Concurrent Use of Opioids and Benzodiazepines (COB) Quality and Patient Safety Measure

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Purpose

This document aims to answer frequently aske questions about the Concurrent Use of Opioids and Benzodiazepines (COB) Quality and Patient Safety Measure developed by the Pharmacy Quality Alliance and used by Medicare as a Medicare Part D safety measure.

1. What are the dangers of co-prescribing benzodiazepines and opioids?

The concurrent use of benzodiazepines and opioids represents a well-documented safety concern in clinical practice, primarily due to overlapping pharmacologic effects and their impact on patient outcomes. From a pharmacist's perspective, the risks are multifactorial and extend beyond simple additive effects.

1. Additive Central Nervous System and Respiratory Depression [i,ii,iii,v]

Both benzodiazepines and opioids exert depressant effects on the central nervous system (CNS), but through different mechanisms, benzodiazepines enhance GABA-mediated inhibition, while opioids act on mu-receptors to reduce neuronal excitability. When combined, these effects become synergistic rather than merely additive.

Clinically, this results in a significantly heightened risk of respiratory depression, which is the primary driver of fatal overdose. Regulatory agencies, including the FDA, have issued boxed warnings highlighting outcomes such as profound sedation, respiratory compromise, coma, and death. The magnitude of risk is reflected in data showing that patients receiving both agents have approximately a tenfold increase in overdose mortality compared with those receiving opioids alone.

2. Increased Overdose and Mortality Risk[i,iii]

Epidemiologic data reinforce the clinical concern. A substantial proportion of opioid-related overdose deaths involve concurrent benzodiazepine use, with estimates indicating that approximately 14% of such deaths include both drug classes. Historical data further demonstrate that co-involvement exceeded 20% of opioid overdose deaths in certain years.

These findings illustrate that co-prescribing is not simply a theoretical risk but a major contributor to real-world morbidity and mortality, particularly in populations with chronic pain, anxiety disorders, or substance use disorders.

3. Cognitive, Psychomotor, and Functional Impairment[i,iv,v]

Beyond overdose risk, combined use significantly impairs cognitive and motor function. Patients often experience decreased alertness, impaired coordination, memory deficits, and slowed decision-making.

From a practical standpoint, this translates into increased risks of falls, motor vehicle accidents, and occupational injuries. Older adults are especially vulnerable due to baseline physiologic changes and comorbidities, leading to higher rates of fractures, including hip fractures, which carry substantial downstream morbidity.

4. Dependence, Tolerance, and Withdrawal

Both benzodiazepines and opioids independently carry risks of tolerance and physical dependence. When used together, these risks are amplified, increasing the likelihood of long-term use and potential misuse.

A key clinical challenge is that abrupt discontinuation of either agent can precipitate withdrawal, ranging from anxiety and insomnia (benzodiazepines) to severe autonomic and pain-related symptoms (opioids). This necessitates careful, individualized tapering strategies, often requiring close monitoring and interdisciplinary management.

5. Worse Clinical Outcomes and Increased Healthcare Utilization

Patients receiving both medications demonstrate higher rates of emergency department visits, hospitalizations, and drug-related adverse events. These outcomes reflect both acute toxicities and chronic complications associated with dual CNS depressant use.

Additionally, broader system-level impacts have been observed, including increased healthcare utilization and poorer overall treatment outcomes. Some reports also associate co-prescribing with elevated suicide risk, underscoring the importance of comprehensive patient assessment and monitoring.

2. What is the pharmacist's role in co-prescribing or deprescribing opioids and benzodiazepines in the ambulatory setting?

Pharmacists have an important role in preventing and managing potentially harmful concurrent opioid and benzodiazepine therapy. Their role extends beyond identifying a drug–drug interaction to comprehensive medication assessment, risk mitigation, deprescribing, patient education, care coordination, and population-health management. Concurrent therapy should not be treated as an automatic indication for discontinuation; decisions should be individualized through shared decision-making and coordinated with the clinician(s) responsible for the patient's pain, psychiatric, and substance-use care. [1,2,3,4,5]

1. Direct Patient Care and Medication Management

- **Identify and assess concurrent therapy.** Use the EHR, claims data, medication management platforms, and prescription drug monitoring program (PDMP) data to identify patients receiving opioids and benzodiazepines concurrently. Confirm active use, indications, prescribers, duration, and whether the combination remains clinically necessary. [vi,vii, xxxviii]
- **Perform a comprehensive medication review.** Assess opioid dose and duration, benzodiazepine agent and dose, other CNS depressants, alcohol or other substance use, renal and hepatic function, respiratory disease, sleep-disordered breathing, history of falls, and previous overdose or substance use disorder. In adults 65 years and older, apply the 2023 AGS Beers Criteria, which recommends avoiding the opioid–benzodiazepine combination because of increased risk of overdose and adverse events. [viii]

- **Assess benefits versus risks.** Determine whether the patient is experiencing meaningful benefit in pain, function, anxiety, sleep, or other treatment goals and whether benefits continue to outweigh the risks. CDC recommends particular caution with concurrent opioid and benzodiazepine prescribing and individualized assessment of benefits and risks. [xxxviii]

- **Review PDMP and medication-use patterns.** Identify overlapping opioid prescriptions, multiple prescribers or pharmacies, escalating doses, early refills, and other patterns that may increase overdose risk. PDMP information should be interpreted with the patient's clinical history rather than used punitively. [vii, xxxviii]

- **Develop individualized deprescribing plans.** When risks outweigh benefits, collaborate with the patient and prescribers on a gradual, patient-specific taper. For long-term opioid therapy, CDC notes that approximately 10% per month or slower may be better tolerated for patients treated for a year or longer. Benzodiazepines should not be stopped abruptly; the 2025 ASAM-led guideline suggests an initial reduction of about 5% to 10% every 2 to 4 weeks for many patients, with slower or paused reductions when withdrawal is significant. [ix, xxxviii]

- **Determine which medication to taper first.** There is no universal sequence. Consider the indication, dose and duration, withdrawal risk, patient priorities, clinical stability, and input from all prescribers. CDC specifically notes that the choice of which medication to taper first should be individualized. [xxxviii]

- **Optimize alternative therapies.** Recommend evidence-based nonopioid and nonbenzodiazepine approaches appropriate to the indication, including nonpharmacologic pain therapies, behavioral interventions, physical therapy, cognitive behavioral therapy, and appropriate nonbenzodiazepine pharmacotherapy. Avoid replacing one high-risk CNS-depressant regimen with another without a clear clinical rationale. [ix, x, xxxviii]

- **Provide structured follow-up.** Monitor withdrawal symptoms, pain or anxiety control, function, adherence, adverse effects, and patient-reported goals. Pharmacists can provide telephone, telehealth, or face-to-face monitoring and communicate clinically important changes to the prescribing team. [vi, xi, xxxviii]

- **Mitigate overdose risk.** Offer or facilitate naloxone for patients at increased risk, including those receiving opioids concurrently with benzodiazepines. Educate patients

and household members about overdose recognition, naloxone use, and the increased overdose risk that may occur after opioid tolerance is reduced during a taper. [x, xxxviii]

2. Interprofessional Collaboration

- **Serve as the medication-management consultant.** Provide targeted, actionable recommendations rather than simply identifying an interaction. Recommendations should state the safety concern, relevant patient-specific factors, proposed intervention, taper considerations, monitoring plan, and follow-up. [vi, xi, xii]
- **Coordinate care across prescribers.** Concurrent therapy may involve primary care, pain management, psychiatry, behavioral health, or addiction medicine. Pharmacists can help establish a shared medication-management plan and ensure that tapering decisions are communicated across clinicians. [vi, xii, xxxviii]
- **Address barriers to deprescribing.** Common barriers include fear of withdrawal or uncontrolled symptoms, stigma, prescriber concern about destabilization, limited visit time, and fragmented care. Pharmacists can address medication-specific concerns and provide longitudinal follow-up. [vi, xii, xii]

3. Population Health and Systems-Level Leadership

- **Use population-level identification and risk stratification.** Develop EHR or claims-based registries to identify patients receiving concurrent therapy and prioritize outreach based on opioid dose, benzodiazepine exposure, additional CNS depressants, age, respiratory disease, overdose history, and other clinical risk factors. [xii, xiii, xxxviii]
- **Use the PQA Concurrent Use of Opioids and Benzodiazepines (COB) measure as a population-health signal—not as an automatic deprescribing mandate.** The COB measure can identify opportunities for medication review and system improvement. It should not be interpreted as requiring discontinuation for every patient; CMS and PQA have emphasized that the measure evaluates concurrent use and does not replace individualized clinical decision-making. [9,10]
- **Develop standardized workflows and clinical decision support.** Partner with informatics, quality, and clinical leadership to create EHR reports, point-of-prescribing

alerts, referral pathways, pharmacist protocols, and standardized tapering resources. Systems should prioritize actionable alerts and minimize alert fatigue.[vi, xii, xliii]

- **Establish pharmacist-led or pharmacist-supported outreach programs.** Evidence supports the feasibility of pharmacist involvement in deprescribing opioids and benzodiazepines, particularly when pharmacists engage directly with patients and prescribers. The evidence base remains limited, so programs should evaluate meaningful clinical and process outcomes rather than medication reduction alone.[vi, xii, xiii xiv]

- **Track quality, safety, and equity outcomes.** In addition to COB, organizations can monitor opioid dose, naloxone access, medication-review completion, taper initiation and completion, emergency department visits, overdose events, falls, and patient-reported outcomes. Where feasible, stratify results to identify disparities in access to safer pain and behavioral-health treatment.[xiii, xv, xliii]

4. Patient and Caregiver Education

- **Frame deprescribing around safety and patient goals.** Use nonjudgmental language and explain that deprescribing is intended to reduce medication-related harm while maintaining or improving outcomes important to the patient.[vi, xii, xiii]

- **Prepare patients for the taper.** Discuss expected withdrawal symptoms, the anticipated pace of dose reduction, circumstances that may warrant slowing or pausing the taper, and how the care team will respond if symptoms worsen. A taper does not necessarily mean complete discontinuation; the goal may be the lowest effective and safest regimen.[xvi, xxxviii]

- **Provide overdose-prevention education.** Explain the risks of combining opioids with benzodiazepines, alcohol, or other sedating substances and provide training on naloxone when appropriate.[x, xxxviii]

5. Key Considerations for Population Health Programs

- **Prioritize high-risk patients.** A population-health program should focus pharmacist time where the potential for preventable harm is greatest rather than treating every concurrent prescription as equally urgent.[vi, xxxviii, xliii]
- **Use a stepped intervention model.** A practical workflow is: identify → risk-stratify → perform medication review → engage the patient → communicate with prescribers → implement risk mitigation or tapering → follow up → measure outcomes. [vi, xii,xiii, xxxviii]
- **Measure meaningful outcomes.** Success should not be defined solely as discontinuation. Appropriate outcomes include reduced high-risk exposure, improved function, successful individualized tapers, reduced adverse events, naloxone access, improved care coordination, and patient-reported confidence and symptom control. [vi, xii, xiii,xvi]

In summary. In ambulatory care, pharmacists can serve as medication-safety and population-health leaders for patients receiving opioids and benzodiazepines. Their highest-value contribution is translating population-level risk signals into individualized medication reviews, coordinated deprescribing plans, overdose-risk mitigation, patient education, and longitudinal follow-up. Current evidence supports the feasibility of pharmacist involvement, although further research is needed to determine which program designs produce the greatest improvements in medication exposure and outcomes.

3. What are best practice considerations (before prescribing, concomitant prescribing, and follow up)?

Before Prescribing or Re-Prescribing Benzodiazepines and Opioid Prescriptions:

- Determine if the patient is at increased risk for adverse outcomes [xxxii, xvii, xviii]
    - Age > 65 years
    - Frailty or low body weight
    - Past Medical History of:
        - Substance Use Disorder (current or past misuse)
        - Renal or Hepatic impairment (Chronic Kidney Disease, Liver disease, Cirrhosis)

        - Respiratory Disease (Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Severe Asthma)
        - Mental Health Disorders (Depression, Anxiety, Post Traumatic Stress Disorder (PTSD))
    - Opioid Dose (≥ 50 morphine milligram equivalent (MME)/day especially when ≥ 90 MME/day)
    - Concurrent CNS Depressants (Z-Drugs, Barbiturates, Gabapentinoids, Antipsychotics, Alcohol)
- Review/Reassess Indications for Medications
    - Is the benzodiazepine still needed?[xvi, xxi, xix, xvii]
        - Are they followed by psychiatry or behavioral health?
        - Is the benzodiazepine still effective for the indication it is being prescribed for?
        - Is a taper appropriate? – Consider taper in the following:[xxi]
            - Elevated fall risk
            - Cognitive decline
            - Prescribed central nervous system depressants
            - Substance use
            - PMH of PTSD
            - Initial indication resolved
            - Side effects on current regimen
    - Is the opioid still needed?[xxxii, xxvii]
        - Are they followed by a pain specialist?
        - Are they getting good relief of pain on their current regimen?
        - Is a taper appropriate? – Consider taper in the following:
            - Poor relief of pain
            - Side effects on pain medication
            - Painful condition has resolved
            - Medical conditions worse with opioids
        - Higher opioid dosages
            - ≥ 50 MME/day
                - Reassess benefits and risks
                - Consider additional precautions
                    - Naloxone
                    - Increased monitoring
                - Avoid increasing the dosage when possible.

- ≥ 90 MME/day
    - Reassess benefits and risks
    - Consider if tapering and or switching to an alternative therapy is appropriate
- Is the patient a good candidate to transition to buprenorphine (Can be determined by pain specialist) – Consider in the following:
    - Poor pain relief
    - MME > 90 (Re-assess benefits and risks and consider additional risk-mitigation strategies, including naloxone)
    - History of overdose
    - Meets criteria for opioid use disorder
- Determine if alternative options can be used

Prescribing Concomitant Benzodiazepine and Opioids [xxxii, xxi, viixxii, xvii]

- Check the Prescription Monitoring Program (PMP)
- If Co-Prescribing is Unavoidable
    - Prescribe Naloxone
    - Limit day supply/quantity supplied
        - For Benzodiazepine Naïve: for example: limit quantity to 2-4 week supply if possible (specified duration is an example; not a universal guideline recommendation)
    - Use lowest effective doses for shortest time
    - Increase monitoring (efficacy of prescribed therapy and side effects)
    - Educate patient on potential adverse effects
    - Education on Risk of Concomitant Use
    - Combination may not be avoidable/ Taper not appropriate in certain patient populations
        - For example: Active cancer, sickle cell, palliative care/hospice care

Follow Up [xxxii, xxii]

- Assess Effectiveness for Indication
- Assess for Adverse Effects
- Documentation of Risk Education Provided

4. What are some strategies to avoid prescribing the combination?

Preventing concurrent use of opioids and benzodiazepines is one of the most effective strategies for reducing overdose risk, respiratory depression, falls, cognitive impairment, and other adverse outcomes. Because patients who develop ≥30 cumulative days of overlapping therapy may be captured in the PQA Concurrent Use of Opioids and Benzodiazepines (COB) measure, prevention is often more effective than attempting to correct overlap after it has occurred.

1. Perform a Comprehensive Medication Review Before Prescribing [xxiii,xxiv]

Prior to initiating an opioid or benzodiazepine, review the patient's complete medication profile, including prescriptions from specialists and outside providers. Query the Prescription Drug Monitoring Program (PDMP) to identify existing controlled substance use and determine whether the patient is already receiving a medication from the opposite class. Medication reconciliation and PDMP review are specifically recommended by national opioid prescribing guidelines to identify high risk combinations and reduce preventable adverse drug events.

2. Utilize Non-Benzodiazepine Treatments for Anxiety and Insomnia

See next section for alternative therapies

3. Optimize Non-Opioid Pain Management Approaches[iv, xxv]

Before initiating opioid therapy, clinicians should maximize non-opioid and non-pharmacologic therapies when appropriate, including:

- Acetaminophen or NSAIDs
- Topical analgesics
- Physical therapy
- Exercise programs
- Antidepressants or anticonvulsants for neuropathic pain
- Interventional pain management options

Reducing opioid exposure decreases the likelihood that future benzodiazepine therapy will result in a high-risk combination.

4. Coordinate Care Among Prescribers [v, xxvi]

Concurrent prescribing frequently occurs when multiple providers are involved in a patient's care. Communication among primary care providers, psychiatrists, pain specialists, emergency medicine clinicians, and pharmacists can reduce unintended duplication and improve medication safety. Clear documentation of treatment goals, duration of therapy, and taper plans is encouraged.

5. Identify Opportunities for Deprescribing [iv, xxvii]

For patients already receiving both medications, evaluate whether either therapy remains clinically necessary. If risks outweigh benefits, implement a gradual, patient-specific tapering strategy. Abrupt discontinuation should generally be avoided because of withdrawal risks associated with both opioids and benzodiazepines

6. Incorporate Pharmacist-Led Interventions [xxviii]

Pharmacists can identify overlapping opioid and benzodiazepine therapy, review PDMP data, perform medication therapy management, recommend therapeutic alternatives, and educate patients regarding overdose risk. Studies have demonstrated that pharmacist involvement can reduce medication-related problems and improve medication safety outcomes.

7. Educate Patients About Risks Early[xxix]

Patients should be counseled that combining opioids and benzodiazepines increases the risk of:

- Excessive sedation
- Respiratory depression
- Overdose
- Falls and fractures
- Motor vehicle accidents
- Cognitive impairment

Patient education promotes informed decision-making and may increase acceptance of alternative therapies or deprescribing recommendations.

8. Consider Naloxone for Higher-Risk Patients [iv]

When concurrent therapy cannot be avoided, clinicians should strongly consider naloxone prescribing and provide education on overdose recognition and response. National guidelines recommend naloxone for patients receiving opioid therapy who have additional overdose risk factors, including benzodiazepine use

Key Practice Point: Preventing overlap is substantially easier than correcting established concomitant use. Routine medication review, PDMP evaluation, interdisciplinary communication, use of safer alternatives for anxiety and pain management, and proactive patient education can significantly reduce opioid-benzodiazepine co-prescribing and improve patient safety

5. What other medications or options are available to help with anxiety and/or pain that may be effective for management?

Medication Alternatives

1. Cognitive behavioral therapy (CBT). CBT therapy is recognized as a practice and series of techniques designed to manage anxiety over time. CBT promotes adaptive thinking and identification of dysfunctional thinking patterns which can improve or ameliorate anxiety. Internet delivered CBT is an emerging alternative in the modern age and is a more accessible and cost -effective opportunity for patients to engage in non-alternative management techniques.[xxx]
2. Mindfulness. This is a practice in which thoughts, feelings, and other experiences can be decentralized resulting in detaching oneself from transient events.[xxxi] Mindfulness based stress reduction has been found by many patients to be effective and shown to be non-inferior to escitalopram, with minimal adverse side effects.[xxxii] Many of these mindfulness practices can be accessed through an app-based product or even online through free videos or different learning platforms.
3. Psychotherapy. Research has found psychotherapy to be a first-line treatment and highly effective management tool for anxiety disorders. Often including cognitive behavioral therapy, psychotherapy can include psychoeducation, relaxation therapy, behavioral therapy licensed therapists may provide patients with thought patterns,

exercises, and human intervention to help manage anxiety and or pain management.[xxxiii]

Alternative Medications

1. Buspirone[xxxiv]
    a. Benefits: indicated for general anxiety disorder. Initial dose is 10-15 mg/day in 2-3 divided doses, max dose 60 mg/day.
    b. Considerations: use caution if renal dysfunction (CrCl less than 60 mL/min) and if renal or severe liver impairment consider starting the lowest possible dose 2.5-5 mg BID. Can cause dizziness (up to 12%)
2. Escitalopram[xxxv]
    a. Benefits: indicated for generalized anxiety disorder, dosed once daily. Max dose is 20 mg daily
    b. Considerations: Can cause QTc prolongation with higher doses (greater than 30 mg daily), start at lowest possible dose 5 mg with CrCl less than 20 mL/min, may cause adverse GI effects, headaches, and ejaculatory disorders and should monitor for adverse side effects.
3. Hydroxyzine[xxxvi]
    a. Benefits: indicated for anxiety dosed up to four times daily as needed
    b. Considerations: Can cause QTc prolongation and a lower starting dose should be used in patients with a CrCl less than 50 mL/min. With liver impairment the maximum daily dose is 25 mg/day. May contribute to drowsiness and caution should be used with older adults and ambulation
4. Sertraline[xxxvii]
    a. Benefits: indicated for generalized anxiety disorder. Initial doses between 25-50 mg dosed once daily. Max daily dose is 200 mg/day.
    b. Considerations: Initiate 50% of the usual dose if preexisting liver cirrhosis or liver impairment develops. May contribute to QTc prolongation with the use of other QTc prolonging medications. Diarrhea and nausea have occurred in up to 20-26% of patients.
5. Venlafaxine[xxxviii]
    a. Benefits: indicated for generalized anxiety disorder and social anxiety disorder. Has as ER formulation for once daily dosing what regimen is established. Max dose is 225 mg/day.

b. Considerations: Use caution if renal or hepatic dysfunction (CrCl less than 30mL/min) and start at lowest possible dose of 37.5 mg daily. Taper off and discontinue therapy if liver function worsens.

6. What are some protocols for managing benzodiazepine and opioid co-prescribing and tapering?

There is no single evidence-based protocol that applies to every patient receiving concurrent opioid and benzodiazepine therapy. Current guidance from the Centers for Disease Control and Prevention (CDC) and the American Society of Addiction Medicine (ASAM) emphasizes individualized, patient-centered decision making when evaluating the need for ongoing therapy and when implementing tapering strategies.[xxxix,xl] Patients receiving either medication alone are at risk for physical dependence, withdrawal, sedation, cognitive impairment, and overdose, and these risks are substantially increased when the medications are used together. Clinicians should regularly reassess the balance of benefits and risks, evaluate functional outcomes, screen for adverse effects and substance use disorders, and engage patients in shared decision making before initiating a taper. If deprescribing is appropriate, abrupt discontinuation should generally be avoided. The CDC recommends gradual opioid tapering, often as slow as 10% of the original dose per month or slower for patients receiving long-term opioid therapy, while ASAM recommends benzodiazepine dose reductions of approximately 5% to 10% at a time, with the pace adjusted according to patient response and generally not exceeding 25% every two weeks.[xli, xlii] Tapers may need to be paused, slowed, or modified based on withdrawal symptoms, pain control, anxiety, insomnia, or other clinical considerations. During tapering, clinicians should optimize nonopioid pain therapies, nonbenzodiazepine treatments for anxiety or insomnia, provide close follow-up, coordinate care among prescribers, and consider naloxone for patients who remain at elevated overdose risk. The overarching goal is not simply medication discontinuation, but rather the safe reduction of harm while maintaining patient function, quality of life, and therapeutic engagement.

7. What quality measures exist measuring the amount or impact of the co-prescribing of benzodiazepines and opioids?

Concurrent Use of Opioids and Benzodiazepines (COB) Measure[xliii]: The Pharmacy Quality Alliance (PQA) COB measure is the primary quality metric for opioid-benzodiazepine co-prescribing. It is used by CMS in Medicare Part D plan performance evaluations and by many Medicaid and commercial payers.

What it measures: The proportion of patients (≥18 years old) with **≥2** fills of an *opioid* ***AND*** **≥2** fills of a *benzodiazepine(BZD)*, with **≥30 cumulative days of overlapping supply** during the measurement year. *A lower rate indicates better performance.*

Denominator: Patients with **≥2 opioid prescription fills with ≥15 days supply** each during the measurement year.

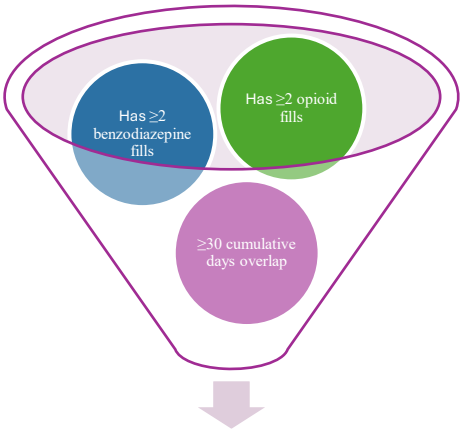
Numerator: Patients in the denominator who **also have ≥2 benzodiazepine fills with ≥30 days of overlap with opioids**.

Common Opioids *	Common Benzodiazepines *
Buprenorphine	Alprazolam
Codeine	Diazepam
Fentanyl	Midazolam
Hydrocodone	Chlordiazepoxide
Hydromorphone	Oxazepam
Methadone	Clonazepam
Morphine	Temazepam
Oxycodone	Lorazepam
Tapentadol	Triazolam
Tramadol	Flurazepam

*The medication lists above are not comprehensive and only provides common examples of opioids and benzodiazepines. To review the full list, please review the Pharmacy Quality Alliance Measure Manual.

Exclusions: *Cancer patients, hospice patients, and certain palliative care populations are typically excluded.*

Why it matters: This is a plan-level, claims-based measure, pharmacy dispensing data directly feeds it. Every overlapping fill counts. ***Once patients fall into the measure, they will NOT fall out of the measure → Prevention is key***



Counted in COB measure (failed measure, added to numerator)

Other Quality Measures to Know

Beyond COB, several complementary measures round out co-prescribing quality monitoring:

Naloxone Co-Dispensing Rate: Percentage of co-prescribed patients offered or dispensed naloxone. National guidelines recommend naloxone for all patients on concurrent BZDs and opioids.

High-Dose Opioid Overlap: Flags patients with ≥30 days of overlap AND a daily opioid dose >120 morphine milligram equivalents (MME).

Multiple Prescriber/Pharmacy Measure: Another PQA opioid measure capturing patients receiving opioids from ≥4 prescribers AND ≥4 pharmacies.

Created by a collaborative effort between the ASHP Pain Management and Palliative Care and Population Health SAGs

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