STATES THAT REQUIRE PRESCRIBERS AND/OR DISPENSERS TO ACCESS PMP DATABASE IN CERTAIN CIRCUMSTANCES

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Colorado

West's Colorado Administrative Code (2012)
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 (2012)
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 prescribing 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 (2012)
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 7. COMPLEX REGIONAL PAIN SYNDROME/REFLEX SYMPATHETIC DYSTROPHY MEDICAL TREATMENT GUIDELINES

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c. Medical Management History:

i. History of diagnostic tests and results including but not limited to any response to sympathetic nerve blocks, results of general laboratory studies, EMG and nerve conduction studies,

radiological examinations, including triple phase bone scan or thermography with autonomic stress testing, and tests of sudomotor functioning such as QSART.

ii. Prior Treatment -- Chronological review of medical records including previous medical evaluations and response to treatment interventions. In other words, what has been tried and what has been helpful?

iii. Prior Surgery -- If the patient has had prior surgery specifically for the pain, he/she may be less likely to have a positive outcome.

iv. History of and current use of medications, including over-the-counter and herbal/dietary supplements to determine drug usage (or abuse) interactions and efficacy of treatment. Drug allergies and other side effects experienced with previous or current medication therapy and adherence to currently prescribed medications should be documented. Ideally, this includes dosing schedules as reported by the patient or patient representative. **Information should be checked against the Colorado Prescription Drug Monitoring Program, offered by the Colorado Pharmacy Board.**

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West's Colorado Administrative Code (2012)
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 9. CHRONIC PAIN DISORDER MEDICAL TREATMENT GUIDELINES

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c. Medical Management History:

i. Diagnostic Tests -- All previous radiological and laboratory investigations should be reviewed.

ii. Prior Treatment -- Chronological review of medical records including previous medical evaluations and response to treatment interventions. In other words, what has been tried and which treatments have helped?

iii. Prior Surgery -- If the patient has had prior surgery specifically for the pain, he/she may be less likely to have a positive outcome.

iv. Medications -- History of and current use of medications, including over the counter and herbal/dietary supplements to determine drug usage (or abuse) interactions and efficacy of treatment. Drug allergies and other side effects experienced with previous or current medication therapy and adherence to currently prescribed medications should be documented. Ideally, this includes dosing schedules as reported by the patient or patient representative. **Information should be checked against the Colorado Prescription Drug Monitoring Program (PDMP), offered by the Colorado Pharmacy Board.**

v. Review of Systems Check List -- Determine if there is any interplay between the pain complaint and other medical conditions.

vi. Psychosocial Functioning -- Determine if any of the following are present: current symptoms of depression or anxiety; evidence of stressors in the workplace or at home; and past history of psychological problems. Other confounding psychosocial issues may be present, including the presence of psychiatric disease. Due to the high incidence of co-morbid problems in populations that develop chronic pain, it is recommended that patients diagnosed with chronic pain should be referred for a full psychosocial evaluation.

vii. Pre-existing Conditions -- Treatment of these conditions is appropriate when the pre-existing condition affects recovery from chronic pain.

viii. Family history pertaining to similar disorders.

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West's Colorado Administrative Code (2012)
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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Delaware

West's Delaware Code Annotated (2012)
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.>

(a) It is the intent of the General Assembly that the Delaware Prescription Monitoring Act established pursuant to this section serves as a means to promote public health and welfare and to detect the illegal use of controlled substances. The Delaware Prescription Monitoring Act shall have the dual purpose of reducing misuse and diversion of controlled substances in the State while promoting improved professional practice and patient care.

(b) Definitions.-

(1) "Administer" or "administration" means the direct application of a drug to the body of a patient by injection, inhalation, ingestion, or any other means.

(2) "Controlled substance" means any substance or drug defined, enumerated or included in this chapter and Title 21, Code of Federal Regulations.

(3) "Dispense" or "dispensing" means the interpretation, evaluation, and implementation of a prescription drug or, including the preparation and delivery of a drug to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient.

(4) "Dispenser" means a person authorized by this State to dispense or distribute to the ultimate user any controlled substance or drug monitored by the program, but shall not include any of the following: a licensed health care facility pharmacy that dispenses or distributes any controlled substance or drug monitored by the program for the purposes of inpatient care, emergency department care for the immediate use of a controlled substance or when dispensing up to a 72-hour supply of a controlled substance or a drug of concern monitored by the program at the time of discharge from such a facility.

(5) "Distribute" or "distribution" means the delivery of a drug other than by administering or dispensing.

(6) “Drug” means any of the following:

a. Any substance recognized as a drug in the official compendium, or supplement thereto, designated by the Office of Controlled Substances for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans.

b. Any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease or pain in humans.

c. Any substance other than food intended to affect the structure or any function of the body of humans.

(7) “Drugs of concern” means drugs other than controlled substances as defined by rule which demonstrate a potential for abuse or diversion.

(8) “Patient” means the person who is the ultimate user of a controlled substance or drug monitored by the program for whom a prescription is issued and for whom a controlled substance or drug is dispensed.

(9) “Prescriber” means a licensed health care professional with the authority to write and issue prescriptions, except it shall not include:

a. A prescriber or other authorized person who administers such controlled substance or drug upon the lawful order of a prescriber.

b. A prescriber or other authorized person who, in providing emergency patient care in a healthcare facility, causes the administration of a controlled substance for immediate relief of symptoms arising from an acute condition.

c. A prescriber or other authorized person who prescribes up to a 72-hour supply of a controlled substance for on call services or emergency care.

d. A veterinarian who prescribes for the purpose of providing veterinary services.

(10) “Prescription monitoring information” means data submitted to and maintained by the prescription monitoring program established under this section.

(11) “Prescription Monitoring Program” or “PMP” means the electronic program established by this section.

(c) The Office of Controlled Substances shall establish and maintain a PMP program to monitor the prescribing and dispensing of all Schedule II, III, IV and V controlled substances by prescribers in this State, and to research the prescribing and dispensing of drugs of concern. The

PMP shall not interfere with the legal use of a controlled substance or drug of concern. The PMP shall be:

(1) Used to provide information to prescribers, dispensers, and patients to help avoid the illegal use of controlled substances;

(2) Used to assist law enforcement to investigate illegal activity related to the prescribing, dispensing and consumption of controlled substances or drugs of concern; and

(3) Designed to minimize inconvenience to patients and prescribing medical practitioners while effectuating the collection and storage of prescription monitoring information.

(d) A dispenser shall submit the required information regarding each prescription dispensed for a controlled substance, in accordance with the transmission methods and frequency established by regulation issued by the Office of Controlled Substances. When needed for bona fide research purposes and in accordance with applicable regulation, the Office of Controlled Substances may require a dispenser to submit the required information regarding each prescription dispensed for a drug of concern, but in no event should dispensers be required to submit such information any more frequently than that required for controlled substances. The following information shall be submitted for each prescription:

(1) Pharmacy name;

(2) Dispenser DEA registration number;

(3) Date drug was dispensed;

(4) Prescription number;

(5) Whether prescription is new or a refill;

(6) NDC code for drug dispensed;

(7) Quantity dispensed;

(8) Approximate number of days supplied;

(9) Patient name and date of birth;

(10) Patient address;

(11) Prescriber DEA registration number and name;

(12) Date prescription issued by prescriber.

(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.

(f) The Office of Controlled Substances may issue a waiver to a prescriber who is unable to access prescription information by electronic means. A prescriber who is unable to access prescription information by electronic means shall obtain a waiver from the OCS on annual basis until such time they can access the prescription information by electronic means.

(g) Unless a court of competent jurisdiction makes a finding of gross negligence, malice or criminal intent, the Office of Controlled Substances, any other state agency, any prescriber or dispenser, or any person or entity in proper possession of information pursuant to this statute is not subject to civil liability, administrative action or other legal or equitable relief for any of the following acts or omissions:

(1) Furnishing information pursuant to this section.

(2) Receiving, using or relying on, or not using or relying on, information received pursuant to this section.

(3) Information that was not furnished to the Office of Controlled Substances.

(4) Information that was factually incorrect or that was released by the Office of Controlled Substance to the wrong person or entity.

(h) Prescription information submitted to the PMP is protected health information, not subject to public or open records law, and not subject to disclosure, except as otherwise provided in this section.

(i) The Office of Controlled Substances shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed, except as provided for in this section.

(1) If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the Office of Controlled Substances shall notify the appropriate law-

enforcement or professional licensure, certification, or regulatory agency or entity and shall provide prescription information required for an investigation.

(2) The Office of Controlled Substances may provide data in the prescription monitoring program in the form of a report to the following persons:

a. A prescriber, or other person authorized by the prescriber, or a dispenser, or other person authorized by the dispenser, who requests information and certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide patient;

b. An individual who requests the individual's own prescription monitoring information in accordance with procedures established pursuant to regulations;

c. A designated representative of any Board or Commission pursuant to § 8735(a) of Title 29 responsible for the licensure, regulation, or discipline of prescribers, dispensers or other persons authorized to prescribe, administer, or dispense controlled substances and who is involved in a bona fide specific investigation involving a designated person;

d. A local, state, or federal law-enforcement or prosecutorial official engaged in the administration, investigation, or enforcement of the laws governing controlled substances and who is involved in a bona fide specific drug-related investigation in which a report of suspected criminal activity involving controlled substances by an identified suspect has been made, and provided that such information be relevant and material to such investigation, limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and include identifying information only if nonidentifying information could not be used;

e. The Delaware Department of Health and Social Services regarding Medicaid program recipients;

f. A properly convened grand jury pursuant to a subpoena properly issued for the records;

g. Personnel of the Division of Professional Regulation for purposes of administration and enforcement of this section;

h. Qualified personnel for the purpose of bona fide research or education; however, data elements that would reasonably identify a specific recipient, prescriber or dispenser must be deleted or redacted from such information prior to disclosure; and further provided that, release of the information may be made only pursuant to a written agreement between qualified personnel and the Office of Controlled Substances in order to ensure compliance with this subsection.

(j) The Division of Professional Regulation may contract with another agency of this State or with a private vendor, as necessary, to ensure the effective operation of the prescription monitoring program. A contractor shall comply with the provisions regarding confidentiality of prescription information under this section is subject to the penalties specified in this section for any unlawful acts.

(k) The Office of Controlled Substances may promulgate regulations setting forth the procedures and methods for implementing this section.

(l) The Office of Controlled Substances shall design and implement an evaluation component to identify cost-benefits of the Prescription Monitoring Program, including its effect on diversion and abuse of controlled substances and drugs of concern, and other information relevant to policy, research and education involving controlled substances and drugs of concern monitored by the Prescription Monitoring Program.

(1) The Office of Controlled Substances shall report to the General Assembly the information obtained pursuant to this subsection on an annual basis.

(2) To the extent such information is made available to the Office of Controlled Substances, the report may include information and data, including surveys, polls, or other data from multi-disciplinary experts and stakeholders, relating to the negative or positive impact of the prescription monitoring program on appropriate prescribing practices of controlled substances and drugs of concern.

(m) A dispenser who fails to submit prescription monitoring information to the Office of Controlled Substances PMP as required by this section, or who knowingly submits incorrect prescription information, shall be subject to disciplinary sanction pursuant to Chapter 25 of Title 24.

(n) A person or persons authorized to have prescription monitoring information pursuant to this section who knowingly discloses this information in violation of this section is guilty of a class G felony and, upon conviction, shall be fined not more than $5,000 nor imprisoned more than 2 years, or both.

(o) A person authorized to have prescription monitoring information pursuant to this section who intentionally uses this information in the furtherance of other crimes is guilty of a class E felony and, upon conviction, shall be fined not more than $10,000 nor imprisoned more than 5 years, or both.

(p) A person or persons not authorized to have prescription monitoring information pursuant to this section who obtain such information fraudulently is guilty of a class E felony and, upon conviction, shall be fined not more than $10,000 nor imprisoned more than 5 years, or both.

Kentucky

Baldwin's Kentucky Revised Statutes Annotated (2012)
Title XVIII. Public Health
Chapter 218A. Controlled Substances

<Text of Section Effective July 20, 2012>

§ 218A._____

(1) Prior to the initial prescribing or dispensing of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, a practitioner shall:

(a) Obtain a complete medical history and conduct a physical examination of the patient and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in Section 4 of this Act for all available data on the patient;

(c) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(2) The practitioner shall conduct, at reasonable intervals based on the patient's individual circumstances, the course of treatment and provide to the patient any new information about the treatment. The course of treatment shall include the practitioner querying the electronic monitoring system established in Section 4 of this Act no less than once every three (3) months for all available data on the patient and reviewing that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(3) For each patient for whom a practitioner prescribes any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone, the practitioner shall keep accurate, readily accessible, and complete medical records which include:

(a) Medical history and physical examination;

(b) Diagnostic, therapeutic, and laboratory results;

(c) Evaluations and consultations;

(d) Treatment objectives;

(e) Discussion of risk, benefits, and limitations of treatments;

(f) Treatments;

(g) Medications, including date, type, dosage, and quantity prescribed or dispensed;

(h) Instructions and agreements; and

(i) Periodic reviews of the patient's file.

(4) This section shall not apply to:

(a) A licensee administering a controlled substance or anesthesia immediately prior to or during surgery;

(b) A licensee administering a controlled substance necessary to treat a patient in an emergency situation:

1. At the scene of the emergency;

2. In a licensed ground or air ambulance; or

3. In the emergency department or intensive care unit of a licensed hospital;

(c) A licensed pharmacist or other person licensed by the Kentucky Board of Pharmacy to dispense drugs or to a licensed pharmacy;

(d) A licensee prescribing or dispensing a controlled substance for a hospice patient when functioning within the scope of a hospice program or hospice inpatient unit licensed under KRS Chapter 216B. The hospice program shall maintain a plan of care in accordance with federal regulations;

(e) The prescribing of a Schedule III, IV, or V controlled substance by a licensed optometrist to a patient in accordance with the provisions of KRS 320.240; or

(f) The prescribing of a three (3) day supply of a Schedule III controlled substance following the performance of oral surgery by a dentist licensed pursuant to KRS Chapter 313.

Louisiana

Louisiana Administrative Code (2012)
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.

Nevada

West's Nevada Revised Statutes (2012)
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.

New York

Mckinney's Consolidated Laws of New York Annotated (2012)
Public Health Law
Chapter 45. Of the Consolidated Laws
Article 33. Controlled Substances
Title IV. Dispensing to Ultimate Users

<Text of Section Effective One Year After Enactment>

§ 3343-a. Prescription Monitoring Program Registry

1. Establishment of system. (A) The commissioner shall, in accordance with the provisions of this section, establish and maintain an electronic system for collecting, monitoring and reporting information concerning the prescribing and dispensing of controlled substances, to be known as the prescription monitoring program registry. The registry shall include information reported by pharmacies on a real time basis, as set forth in subdivision four of section thirty-three hundred thirty-three of this article.

(B) The registry shall include, for each person to whom a prescription for controlled substances has been dispensed, all patient-specific information covering such period of time as is deemed appropriate and feasible by the commissioner, but no less than six months and no more than five years. Such patient-specific information shall be obtained from the prescription information reported by pharmacies pursuant to subdivision four of section thirty-three hundred thirty-three of this article and by practitioners who dispense pursuant to subdivision six of section thirty-three hundred thirty-one of this article, and shall be processed and included in the registry by the department without undue delay. For purposes of this article, "patient-specific information" means information pertaining to individual patients included in the registry, which shall include the following information and such other information as is required by the department in regulation:

(I) The patient's name;

(II) The patient's residential address;

(III) The patient's date of birth;

(IV) The patient's gender;

(V) The date on which the prescription was issued;

(VI) The date on which the controlled substance was dispensed;

(VII) The metric quantity of the controlled substance dispensed;

(VIII) The number of days supply of the controlled substance dispensed;

(IX) The name of the prescriber;

(X) The prescriber's identification number, as assigned by the Drug Enforcement Administration;

(XI) The name or identifier of the drug that was dispensed; and

(XII) The payment method.

(C) The registry shall be secure, easily accessible by practitioners and pharmacists, and compatible with the electronic transmission of prescriptions for controlled substances, as required by section two hundred eighty-one of this chapter, and section sixty-eight hundred ten of the Education Law, and any regulations promulgated pursuant thereto. To the extent practicable, implementation of the electronic transmission of prescriptions for controlled substances shall serve to streamline consultation of the registry by practitioners and reporting of prescription information by pharmacists. The registry shall be interoperable with other similar registries operated by federal or state governments, to the extent deemed appropriate by the commissioner, and subject to the provisions of section thirty-three hundred seventy-one-a of this article.

(D) The department shall establish and implement such protocols as are reasonably necessary to ensure that information contained in the registry is maintained in a secure and confidential manner and is accessible only by practitioners, pharmacists or their designees for the purposes established in subdivisions two and three of this section, or as otherwise set forth in sections thirty-three hundred seventy-one and thirty-three hundred seventy-one-a of this article. Such protocols shall include a mechanism for the department to monitor and record access to the registry, which shall identify the authorized individual accessing and each controlled substance history accessed.

2. Duty to consult prescription monitoring program registry; practitioners. (A) Every practitioner shall consult the prescription monitoring program registry prior to prescribing or dispensing any controlled substance listed on Schedule II, III or IV of section thirty-three hundred six of this article, for the purpose of reviewing a patient's controlled substance history as set forth in such registry; provided, however, that nothing in this section shall preclude an authorized practitioner, other than a veterinarian, from consulting the registry at his or her option prior to prescribing or dispensing any controlled substance. The duty to consult the registry shall not apply to:

(I) Veterinarians;

(II) A practitioner dispensing pursuant to subdivision three of section thirty-three hundred fifty-one of this article;

(III) A practitioner administering a controlled substance;

(IV) A practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser pursuant to section thirty-three hundred forty-two of this title;

(V) A practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

(VI) A practitioner prescribing a controlled substance to a patient under the care of a hospice, as defined by section four thousand two of this chapter;

(VII) A practitioner when:

(a) It is not reasonably possible for the practitioner to access the registry in a timely manner;

(b) No other practitioner or designee authorized to access the registry, pursuant to paragraph (B) of this subdivision, is reasonably available; and

(c) The quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

(VIII) A practitioner acting in compliance with regulations that may be promulgated by the commissioner as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient;

(IX) A situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation; or

(X) A practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner, pursuant to a process established in regulation, and in the discretion of the commissioner.

(B) For purposes of this section, a practitioner may authorize a designee to consult the prescription monitoring program registry on his or her behalf, provided that:

(I) The designee so authorized is employed by the same professional practice or is under contract with such practice;

(II) The practitioner takes reasonable steps to ensure that such designee is sufficiently competent in the use of the registry;

(III) The practitioner remains responsible for ensuring that access to the registry by the designee is limited to authorized purposes and occurs in a manner that protects the confidentiality of the information obtained from the registry, and remains responsible for any breach of confidentiality; and

(IV) The ultimate decision as to whether or not to prescribe or dispense a controlled substance remains with the practitioner and is reasonably informed by the relevant controlled substance history information obtained from the registry.

The commissioner shall establish in regulation reasonable parameters with regard to a practitioner's ability to authorize designees pursuant to this section, which shall include processes necessary to allow the department to:

(a) Grant access to the registry in a reasonably prompt manner to as many designees as are authorized by practitioners, up to the number deemed appropriate by the commissioner for particular professional practices or types of practices, taking into account the need to maintain security of the registry and the patient-specific information maintained therein, and the objective of minimizing burdens to practitioners to the extent practicable;

(b) Require that practitioners notify the department upon terminating the authorization of any designee; and

(c) Establish a mechanism to prevent such terminated designees from accessing the registry in a reasonably prompt manner following such notification.

3. Authority to consult prescription monitoring program registry; pharmacists. (A) A pharmacist may consult the prescription monitoring program registry in order to review the controlled substance history of an individual for whom one or more prescriptions for controlled substances is presented to such pharmacist.

(B) For purposes of this section, a pharmacist may designate another pharmacist, a pharmacy intern, as defined by section sixty-eight hundred six of the Education Law, or other individual as may be permitted by the commissioner in regulation, to consult the prescription monitoring program registry on the pharmacist's behalf, provided that such designee is employed by the same pharmacy or is under contract with such pharmacy. The commissioner shall establish in regulation reasonable parameters with regard to a pharmacist's ability to authorize designees pursuant to this section, which shall include processes necessary to allow the department to:

(a) Grant access to the registry in a reasonably prompt manner to as many designees as are authorized by pharmacists, up to the number deemed appropriate by the commissioner for particular pharmacies, taking into account the need to maintain security of the registry and the patient-specific information maintained therein, and the objective of minimizing burdens to pharmacists to the extent practicable;

(b) Require that pharmacists notify the department upon terminating the authorization of any designee; and

(c) Establish a mechanism to prevent such terminated designees from accessing the registry in a reasonably prompt manner following such notification.

4. Immunity. No practitioner or pharmacist, and no person acting on behalf of such practitioner or pharmacist as permitted under this section, acting with reasonable care and in good faith shall be subject to civil liability arising from any false, incomplete or inaccurate information submitted to or reported by the registry or for any resulting failure of the system to accurately or timely report such information; provided, however, that nothing in this subdivision shall be deemed to alter the obligation to submit or report prescription information to the department as otherwise set forth in this article or in regulations promulgated pursuant thereto.

5. Guidance to practitioners and pharmacists. The commissioner shall, in consultation with the commissioner of education, provide guidance to practitioners, pharmacists, and pharmacies regarding the purposes and uses of the registry established by this section and the means by which practitioners and pharmacists can access the registry. Such guidance shall reference educational information available pursuant to the prescription pain medication awareness program established pursuant to section thirty-three hundred nine-a of this article.

6. Individual access to controlled substance histories. The commissioner shall establish procedures by which an individual may:

(A) Request and obtain his or her own controlled substances history consisting of patient-specific information or, in appropriate circumstances, that of a patient who lacks capacity to make health care decisions and for whom the individual has legal authority to make such decisions and would have legal access to the patient's health care records; or

(B) Seek review of any part of his or her controlled substances history or, in appropriate circumstances, that of a patient who lacks capacity to make health care decisions and for whom the individual has legal authority to make such decisions and would have legal access to the patient's health care records, that such individual disputes.

Such procedures shall require the department to promptly revise any information accessible through the registry that the department determines to be inaccurate. Such procedures shall be described on the department's website and included with the controlled substances history

provided to an individual pursuant to a request made under this subdivision or under subparagraph (IV) of paragraph (A) of subdivision two of section thirty-three hundred seventy-one of this article.

7. Department analysis of data. The department shall periodically analyze data contained in the prescription monitoring program registry to identify information that indicates that a violation of law or breach of professional standards may have occurred and, as warranted, provide any relevant information to appropriate entities as permitted under section thirty-three hundred seventy-one of this article. The department shall keep a record of the information provided, including, but not limited to, the specific information provided and the agency to which such information was provided, including the name and title of the person to whom such information was provided and an attestation from such person that he or she has authority to receive such information.

8. Funding the prescription monitoring program registry. (A) The commissioner shall make reasonable efforts to apply for monies available from the federal government and other institutions, to the extent deemed appropriate by the commissioner, and use any monies so obtained to supplement any other monies made available for the purposes of this title.

(B) Operation of the registry established by this section shall not be funded, in whole or in part, by fees imposed specifically for such purposes upon practitioners, pharmacists, designees or patients subject to this section.

9. Rules and regulations. The commissioner shall promulgate such rules and regulations as are necessary to effectuate the provisions of this section, in consultation with the work group established pursuant to subdivision three of section thirty-three hundred nine-a of this article.

North Carolina

Per the state PDMP representative, North Carolina requires medical directors of opioid treatment programs to access the PMP database upon admission of a new patient and at least annually thereafter.

Ohio

Baldwin's Ohio Administrative Code (2012)
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.

Baldwin's Ohio Revised Code Annotated (2012)
Title XLVII. Occupations--Professions
Chapter 4731. Physicians; Limited Practitioners
State Medical Board

§ 4731.055 Review of patient information available through drug database

(A) As used in this section:

(1) “Drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(2) “Physician” means an individual authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) The state medical board shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures to be followed by a physician 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 Administrative Code (2012)
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 (2012)
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 Administrative Code Annotated (2012)
4715 Dental Board
Chapter 4715-6. Automated Prescription Reporting System

4715-6-01 Standards and procedures for review of Ohio Automated Rx Reporting System (OARRS)

(A) For purposes of this rule and sections 4715.30 (A)(13) and 4715.302 of the Revised Code:

(1) “OARRS” means Ohio Automated Prescription Reporting System;

(2) “OARRS report” means a report of information related to a specific patient generated by the drug database established and maintained by the State board of pharmacy pursuant to section 4729.75 of the Revised Code.

(3) “Personally furnishing” does not include the administration of a drug.

(4) “Reported drugs” includes the following:

(a) All controlled substances in scheduled II, III, IV, and V; and

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

(5) “Diversion” includes but is not limited to the following:

(a) Selling drugs;

(b) Borrowing drugs;

(c) Sharing drugs.

(6) “Protracted basis” means for a period in excess of twelve continuous weeks, and for no more than twenty four weeks over a period of one year.

(B) If a dentist knows or has reason to believe that a patient may be abusing or diverting drugs, the dentist shall use sound clinical judgment in determining whether or not a reported drug should be prescribed or personally furnished to the patient under the circumstances. To assist in this determination, the dentist shall consider whether to access OARRS and document receipt and assessment of the information received if the patient exhibits signs of drug abuse or diversion. These signs may include, but are not limited to, the following:

(1) Engaging in or has a history of drug related criminal activity;

(2) Is receiving reported drugs from multiple prescribers;

(3) Has family members, friends, law enforcement officers, or health care professionals express concern related to the patient's use of illegal or reported drug;

(4) Has a known history of chemical abuse or dependency;

(5) Is requesting reported drugs by street name, color, or identifying marks;

(6) Frequently requesting early refills of reported drugs;

(7) Frequently losing prescriptions for reported drugs.

(C) Following review of OARRS report information, the dentist shall document receipt of the information in the patient's record.

(D) A dentist licensed under this chapter who prescribes or personally furnishes 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 dentist has reason to believe that treatment will be required on a protracted basis;

(2) At least once annually thereafter.

(E) In requesting OARRS reports according to this rule:

(1) Reports requested should cover a time period of at least one year;

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

(F) Paragraph (D) above 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 (2012)
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 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 Administrative Code Annotated (2012)
4723 Nursing Board
Chapter 4723-9. Prescriptive Authority

4723-9-12 Standards and procedures for review of OARRS

(A) For the purposes of this rule:

(1) "OARRS" means the Ohio automated RX reporting system established and maintained according 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 maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

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

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

(a) Controlled substance schedules II, III, IV, and V; and

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

(B) In addition to the requirements set forth in rule 4723-9-08 and rule 4723-9-09 of the Administrative Code, if a nurse who holds a current valid certificate to prescribe believes, or has reason to believe, that a patient may be abusing or diverting drugs, the nurse shall use sound clinical judgment in determining whether or not a reported drug should be prescribed or personally furnished to the patient.

(1) In making this determination, the nurse shall not personally furnish or prescribe a reported drug without first reviewing a patient's OARRS report if the patient exhibits the following signs of drug abuse or diversion:

(a) Illegally selling 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 nurse's care;

(g) Receiving reported drugs from multiple prescribers; 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 that may necessitate review of the patient's OARRS report 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 examination;

(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 nurse who holds a current valid certificate to prescribe and personally furnishes or prescribes a reported drug to a patient following review of an OARRS report under paragraph (B) of this rule, and determines, based on the OARRS report and indicia described in paragraph (B) of this rule that the patient may be misusing reported drugs, shall first consult with their collaborating physician prior to personally furnishing or prescribing a reported drug at the patient's next visit.

(D) Following review of OARRS report information, the nurse who holds a current valid certificate to prescribe shall document receipt and assessment of the information in the patient's record, including any consultation with the collaborating physician that occurred based on the OARRS report information or required by paragraph (C) of this rule.

(E) A nurse who holds a current valid certificate to prescribe and utilizes reported drugs to treat a patient on what the nurse has reason to believe will be a protracted basis shall, at minimum, review an OARRS report, and document receipt and assessment of the information in the patient's record:

(1) At the beginning of treatment; and

(2) At least once annually after treatment begins.

(F) In requesting OARRS reports according to this rule:

(1) Initial reports requested shall cover a time period of at least one year;

(2) Subsequent reports requested shall at minimum cover the period of time from the date of the last report reviewed to the present; and

(3) In the event an OARRS report is not immediately available, the nurse who holds a current valid certificate to prescribe shall document the response from the drug database in the patient record.

(G) Paragraph (E) 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 (2012)
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.

Baldwin's Ohio Revised Code Annotated (2012)
Title XLVII. Occupations--Professions
Chapter 4729. Pharmacists; Dangerous Drugs
Registration of Pharmacists

§ 4729.162 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 pharmacy shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures to be followed by a pharmacist 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 board no longer maintains the drug database.

Baldwin's Ohio Revised Code Annotated (2012)
Title XLVII. Occupations--Professions
Chapter 4730. Physician Assistants

§ 4730.53 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 medical board shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures to be followed by a physician assistant who holds a certificate to prescribe issued under this chapter 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

Oklahoma Statutes Annotated (2012)
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

A. Every person who manufactures, distributes, dispenses, prescribes, administers or uses for scientific purposes any controlled dangerous substance within this state, or who proposes to engage in the manufacture, distribution, dispensing, prescribing, administering or use for scientific purposes of any controlled dangerous substance within this state shall obtain a registration issued by the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control, in accordance with rules promulgated by the Director. Persons registered by the Director under Section 2-101 et seq. of this title to manufacture, distribute, dispense, or conduct research with controlled dangerous substances may possess, manufacture, distribute, dispense, or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this article. Every wholesaler, manufacturer or distributor of any drug product containing pseudoephedrine or phenylpropanolamine, or their salts, isomers, or salts of isomers shall obtain a registration issued by the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control in accordance with rules promulgated by the Director and as provided for in Section 2-332 of this title.

B. Out-of-state pharmaceutical suppliers who provide controlled dangerous substances to individuals within this state shall obtain a registration issued by the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control, in accordance with rules promulgated by the Director; provided that this provision shall not apply to wholesale distributors who ship controlled dangerous substances to pharmacies or other entities registered within this state in accordance with rules promulgated by the Director.

C. Manufacturers, distributors, home care agencies, hospices, home care services, and scientific researchers shall obtain a registration annually. Other practitioners shall obtain a registration for a period to be determined by the Director that will be for a period not less than one (1) year nor more than three (3) years.

D. Every trainer or handler of a canine controlled dangerous substances detector who, in the ordinary course of such trainer's or handler's profession, desires to possess any controlled dangerous substance, annually, shall obtain a registration issued by the Director for a fee of Seventy Dollars ($70.00). Such persons shall be subject to all applicable provisions of Section 2-101 et seq. of this title and such applicable rules promulgated by the Director for those

individuals identified in subparagraph a of paragraph 32 of Section 2-101 of this title. Persons registered by the Director pursuant to this subsection may possess controlled dangerous substances to the extent authorized by their registration and in conformity with the other provisions of this article.

E. The following persons shall not be required to register and may lawfully possess controlled dangerous substances under the provisions of Section 2-101 et seq. of this title:

1. An agent, or an employee thereof, of any registered manufacturer, distributor, dispenser or user for scientific purposes of any controlled dangerous substance, if such agent is acting in the usual course of such agent's or employee's business or employment;

2. Any person lawfully acting under the direction of a person authorized to administer controlled dangerous substances under Section 2-312 of this title;

3. A common or contract carrier or warehouser, or an employee thereof, whose possession of any controlled dangerous substance is in the usual course of such carrier's or warehouser's business or employment;

4. An ultimate user or a person in possession of any controlled dangerous substance pursuant to a lawful order of a practitioner;

5. An individual pharmacist acting in the usual course of such pharmacist's employment with a pharmacy registered pursuant to the provisions of Section 2-101 et seq. of this title;

6. A nursing home licensed by this state;

7. Any Department of Mental Health and Substance Abuse Services employee or any person whose facility contracts with the Department of Mental Health and Substance Abuse Services whose possession of any dangerous drug, as defined in Section 353.1 of Title 59 of the Oklahoma Statutes, is for the purpose of delivery of a mental health consumer's medicine to the consumer's home or residence; and

8. Registered nurses and licensed practical nurses.

F. The Director may, by rule, waive the requirement for registration or fee for registration of certain manufacturers, distributors, dispensers, prescribers, administrators, or users for scientific purposes if the Director finds it consistent with the public health and safety.

G. A separate registration shall be required at each principal place of business or professional practice where the applicant manufactures, distributes, dispenses, prescribes, administers, or uses for scientific purposes controlled dangerous substances.

H. The Director is authorized to inspect the establishment of a registrant or applicant for registration in accordance with rules promulgated by the Director.

I. No person engaged in a profession or occupation for which a license to engage in such activity is provided by law shall be registered under this act unless such person holds a valid license of such person's profession or occupation.

J. Registrations shall be issued on the first day of November of each year. Registrations may be issued at other times, however, upon certification of the professional licensing board.

K. The licensing boards of all professions and occupations to which the use of controlled dangerous substances is incidental shall furnish a current list to the Director, not later than the first day of October of each year, of the persons holding valid licenses. All such persons except persons exempt from registration requirements under subsection E of this section shall be subject to the registration requirements of Section 2-101 et seq. of this title.

L. The licensing board of any professional defined as a mid-level practitioner shall notify and furnish to the Director, not later than the first day of October of each year that such professional holds a valid license, a current listing of individuals licensed and registered with their respective boards to prescribe, order, select, obtain and administer controlled dangerous substances. The licensing board shall immediately notify the Director of any action subsequently taken against any such individual.

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.

Tennessee

Tennessee Rules and Regulations (2012)
1200. Department of Health and Department of Environment and Conservation
1200-34. Division of Pain Management Clinics
Chapter 1200-34-01. Pain Management Clinics

1200-34-01-.07 MEDICAL DIRECTOR RESPONSIBILITIES.

(1) Clinic Operation and Personnel.

(a) The medical director of a pain management clinic shall:

1. oversee all of the pain management services provided at the clinic;

2. be on-site at the clinic at least twenty percent (20%) of the clinic's weekly total number of operating hours;

3. ensure that each supervising physician for each of the health care providers working at the clinic complies with the supervision requirements contained in Tenn. Comp. Rules and Regulations Chapter 0880-03 and Chapter 0880-06, or Rule 1050-02-. 15, as applicable. Should the medical director of the clinic serve as a health care provider's supervising physician, the medical director must ensure that he or she complies with Chapter 0880-03 and Chapter 0880-06. or Rule 1050-02-. 15, as applicable;

4. ensure that all health care providers employed by or working at the pain management clinic comply with applicable state and federal laws and rules relative to the prescribing of controlled substances in the pain management clinic;

5. ensure the establishment of protocols for the health care providers employed by or working at the pain management clinic as provided in Tenn. Comp. Rules and Regulations Chapter 0880-03 and Chapter 0880-06 and ensure that providers comply with such protocols, as well as any other established policies and procedures;

6. ensure that, in the event that the medical director for the clinic is unable to fulfill his or her duties on a temporary basis because of illness, vacation, or unavailability, there is an alternate or substitute medical director meeting the same qualifications as a medical director under 1200-34-01-.09;

7. establish quality assurance policies and procedures, which, at a minimum, include, but are not limited to:

(i) documentation of the background, training, licensure, and certifications for all pain management clinic staff providing patient care;

(ii) a written drug screening policy and compliance plan for patients to include random urine drug screening as clinically indicated, but at a minimum, upon each new admission and once every six (6) months thereafter;

(iii) use of substance abuse risk assessment tools upon new patient admission and periodic review or re-assessment;

(iv) evaluating and monitoring the quality and appropriateness of patient care, the methods of improving patient care as well as identifying and correcting deficiencies, and the opportunities to improve the clinic's performance and quality of care;

(v) medication counts for any controlled substances prescribed by the clinic to the clinic's patients;

(vi) use of patient agreements and periodic review of such agreements;

(vii) health care provider access to and review of patient information contained in the controlled substance monitoring database in accordance with T.C.A. §§ 53-10-301 - 53-10-309, as clinically indicated, but at a minimum upon each new admission and once every six (6) months thereafter;

(viii) documentation of requests for records from other health care providers;

8. establish an infection control program to provide a sanitary environment for the prevention, control, and investigation of infections and communicable diseases, including, but not limited to:

(i) written infection control policies and procedures;

(ii) techniques and systems for identifying, reporting, investigating and controlling infections at the clinic;

(iii) written policies and procedures relative to the use of aseptic techniques;

(iv) training for clinic staff providing direct patient care relative to infection control and aseptic techniques; and

(v) a log of incidents related to infectious and communicable diseases and the corrective action taken;

9. establish written policies and procedures for health and safety requirements at the clinic;

10. ensure compliance with the patient safety standards established by the licensing boards for each health care provider;

11. establish written policies and procedures to assure patient access to their medical records and continuity of care should the pain management clinic close.

(2) Records, Reporting Requirements, and Patient Billing Procedures.

(a) The medical director shall ensure that each health care provider employed by or working at a certified pain management clinic shall maintain complete and accurate medical records of patient consultation, examination, diagnosis, and treatment, which shall include, but not be limited to the following:

1. patient medical history;

2. physical examination;

3. diagnostic, therapeutic, and laboratory results;

4. evaluations and consultations;

5. treatment objectives;

6. documentation of informed consent and discussion of risks and benefits of treatment provided;

7. treatments and treatment options;

8. medications prescribed (including date, type, dosage and quantity prescribed);

9. instructions and agreements;

10. periodic reviews;

11. reason for prescribing or dispensing more than a seventy-two (72) hour dose of controlled substances for the treatment of chronic nonmalignant pain;

12. a notation indicating whether the controlled substance monitoring database had been accessed for a particular patient;

13. copies of records, reports, or other documentation obtained from other health care providers;

14. results of urine drug screens to be performed as clinically indicated, but at a minimum upon each new admission and once every six (6) months thereafter.

West's Tennessee Code Annotated (2012)
Title 53. Food, Drugs and Cosmetics
Chapter 10. Legend Drugs
Part 3. Controlled Substance Monitoring Act of 2002

<Text of Section Effective January 1, 2013>

§ 53-10-310. Electronic access to controlled substance database; penalty

(a) Each person or entity operating a practice site where a controlled substance is prescribed or dispensed to a human patient shall provide for electronic access to the database at all times when a prescriber or dispenser provides health care services to a human patient potentially receiving a controlled substance.

(b) This section shall not apply to any dispensers that are not required to report pursuant to § 53-10-304(d) or §53-10-305(g).

(c) A violation of subsection (a) is punishable by a civil penalty not to exceed one hundred dollars ($100) per day assessed against the person or entity operating the practice site; provided, however, that the penalty shall only be imposed where there is a continued pattern or practice of not providing electronic access to the database.

(d) Any prescriber, dispenser, individual or entity who is authorized to access the database by this part shall not be subject to a suit for civil damages or held civilly liable for the failure to register in, report to, or check the database, or for actions taken after reasonable reliance on information in the database, or accessing the database to determine whether or not the prescriber or dispenser's professional medical credentials are being inappropriately used or for reporting the same to the appropriate authorities, except as otherwise provided in this.

<Text of Section Effective April 1, 2013>

(e)(1) All prescribers or their designated health care practitioner's extenders, unless otherwise exempted under this part, shall check the controlled substance database prior to prescribing one of the controlled substances identified in subdivision (e)(3) to a human patient at the beginning of a new episode of treatment and shall check the controlled substance database for that human patient at least annually when that prescribed controlled substance remains part of the treatment.

<Text of Section Effective January 1, 2013>

(2) Before dispensing, a dispenser shall have the professional responsibility to check the database or have a health care practitioner extender check the database if the dispenser is aware or reasonably certain that a person is attempting to obtain a Schedule II-V

controlled substance, identified by the committee as demonstrating a potential for abuse for fraudulent, illegal, or medically inappropriate purposes, in violation of § 53-11-402.

(3) The controlled substances which trigger a check of the controlled substance database pursuant to subdivision (e)(1) include, but are not limited to, all opioids and benzodiazepines. By rule, the committee may require a check of the database for additional Schedule II-V controlled substances that are identified by the committee as demonstrating a potential for abuse.

(4) The board shall adopt rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, that establish standards and procedures to be followed by a dispenser regarding the review of patient information available through the database.

(5) Prescribers are not required to check the controlled substance database before prescribing or dispensing one of the controlled substances identified in subdivision (e)(3) or added to that list by the committee if one or more of the following conditions is met:

(A) The controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care;

(B) The committee has determined that prescribers in a particular medical specialty shall not be required to check the database as a result of the low potential for abuse by patients receiving treatment in that medical specialty;

(C) The controlled substance is prescribed or dispensed to a patient as a non-refillable prescription as part of treatment for a surgical procedure that occurred in a licensed health care facility.

(D) The quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, seven (7) day treatment period and does not allow a refill.

(f) Each appropriate licensure board shall promulgate rules pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, to establish procedures, notice requirements, and penalties for prescribers and dispensers who fail to register in, report to, or check the controlled substance database as required.

(g) Notwithstanding any other provision of this part to the contrary, a prescriber, dispenser, or health care practitioner extender shall not be in violation of this part during any time period in which the controlled substance database is suspended or not operational or the Internet is not operational or available as defined by rules promulgated by the commissioner after consultation with the committee.

West Virginia

West's Annotated Code of West Virginia (2012)
Chapter 60A. Uniform Controlled Substances Act
Article 9. Controlled Substances Monitoring

§ 60A–9–5. Confidentiality; limited access to records; period of retention; no civil liability for required reporting.

(a)(1) The information required by this article to be kept by the State Board of Pharmacy is confidential and not subject to the provisions of chapter twenty-nine-b of this code or obtainable as discovery in civil matters absent a court order and is open to inspection only by inspectors and agents of the State Board of Pharmacy, members of the West Virginia State Police expressly authorized by the Superintendent of the West Virginia State Police to have access to the information, authorized agents of local law-enforcement agencies as members of a federally affiliated drug task force, authorized agents of the federal Drug Enforcement Administration, duly authorized agents of the Bureau for Medical Services, duly authorized agents of the Office of the Chief Medical Examiner for use in post-mortem examinations, duly authorized agents of licensing boards of practitioners in this state and other states authorized to prescribe Schedules II, III and IV controlled substances, prescribing practitioners and pharmacists and persons with an enforceable court order or regulatory agency administrative subpoena: Provided, That all law-enforcement personnel who have access to the Controlled Substances Monitoring Program database shall be granted access in accordance with applicable state laws and Board of Pharmacy legislative rules, shall be certified as a West Virginia law-enforcement officer and shall have successfully completed United States Drug Enforcement Administration Diversion Training and National Association of Drug Diversion Investigation Training. All information released by the State Board of Pharmacy must be related to a specific patient or a specific individual or entity under investigation by any of the above parties except that practitioners who prescribe or dispense controlled substances may request specific data related to their Drug Enforcement Administration controlled substance registration number or for the purpose of providing treatment to a patient: Provided, however, That the West Virginia Controlled Substances Monitoring Program Database Review Committee established in subsection (b) of this section is authorized to query the database to comply with said subsection.

(2) Subject to the provisions of subdivision (1) of this subsection, the board shall also review the West Virginia Controlled Substance Monitoring Program database and issue reports that identify abnormal or unusual practices of patients who exceed parameters as determined by the advisory committee established in this section. The board shall communicate with prescribers and dispensers to more effectively manage the medications of their patients in the manner recommended by the advisory committee. All other reports produced by the board shall be kept confidential. The board shall maintain the information required by this article for a period of not less than five years. Notwithstanding any other provisions of this code to the contrary, data obtained under the provisions of this article may be used for compilation of educational,

scholarly or statistical purposes, and may be shared with the West Virginia Department of Health and Human Resources for those purposes, as long as the identities of persons or entities and any personally identifiable information, including protected health information, contained therein shall be redacted, scrubbed or otherwise irreversibly destroyed in a manner that will preserve the confidential nature of the information. No individual or entity required to report under section four of this article may be subject to a claim for civil damages or other civil relief for the reporting of information to the Board of Pharmacy as required under and in accordance with the provisions of this article.

(3) The board shall establish an advisory committee to develop, implement and recommend parameters to be used in identifying abnormal or unusual usage patterns of patients in this state. This advisory committee shall:

(A) Consist of the following members: A physician licensed by the West Virginia Board of Medicine, a dentist licensed by the West Virginia Board of Dental Examiners, a physician licensed by the West Virginia Board of Osteopathy, a licensed physician certified by the American Board of Pain Medicine, a licensed physician board certified in medical oncology recommended by the West Virginia State Medical Association, a licensed physician board certified in palliative care recommended by the West Virginia Center on End of Life Care, a pharmacist licensed by the West Virginia Board of Pharmacy, a licensed physician member of the West Virginia Academy of Family Physicians, an expert in drug diversion and such other members as determined by the board.

(B) Recommend parameters to identify abnormal or unusual usage patterns of controlled substances for patients in order to prepare reports as requested in accordance with subsection (a), subdivision (2) of this section.

(C) Make recommendations for training, research and other areas that are determined by the committee to have the potential to reduce inappropriate use of prescription drugs in this state, including, but not limited to, studying issues related to diversion of controlled substances used for the management of opioid addiction.

(D) Monitor the ability of medical services providers, health care facilities, pharmacists and pharmacies to meet the twenty-four hour reporting requirement for the Controlled Substances Monitoring Program set forth in section three of this article, and report on the feasibility of requiring real-time reporting.

(E) Establish outreach programs with local law enforcement to provide education to local law enforcement on the requirements and use of the Controlled Substances Monitoring Program database established in this article.

(b) The Board of Pharmacy shall create a West Virginia Controlled Substances Monitoring Program Database Review Committee of individuals consisting of two prosecuting attorneys

from West Virginia counties, two physicians with specialties which require extensive use of controlled substances and a pharmacist who is trained in the use and abuse of controlled substances. The review committee may determine that an additional physician who is an expert in the field under investigation be added to the team when the facts of a case indicate that the additional expertise is required. The review committee, working independently, may query the database based on parameters established by the advisory committee. The review committee may make determinations on a case-by-case basis on specific unusual prescribing or dispensing patterns indicated by outliers in the system or abnormal or unusual usage patterns of controlled substances by patients which the review committee has reasonable cause to believe necessitates further action by law enforcement or the licensing board having jurisdiction over the prescribers or dispensers under consideration. The review committee shall also review notices provided by the chief medical examiner pursuant to subsection (h), section ten, article twelve, chapter sixty-one of this code and determine on a case-by-case basis whether a practitioner who prescribed or dispensed a controlled substance resulting in or contributing to the drug overdose may have breached professional or occupational standards or committed a criminal act when prescribing the controlled substance at issue to the decedent. Only in those cases in which there is reasonable cause to believe a breach of professional or occupational standards or a criminal act may have occurred, the review committee shall notify the appropriate professional licensing agency having jurisdiction over the applicable prescriber or dispenser and appropriate law-enforcement agencies and provide pertinent information from the database for their consideration. The number of cases identified shall be determined by the review committee based on a number that can be adequately reviewed by the review committee. The information obtained and developed may not be shared except as provided in this article and is not subject to the provisions of chapter twenty-nine-b of this code or obtainable as discovering in civil matters absent a court order.

(c) The Board of Pharmacy is responsible for establishing and providing administrative support for the advisory committee and the West Virginia Controlled Substances Monitoring Program Database Review Committee. The advisory committee and the review committee shall elect a chair by majority vote. Members of the advisory committee and the review committee may not be compensated in their capacity as members but shall be reimbursed for reasonable expenses incurred in the performance of their duties.

(d) The board shall promulgate rules with advice and consent of the advisory committee, in accordance with the provisions of article three, chapter twenty-nine-a of this code on or before June 1, 2013. The legislative rules must include, but shall not be limited to, the following matters: (1) Identifying parameters used in identifying abnormal or unusual prescribing or dispensing patterns; (2) processing parameters and developing reports of abnormal or unusual prescribing or dispensing patterns for patients, practitioners and dispensers; (3) establishing the information to be contained in reports and the process by which the reports will be generated and disseminated; and (4) setting up processes and procedures to ensure that the privacy, confidentiality, and security of information collected, recorded, transmitted and maintained by the review committee is not disclosed except as provided in this section.

(e) All practitioners, as that term is defined in section one hundred-one, article two of this chapter who prescribe or dispense schedule II, III or IV controlled substances shall, on or before July 1, 2011, have online or other form of electronic access to the West Virginia Controlled Substances Monitoring Program database;

(f) Persons or entities with access to the West Virginia Controlled Substances Monitoring Program database pursuant to this section may, pursuant to rules promulgated by the Board of Pharmacy, delegate appropriate personnel to have access to said database;

(g) Good faith reliance by a practitioner on information contained in the West Virginia Controlled Substances Monitoring Program database in prescribing or dispensing or refusing or declining to prescribe or dispense a schedule II, III or IV controlled substance shall constitute an absolute defense in any civil or criminal action brought due to prescribing or dispensing or refusing or declining to prescribe or dispense; and

(h) A prescribing or dispensing practitioner may notify law enforcement of a patient who, in the prescribing or dispensing practitioner's judgment, may be in violation of section four hundred ten, article four of this chapter, based on information obtained and reviewed from the controlled substances monitoring database. A prescribing or dispensing practitioner who makes a notification pursuant to this subsection is immune from any civil, administrative or criminal liability that otherwise might be incurred or imposed because of the notification if the notification is made in good faith.

(i) Nothing in the article may be construed to require a practitioner to access the West Virginia Controlled Substances Monitoring Program database except as provided in section five-a of this article.

(j) The Board of Pharmacy shall provide an annual report on the West Virginia Controlled Substance Monitoring Program to the Legislative Oversight Commission on Health and Human Resources Accountability with recommendations for needed legislation no later than January 1 of each year.

West's Annotated Code of West Virginia (2012)
Chapter 60A. Uniform Controlled Substances Act
Article 9. Controlled Substances Monitoring

§ 60A–9–5a. Practitioner requirements to conduct annual search of the database; required rulemaking.

(a) Upon initially prescribing or dispensing any pain-relieving controlled substance for a patient and at least annually thereafter should the prescriber or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority

and in possession of a valid Drug Enforcement Administration registration identification number and, who are licensed by the Board of Medicine as set forth in article three, chapter thirty of this code, the Board of Registered Professional Nurses as set forth in article seven, chapter thirty of this code, the Board of Dental Examiners as set forth in article four, chapter thirty of this code and the Board of Osteopathy as set forth in article fourteen, chapter thirty of this code shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program database for the patient shall be documented in the patient's medical record. A pain-relieving controlled substance shall be defined as set forth in section one, article three-a, chapter thirty of this code.

(b) The various boards mentioned in subsection (a) above shall promulgate both emergency and legislative rules pursuant to the provisions of article three, chapter twenty-nine-a of this code to effectuate the provisions of this section.

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.