STATES THAT REQUIRE PRACTITIONERS TO ACCESS PMP DATABASE IN CERTAIN CIRCUMSTANCES

West's Colorado Administrative Code (2011)
Title 1100. Department of Labor and Employment
1101. Division of Workers' Compensation
7 CCR 1101-3. Workers' Compensation Rules of Procedure with Treatment Guidelines

1101-3:17 EXHIBIT 5. CUMULATIVE TRAUMA CONDITIONS MEDICAL TREATMENT GUIDELINES

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c. Narcotics: should be primarily reserved for the treatment of severe upper extremity pain. There are circumstances where prolonged use of narcotics is justified based upon specific diagnosis, and in these cases, it should be documented and justified. In mild-to-moderate cases of upper extremity pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a pain scale and assessment of function to rate effectiveness of the narcotic prescribed. Any use beyond the maximum duration should be documented and justified based on the diagnosis and/or invasive procedures.

• Optimal Duration: 3 to 7 days.

• Maximum Duration: 2 weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to the Chronic Pain Guidelines which gives a detailed discussion regarding medication use in chronic pain management. When prescribing beyond the maximum duration, it is recommended physicians access the Colorado Prescription Drug Monitoring Pro-gram (PDMP). This system allows the prescribing physician to see all controlled substances prescribed by other physicians for an individual patient.

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West's Colorado Administrative Code (2011)
Title 1100. Department of Labor and Employment
1101. Division of Workers' Compensation
7 CCR 1101-3. Workers' Compensation Rules of Procedure with Treatment Guidelines

1101-3:17 EXHIBIT 6. LOWER EXTREMITY INJURY MEDICAL TREATMENT GUIDELINES

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e. Narcotics should be primarily reserved for the treatment of severe lower extremity pain. There are circumstances where prolonged use of narcotics is justified based upon specific diagnosis, and in these cases, it should be documented and justified. In mild-to-moderate cases of lower extremity pain, narcotic medication should be used cautiously on a case-by-case basis. Adverse effects include respiratory depression, the development of physical and psychological dependence, and impaired alertness.

Narcotic medications should be prescribed with strict time, quantity, and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a pain scale and assessment of function to rate effectiveness of the narcotic prescribed. Any use beyond the maximum duration should be documented and justified based on the diagnosis and/or invasive procedures.

Optimal Duration: 3 to 7 days.

Maximum Duration: 2 weeks. Use beyond two weeks is acceptable in appropriate cases. Refer to Chronic Pain Guidelines which gives a detailed discussion regarding medication use in chronic pain management. When pre-scribing beyond the maximum duration, it is recommended physicians access the Colorado PDMP (Prescription Drug Monitoring Program). This system allows the prescribing physician to see all controlled substances prescribed by other physicians for an individual patient.

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West's Colorado Administrative Code (2011)
Title 1100. Department of Labor and Employment
1101. Division of Workers' Compensation
7 CCR 1101-3. Workers' Compensation Rules of Procedure with Treatment Guidelines

1101-3:18. MEDICAL FEE SCHEDULE

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(5) Chronic Opioid Management Report

(a) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and also review the Colorado State Board of Medical Examiners' Policy # 10-14, “Guidelines for the Use of Controlled Substances for the Treatment of Pain.” Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and

quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring.

(1) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.

(2) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).

(3) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:

(i) Concern regarding the functional status of the patient

(ii) Abnormal results on previous testing

(iii) Change in management of dosage or pain

(iv) Chronic daily opioid dosage above 150 mg of morphine or equivalent

(4) The opioids prescribed for long-term treatment shall be provided through a pharmacy.

(5) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.

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West's Delaware Code Annotated (2011)
Title 16. Health and Safety
Part IV. Food and Drugs
Chapter 47. Uniform Controlled Substances Act
Subchapter VII. Miscellaneous

§ 4798. The Delaware Prescription Monitoring Program

<Text of section effective upon the availability of appropriations, or of other adequate funding to implement and maintain the Prescription Monitoring Program. See Historical and Statutory Notes below.>

. . .

(e) A prescriber, or other person authorized by the prescriber, shall obtain, before writing a prescription for a controlled substance listed in Schedule II, III, IV or V for a patient, a patient utilization report regarding the patient for the preceding 12 months from the computerized program established by the Office of Controlled Substances when the prescriber has a reasonable belief that the patient may be seeking the controlled substance, in whole or in part, for any reason other than the treatment of an existing medical condition. The prescriber shall review the patient utilization report to assess whether the prescription for the controlled substance is necessary.

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Louisiana Administrative Code (2011)
Title 48. Public Health general
Part I. General Administration
Subpart 3. Licensing
Chapter 78. Pain Management Clinics
Subchapter C. Clinic Administration

§ 7831. Medical Director

A. Each clinic shall be under the direction of a medical director who shall be a physician who:

1. possesses a current, unrestricted license from the board to practice medicine in Louisiana;

2. during the course of his practice, has not been denied the privilege of prescribing, dispensing, administering, supplying, or selling any controlled dangerous substance; and

3. during the course of his practice has not had any board action taken against his medical license as a result of dependency on drugs or alcohol.

B. The medical director shall be a physician certified in the subspecialty of pain management by a member board of the American Boards of Medical Specialties, except for the following exemption.

1. A clinic which has been verified as being in operation on or before June 15, 2005, is required to have a medical director, but is exempt from having a medical director who is certified in the subspecialty of pain management by a member board of the American Boards of Medical Specialties.

C. Responsibilities. The medical director is responsible for the day-to-day operation of a clinic and shall be on-site 50 percent of the time during the operational hours of the clinic. In the event the medical director is not on-site during the hours of operation, then the medical director shall be available by telecommunications and shall be able to be on-site within 30 minutes.

1. The medical director shall oversee all medical services provided at the clinic.

2. The medical director shall ensure that all qualified personnel perform the treatments or procedures for which each is assigned. The clinic shall retain documentation of proficiency and training.

3. The medical director, or his designee, is responsible for ensuring a medical referral is made to an addiction facility, when it has been determined that a patient or staff member has been diverting drugs or participating in the illegal use of drugs.

4. The medical director is responsible for ensuring a urine drug screen of each patient is obtained as part of the initial medical evaluation and intermittently, no less than quarterly, during the course of treatment for chronic pain.
5. The medical director shall ensure that patients are informed of after-hours contact and treatment procedure.

6. The medical director is responsible for applying to access and query the Louisiana Prescription Monitoring Program (PMP).

a. The PMP is to be utilized by the medical director and the pain specialist as part of a clinics' quality assurance program to ensure adherence to the treatment agreement signed by the patient.

i. The treatment agreement states that the patient has been informed that he shall only obtain and receive narcotic prescriptions from the clinic where he is being treated for chronic pain.

(a). The patient shall be subject to periodic unannounced drug screens and shall not participate in diversion of any controlled dangerous substance.

b. Compliance to this agreement is to be determined and evaluated at each subsequent visit to a clinic when the patient receives a prescription for a controlled dangerous substance.

West's Nevada Revised Statutes (2011)
Title 54. Professions, Occupations and Businesses
Chapter 639. Pharmacists and Pharmacy
Prescriptions

§ 639.23507. Patient utilization report required before writing prescription for controlled substance

A practitioner shall, before writing a prescription for a controlled substance listed in schedule II, III or IV for a patient, obtain a patient utilization report regarding the patient for the preceding 12 months from the computerized program established by the Board and the Investigation Division of the Department of Public Safety pursuant to NRS 453.1545 if the practitioner has a reasonable belief that the patient may be seeking the controlled substance, in whole or in part, for any reason other than the treatment of an existing medical condition and:

1. The patient is a new patient of the practitioner; or

2. The patient has not received any prescription for a controlled substance from the practitioner in the preceding 12 months.

The practitioner shall review the patient utilization report to assess whether the prescription for the controlled substance is medically necessary.

Baldwin's Ohio Administrative Code (2011)
4729 Pharmacy Board
Chapter 4729-5. Pharmacy Practice--Administration

4729-5-20 Prospective drug utilization review

(A) Prior to dispensing any prescription, a pharmacist shall review the patient profile for the purpose of identifying:

(1) Over-utilization or under-utilization;

(2) Therapeutic duplication;

(3) Drug-disease state contraindications;

(4) Drug-drug interactions;

(5) Incorrect drug dosage;

(6) Drug-allergy interactions;

(7) Abuse/misuse;

(8) Inappropriate duration of drug treatment;

(9) Food-nutritional supplements-drug interactions.

(B) Upon recognizing any of the above, a pharmacist, using professional judgment, shall take appropriate steps to avoid or resolve the potential problem. These steps may include requesting and reviewing an OARRS report or another state's report if applicable and available, and/or consulting with the prescriber and/or counseling the patient.

(C) Prospective drug utilization review shall be performed using predetermined standards consistent with, but not limited to, any of the following:

(1) Peer-reviewed medical literature (that is, scientific, medical, and pharmaceutical publications in which original manuscripts are rejected or published only after having been critically reviewed by unbiased independent experts);

(2) American hospital formulary service drug information;

(3) United States pharmacopoeia drug information;

(4) American medical association evaluations.

(D) Prior to dispensing a prescription, at a minimum, a pharmacist shall request and review an OARRS report covering at least a one year time period and/or another state's report, where applicable and available, if a pharmacist becomes aware of a person currently:

(1) Receiving reported drugs from multiple prescribers;

(2) Receiving reported drugs for more than twelve consecutive weeks;

(3) Abusing or misusing reported drugs (i.e. over-utilization, early refills, appears overly sedated or intoxicated upon presenting a prescription for a reported drug, or an unfamiliar patient requesting a reported drug by specific name, street name, color, or identifying marks);

(4) Requesting the dispensing of reported drugs from a prescription issued by a prescriber with whom the pharmacist is unfamiliar (i.e. prescriber is located out-of-state or prescriber is outside the usual pharmacy geographic prescriber care area); or.

(5) Presenting a prescription for reported drugs when the patient resides outside the usual pharmacy geographic patient population.

After obtaining an initial OARRS report on a patient, a pharmacist shall use professional judgment based on prevailing standards of practice in deciding the frequency of requesting and reviewing further OARRS reports and/or other states' reports for that patient.

In the rare event a report is not immediately available, the pharmacist shall use professional judgment in determining whether it is appropriate and in the patient's best interest to dispense the prescription prior to receiving and reviewing a report.

Effective: 10/27/2011

Baldwin's Ohio Administrative Code (2011)
4731 Medical Board
Chapter 4731-11. Controlled Substances

4731-11-11 Standards and procedures for review of Ohio Automated Rx Reporting System (OARRS)

(A) For purposes of this rule:

(1) "OARRS" means the "Ohio Automated Rx Reporting System" drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(2) "OARRS report" means a report of information related to a specified patient generated by the drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(3) "Personally furnish" means the distribution of drugs by a prescriber to the prescriber's patients for use outside the prescriber's practice setting.

(4) "Protracted basis" means a period in excess of twelve continuous weeks.

(5) "Reported drugs" means all the drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained pursuant to section 4729.75 of the Revised Code, including:

(a) Controlled substances in schedules II, III, IV, and V, and

(b) All dangerous drug products containing carisoprodol or tramadol.

(B) If a physician believes or has reason to believe that a patient may be abusing or diverting drugs, the physician shall use sound clinical judgment in determining whether or not the reported drug should be prescribed or personally furnished to the patient under the circumstances.

(1) To assist in this determination, the physician shall access OARRS and document receipt and assessment of the information received if the patient exhibits the following signs of drug abuse or diversion:

(a) Selling prescription drugs;

(b) Forging or altering a prescription;

(c) Stealing or borrowing reported drugs;

(d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;

(e) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;

(f) Having been arrested, convicted or received diversion, or intervention in lieu of conviction for a drug related offense while under the physician's care;

(g) Receiving reported drugs from multiple prescribers, without clinical basis; or

(h) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs.

(2) Other signs of possible abuse or diversion which may necessitate accessing OARRS include, but are not limited to the following:

(a) A known history of chemical abuse or dependency;

(b) Appearing impaired or overly sedated during an office visit or exam;

(c) Requesting reported drugs by specific name, street name, color, or identifying marks;

(d) Frequently requesting early refills of reported drugs;

(e) Frequently losing prescriptions for reported drugs;

(f) A history of illegal drug use;

(g) Sharing reported drugs with another person; or

(h) Recurring emergency department visits to obtain reported drugs.

(C) A physician prescribing or personally furnishing reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances:

(1) Once the physician has reason to believe that the treatment will be required on a protracted basis; and

(2) At least once annually, thereafter.

(D) A physician shall document receipt and assessment of all OARRS reports in the patient record.

(1) Initial reports requested in compliance with this rule shall cover a time period of at least one year;

(2) Subsequent reports requested in compliance with this rule shall, at a minimum, cover the period from the date of the last report to present.

(E) In the event an OARRS report is not available prior to writing a prescription for a reported drug or personally furnishing the reported drug, a physician shall document in the patient record why the OARRS report was not available.

(F) Paragraph (C) of this rule does not apply to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code.

Baldwin's Ohio Revised Code Annotated (2011)[1]
Title XLVII. Occupations--Professions
Chapter 4715. Dentists; Dental Hygienists
Disciplinary Action; Prohibitions

§ 4715.302 Review of patient information available through drug database

(A) As used in this section, "drug database" means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(B) The state dental board shall adopt rules in accordance with Chapter 119 of the Revised Code that establish standards and procedures to be followed by a dentist regarding the review of patient information available through the drug database.

(C) This section and the rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Baldwin's Ohio Revised Code Annotated (2011)
Title XLVII. Occupations--Professions
Chapter 4723. Nurses
Certificates to Prescribe

§ 4723.487 Review of patient information available through drug database

(A) As used in this section, "drug database" means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(B) The board of nursing shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures to be followed by an advanced practice nurse with a

[1] Ohio Code Annotated §§ 4715.302, 4723.487 and 4725.092 require the respective boards to adopt rules regarding accessing the drug database. These rules are to be adopted with the understanding that the practitioners will be required to access the database.

certificate to prescribe issued under section 4723.48 of the Revised Code regarding the review of patient information available through the drug database.

(C) This section and the rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Baldwin's Ohio Revised Code Annotated (2011)
Title XLVII. Occupations--Professions
Chapter 4725. Optometrists; Dispensing Opticians
State Board of Optometry

§ 4725.092 Review of patient information available through drug database

(A) As used in this section, "drug database" means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(B) The state board of optometry shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures to be followed by an optometrist who holds a therapeutic pharmaceutical agents certificate regarding the review of patient information available through the drug database.

(C) This section and the rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Oklahoma Statutes Annotated (2011)
Title 63. Public Health and Safety
Chapter 2. Uniform Controlled Dangerous Substances Act
Article III. Regulation of Manufacture, Distribution, Dispensing, Prescribing, Administering and Using for Scientific Purposes of Controlled Dangerous Substances
Registration

§ 2-302. Registration requirements

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M. Beginning November 1, 2010, each registrant that prescribes, administers or dispenses methadone shall be required to check the prescription profile of the patient on the central repository of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control.

West Virginia Code of State Rules (2011)
Title 64. Bureau for Public Health -- Department of Health and Human Resources
Legislative Rule (Ser. 90)
Series 90. Regulation of Opioid Treatment Programs

§ 64-90-40. Toxicology Screens.

40.1. Urine drug screening and other adequately tested toxicological procedures shall be used as an aid in monitoring and evaluating a patient's progress in treatment.

40.2. Drug screening procedures shall be individualized and shall include:

40.2.a. At least eight random drug screens per year for each person receiving methadone maintenance services. The program shall test new patients upon admission and at approximately fourteen days of treatment, then monthly through the remainder of the first year;

40.2.b. More frequent collection and analysis of samples during medically-supervised or other types of withdrawal;

40.2.c. Collection of observed specimens on an unannounced basis when using urine as a screening mechanism if the staff believes that observation is necessary based on patient behavior or need. Collection shall be done in a manner that assures respect for the patient and minimizes the chance of adulterating or substituting another individual's urine; and

40.2.d. Toxicological analysis for drugs of abuse, including, but not limited to:

40.2.d.1. Opiates including oxycodone at common levels of dosing;

40.2.d.2. Methadone or any other medication used by the program as an intervention for that patient;

40.2.d.3. Benzodiazepines (including testing procedures that detect diazepam, clonazepam, alprazolam and lorazepam);

40.2.d.4. Cocaine;

40.2.d.5. Methamphetamine/ amphetamines; and

40.2.d.6. Other drugs as determined by community standards, regional variation or clinical indication (e.g., carisoprodol, barbiturates).

40.3. Marijuana shall be included in the testing process on a random basis at least three times per year. Positive marijuana screens shall be carefully clinically evaluated and shall in most cases

result in reduction in take-home privileges unless other action is considered appropriate by the medical director or program physician and primary counselor.

40.4. Collection and testing shall be done in a manner that assures a method of confirmation for positive results and documents the chain of custody of the collection.

40.5. Any refusal to participate in a random drug test shall be considered a positive test.

40.6. When necessary and appropriate, breathalyzers or other testing equipment may be used to screen for possible alcohol abuse. No individual shall receive a daily dose who has a breathalyzer result which is equal to or greater than .02. The individual may return to the clinic for dosing during the same day if the breathalyzer results reach acceptable limits.

40.7. A positive test is a test that results in the presence of any drug or substance listed in Subdivision 40.2.d of this rule, or any other drug or substance prohibited by the opioid treatment program; provided that the presence of medication which is part of the patient's treatment plan shall not be considered a positive test.

40.8. A positive drug test result after the first six months in an opioid treatment program shall result in the following:

40.8.a. Upon the first positive drug test result, the opioid treatment program shall:

40.8.a.1. Provide mandatory and documented weekly counseling, which shall include weekly meetings with a counselor who is licensed, certified or enrolled in the process of obtaining licensure or certification in compliance with the rules on staff at the opioid treatment program; and

40.8.a.2. Immediately revoke the take-home privilege for a minimum of thirty days;

40.8.b. Upon a second positive drug test result within six months of a pervious positive drug test result, the opioid treatment program shall:

40.8.b.1. Provide mandatory and documented weekly counseling, which shall include weekly meetings with a counselor who is licensed, certified or enrolled in the process of obtaining licensure or certification in compliance with the rules on staff at the opioid treatment program;

40.8.b.2. Immediately revoke the take-home privilege for a minimum of sixty days; and

40.8.b.3. Provide mandatory documented treatment team meetings with the patient;

40.8.c. Upon a third positive drug test result within a period of six months the opioid treatment program shall:

40.8.c.1. Provide mandatory and documented weekly counseling, which shall include weekly meetings with a counselor who is licensed, certified, or enrolled in the process of obtaining licensure or certification in compliance with the rules on staff at the opioid treatment program;

40.8.c.2. Immediately revoke the take-home privilege for a minimum of one hundred twenty days; and

40.8.c.3. Provide mandatory and documented treatment team meetings with the patient which will include, at a minimum: the need for continuing treatment; a discussion of other treatment alternatives; and the execution of a contract with the patient advising the patient of discharge for continued positive drug tests; and

40.8.d. Upon a fourth positive drug test within a six month period, the patient shall be immediately discharged from the opioid treatment program, or, at the option of the patient, shall immediately be provided the opportunity to participate in a 21-day detoxification plan, followed by immediate discharge from the opioid treatment program.

40.9. Programs shall document both the results of toxicological tests and the follow-up therapeutic action taken in the patient record.

40.10. Treatment programs shall work carefully with toxicology laboratories to ensure valid, appropriate results of toxicological screens. Workplace testing standards are not appropriate for urine testing. Testing shall be done only by laboratories with appropriate federal certification.

40.11. The program shall ensure that physicians demonstrate competence in interpretation of "false negative" and "false positive" laboratory results as they relate to physiological issues, differences among laboratories, and factors that impact absorption, metabolism and elimination of opiates.

40.12. The program physician shall thoroughly evaluate a positive toxicological screen for any potentially licit substance such as benzodiazepines, carisoprodol, barbiturates and amphetamines. The program shall verify with appropriate releases of information that:

40.12.a. The patient has been prescribed these medications by a licensed physician for a legitimate medical purpose; and

40.12.b. The prescribing physician is aware that the patient is enrolled in an opioid treatment program.

40.13. If the patient refuses the release of information to contact his or her physician but can produce prescriptions and/or other evidence of legitimate prescription (such as current medication bottles, fully labeled), the team shall consider the patient's individual situation and the possibility that he or she may be dismissed from the care of his or her physician if the physician discovers that the patient is in medication-assisted treatment. The program physician

shall make the ultimate decision as to the patient's continuing care in the clinic and the circumstances of that care.

40.14. Absence of methadone or other medications prescribed by the program for the patient shall be considered evidence of possible medication diversion and evaluated by the physician and interdisciplinary team accordingly.

40.15. As appropriate and necessary, the state authority shall develop guidelines for frequency of toxicological screening for alternative treatment modalities such as buprenorphine.

40.16. The program shall comply with policies and procedures developed by the designated state oversight agency and the West Virginia Board of Pharmacy to allow access to the Prescription Drug Registry maintained by the West Virginia Board of Pharmacy:

40.16.a. Before the administration of methadone or other treatment in an opioid treatment program;

40.16.b. After any positive drug test; and

40.16.c. At each ninety-day treatment review.

40.17. Each Prescription Drug Registry access shall confirm that the patient is not seeking prescription medication from multiple sources.

40.18. Nothing contained in this rule shall preclude any opioid treatment program from administering any additional drug tests it determines necessary.