9/27/26
CVS - Jessica Stine PharmD

Re: Why my immediate-release opioid pill counts (e.g., 180 vs. 120) are individualized, guideline-concordant, and not a diversion signal

Dear Jessica Stine PharmD,

Thank you for your diligence and our shared commitment to safe opioid prescribing. I write to address the concern that I prescribe higher quantities of immediate-release (IR) opioids — for example, 180 tablets per month rather than 120 — and that this has flagged my practice as an "outlier." My aim is to explain why that quantity is the predictable, defensible result of a longitudinal medical-management model and why my monitoring directly answers any diversion concern.

1. My practice is a fundamentally different specialty model than the benchmark.

Most board-certified pain specialists complete a one-year interventional fellowship and derive analgesia largely from procedures, deliberately keeping opioids low. My model is longitudinal medical management, in which opioids — embedded in a broader integrative plan — are a primary rather than adjunctive tool. As overall opioid prescribing fell from 2010–2024, long-term opioid prescribing became increasingly concentrated among pain medicine specialists [1], and pain medicine has historically had the highest proportion of prescriptions that are opioids of any specialty [2]. A practice devoted to complex, long-term opioid management is expected to sit at the higher end of the distribution by design.

2. My case mix predicts higher quantities — a referral and tenure effect, not aberrancy.

- Most of my patients have already tried and failed interventional options — through prior failure, intolerance, or procedural phobia — and many are referred to me by interventional colleagues precisely because procedures did not work. When the interventional avenue is exhausted, therapeutic weight shifts to pharmacologic management, and opioid requirements are correspondingly higher.
- My practice is 18 years old; many patients have been on stable therapy for 10, 15, and 20+ years, some since the 1980s–1990s. Tolerance builds and doses reach a stable maintenance plateau over years, so a practice weighted toward multi-decade patients carries higher steady-state quantities than one weighted toward newer episodes.

3. IR pill counts are individualized decisions the CDC expressly declines to cap by number.

- The 2022 CDC guideline deliberately removed dose and quantity thresholds from its recommendation statements to prevent their misapplication as inflexible rules,

and states the recommendations are not to be applied as rigid standards of care [3]. Commentary in JAMA Internal Medicine confirms the 2016 thresholds were widely misapplied by systems and payers into forced tapers and dismissals — precisely the harm the 2022 revision sought to correct [4].

- How many IR tablets a patient needs reflects an individualized assessment of the expected duration and pattern of pain severe enough to warrant opioids — not a fixed number such as 120 or 180. For severe, breakthrough-prone, or multi-site pain requiring more frequent dosing intervals, a higher tablet count at a given per-tablet strength can be pharmacokinetically appropriate.
- For patients already on opioids, CDC Recommendation 5 directs individualized care: if benefits outweigh risks, continue therapy while optimizing non-opioid treatments; taper only if benefits do not outweigh risks, and — absent a life-threatening issue such as impending overdose — do not discontinue abruptly or rapidly reduce from higher dosages [3]. A quantity-only reduction from a stable 180-tablet regimen runs directly against this guidance.
- I do routinely recommend tapering where appropriate — to test lower effective doses, limit tolerance, and maintain a small emergency reserve for hurricane evacuation. Some patients tolerate this; many do not. I counsel patients that the goal is function and quality of life, not a target pain number. In my direct observation, patients force-tapered by pharmacy refusal (cut from 180 to 120–150) have suffered impaired sleep, work performance, mental health, and daily function. Discontinuation in stable patients is associated with more frequent illicit and non-prescribed opioid use [6]; destabilizing a well-managed patient can increase, not decrease, the harm we both aim to prevent.

4. Diversion Concerns — and why my monitoring specifically resolves them

- The larger epidemiology matters: prescription opioids are a small and shrinking contributor to opioid mortality. System-dynamics modeling projects prescription opioid use disorder falling ~31% between 2015 and 2025 while the number of people using illicit opioids rises ~61%, and the share of people who initiate opioid use directly with an illicit opioid rising from ~30% to ~48% [10]. The same modeling shows that even highly successful prevention of prescription-opioid misuse would reduce total overdose deaths by only ~4–5%, because roughly 80% of projected deaths are attributable to illicit opioids. Refusing a monitored maintenance patient's refill therefore acts on the wrong reservoir.
- Diversion overwhelmingly originates from unused, shared, or stockpiled pills, not from the ongoing, monitored consumption of an established maintenance patient. The authoritative characterization is that the most common form of diversion is transfer of legitimately prescribed opioids to family or friends — best managed by education, safe storage, and disposal, not by refusing to treat the patient [5]. Roughly 7–10% of diversion involves patients who feign pain across multiple prescribers — the exact behavior PMP review detects. The DEA's own data estimate that less than 1% of oxycodone (0.3%) and hydrocodone (0.42%) is lost, stolen, or diverted.

- The principal reservoir is unused surgical and acute-care surplus, not maintenance refills. Across studies, 67–92% of surgical patients report leftover opioids and 42–71% of dispensed pills go unused, most stored unlocked and undisposed; a JAMA Surgery systematic review concluded that this combination of oversupply, poor storage, and non-disposal is what sets the stage for diversion [11][12]. Approximately 65% of people who misuse prescription opioids obtain them from a source other than their own prescription — most often a friend's or relative's supply. This is a supply-side problem of excess dispensing to intermittent users, categorically different from a titrated daily regimen in a monitored, opioid-tolerant patient.
- The safeguards my practice already employs are the interventions the evidence identifies as countermeasures: PMP review at every visit (targets doctor-shopping), scheduled/random urine drug monitoring (confirms the patient is actually consuming the drug), single-prescriber/single-pharmacy arrangements, controlled-substance agreements, pill counts, documented functional benefit, and co-prescribed naloxone. A patient who consistently shows the prescribed drug on toxicology, reflects a single prescriber/pharmacy on the PMP, and demonstrates functional benefit is the opposite of the surplus-pill and doctor-shopping channels that actually drive diversion.
- Every patient undergoes a structured Safety & Compliance assessment at intake and annually (with brief focused reassessments when a concern arises), stratifying each patient by safety and compliance and assigning individualized toxicology frequency. Millennium, the largest urine toxicology provider in Louisiana, has identified my practice as having the lowest percentage of aberrant drug screens in its Louisiana cohort — objective evidence against a diversion hypothesis.
- Cash payment has been associated with higher-intensity opioid prescriptions and greater diversion potential [9], and I take that association seriously. In my practice, a higher share of cash payment reflects an underserved population — patients who are frequently disabled, unemployed, or low-income, and who are often declined elsewhere for lack of insurance — not pharmacy shopping. I do not track how patients pay, yet every cash-pay patient undergoes the identical individualized assessment, monthly PMP review, and toxicology monitoring as every other patient, which is the appropriate way to distinguish legitimate need from diversion risk; the lowest-in-state aberrant-screen rate noted above applies to them as well.
- Where appropriate, I actively favor abuse-deterrent formulations (Roxybond IR; Hysingla ER, Xtampza ER) over larger IR quantities, and I am working with CVS and other pharmacies to expand their availability.

5. Continuity is what makes this level of individualization safe.

I see patients every 30 days — exceeding CDC's commonly recommended reassessment interval — often for many years, and I involve family as a team. Higher continuity of care is associated with delayed opioid initiation, less escalation, and less potentially inappropriate prescribing [7][8]. This intensity of monitoring is precisely what

lets me safely individualize — and, where warranted, sustain — a higher quantity for a specific patient.

6. My perspective.

Under Louisiana law the pharmacist shares corresponding responsibility to confirm a legitimate medical purpose, and they may decline to fill based on a legitimate, objective safety evaluation. Federal case law on corresponding responsibility reinforces that this duty runs in both directions: a pharmacist must make efforts to resolve a red flag through sound professional judgment and fact-based verification — gathering objective findings, such as PMP data showing overlapping fills or evidence of a drug–drug interaction — before declining to dispense, rather than relying on a single metric or an accusatory assumption. Recent Fifth Circuit rulings on corresponding responsibility, and the February 2026 federal appeals decision involving a Louisiana pharmacy (enclosed), are consistent with this standard. A high pill count, standing alone and absent evidence of diversion, does not by itself justify refusing a valid prescription written within the usual course of the prescribers professional practice.

Unfortunately, many of my patients have been denied 180 tablets with no more than the comment that "that's a lot of tablets, you don't need that many," with no attempt to contact me — resulting in serious harm from unilateral forced tapers. I fully support your duty to be comfortable dispensing, and I welcome direct contact to resolve any concern. The clinically meaningful question is not how my quantities compare to a predominantly interventional peer group, but whether each individual prescription is justified by documented benefit and risk mitigation.

Ultimately, the question that needs to be asked is whether I am adequately trained and educated and whether my practice meets pain-management safety standards, including those recommended by the CDC. I believe the evidence provided answers these questions overwhelmingly in the affirmative.

Having established a legitimate medical purpose for these prescriptions, I believe the identified red flags can now be resolved, and I welcome the opportunity to address any remaining questions directly.

I value this opportunity to introduce what I believe to be an exemplary pain management practice, and I thank you for your time.

Respectfully,

Eric Ehlenberger MD
Accurate Clinic

References

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