26	22	19	25
Sagadahoc	78	73	56	47	57	53	56
Somerset	137	117	112	107	102	93	76
Waldo	85	97	74	66	68	58	48
Washington	67	64	49	47	54	43	47
York	553	516	429	372	344	322	301
State Total	3,246	2,890	2,579	2,223	2,155	2,032	1,876

Source: Maine Office of Behavioral Health

Section 5: Interstate Information Sharing

Maine shares PMP data with 39 states/territories/systems. Due to varying regulations across states, only registered prescribers (not delegates) are authorized to access interstate data sharing.



Source: Maine Office of Behavioral Health

Dark Blue: States with a Maine PMP Connection

Light Blue: States without a Maine PMP Connection

Appendices

Appendix A: Aggregate Number of Prescriptions of Each Drug Required to be in the PMP

Table A. Medication Count by Prescription & Patient, 2025

Generic Name	Prescription Count	Patient Count
acetaminophen with codeine phosphate	10,469	4,082
alprazolam	77,009	17,856
amphetamine	136	32
amphetamine sulfate	128	36
armodafinil	2,587	490
brivaracetam	4,519	536
buprenorphine	17,995	3,232
buprenorphine HCl	43,971	3,978
buprenorphine HCl/naloxone HCl	223,711	16,336
butalbital/acetaminophen*	148	50
butalbital/acetaminophen/caffeine*	4,974	1,360
butalbital/acetaminophen/caffeine/codeine phosphate*	1,105	221
butalbital/aspirin/caffeine*	1,489	398
butorphanol tartrate	313	39
carisoprodol	3,864	699
cenobamate	3,552	341
chlordiazepoxide HCl	3,747	1,480
clobazam	4,259	516
clonazepam	112,508	16,581
clorazepate dipotassium	1,181	353
codeine phosphate/butalbital/aspirin/caffeine	497	81
codeine phosphate/guaifenesin	5,996	4,590
codeine sulfate	407	117
daridorexant HCl	570	160
dexmethylphenidate HCl	46,513	6,109
dextroamphetamine	124	26
dextroamphetamine sulfate	8,369	1,223
dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate	305,858	35,866
diazepam	49,143	17,708
diethylpropion HCl	79	23
diphenoxylate HCl/atropine sulfate	5,701	1,975
dronabinol	429	190
eluxadoline	311	74
esketamine HCl	4,534	292

estazolam	133	25
estrogens,esterified/methyltestosterone	441	112
eszopiclone	12,250	2,386
fentanyl	13,350	1,984
fentanyl citrate	62	14
fentanyl citrate/PF	37	11
Generic Name	2025	2025
hydrocodone bitartrate	633	109
hydrocodone bitartrate/acetaminophen	116,658	34,801
hydrocodone bitartrate/homatropine methylbromide	2,086	858
hydrocodone polistirex/chlorpheniramine polistirex	2,537	1,817
hydrocodone/ibuprofen	166	35
hydromorphone HCl	24,170	7,505
hydromorphone HCl/PF	695	136
ketamine HCl	4,751	1,342
lacosamide	9,887	1,478
lasmiditan succinate	180	50
lemborexant	757	204
lisdexamfetamine dimesylate	171,366	24,904
lorazepam	166,563	50,416
methadone HCl	10,694	1,103
methylphenidate	428	142
methylphenidate HCl	185,573	24,817
midazolam	1,414	674
midazolam HCl	76	62
midazolam HCl/PF	443	287
modafinil	8,936	1,844
morphine sulfate	47,590	12,323
nandrolone decanoate	152	90
opium tincture	161	35
oxandrolone	102	75
oxazepam	645	126
oxycodone HCl	214,198	78,295
oxycodone HCl/acetaminophen	30,228	9,251
oxycodone myristate	2,342	277
oxymorphone HCl	319	26
perampanel	599	70
phendimetrazine tartrate	64	14
phenobarbital*	15,303	2,975
phenobarbital sodium*	157	60
phentermine HCl	39,895	9,749

phentermine HCl/topiramate	3,490	696
pregabalin	89,052	16,855
promethazine HCl/codeine	103	74
serdexmethylphenidate chloride/dexmethylphenidate HCl	961	168
sodium oxybate	334	39
sodium oxybate/calcium oxybate/magnesium oxybate/pot oxybate	521	76
solriamfetol HCl	732	132
suvorexant	1,998	513
tapentadol HCl	403	48
temazepam	6,950	1,244
testosterone	15,282	3,771
testosterone cypionate	35,848	8,868
testosterone cypionate, micronized	945	401
testosterone enanthate	1,464	410
testosterone micronized	7,674	3,248
testosterone propionate	30	14
testosterone undecanoate	962	179
tramadol HCl	108,155	33,228
tramadol HCl/acetaminophen	300	74
triazolam	2,670	1,648
Unspecified	450	241
zaleplon	1,810	515
zolpidem tartrate	80,844	14,877
zuranolone	26	26
Total (prescriptions only)	2,395,266	

**Some versions of combination medications containing these controlled substances are exempt from controlled substance status/reporting by the DEA*

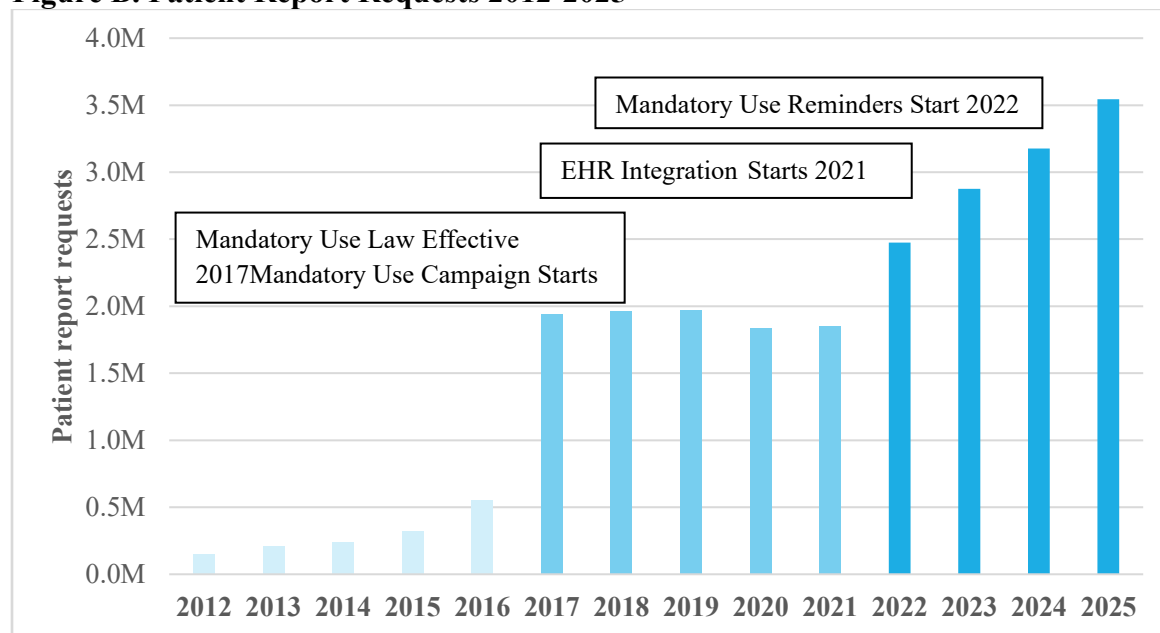
Note: Medications dispensed to less than 10 patients were redacted to maintain privacy.

Source: Maine Office of Behavioral Health

Appendix B: Maine PMP Patient Report Requests

Two substantial upticks in PMP patient report requests occurred in the past decade, first in 2017, related to legislation requiring a query of the PMP in certain prescribing circumstances, and then in 2022, when the PMP received additional funding to add a clinical member to the team and increased messaging on the requirement.

Figure B. Patient Report Requests 2012-2025

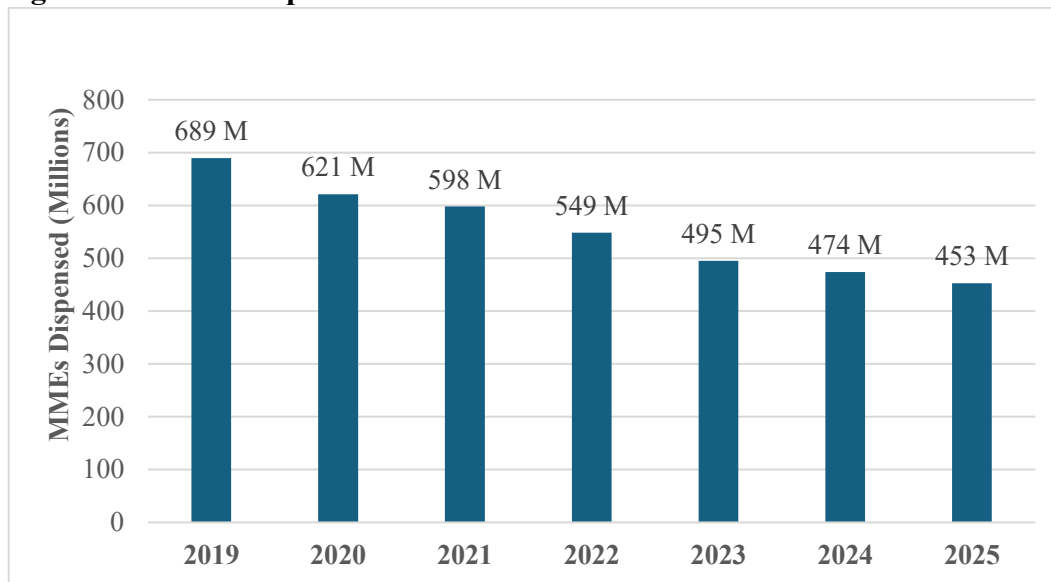


Source: Maine Office of Behavioral Health

Appendix C: Morphine Milligram Equivalents (MMEs) Dispensed, 2019-2025

Morphine milligram equivalents (MMEs) are a standardized measurement, equivalent to the amount of morphine in a prescription per day. The higher the MME of an opioid prescription, the higher the risk of nonfatal and fatal accidental overdose, development of opioid use disorder and other side effects.

Figure C. MMEs Dispensations Over Time

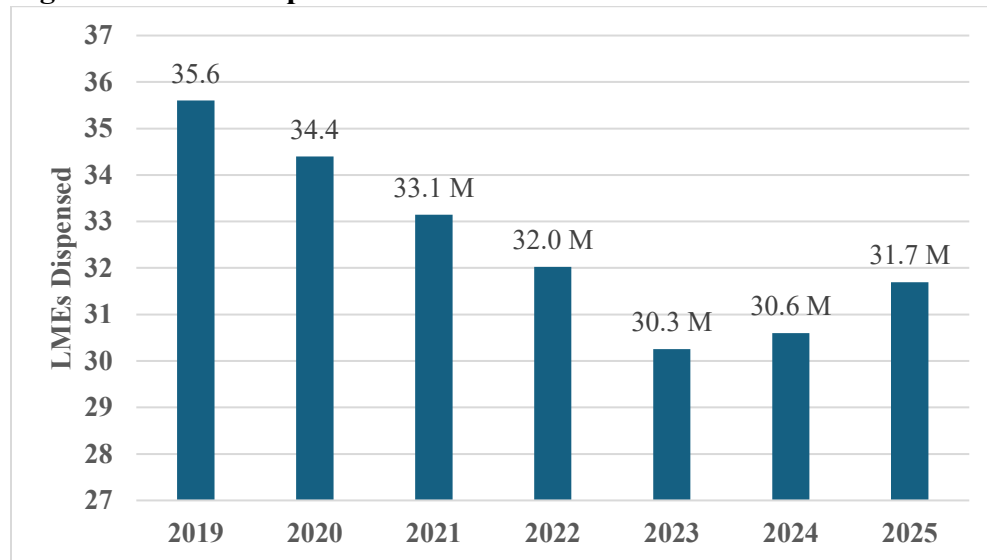


Source: Maine Office of Behavioral Health

Appendix D: Average Lorazepam Milligram Equivalents (LMEs) Dispensed, 2019-2025

Lorazepam milligram equivalents (LMEs) are used to assist in standardizing benzodiazepine doses. The higher the LME, the higher the risk of side effects. Some patients are at risk of developing benzodiazepine use disorder from taking prescription drugs. In general, LME numbers have decreased slowly since 2018. Numbers in 2025 will need to be evaluated before making determinations about the slight increase in 2024.

Figure D. LMEs Dispensations Over Time



Note: Excludes doses dispensed in either milliliter or gram form

Source: Maine Office of Behavioral Health