Naloxone is an opioid receptor antagonist medication that can reverse an opioid overdose, giving individuals time to access emergency medical care and saving lives as a result.

Summary of current Maryland state law
As of October 2015, doctors at the state health department can write a blanket prescription to anyone who is trained to administer naloxone. They must present the prescription and a card that certifies they were trained by a state-certified trainer.1

Maryland’s Good Samaritan Law protects a person who “seeks, provides, or assists with the provision of medical assistance” for someone experiencing a drug or alcohol related medical emergency from criminal arrest, charge, or prosecution. The law also protects the person experiencing the medical emergency.2 A person is protected as long as the evidence for the criminal arrest, charge, or prosecution was “obtained solely as a result of the person seeking or receiving medical assistance.”3

Research evidence
Naloxone was approved for use by the Federal Drug Administration in 1971. The Chicago Recovery Alliance program started the first naloxone distribution program in the US in 1996.

In Maryland, the statewide overdose rate increased from 11.3 per 100,000 in 20104 to 17.9 per 100,000 in 2014.5 Naloxone is safe and effective in preventing fatal overdose, and requires minimal training through intranasal or intramuscular administration.6

Providing naloxone kits to people at risk for overdose and people who may be likely to witness an overdose is a cost-effective way of reducing opioid overdose deaths.7 A research study in Ohio found that intranasal naloxone administration by law enforcement officers is associated with decreased opioid overdose deaths.8

Increasing access to naloxone does not lead to increased risk-taking behavior or increased drug use.9

Policy recommendations
1) Eliminate prescription requirement for naloxone following other state models (NM, VT, CA, others).
2) Incentivize hospitals to provide naloxone upon discharge for high-risk patients.
3) Incentivize providers to distribute naloxone to high-risk patients and their families.
4) Mandate providers to co-prescribe naloxone with all high-risk, long-acting, sustained release opioids.

Implementation considerations
Research suggests there is a need to improve physician self-efficacy related to addressing opioid overdose through training on recognizing risk-behaviors for overdose, as well as understanding patient need for a naloxone prescription.10 One study showed that participants in overdose prevention training were more willing to prescribe the nasal spray form of naloxone rather than the injectable form to patients.11

Distribution of naloxone should be accompanied with educational materials on overdose prevention, risk of HIV and other infections, and referral to substance use treatment and other healthcare and social services.

Barriers for gaining public support of naloxone include lack of knowledge, concerns regarding unintended consequences and lack of sympathy for people at risk of overdose. These barriers can be overcome by effective communication strategies.12

Federal, state and local governments will need to work together with the pharmaceutical industry to determine methods of bringing down the price of naloxone. For the Baltimore City Health Department, the cost of the drug doubled from $20 per dose in February 2015 to $40 per dose in July 2015.13
“The act of seeking medical assistance for a person who is experiencing a medical emergency after ingesting alcohol or drugs may be used as a mitigating factor in a criminal prosecution” (emphasis added). MD. CODE ANN., CRIM. PROC. §1-210(a)-(b).

MD. CODE REGS., 10.47.08 (2015).

MD. CODE ANN., HEALTH-GEN. §13-3110.


