



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

Research current through June 2014.

This project was supported by Grant No. G1399ONDCP03A, awarded by the Office of National Drug Control Policy. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government.

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Introduction

A growing number of states are requiring certain practitioners and/or dispensers to access the prescription monitoring program database in certain circumstances, typically before prescribing a Schedule II or III controlled substance; however, the circumstances under which a practitioner is required to access the database vary from state-to-state. Any specific questions regarding whether a practitioner is required to access the database in a particular situation should be directed to the practitioner's licensing entity.

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Arizona
§ 23-1062.02

Arizona Revised Statutes Annotated (2014)
Title 23. Labor
Chapter 6. Workers' Compensation
Article 9. Payment of Compensation

§ 23-1062.02. Off-label prescription of controlled substances; prescription of schedule II controlled substances; reports; treatment plans; definition

A. A physician shall include in the report required under commission rule information pertaining to the following:

1. The off-label use of a narcotic, opium based controlled substance or schedule II controlled substance by a claimant.
2. The use of a narcotic or opium based controlled substance or the prescription of a combination of narcotics or opium based controlled substances at or exceeding a one hundred twenty milligram morphine equivalent dose per day.
3. The prescription of a long-acting or controlled release opioid for acute pain.

B. The information required pursuant to subsection A of this section shall include the justification for use of the controlled substance, and a treatment plan that includes a description of measures that the physician will implement to monitor and prevent the development of abuse, dependence, addiction or diversion by the employee. The physician shall include in the treatment plan a medication agreement, a plan for subsequent follow-up visits and random drug testing and documentation that the medication regime is providing relief that is demonstrated by clinically meaningful improvement in function. If the drug test of the employee reveals inconsistent results, the physician within five business days shall provide a written report to the carrier, self-insured employer or commission setting forth a treatment plan to address the inconsistent drug test results.

C. Within two business days of writing or dispensing an initial prescription order for at least a thirty-day supply of an opioid medication for the employee, a physician shall submit an inquiry to the Arizona State Board of Pharmacy requesting the employee's prescription information that is compiled under the controlled substances prescription monitoring program prescribed in Title 36, Chapter 28. The physician shall report the results to the carrier, self-insured employer or commission as soon as reasonably practicable but no later than thirty days from the date of the inquiry. Thereafter, the carrier, self-insured employer or commission may request no more than once every two months that the physician perform additional inquiries to the Arizona State Board of Pharmacy.

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D. If the result of an inquiry to the Arizona State Board of Pharmacy reveals that the employee is receiving opioids from another undisclosed health care provider, the physician shall within five business days report the results to the carrier, self-insured employer or commission.

E. If the physician does not comply with this section:

1. The carrier, self-insured employer or commission is not responsible for payment for the physician's services until the physician complies with this section.

2. Except for a self-insured employer that provides medical care pursuant to section 23-1070, an employer, carrier or commission may request a change of physician after making a written request to the physician to comply with this section and the request identifies the area of noncompliance. If a change of physician is ordered and the order becomes final, the employee shall select a physician whose practice includes pain management and who agrees to comply with this section. If other medical providers are not available in the employee's area of residence, the employer, carrier or commission shall pay in advance for the employee's reasonable travel expenses, including the cost of transportation, food, lodging and loss of pay, if applicable.

F. If medically necessary, the carrier, self-insured employer or commission shall provide drug rehabilitation and detoxification treatment for an employee who becomes dependent on or addicted to opioids that are prescribed for a work-related injury. In the event of a medical conflict regarding the necessity for drug rehabilitation and detoxification, the carrier, self-insured employer or commission shall continue to provide the opioids until a determination is made after a hearing by an administrative law judge.

G. If the employee resides out of state, the carrier, self-insured employer or commission may not be responsible for providing medications that are subject to this section if the out-of-state physician fails to comply with this section. If the other state has a controlled substances monitoring program, the physician shall submit an inquiry to the database as prescribed in subsection C of this section.

H. This section does not apply to medications administered to the employee while the employee is receiving inpatient hospital treatment.

I. A carrier, self-insured employer or the commission may require physician compliance with this section notwithstanding the existence of a prior award addressing medical maintenance benefits for medications. A carrier or self-insured employer is not liable for bad faith or unfair claims processing for any act taken in compliance of and consistent with this section.

J. For the purposes of this section: -

1. "Clinically meaningful improvement in function" means any of the following:

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(a) A clinically documented improvement in range of motion.

(b) An increase in the performance of activities of daily living.

(c) A return to gainful employment.

2. “Inconsistent results” means:

(a) The employee’s reported medications, including the parent drugs or metabolites, are not detected.

(b) Controlled substances are detected that are not reported by the employee.

3. “Off-label use” means use of a prescription medication by the physician to treat a condition other than the use for which the drug was approved by the United States food and drug administration.

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Colorado

2 CCR 502-1:21.320.3

7 CCR 1101-3:18

West's Colorado Administrative Code (2014)

Title 500. Department of Human Services

502. Behavioral Health

2 CCR 502-1. Care and Treatment of the Mentally Ill

502-1:21.300. Licensing of Addiction Programs Using Controlled Substances

502-1:21.320. Opioid Medication Assisted Treatment (Omat)

502-1:21.320.3. ADMINISTRATIVE AND MEDICAL RESPONSIBILITY

21.320.31 OMAT Program Sponsors

OMAT program sponsors are responsible for the following:

A. Overall operation of the program including, but not limited to:

1. Compliance with all applicable state and federal laws, rules, and regulations;
2. Medical and counseling personnel are qualified to provide opioid replacement treatment;
3. Individuals are enrolled on their own volition;
4. Full disclosure is made to individuals about opioids and their use in treatment.
5. Written, informed consents for opioid replacement treatment are signed by individuals eighteen (18) years of age and older;
6. Written, informed consents for all aspects of opioid replacement treatment are signed by parents, legal guardians or other responsible adults designated by appropriate state authorities for individuals under age eighteen (18) years old;
7. Individual/counselor ratios do not exceed fifty to one (50:1) for full-time counseling staff, forty (40) hours per week, and twenty five to one (25:1) for half-time counseling staff, twenty (20) hours per week;
8. Written (OMAT) policies and procedures are developed, implemented and maintained that are based on and in compliance with Department rules;

9. All reasonable and clinically indicated efforts are made to coordinate treatment with other healthcare and behavioral health providers. Documentation includes obtaining individuals' consent to release information to communicate with those practitioners.

10. Methadone and other controlled substances are disposed of in accordance with the federal regulations.

11. Printed acknowledgements are signed by patients and kept in patient records stating that they have been informed of the United States Department of Transportation regulation against the use of OTP prescribed methadone by commercial drivers and the possible loss of commercial driver's license if taking methadone for addiction is discovered.

B. Training

1. Training for new (OMAT) staff is documented in personnel records including, but not limited to provisions of Section 21.160.1, A, 3, and:

a. Federal Opioid Medication Assisted Treatment regulations;

b. OMAT treatment rules;

c. OMAT policies and procedures;

d. Clinical practices including, but not limited to:

1) Protocols around special exception requests, phase level requests, and any take-home protocol such as holiday dosing, weekend dosing, hold doses, hospitalization of individuals, incarceration, nursing home stays, and courtesy dosing; and,

2) All other items agreed upon in the State Memorandum of Understanding.

e. Pharmacology of methadone including, but not limited to, loss of tolerance to opioids, dangerous drug or alcohol interactions, signs and symptoms of overdose, purpose of its use.

2. Annual training for OMAT staff including, but not limited to:

a. Most current pharmacology of medications used, and clinical practices applicable to OMAT, including problems with interactions of medications.

b. Review of federal and state regulations and rules.

c. Review of current OMAT policies and procedures.

d. Infectious disease risks and screening.

21.320.32 OMAT Medical Directors

A. Agencies shall have designated medical directors who shall authorize and oversee other physicians, other appropriately licensed and/or certified medical personnel and all medical services provided.

B. Medical directors and other medical healthcare providers shall currently possess and maintain licenses to practice medicine/nursing in compliance with the credentialing requirements of their own profession in Colorado as provided by Article 36, Title 12, C.R.S. OMAT medical directors shall assure appropriate credentials and training for other OMAT physicians and other qualified health care providers to deliver ORT.

C. Medical directors shall ensure that the OMAT agency is in compliance with all state and federal rules and regulations regarding medical treatment for opioid addiction.

D. OMAT medical directors, other OMAT physicians and authorized OMAT medical personnel shall ensure the following:

1. Medical evaluations including evidence of current physiological dependence and/or history of addiction or exceptions to admission criteria that are documented prior to initial dosing;
2. These medical evaluations are done at admission prior to initial dose.
3. The physical examinations and all appropriate laboratory tests are performed and reviewed within fourteen (14) calendar days following treatment admission;
4. All medical professionals shall educate individuals regarding risks and benefits of OMAT and document that individuals are entering voluntarily.
5. All medical orders are properly signed or countersigned including initial orders for approved controlled substances and other medications, subsequent dose increases or decreases, changes in take-home dose privileges, emergency situations and other special circumstances by the medical director.

E. Medical directors or other physicians shall review, countersign and date intake evaluations written by authorized medical personnel before initial doses may be administered to individuals. When medical directors and other physicians are not available on-site to review, countersign and date evaluations for admission written by medical personnel, required physician reviews may be conducted by telephone and initial doses may be administered to individuals on physicians' verbal or standing orders. In such cases, medical personnel shall document in individual records that no physicians were available on site and that physician reviews were conducted by telephone. Medical directors or other physicians shall review and countersign authorizations.

F. Medical directors and other qualified health care professionals shall utilize the information obtained from the Colorado State Board of Pharmacy's electronic Prescription Drug Monitoring Program (PDMP) as clinically appropriate upon intake.

West's Colorado Administrative Code (2014)
Title 1100. Department of Labor and Employment
1101. Division of Workers' Compensation
7 CCR 1101-3. Workers' Compensation Rules of Procedure

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.

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(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

16 § 4798

West's Delaware Code Annotated (2014)
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 and upon 3-1-2014. See Historical and Statutory Notes below.>

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(e) When a dispenser has a reasonable belief that a patient may be seeking a controlled substance listed in Schedule II, III, IV or V for any reason other than the treatment of an existing medical condition, the dispenser shall obtain a patient utilization report regarding the patient for the preceding 12 months from the Prescription Monitoring Program before dispensing the prescription.

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

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Indiana

§ 35-48-7-12.1

West's Annotated Indiana Code (2014)
Title 35. Criminal Law and Procedure
Article 48. Controlled Substances
Chapter 7. Central Repository for Controlled Substances Data

§ 35-48-7-12.1 Adoption of rules to implement chapter; powers of board

Sec. 12.1. (a) The board shall adopt rules under IC 4-22-2 to implement this chapter, including the following:

(1) Information collection and retrieval procedures for the INSPECT program, including the controlled substances to be included in the program required under section 8.1 of this chapter.

(2) Design for the creation of the data base required under section 10.1 of this chapter.

(3) Requirements for the development and installation of online electronic access by the board to information collected by the INSPECT program.

(4) Identification of emergency situations or other circumstances in which a practitioner may prescribe, dispense, and administer a prescription drug specified in section 8.1 of this chapter without a written prescription or on a form other than a form specified in section 8.1(a)(4) of this chapter.

(5) Requirements for a practitioner providing treatment for a patient at an opioid treatment program operating under IC 12-23-18 to check the INSPECT program:

(A) before initially prescribing a controlled substance to a patient; and

(B) periodically during the course of treatment that uses a controlled substance.

(b) The board may:

(1) set standards for education courses for individuals authorized to use the INSPECT program;

(2) identify treatment programs for individuals addicted to controlled substances monitored by the INSPECT program; and

(3) work with impaired practitioner associations to provide intervention and treatment.

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Kentucky

§ 218A.172

201 KAR 8:540

201 KAR 9:016

201 KAR 9:260

201 KAR 20:057

201 KAR 25:090

Baldwin's Kentucky Revised Statutes Annotated (2014)

Title XVIII. Public Health

Chapter 218A. Controlled Substances

§ 218A.172 Administrative regulations on prescribing or dispensing of Schedule II controlled substance or Schedule III controlled substance containing hydrocodone; continuing course of treatment; recordkeeping; exemptions

(1) Administrative regulations promulgated under KRS 218A.205(3) shall require that, 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 medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient's medical complaint, and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in KRS 218A.202 for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;

(c) Make a written 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) (a) Administrative regulations promulgated under KRS 218A.205(3) shall require that a practitioner prescribing or dispensing additional amounts of Schedule II controlled substances or Schedule III controlled substances containing hydrocodone for the same medical complaint and related symptoms shall:

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1. Review, at reasonable intervals based on the patient's individual circumstances and course of treatment, the plan of care;
2. Provide to the patient any new information about the treatment; and
3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment extends beyond three (3) months, the administrative regulations shall also require that the practitioner:

1. Query the electronic monitoring system established in KRS 218A.202 no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and

2. Review 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) Administrative regulations promulgated under KRS 218A.205(3) shall require that, 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, as appropriate:

- (a) Medical history and physical or mental health 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) Administrative regulations promulgated under KRS 218A.205(3) may exempt, in whole or in part, compliance with the mandatory diagnostic, treatment, review, and other protocols and standards established in this section for:

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(a) A licensee prescribing or administering a controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or the delivery and the medication usage does not extend beyond the fourteen (14) days;

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

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

(d) A licensee prescribing or dispensing a controlled substance:

1. For administration in a hospital or long-term-care facility if the hospital or long-term-care facility with an institutional account, or a practitioner in those hospitals or facilities where no institutional account exists, queries the electronic monitoring system established in KRS 218A.202 for all available data on the patient or resident for the twelve (12) month period immediately preceding the query within twelve (12) hours of the patient's or resident's admission and places a copy of the query in the patient's or resident's medical records during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing:

a. Is done as a substitute for the initial prescribing or dispensing;

b. Cancels any refills for the initial prescription; and

c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing is done by another practitioner in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition; or

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federalwide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections, where the research involves

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single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health;

(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.

(5) (a) A state licensing board promulgating administrative regulations under KRS 218A.205(3) may promulgate an administrative regulation authorizing exemptions supplemental or in addition to those specified in subsection (4) of this section. Prior to exercising this authority, the board shall:

1. Notify the Kentucky Office of Drug Control Policy that it is considering a proposal to promulgate an administrative regulation authorizing exemptions supplemental or in addition to those specified in subsection (4) of this section and invite the office to participate in the board meeting at which the proposal will be considered;

2. Make a factual finding based on expert testimony as well as evidence or research submitted to the board that the exemption demonstrates a low risk of diversion or abuse and is supported by the dictates of good medical practice; and

3. Submit a report to the Governor and the Legislative Research Commission of its actions, including a detailed explanation of the factual and policy basis underlying the board's action. A copy of this report shall be provided to the regulations compiler.

(b) Within one (1) working day of promulgating an administrative regulation authorizing an exemption under this section, the promulgating board shall e-mail to the Kentucky Office of Drug Control Policy:

1. A copy of the administrative regulation as filed, and all attachments required by KRS 13A.230(1); and

2. A request from the board that the office review the administrative regulation in the same manner as would the Commission on Small Business Advocacy under KRS 11.202(1)(e), and submit its report or comments in accordance with the deadline established in KRS 13A.270(1)(c). A copy of the report or comments shall be filed with the regulations compiler.

Kentucky Administrative Regulations (2014)
Title 201. General Government Cabinet
Chapter 8. Board of Dentistry

201 KAR 8:540. Dental practices and prescription writing

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Section 4. Prescribing of Controlled Substances by Dentist. (1) Prior to the initial prescribing of any controlled substance, each dentist shall:

(a) Except as provided in subsection (2) of this section, and review a KASPER report for all available data on the patient;

(b) Document relevant information in the patient's record;

(c) Consider the available information to determine if it is medically appropriate and safe to prescribe a controlled substance;

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

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

(f) 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

(g) Obtain written consent for the treatment.

(2) A dentist shall not be required to obtain and review a KASPER report if:

(a)1. The dentist prescribes a Schedule III controlled substance or one (1) of the Schedule IV controlled substances listed in subsection (3) of this section after the performance of oral surgery; and

2. No more than a seventy-two (72) hour supply of the controlled substance is prescribed;

(b) The dentist prescribes or dispenses a Schedule IV or V controlled substance not listed in subsection (3) of this section; or

(c)1. The dentist prescribes pre-appointment medication for the treatment of procedure anxiety; and

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2. The prescription is limited to a two (2) day supply and has no refills.

(3) A dentist shall obtain and review a KASPER report before initially prescribing any of the following Schedule IV controlled substances:

(a) Ambien;

(b) Anorexics;

(c) Ativan;

(d) Klonopin;

(e) Librium;

(f) Nubain;

(g) Oxazepam;

(h) Phentermine;

(i) Soma;

(j) Stadol;

(k) Stadol NS;

(l) Tramadol;

(m) Versed; and

(n) Xanax.

(4) A dentist may provide one (1) refill within thirty (30) days of the initial prescription for the same controlled substance for the same amount or less or prescribe a lower schedule drug for the same amount without a clinical reevaluation of the patient by the dentist.

(5) A patient who requires additional prescriptions for a controlled substance shall be clinically reevaluated by the dentist and the provisions of this section, shall be followed.

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Kentucky Administrative Regulations (2014)
Title 201. General Government Cabinet
Chapter 9. Board of Medical Licensure

201 KAR 9:016. Restrictions on use of amphetamine and amphetamine-like anorectic controlled substances

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Section 4. Treatment of Obesity with a Schedule III or IV Amphetamine-like Controlled Substance. (1) Prior to prescribing, administering, dispensing, ordering, selling, supplying, or giving a Schedule III or IV amphetamine-like controlled substance to treat obesity in a patient sixteen (16) years of age or older, the physician shall:

(a) Establish a physician/patient relationship;

(b) Determine that the patient is obese or overweight with medical risk factors and is a proper candidate for weight reduction treatment;

(c) Determine and record the extent of prior anorectics or other controlled substances used by the patient. The prescribing physician shall obtain and review a KASPER report for the twelve (12) month period immediately preceding the patient encounter, before prescribing or dispensing controlled substances to the patient;

(d) Determine that the patient has either:

1. A body mass index of twenty-seven (27) or more, unless the body mass index is twenty-five (25) to twenty-seven (27) and the patient has a co-morbidity such as a cardiovascular disease, diabetes mellitus, dyslipidemia, hypertension, or sleep apnea;

2. Body fat greater than or equal to thirty (30) percent in females or greater than or equal to twenty-five (25) percent in males;

3. Current body weight greater than or equal to 120 percent of a well documented, long-standing, healthy weight that the patient maintained after age eighteen (18);

4. A waist-hip ratio or waist circumference at a level indicating that the individual is known to be at increased cardiovascular or co-morbidity risk because of abdominal visceral fat; or

5. Presence of a co-morbid condition or conditions aggravated by the patient's excessive adiposity; and

(e) Provide the patient with carefully prescribed diet, together with counseling on exercise, behavior modification, and other appropriate supportive and collateral therapies.

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(2) During treatment for obesity, a physician shall:

- (a) Maintain a physician/patient relationship throughout the treatment process;
- (b) Maintain an adequate patient record in accordance with subsection (4) of this section; and

(c) Justify in the patient record the use of any Schedule III or IV amphetamine-like controlled substance beyond three (3) months. Before the physician continues the use of a substance beyond three (3) months, the physician shall obtain and review a current KASPER report.

(3) A physician shall terminate the use of Schedule III or IV amphetamine-like controlled substances if:

(a) The patient does not demonstrate weight loss and does not attempt to comply with exercise and dietary changes;

(b) The body mass index of the patient without a co-morbid condition is less than twenty-seven (27) and the percentage of body fat is normal at less than thirty (30) percent in females or less than twenty-five (25) percent in males;

(c) The body mass index of the patient with a co-morbid condition is less than twenty-five (25) and the percentage of body fat is normal at less than thirty (30) percent in females or less than twenty-five (25) percent in males;

(d) The patient has regained the weight lost, using sympathomimetics as part of a complete program and reuse of the medication does not produce loss of the weight gain to help maintain a minimum of five (5) percent weight loss; or

(e) The patient has obtained a Schedule III or IV amphetamine-like controlled substance from another physician without the prescriber's knowledge and consent.

(4) The board shall consider the following factors in reviewing the adequacy of a patient record:

(a) Medical history, including:

1. Illnesses, with particular emphasis on cardiovascular diseases;
2. Surgery;
3. Lifestyle;
4. Medications, including controlled substances;
5. Eating habits;

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6. Exercise;
 7. Weight gain or loss;
 8. Prior efforts at weight control or reduction;
 9. Prior treatment compliance;
 10. Menstruation or pregnancy; and
 11. Psychiatric history with particular reference to depression, paranoia, psychosis, or chemical dependency;
- (b) Social history;
 - (c) Family history;
 - (d) Complete physical examination;
 - (e) Evaluation of laboratory tests including:
 1. CBC;
 2. Fasting blood sugar;
 3. Thyroid panel or TSH;
 4. Lipid profile;
 5. Serum potassium;
 6. Liver function test; and
 7. Renal function test;
 - (f) An informed consent signed by the patient that cites the limitations and risk of anorectic treatment including potential dependency or psychiatric illness;
 - (g)1. A signed agreement that the patient has voluntarily agreed to:
 - a. Have one (1) prescribing physician for controlled substances;
 - b. Use one (1) pharmacy to fill prescriptions for controlled substances;
 - c. Not have early refills on the prescriptions for controlled substances; and

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- d. Provide full disclosure of other medications taken; or
- 2. Documentation that:
 - a. The physician requested the patient sign an agreement meeting the requirements of subparagraph 1 of this paragraph;
 - b. The patient declined to sign the agreement; and
 - c. Indicates the physician's clinical reasons for prescribing, or continuing to prescribe, a Schedule III or IV amphetamine-like controlled substance to the patient, in light of the patient's refusal to sign the agreement; and
- (h) A record of each office visit, including:
 - 1. The patient's weight;
 - 2. The patient's blood pressure;
 - 3. The patient's pulse;
 - 4. The presence or absence of medication side effects or complications;
 - 5. The doses of medications prescribed;
 - 6. The patient's body mass index; and
 - 7. Evaluation of the patient's compliance with the total treatment regimen.
- ...

Kentucky Administrative Regulations (2014)
Title 201. General Government Cabinet
Chapter 9. Board of Medical Licensure

201 KAR 9:260. Professional standards for prescribing and dispensing controlled substances

Section 1. Applicability. (1) A physician who is authorized to prescribe or dispense a controlled substance shall comply with the standards of acceptable and prevailing medical practice for prescribing and dispensing a controlled substance established in this administrative regulation.

(2) The professional standards established in this administrative regulation shall not apply to a physician prescribing or dispensing a controlled substance:

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- (a) To a patient as part of the patient's hospice or end-of-life treatment;
- (b) To a patient admitted to a licensed hospital as an inpatient, outpatient, or observation patient, during and as part of a normal and expected part of the patient's course of care at that hospital;
- (c) To a patient for the treatment of pain associated with cancer or with the treatment of cancer;
- (d) To a patient who is a registered resident of a long-term-care facility as defined in KRS 216.510;
- (e) During the effective period of any period of disaster or mass casualties which has a direct impact upon the physician's practice;
- (f) In a single dose prescribed or dispensed to relieve the anxiety, pain, or discomfort experienced by that patient submitting to a diagnostic test or procedure; or
- (g) That has been classified as a Schedule V controlled substance.

Section 2. Professional Standards for Documentation of Patient Assessment, Education, Treatment Agreement and Informed Consent, Action Plans, Outcomes and Monitoring. (1) Each physician prescribing or dispensing a controlled substance shall obtain and document all relevant information in a patient's medical record in a legible manner and in sufficient detail to enable the board to determine whether the physician is conforming to professional standards for prescribing or dispensing controlled substances and other relevant professional standards.

(2) If a physician is unable to conform to professional standards for prescribing or dispensing controlled substances due to circumstances beyond the physician's control, or the physician makes a professional determination that it is not appropriate to comply with a specific standard, based upon the individual facts applicable to a specific patient's diagnosis and treatment, the physician shall document those circumstances in the patient's record and only prescribe or dispense a controlled substance to the patient if the patient record appropriately justifies the prescribing or dispensing of a controlled substance under the circumstances.

Section 3. Professional Standards for the Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. Prior to the initial prescribing or dispensing of any controlled substance for pain or other symptoms associated with the same primary medical complaint, the first physician prescribing or dispensing a controlled substance shall:

- (1) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and:
 - (a) If the complaint does not relate to a psychiatric condition, conduct a physical examination of the patient relevant to the medical complaint and related symptoms and document the information in the patient's medical record; or

(b) If the complaint relates to a psychiatric condition, perform, or have performed by a psychiatrist or other designated mental health provider, an evaluation appropriate to the presenting complaint and document the relevant findings;

(2) Obtain and review a KASPER report for that patient for the twelve (12) month period immediately preceding the patient encounter, and appropriately utilize that information in the evaluation and treatment of the patient;

(3) After examining the benefits and risks of prescribing or dispensing a controlled substance to the patient, including nontreatment or other treatment, make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified;

(4) Not prescribe or dispense a long-acting or controlled-release opioid (e.g. OxyContin, fentanyl patches, or methadone) for acute pain that is not directly related to and close in time to a specific surgical procedure;

(5) Explain to the patient that a controlled substance used to treat an acute medical complaint is for time-limited use, and that the patient should discontinue the use of the controlled substance when the condition requiring the controlled substance use has resolved; and

(6) Explain to the patient how to safely use and properly dispose of any unused controlled substance.

Section 4. Professional Standards for Commencing Long Term Use of Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. (1) Before a physician commences to prescribe or dispense any controlled substance to a patient sixteen (16) years or older for pain or other symptoms associated with the same primary medical complaint for a total period of longer than three (3) months, the physician shall comply with the mandatory professional standards established in subsection (2) of this section. These standards may be accomplished by different licensed practitioners in a single group practice at the direction of or on behalf of the prescribing physician if:

(a) Each practitioner involved has lawful access to the patient's medical record;

(b) There is compliance with all applicable standards; and

(c) Each practitioner performing an action to meet the required standards is acting within the practitioner's legal scope of practice.

(2)(a) The physician shall obtain the following information from the patient and record all relevant information in the patient's medical record:

1. History of present illness;

2. Past medical history;
3. History of substance use and any prior treatment for that use by the patient, and history of substance abuse by first degree relatives of the patient;
4. Past family history of relevant illnesses and treatment; and
5. Psychosocial history.

(b) The physician shall conduct an appropriate physical examination of the patient sufficient to support the medical indications for prescribing or dispensing a controlled substance on a long-term basis.

(c) The physician shall perform appropriate baseline assessments to establish beginning values to assist in establishing and periodically evaluating the functional goals of any treatment plan.

(d) If a specific or specialized evaluation is necessary for the formulation of a working diagnosis or treatment plan, the physician shall only continue the use of a controlled substance after determining that continued use of the controlled substance is safe and medically appropriate in the absence of that information.

(e) If the physician determines that the patient has previously received medical treatment for the presenting medical complaint or related symptoms and that review of the prior treatment records is necessary to justify long-term prescribing of a controlled substance, the physician shall obtain those prior medical records and incorporate the information therein into the evaluation and treatment of the patient.

(f)1. Based upon consideration of all information available, the physician shall promptly formulate and document a working diagnosis of the source of the patient's medical complaint and related symptoms without simply describing or listing the related symptoms.

2. If the physician is unable, despite best efforts, to formulate a working diagnosis, the physician shall consider the usefulness of additional information, such as a specialized evaluation or assessment, referral to an appropriate specialist, and the usefulness of further observation and evaluation, before attempting again to formulate a working diagnosis.

3. If the physician is unable to formulate a working diagnosis, despite the use of an appropriate specialized evaluation or assessment, the physician shall only prescribe long term use of a controlled substance after establishing that its use at a specific level is medically indicated and appropriate.

(g)1. To the extent that functional improvement is medically expected based upon the patient's condition, the physician shall formulate an appropriate treatment plan.

2. The treatment plan shall include specific and verifiable goals of treatment, with a schedule for periodic evaluations.

(h)1. The physician shall utilize appropriate screening tools to screen each patient to determine if the patient:

a. Is presently suffering from another medical condition which may impact the prescribing or dispensing of a controlled substance; or

b. Presents a significant risk for illegal diversion of a controlled substance.

2. If, after screening, the physician determines that there is a reasonable likelihood that the patient suffers from substance abuse or dependence, or a psychiatric or psychological condition, the physician shall take the necessary actions to facilitate a referral to an appropriate treatment program or provider. The physician shall appropriately incorporate the information from the treatment program or provider into the evaluation and treatment of the patient.

3. If, after screening, the physician determines that there is a risk that the patient may illegally divert a controlled substance, but determines to continue long term prescribing of the controlled substance, the physician shall use a prescribing agreement that meets professional standards. The prescribing agreement and informed consent document may be combined into one (1) document.

4. The physician shall obtain and document a baseline drug screen.

5. If, after screening, the physician determines that the controlled substance prescribed to the patient will be used or is likely to be used other than medicinally or other than for an accepted therapeutic purpose, the physician shall not prescribe any controlled substance to that patient.

(i) After explaining the risks and benefits of long-term use of a controlled substance, the physician shall obtain the written informed consent of the patient in a manner that meets professional standards.

(j) The physician shall initially attempt, to the extent possible, or establish and document a previous attempt by another physician, of a trial of noncontrolled modalities and lower doses of a controlled substance in increasing order to treat the pain and related symptoms associated with the primary medical complaint, before continuing with long term prescribing of a controlled substance at a given level.

Section 5. Professional Standards for Continuing Long Term Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. (1) If a physician continues to prescribe or dispense a controlled substance beyond three (3) months to a patient sixteen (16) years or older for pain and related symptoms associated with the primary medical complaint, the physician shall comply with the professional standards established in subsection (2) of this section. These standards may be accomplished by different licensed practitioners in a single group practice at the direction of or

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on behalf of the prescribing physician as established in Section 4(1) of this administrative regulation.

(2)(a)1. The physician shall ensure that the patient is seen at least once a month initially for evaluation and review of progress. The physician may determine that the patient is to be evaluated less frequently, on a schedule determined by the physician's professional judgment after the physician has determined:

- a. The controlled substance prescribed or dispensed has been titrated to the level appropriate and necessary to treat the medical complaint and related symptoms;
- b. The controlled substance prescribed or dispensed is not causing unacceptable side effects; and
- c. There is sufficient monitoring in place to minimize the likelihood that the patient will use the controlled substance in an improper or inappropriate manner or divert it for an improper or inappropriate use.

(b) At appropriate intervals, the physician shall:

1. Ensure that a current history is obtained from the patient;
2. Ensure that a focused physical examination is considered, and performed, if appropriate; and
3. Perform appropriate measurable examinations as indicated in the treatment plan.

(c) At appropriate intervals, the physician shall evaluate the working diagnosis and treatment plan based upon the information gained to determine whether there has been functional improvement or any change in baseline measures. The physician shall modify the diagnosis, treatment plan, or controlled substance therapy, as appropriate.

(d) If the physician determines that the patient presents a significant risk of diversion or improper use of a controlled substance, the physician shall discontinue the use of the controlled substance or justify its continued use in the patient record.

(e) If the medical complaint and related symptoms continue with no significant improvement in function despite treatment with a controlled substance, and if improvement is medically expected, the physician shall obtain appropriate consultative assistance to determine whether there are undiagnosed conditions to be addressed in order to resolve the medical complaint.

(f) For a patient exhibiting symptoms suggestive of a mood, anxiety, or psychotic disorder, the physician shall obtain a psychiatric or psychological consultation for intervention if appropriate.

(g) If a patient reports experiencing episodes of breakthrough pain, the physician shall:

1. Attempt to identify the trigger or triggers for each episode;

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2. Determine whether the breakthrough pain may be adequately treated through noncontrolled treatment; and

3. If the physician determines that the nonmedication treatments do not adequately address the triggers, and after considering the risks and benefits, determines to add an as-needed controlled substance to the regimen, take appropriate steps to minimize the improper or illegal use of the additional controlled substance.

(h) At least once a year, the physician shall perform or shall ensure that the patient's primary treating physician performs a preventive health screening and physical examination appropriate to the patient's gender, age, and medical condition.

(i)1. At least once every three (3) months, the physician shall obtain and review a current KASPER report, for the twelve (12) month period immediately preceding the request, and appropriately use that information in the evaluation and treatment of the patient.

2. If the physician obtains or receives specific information that the patient is not taking the controlled substance as directed, is diverting a controlled substance, or is engaged in any improper or illegal use of a controlled substance, the physician shall immediately obtain and review a KASPER report and appropriately use the information in the evaluation and treatment of the patient.

3. If a KASPER report discloses that the patient is obtaining a controlled substance from another practitioner without the physician's knowledge and approval, in a manner that raises suspicion of illegal diversion, the physician shall promptly notify the other practitioner of the relevant information from the KASPER review.

4. The physician shall obtain consultative assistance from a specialist if appropriate.

(j) If appropriate, the physician shall conduct random pill counts and appropriately use that information in the evaluation and treatment of the patient.

(k)1. During the course of long-term prescribing or dispensing of a controlled substance, the physician shall utilize drug screens, appropriate to the controlled substance and the patient's condition, in a random and unannounced manner at appropriate times. If the drug screen or other information available to the physician indicates that the patient is noncompliant, the physician shall:

a. Do a controlled taper;

b. Stop prescribing or dispensing the controlled substance immediately; or

c. Refer the patient to an addiction specialist, mental health professional, pain management specialist, or drug treatment program, depending upon the circumstances.

2. The physician shall discontinue controlled substance treatment or refer the patient to addiction management if:

- a. There has been no improvement in function and response to the medical complaint and related symptoms, if improvement is medically expected;
- b. Controlled substance therapy has produced significant adverse effects; or
- c. The patient exhibits inappropriate drug-seeking behavior or diversion.

Section 6. Professional Standards for the Prescribing and Dispensing of Controlled Substances in an Emergency Department. In addition to complying with the standards for the initial prescribing or dispensing of a controlled substance as established in Sections 3 and 7 of this administrative regulation, a physician prescribing or dispensing a controlled substance for a specific medical complaint and related symptoms to a patient in an emergency department shall not routinely:

- (1) Administer an intravenous controlled substance for the relief of acute exacerbations of chronic pain, unless intravenous administration is the only medically appropriate means of delivery;
- (2) Provide a replacement prescription for a controlled substance that was lost, destroyed, or stolen;
- (3) Provide a replacement dose of methadone, suboxone, or subutex for a patient in a treatment program;
- (4) Prescribe a long-acting or controlled-release controlled substance, such as OxyContin, fentanyl patches, or methadone or a replacement dose of that medication;
- (5) Administer Meperidine to the patient; or
- (6) Prescribe or dispense more than the minimum amount medically necessary to treat the patient's medical condition until the patient can be seen by the primary treating physician or another physician, with no refills. If the controlled substance prescription exceeds seven (7) days in length, the patient record shall justify the amount of the controlled substance prescribed.

Section 7. Professional Standards for the Prescribing and Dispensing of Controlled Substances for the Treatment of Other Conditions. (1) Before initially prescribing or dispensing a controlled substance to a patient for a condition other than pain, the physician shall:

- (a) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and:

1. If the complaint does not relate to a psychiatric condition, conduct a physical examination of the patient relevant to the medical complaint and related symptoms and document the information in the patient's medical record; or

2. If the complaint relates to a psychiatric condition, perform, or have performed by a psychiatrist or other designated mental health provider, an evaluation appropriate to the presenting complaint and document the relevant findings;

(b) Obtain and review a KASPER report for that patient, for the twelve (12) month period immediately preceding the patient encounter, and appropriately utilize that information in the evaluation and treatment of the patient;

(c) After examining the benefits and risks of prescribing or dispensing a controlled substance to the patient, including nontreatment or other treatment, make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified;

(d) Avoid providing more controlled substances than necessary by prescribing or dispensing only the amount of a controlled substance needed to treat the specific medical complaint;

(e) Explain to the patient that a controlled substance used to treat an acute medical complaint is for time-limited use, and that the patient should discontinue the use of a controlled substance when the condition requiring the controlled substance use has resolved; and

(f) Explain to the patient how to safely use and properly dispose of any unused controlled substance.

(2) If the physician continues to prescribe or dispense a controlled substance to a patient for the same medical complaint and related symptoms, the physician shall fully conform to the standards of acceptable and prevailing practice for treatment of that medical complaint and for the use of the controlled substance.

(3) If a physician receives a request from an established patient to prescribe or dispense a limited amount of a controlled substance to assist the patient in responding to the anxiety or depression resulting from a nonrecurring single episode or event, the physician shall:

(a) Obtain and review a KASPER report for that patient for the twelve (12) month period immediately preceding the patient request and appropriately utilize the information obtained in the evaluation and treatment of the patient;

(b) Make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified, with or without requiring a personal encounter with the patient to obtain a more detailed history or to conduct a physical examination; and

(c) If the decision is made that it is medically appropriate to prescribe or dispense the controlled substance, prescribe or dispense the minimum amount of the controlled substance to appropriately treat the situational anxiety or depression.

Section 8. Responsibility to Educate Patients Regarding the Dangers of Controlled Substance Use. (1) A physician prescribing or dispensing a controlled substance shall take appropriate steps to educate a patient receiving a controlled substance.

(2) Educational materials relating to these subjects may be found on the board's Web site, www.kbml.ky.gov.

Section 9. Additional Standards for Prescribing or Dispensing Schedule II Controlled Substances or Schedule III Controlled Substances Containing Hydrocodone. (1) In addition to the other standards established in this administrative regulation, prior to the initial prescribing or dispensing of a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, a physician shall:

(a) Obtain a medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient's medical complaint, and document the information in the patient's medical record;

(b) Query KASPER for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;

(c) Make a written 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)(a) In addition to the other standards established in this administrative regulation, a physician prescribing or dispensing additional amounts of a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone for the same medical complaint and related symptoms shall:

1. Review, at reasonable intervals based on the patient's individual circumstances and course of treatment, the plan of care;

2. Provide to the patient any new information about the treatment; and

3. Modify or terminate the treatment as appropriate.

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(b) If the course of treatment extends beyond three (3) months, the physician shall:

1. Query KASPER no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and

2. Review 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) To the extent not already required by the standards established in this administrative regulation, for each patient for whom a physician prescribes or dispenses a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone, the physician shall keep accurate, readily accessible, and complete medical records which include, as appropriate:

(a) Medical history and physical or mental health 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) The additional standards for prescribing or dispensing a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone established in this section shall not apply to:

(a) A physician prescribing or administering that controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or delivery and the medication usage does not extend beyond the fourteen (14) days;
or

(b) A physician prescribing or dispensing that controlled substance:

1. For administration in a hospital or long-term-care facility if the hospital or long-term-care facility with an institutional account, or a physician in those hospitals or facilities if no institutional account exists, queries KASPER for all available data on the patient or resident for the twelve (12) month period immediately preceding the query, within twelve (12) hours of the patient's or resident's admission, and places a copy of the query in the patient's or resident's medical records for use during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing:

a. Is done as a substitute for the initial prescribing or dispensing;

b. Cancels any refills for the initial prescription; and

c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing is done by another physician in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition; or

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federalwide assurance number from the United States Department for Health and Human Services, Office for Human Research Protections if the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health.

Section 10. Violations. (1) Any violation of the professional standards established in this administrative regulation shall constitute a violation of KRS 311.595(12) and (9), which may result in the imposition of disciplinary sanctions by the board, pursuant to KRS 311.595.

(2) Each violation of the professional standards established in this administrative regulation shall be established by expert testimony by one (1) or more physicians retained by the board, following a review of the licensee's patient records and other available information including KASPER reports.

Kentucky Administrative Regulations (2014)
Title 201. General Government Cabinet
Chapter 20. Board of Nursing

201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses

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Section 9. Prescribing Standards for Controlled Substances. (1)(a) This section shall apply to an APRN with a CA-PA-CS if prescribing a controlled substance other than a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN's role and population focus.

...

(3) The APRN shall, prior to initially prescribing a controlled substance for a medical complaint for a patient:

(a) Obtain the patient's medical history and conduct an examination of the patient and document the information in the patient's medical record. An APRN certified in psychiatric/mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient's medical record;

(b) Query KASPER 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 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:

1. The risks and benefits of the use of controlled substances, including the risk of tolerance and drug dependence;

2. That the controlled substance should be discontinued when the condition requiring its use has resolved; and

3. Document that the discussion occurred and that the patient consented to the treatment.

(4) The treatment plan shall include an exit strategy, if appropriate, including potential discontinuation of the use of controlled substances.

(5) For subsequent or continuing long-term prescriptions of a controlled substance for the same medical complaint, the APRN shall:

(a) Update the patient's medical history and document the information in the patient's medical record;

(b) Modify the treatment plan as clinically appropriate; and

(c) Discuss the risks and benefits of any new controlled substances prescribed 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.

(6) During the course of treatment, the APRN shall query KASPER no less than once every three (3) months for all available data on the patient before issuing a new prescription or a refill for a controlled substance.

(7) These requirements may be satisfied by other licensed practitioners in a single group practice if:

(a) Each licensed practitioner involved has lawful access to the patient's medical record;

(b) Each licensed practitioner performing an action to meet these requirements is acting within the scope of practice of his or her profession; and

(c) There is adequate documentation in the patient's medical record reflecting the actions of each practitioner.

(8) If prescribing a controlled substance for the treatment of chronic, noncancer pain, the APRN, in addition to the requirements of this section, shall obtain a baseline drug screen or further random drug screens if the APRN:

(a) Deems a drug screen to be clinically appropriate; or

(b) Believes that it is appropriate to determine whether or not the controlled substance is being taken by the patient.

(9) If prescribing a controlled substance for the treatment of a mental health condition, the APRN shall meet the requirements of this section.

(10) If prescribing a controlled substance for a patient younger than sixteen (16) years of age, the APRN shall obtain and review an initial KASPER report. If prescribing a controlled substance for an individual sixteen (16) years of age or older, the requirements of this section shall apply.

(11) Prior to prescribing a controlled substance for a patient in the emergency department of a hospital that is not an emergency situation as specified in subsection (2) of this section, the APRN shall:

(a) Obtain the patient's medical history, conduct an examination of the patient and document the information in the patient's medical record. An APRN certified in psychiatric/mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient's medical record;

(b) Query KASPER 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 document that the discussion occurred and that the patient consented to the treatment.

Section 10. Prescribing Standards for Controlled Substances from Schedule II and Schedule III Containing Hydrocodone. (1)(a) This section shall apply to an APRN with a CAPA-CS if prescribing a controlled substance from Schedule II or Schedule III controlled substance containing hydrocodone.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN's role and population focus.

...

(3) Prior to the initial prescribing of a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, an APRN shall:

(a) Obtain a medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient's medical complaint, and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in KRS 218A.202 for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;

(c) Make a written 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.

(4)(a) An APRN prescribing an additional amount of a Schedule II controlled substance or Schedule III controlled substance containing hydrocodone for the same medical complaint and related symptoms shall:

1. Review the plan of care at reasonable intervals based on the patient's individual circumstances and course of treatment;
2. Provide to the patient any new information about the treatment; and
3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment extends beyond three (3) months, the licensee shall:

- 1. Query KASPER no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and**
- 2. Review 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.**

Kentucky Administrative Regulations (2014)
Title 201. General Government Cabinet
Chapter 25. Board of Podiatry

201 KAR 25:090. Prescribing and dispensing controlled substances

Section 1. Prescribing or dispensing a controlled substance. (1) This administrative regulation governs the prescribing and dispensing of controlled substances listed in Schedule II through V as classified in KRS 218A.060, 218A.070, 218A.080, 218A.090, 218A.100, 218A.110, 218A.120, and 218A.130.

(2) If initially prescribing or dispensing a controlled substance, a licensee shall:

(a) Obtain a complete medical history and conduct a physical examination of the patient;

(b) Complete a written treatment plan which states the objectives of the treatment underlying the prescription of the controlled substance and which includes an outline of any further diagnostic examinations that may be required;

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(c) Discuss the risks and benefits of the use of controlled substances with the patient or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence;

(d) Verify that the patient is the person that he or she has identified himself or herself as being by requiring the person to produce proper government issued identification;

(e) Query the Kentucky All-Schedule Prescription Electronic Reporting System (KASPER) for all information available on the patient if prescribing controlled substances that are included in:

1. Schedule II;

2. Schedule III; and

3. The following from Schedule IV:

a. Ambien;

b. Anorexics;

c. Ativan;

d. Klonopin;

e. Librium;

f. Nubain;

g. Oxazepam;

h. Phentermine;

i. Soma;

j. Stadol;

k. Stadol NS;

l. Tramadol;

m. Valium;

n. Versed; and

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o. Xanax;

- (f) Obtain consent for the treatment from the patient in writing; and
 - (g) Document the patient's file as required by Section 2 of this administrative regulation.
- (3) If it is necessary to continue the prescription or dispensation of a controlled substance after the initial supply is completed, a licensee shall:
- (a) Conduct, at reasonable intervals under the circumstances presented, all clinically indicated steps;
 - (b) Review the course of treatment that he initially prepared to determine if any changes are required;
 - (c) Provide any new information about the course of treatment or any changes made to the patient;
 - (d) Query KASPER for all information available on the patient no less than once every three months for all available data on the patient to review that data before issuing any new prescription or refill for the patient for controlled substance specified in subsection (2)(e) of this section; and**
 - (e) Document the patient's file as required by Section 2 of this administrative regulation.

Section 2. Podiatric medical records for patients being prescribed controlled substance shall include at a minimum:

- (1) The patient's name;
- (2) The patient's date of birth;
- (3) The information concerning the patient's medical history and physical examination required by Section 1 of this administrative regulation;
- (4) The podiatrist's diagnosis of the patient's condition;
- (5) The procedures and treatments to be undertaken and their objectives;
- (6) The date of the procedures or treatments;
- (7) (Whether local or general anesthetics were used, including the type and the amount administered;
- (8) Diagnostic, therapeutic, and laboratory results;

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- (9) The findings and recommendations of any other evaluations or consultations;
- (10) All medications administered or prescribed by the podiatrist, including the date, type, dosage, and quantity administered or prescribed;
- (11) Any post-treatment instructions from the podiatrist; and
- (12) Documentation that the KASPER query required by Section 3 of this administrative regulation was completed.**

Section 3. If a prescription for a controlled substance is written, a podiatrist shall:

- (1) Obtain and document in the patient's podiatric medical record the information concerning the patient's medical history and physical examination required by Section 1 of this administrative regulation;
- (2) Query the Kentucky All-Scheduled Prescription Electronic Reporting System (KASPER) for all available data on the patient if the controlled substance is one specified in Section 1(2)(e) of this administrative regulation and record the results of the query in the patient's record;**
- (3) 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
- (4) Obtain consent for the treatment from the patient in writing.

Section 4. Dispensing Schedule II or Schedule III controlled substances containing hydrocodone.

- (1) A licensee shall not dispense more than a forty-eight (48) hour supply of Schedule II or Schedule III controlled substances containing hydrocodone.
- (2) If a patient continues to present with pain after the initial supply has been completed and the podiatrist believes that an additional prescription for a controlled substance is medically appropriate, the podiatrist shall at a minimum:
 - (a) Follow the requirements of Section 1 of this administrative regulation; and
 - (b) Prescribe only that amount of the controlled substance that is appropriate under accepted and prevailing practice standards.

Section 5. Authority to prescribe controlled substances. (1) A podiatrist licensed by the board may prescribe any medicine necessary for the treatment of a patient that comes within the practice of podiatry as defined by KRS 311.380(2), including Schedule II and Schedule III controlled substances containing hydrocodone, if the licensee:

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- (a) Has obtained a license number from the Drug Enforcement Administration;
- (b) Registers with and utilizes the Kentucky All-Schedule Prescription Electronic Reporting System (KASPER) as required by KRS 218A.202;
- (c) Follows the requirements of this administrative regulation; and
- (d) Meets all the requirements for utilizing KASPER promulgated by the Cabinet as well as the requirements set forth in KRS 218A.202.**

(2) A licensed podiatrist shall not prescribe or dispense:

- (a) With the intent or knowledge that a medication will be used or is likely to be used for any purpose other than one that is necessary for medical treatment or therapeutic use;
- (b) With the intent to evade any law governing the sale, use, or disposition of the medication;
- (c) When the licensee knows or has reason to know that the abuse of the controlled substance is occurring or may result therefrom; and
- (d) In amounts that the licensee knows or has reason to know, under the circumstance, that the amount prescribed is excessive under accepted and prevailing practice standards.

(3) After a hearing conducted under KRS Chapter 13B and 201 KAR 25:051, the board shall fine a licensee who otherwise has the authority to prescribe controlled substances, but who has failed to register for an account with KASPER, an amount not less than \$250 per prescription for each prescription that individual has written while not properly registered.

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Louisiana

§ 40:978 (eff. Aug. 1, 2014)
ADC Title 48, Part I, § 7831

West's Louisiana Statutes Annotated (2014)
Louisiana Revised Statutes
Title 40. Public Health and Safety
Chapter 4. Food and Drugs
Part X. Uniform Controlled Dangerous Substances Law

§ 978. Prescriptions

<Text of Section Effective August 1, 2014>

A. Except when dispensed or administered directly by a medical practitioner or administered by a person authorized to administer by such practitioner, other than a pharmacist, to an ultimate user, no controlled dangerous substance included in Schedule II, which is a prescription drug as determined under the Louisiana Revised Statutes, of 1950, may be dispensed or administered without either the written prescription of a practitioner, or an electronic prescription order as provided by federal law or regulation, except that in emergency situations, as prescribed by the department by regulation, such drug may be dispensed or administered upon oral prescription reduced promptly to writing and filed by the pharmacist. Prescriptions shall be retained in conformity with the requirements of R.S. 40:976. No prescription for a Schedule II substance may be refilled nor may such prescription be filled more than ninety days after the date of the prescription.

B. Except when dispensed or administered directly by a practitioner or administered by a person authorized to administer by such practitioner, other than a pharmacist, to an ultimate user, no controlled dangerous substance included in Schedule III and IV which is a prescription drug as determined under the Louisiana Revised Statutes may be dispensed or administered without either a written prescription, an oral prescription, or an electronic prescription order as provided by federal law or regulation. Such prescription may not be filled or refilled more than six months after the date thereof or refilled more than five times after the date of the prescription, unless renewed by the practitioner.

C. No controlled dangerous substance included in Schedule V may be distributed, administered or dispensed other than for a medical purpose by prescription of a licensed practitioner or as otherwise permitted by the provisions of this Part. However, nothing contained in this Subsection shall prohibit a practitioner from delegating the authority to administer controlled dangerous substances in Schedule V to a person authorized by such practitioner.

D. Notwithstanding the requirements of this Section, a prescription for a controlled substance listed in Schedule II, III, IV, or V may be generated, signed, transmitted, and received in

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electronic form, but only in conformance with the federal rules established by the United States Drug Enforcement Administration at 21 CFR 1311.

E.(1) The pharmacist shall not dispense more than a ten-day supply at a dosage not to exceed the United States Food and Drug Administration's approved labeling for the medication if the prescriber for such medication is not licensed by the state of Louisiana, and the medication is an opioid derivative Schedule II or an opioid derivative Schedule III controlled dangerous substance. The dispensing pharmacist shall notify the prescriber of the supply dispensed and the cancellation of the remainder of the prescription.

(2) Within sixty days of the dispensing of a medication pursuant to Paragraph (1) of this Subsection, such a medication shall not be dispensed again for the individual by a prescriber not licensed by the state of Louisiana.

F. A prescriber shall access the Prescription Monitoring Program prior to initially prescribing any Schedule II controlled dangerous substance to a patient for the treatment of non-cancer-related chronic or intractable pain.

Louisiana Administrative Code (2014)
Title 48. Public Health—General
Part I. General Administration Subpart 1. General
Subpart 3. Licensing and Certification
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

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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.

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Massachusetts

94C § 24A

105 CMR 725.010

234 CMR 5.06

243 CMR 2.07

247 CMR 9.04

249 CMR 4.02

263 CMR 5.07

Massachusetts General Laws Annotated (2014)
Part I. Administration of the Government (Ch. 1-182)
Title XV. Regulation of Trade (Ch. 93-110H)
Chapter 94C. Controlled Substances Act

§ 24A. Electronic monitoring of the prescribing and dispensing of controlled substances and certain additional drugs

...

(c) For the purposes of monitoring the prescribing and dispensing of all schedule II to V, inclusive, controlled substances and additional drugs, as authorized in subsection (a), the department shall promulgate regulations including, but not limited to, (1) a requirement that each pharmacy that delivers a schedule II to V, inclusive, controlled substance or a substance classified as an additional drug by the department to the ultimate user shall submit to the department, by electronic means, information regarding each prescription dispensed for a drug included under subsection (a); and (2) a requirement that each pharmacy collects and reports, for each prescription dispensed for a drug under subsection (a), a customer identification number and other information associated with the customer identification number, as specified by the department. Each pharmacy shall submit the information in accordance with transmission methods and frequency requirements promulgated by the department; provided, however, that the information shall be submitted at least once every 7 days. The department may issue a waiver to a pharmacy that is unable to submit prescription information by electronic means. The waiver shall permit the pharmacy to submit prescription information by other means promulgated by the department; provided, however, that all information required in this section is submitted in this alternative format.

The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants, which shall include requiring participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of a prescription for a narcotic drug that is contained in schedule II or III. The department may require participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of benzodiazepines or any

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other schedule IV or V prescription drug, which is commonly abused and may lead to physical or psychological dependence or which causes patients with a history of substance dependence to experience significant addictive symptoms. The regulations shall specify the circumstances under which such narcotics may be prescribed without first utilizing the prescription monitoring program. The regulations may also specify the circumstances under which support staff may use the prescription monitoring program on behalf of a registered participant. When promulgating the rules and regulations, the department shall also require that pharmacists be trained in the use of the prescription monitoring program as part of the continuing education requirements mandated for licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs.

...

Code of Massachusetts Regulations (2014)

Title 105: Department of Public Health

Chapter 725.000: Implementation of an Act for the Humanitarian Medical Use of Marijuana

725.010: Certifying Physician's Written Certification of a Debilitating Medical Condition for a Qualifying Patient

(A) A certifying physician issuing a written certification on or after July 1, 2014, must have completed a minimum of 2.0 Category 1 continuing professional development credits as defined in 243 CMR 2.06(6)(a)1. Such program must explain the proper use of marijuana, including side effects, dosage, and contraindications, including with psychotropic drugs, as well as on substance abuse recognition, diagnosis, and treatment related to marijuana.

(B) A certifying physician issuing a written certification shall comply with generally accepted standards of medical practice, including regulations of the Board of Registration in Medicine at 243 CMR 1.00 through 3.00.

(C) A certifying physician may not delegate to any other health care professional or any other person, authority to diagnose a patient as having a debilitating medical condition.

(D) A certifying physician may issue a written certification only for a qualifying patient with whom the physician has a bona fide physician-patient relationship.

(E) Before issuing a written certification, a certifying physician must utilize the Massachusetts Prescription Monitoring Program, unless otherwise specified by the Department, to review the qualifying patient's prescription history.

...

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Code of Massachusetts Regulations (2014)
Title 234: Board of Registration in Dentistry
Chapter 5.00: Requirements for the Practice of Dentistry and Dental Hygiene

5.06: Controlled Substances

(1) Dentists registered to dispense, administer and prescribe any controlled substances shall do so in accordance with M.G.L. c. 94C and 105 CMR 700.00 and all applicable state and federal statutes and regulations pertaining to controlled substances.

(2) Dentists are limited to writing prescriptions for controlled substances for legitimate dental purposes in the usual course of practice and are prohibited from prescribing controlled substances in Schedules II-IV for personal use.

(3) Except in an emergency, a dentist is prohibited from prescribing Schedule II controlled substances to a member of his/her immediate family including a spouse (or equivalent), parent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling, or other relative permanently residing in the same residence as the licensee.

(4) Prior to prescribing hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s) and a check of the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy that includes the patient's diagnoses and treatment plan, verifies that other pain management treatments have failed, indicates that a risk assessment was performed and that the licensee and the patient have entered into a Pain Management Treatment Agreement; and

(e) Document 234 CMR 5.06(4)(a) through (d) in the patient's medical record.

Code of Massachusetts Regulations (2014)
Title 243: Board of Registration in Medicine
Chapter 2.00: The Practice of Medicine

2.07: General Provisions Governing the Practice of Medicine

243 CMR 2.07 addresses some issues relating to the practice of medicine by licensees. The Practice of Medicine is defined in 243 CMR 2.01(4).

...

(25) Prescribing Hydrocodone-only Extended-release Medication. Prior to prescribing hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s) and a check of the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy that includes the patient's diagnoses and treatment plan, verifies that other pain management treatments have failed, indicates that a risk assessment was performed and that the licensee and the patient have entered into a Pain Management Treatment Agreement; and

(e) Document 243 CMR 2.07(25)(a) through (d) in the patient's medical record.

The purpose of 243 CMR 2.07(25) is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 243 CMR 2.07(25) shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.

Code of Massachusetts Regulations (2014)
Title 247: Board of Registration in Pharmacy
Chapter 9.00: Code of Professional Conduct; Professional Standards for Registered Pharmacists, Pharmacies and Pharmacy Departments

9.04: Requirements for Dispensing and Refilling Prescriptions

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- (1) Whenever a prescription drug has been distributed solely under a generic name, the dispensing pharmacist shall record on the prescription the name of the manufacturer or, if the manufacturer's name is not available, the name of the distributor, packer, or repacker.
- (2) The information on the label which the pharmacist, pharmacy intern, pharmacy technician or pharmacy technician trainee affixes to a prescription drug container shall be clearly printed or typed.
- (3) Only a pharmacist, pharmacy intern, and certified pharmacy technician who has the approval of the pharmacist on duty may receive new prescriptions over the telephone from a prescriber or authorized agent.
- (4) A pharmacist who refills a prescription for a controlled substance in Schedules III through VI shall record on the prescription:
 - (a) the date of dispensing;
 - (b) the amount of the drug dispensed; and
 - (c) his or her initials.
- (5) A dispensing pharmacist who does not indicate the quantity of a drug dispensed on the back of a prescription which the pharmacist has refilled shall be deemed to have dispensed a refill for the full face amount of the prescription.
- (6) Subject to the provisions of federal regulations at 21 CFR 1306, an automated data-processing system may be used as an alternative to the provisions of 247 CMR 9.04 (4) and (5). This data-processing system may be used for the storage and retrieval of information pertaining to the refilling of prescriptions for controlled substances in Schedules III through VI.
- (7) A pharmacist or anyone acting on behalf of a pharmacy or pharmacy department shall not collect prescriptions at industrial plants, places of business, or other sites where specific groups of people are regularly employed or affiliated, unless the prescriptions meet the following requirements:
 - (a) the prescriptions are for persons regularly employed at, or affiliated with, such plant, place of business or other such site;
 - (b) the prescriptions are collected in person by a pharmacist, pharmacy employee, or authorized agent of the pharmacy;
 - (c) the prescriptions are distributed in person to the patients or an authorized agent of the patient by a pharmacist, pharmacy employee, or authorized agent of the pharmacy; and

(d) the pharmacist shall be responsible for the conduct of any pharmacy employee or authorized agent acting on the pharmacist's behalf, and for verifying the authority of any person purporting to act on a patient's behalf; nothing in 247 CMR 9.04(7) shall be deemed to permit conduct of a prescription business in violation of any other regulation of the Board.

(8) A pharmacist may not fill or dispense any prescription for a hydrocodone-only extended release medication that is not in an abuse deterrent form unless:

(a) the medication is stored in a securely locked and substantially constructed cabinet at all times while on pharmacy premises;

(b) the medication is dispensed in a container with a child proof safety cap or within a locked box;

(c) the prescriber has supplied a Letter of Medical Necessity for each prescription that is compliant with 243 CMR 2.07(25): Prescribing Hydrocodone-only Extended-release Medication and that includes the patient's diagnoses and treatment plan, verifies other pain management treatments have failed, and indicates a risk assessment was performed and the prescriber and patient entered into a Pain Management Treatment Agreement and the pharmacist keeps the Letter of Medical Necessity in a readily retrievable manner;

(d) each prescription is accompanied by a written warning approved by the Board regarding the specific dangers of hydrocodone-only extended release medication that is not in abuse deterrent form;

(e) the pharmacist provides counseling that includes a review of the written warning supplied in accordance with 247 CMR 9.04(8)(c) and may include, but is not limited to:

1. the name and description of the medication;
2. the dosage form, dosage, route of administration and duration of drug therapy;
3. special instructions and precautions for preparation, administration and use by the patient;
4. common adverse or severe side effects or interactions and therapeutic contraindications;
5. techniques for self-monitoring drug therapy;
6. proper storage;
7. prescription refill information;
8. action to be taken in the event of a missed dose; and

(f) the pharmacist checks the patient's history on the online Prescription Monitoring Program.

Code of Massachusetts Regulations (2014)
Title 249: Board of Registration in Podiatry
Chapter 4.00: Practice of Podiatric Medicine

4.02: Drug Dispensing and Prescribing

(1) In accordance with M.G.L. c. 94C, a podiatrist has the same rights in possessing, administering, dispensing and prescribing drugs as other practitioners and may prescribe, dispense and administer all reasonable substances which shall include but not be limited to all prescription drugs and controlled substances; or he or she may cause the same to be administered under his or her direction by a nurse.

(2) Prior to prescribing hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s) and a check of the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy that includes the patient's diagnoses and treatment plan, verifies that other pain management treatments have failed, indicates that a risk assessment was performed and that the licensee and the patient have entered into a Pain Management Treatment Agreement; and

(e) Document 249 CMR 4.02(2)(a) through (d) in the patient's medical record.

The purpose of 249 CMR 4.02(2) is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 249 CMR 4.02(2) shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.

5.07: Prescription Practices of a Physician Assistant

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(12) Prescribing Hydrocodone-only Extended-release Medication. Prior to prescribing hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s) and a check of the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy that includes the patient's diagnoses and treatment plan, verifies that other pain management treatments have failed, indicates that a risk assessment was performed and that the licensee and the patient have entered into a Pain Management Treatment Agreement; and

(e) Document 263 CMR 5.07(12)(a) through (d) in the patient's medical record.

The purpose of 263 CMR 5.07(12) is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 263 CMR 5.07(12) shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.

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Minnesota

§ 245A.192

Minnesota Statutes Annotated (2014)
Public Welfare and Related Activities
Chapter 245A. Human Services Licensing

§ 245A.192. Providers licensed to provide treatment of opioid addiction

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Subd. 11. Prescription monitoring program. (a) Upon admission to a methadone clinic outpatient treatment program, clients shall be notified that the Department of Human Services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received. **The medical director or the medical director's delegate must review data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance as defined under section 152.126, subdivision 1, paragraph (b), including medications used for the treatment of opioid addiction. The subsequent reviews of the PMP data must occur quarterly and be documented in the client's individual file. When the PMP data shows a recent history of multiple prescribers or multiple prescriptions for controlled substances, then subsequent reviews of the PMP data must occur monthly and be documented in the client's individual file.** If, at any time, the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. Additionally, any findings from the PMP data that are relevant to the medical director's course of treatment for the client must be documented in the client's individual file. **A review of the PMP is not required for every medication dose adjustment.**

(b) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system through which the commissioner shall routinely access the data from the Minnesota Board of Pharmacy prescription monitoring program established under section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction treatment program licensed according to this section has also been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

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(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(c) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, part 2.34, item (c), prior to implementing this paragraph.

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Mississippi

ADC 24-2:59.2

West's Mississippi Administrative Code (2014)

Title 24. Mental Health

Part 2. Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers

Chapter 59. Opioid Treatment Services Utilizing Methadone

24-2:59.2. Admissions to Opioid Treatment Programs

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E. Each individual must be reviewed prior to admission and annually thereafter from the date of admission on the Prescription Drug Monitoring Program (PDMH) in MS and nearby states for which access is available to assess for appropriateness of Opiate Treatment Services. No individual is eligible for admission or continued services/treatment whose review indicates the potential for diversion and/or abuse of Methadone.

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Nevada
§ 639.23507

West's Nevada Revised Statutes Annotated (2014)
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.

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New Mexico

ADC 16.5.57

ADC 16.10.14

ADC 16.11.2

ADC 16.12.9

ADC 16.16.15

ADC 16.17.5

ADC 16.19.4

ADC 16.21.9

Code of New Mexico Rules (2014)

Title 16. Occupational and Professional Licensing

Chapter 5. Dentistry (Dentists, Dental Hygienists, etc.)

Part 57. Management of Pain with Controlled Substances

16.5.57. MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

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16.5.57.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of requiring participation in the PMP is to assist dentists in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A dentist who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A dentist shall before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when one of the following exists:

(1) the patient is a new patient of the dentist, in which situation a patient PMP report for the previous 12 months shall only be required when Schedules II, III and IV drugs are prescribed for a period greater than 10 days; and

(2) during the continuous use of controlled substances by established patients a PMP shall be requested a minimum of once every six months.

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Code of New Mexico Rules (2014)
Title 16. Occupational and Professional Licensing
Chapter 10. Medicine and Surgery Practitioners
Part 14. Management of Pain with Controlled Substances

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16.10.14.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the New Mexico medical board in requiring participation in the PMP is to assist practitioners in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A health care practitioner who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A health care practitioner shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when one of the following situations exists:

(1) the patient is a new patient of the practitioner, in which situation a patient PMP report for the previous 12 months shall only be required when Schedules II, III, and IV drugs are prescribed for a period greater than 10 days; and

(2) during the continuous use of opioids by established patients a PMP shall be requested and reviewed a minimum of once every six months.

...

Code of New Mexico Rules (2014)
Title 16. Occupational and Professional Licensing
Chapter 11. Midwives
Part 2. Certified Nurse Midwives

16.11.2. CERTIFIED NURSE MIDWIVES

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C. Guidelines for management of chronic pain with controlled substances. The treatment of chronic pain with various modalities, including controlled substances such as opiates and opioids, is a legitimate practice when done in the usual course of CNM practice. The goal when treating chronic pain is to reduce or eliminate pain and also to avoid development of or contribution to addiction, drug abuse and overdosing. Effective dosages should be prescribed, with both under- and over-prescribing to be avoided, using patient protection as a guiding

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principle. The CNM should provide control of the patient's pain for its duration, while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. A CNM may treat patients with addiction, physical dependence or tolerance who have legitimate pain, however such patients require very close monitoring and precise documentation.

(1) If, in a CNM's professional opinion, a patient is seeking pain medication for reasons that are not medically justified, the CNM is not required to prescribe controlled substances for the patient.

(2) When prescribing, dispensing or administering controlled substances for management of chronic pain, a CNM shall:

(a) obtain a PMP report for the patient covering the preceding 12 months from the New Mexico board of pharmacy, or another state's report where applicable and available;

(b) complete a history and physical examination and include an evaluation of the patient's psychological and pain status, any previous history of significant pain, past history of alternate treatments for pain, potential for substance abuse, coexisting disease or medical conditions, and the presence of medical indications or contra-indications related to controlled substances;

(c) be familiar with and employ screening tools, as well as the spectrum of available modalities for therapeutic purposes, in the evaluation and management of pain, and consider an integrative approach to pain management in collaboration with other care providers, including but not limited to acupuncturists, chiropractors, doctors of oriental medicine, exercise physiologists, massage therapists, pharmacists, physical therapists, psychiatrists or psychologists;

(d) develop a written individual treatment plan taking age, gender and culture into consideration, with stated objectives by which treatment can be evaluated, such as degree of pain relief, improved physical and psychological function, or other accepted measures, and including any need for further testing, consultation, referral or use of other treatment modalities as appropriate;

(e) discuss the risks and benefits of using controlled substances with the patient or legal guardian and document this discussion in the record;

(f) make a written agreement with the patient or legal guardian outlining patient responsibilities, including that the chronic pain patient will receive all chronic pain management prescriptions from one practitioner and one pharmacy whenever possible;

(g) maintain complete and accurate records of care provided and drugs prescribed, including the indications for use, the name of the drug, quantity, prescribed dosage and number of refills authorized;

(h) when indicated by the patient's condition, consult with health care professionals who are experienced in the area of the chronic pain, though not necessarily specialists in pain control, both early in the course of long-term treatment and at least every six months;

(i) when treating patients with drug addiction or physical dependence, use drug screening prior to and during the course of treatment to identify actual drugs being consumed and to compare with patients' self reports (this should be included in the written agreement, see Subparagraph (f) above);

(j) note the following possible indications of drug abuse by a patient and take appropriate steps to further investigate and to avoid contributing to drug abuse; such steps may include termination of treatment; some of this information may be available only through PMP reports;

(i) receiving controlled substances from multiple prescribers;

(ii) receiving controlled substances for more than 12 consecutive weeks;

(iii) receiving more than one controlled substance analgesic;

(iv) receiving a new prescription for any long-acting controlled substance analgesic formulation, including oral or transdermal dosage forms or methadone;

(v) overutilization, early refills;

(vi) appearing overly sedated or intoxicated upon presentation; or

(vii) an unfamiliar patient requesting a controlled substance by specific name, street name, color, or identifying marks.

...

Code of New Mexico Rules (2014)

Title 16. Occupational and Professional Licensing

Chapter 12. Nursing and Health Care Related Providers

Part 9. Management of Chronic Pain with Controlled Substances

16.12.9. MANAGEMENT OF CHRONIC PAIN WITH CONTROLLED SUBSTANCES

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16.12.9.9 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the NM board of nursing in requiring participation in the PMP is to assist practitioners in balancing the promotion of the safe use of controlled substances for the provision of nursing care

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and services with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A health care provider who holds a federal drug enforcement administration registration and licensure to prescribe opioids shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. Upon prescribing, ordering, administering or dispensing a controlled substance, the practitioner shall obtain and review a prescription monitoring report covering at least a one year time period or another state's report, where applicable and available. The practitioner shall be aware of a person currently:

(1) receiving opiates from multiple prescribers;

(2) receiving opiates for more than twelve consecutive weeks;

(3) receiving more than one controlled substance analgesic;

(4) receiving a new prescription for any long-acting controlled substance analgesic formulation, including oral dosage forms and transdermal (e.g. fentanyl) or methadone;

(5) exhibiting potential for abuse or misuse of opiates (i.e. over-utilization, early refills, appears overly sedated or intoxicated upon presentation, or an unfamiliar patient requesting an opiate by specific name, street name, color, or identifying marks, or paying cash when the patient has prescription insurance).

C. Upon recognizing any of the above, the practitioner, using professional judgment, shall take appropriate steps to avoid or resolve the potential problem. These steps may include requesting and reviewing additional controlled substance prescription monitoring reports or another state's report if applicable and available, or consulting with a pain management specialist or addiction treatment specialist or counseling the patient, which may include termination of treatment. The practitioner shall document steps taken to resolve the potential problem, which may include termination from treatment.

D. After obtaining an initial prescription monitoring report on a patient, the practitioner shall use professional judgment based on prevailing standards of practice in deciding the frequency of requesting and reviewing further prescription monitoring reports or other state's report on that patient. Prescription monitoring reports shall be requested and reviewed a minimum of once every six months during the continuous use of opioids for each established patient. The practitioner shall document the review of these reports.

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Code of New Mexico Rules (2014)
Title 16. Occupational and Professional Licensing
Chapter 16. Optometric Practitioner
Part 15. Management of Pain with Controlled Substances

16.16.15. MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

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16.16.15.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the optometry board requiring participation in the PMP is to assist optometrists in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. An optometrist who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. An optometrist shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule III or IV, obtain a patient PMP report for the preceding 12 months when one of the following exists:

(1) for a new patient of the optometrist, a patient PMP report for the previous 12 months shall only be required when Schedules III or IV drugs are prescribed for a period greater than 10 days; and

(2) for an established patient during the continuous use of controlled substances, a PMP shall be requested a minimum of once every six months.

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Code of New Mexico Rules (2014)
Title 16. Occupational and Professional Licensing
Chapter 17. Osteopathic Medicine and Surgery Practitioners
Part 5. Prescribing and Distribution of Controlled Substances

16.17.5. PRESCRIBING AND DISTRIBUTION OF CONTROLLED SUBSTANCES

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16.17.5.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the New Mexico osteopathic medical board in requiring participation in the PMP is to assist practitioners in balancing the promotion of the safe use of controlled substances for the

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provision of medical care and services with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A health care practitioner who holds a federal drug enforcement administration registration and licensure to prescribe opioids shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A health care practitioner shall, before prescribing, ordering, administering or dispensing a controlled substance listed in schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when the patient is a new patient of the practitioner.

C. Prescription monitoring reports shall be requested and reviewed a minimum of once every six months during the continuous use of opioids for each established patient. The practitioner shall document the review of these reports.

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Code of New Mexico Rules (2014)
Title 16. Occupational and Professional Licensing
Chapter 19. Pharmacists
Part 4. Pharmacist
16.19.4. PHARMACIST

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16.19.4.16 RESPONSIBILITIES OF PHARMACIST AND PHARMACIST INTERN:

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E. Prescription monitoring report for opiate prescriptions. When presented with an opiate prescription for a patient, obtaining and reviewing a prescription monitoring report for that patient can be an important tool that assists the pharmacist in identifying issues or problems that put his or her patient at risk of prescription drug abuse or diversion. A pharmacist shall use professional judgment based on prevailing standards of practice in determining whether to obtain and review a prescription monitoring report before dispensing an opiate prescription to that patient, and shall document his or her action regarding such reports.

(1) A pharmacist shall request and review a prescription monitoring report covering at least a one year time period and another states' report, where applicable and available if;

(a) a pharmacist becomes aware of a person currently exhibiting potential abuse or misuse of opiates (i.e. over-utilization, early refills, multiple prescribers, appears overly sedated or intoxicated upon presenting a prescription for an opiate or an unfamiliar patient

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requesting an opiate by specific name, street name, color, or identifying marks, or paying cash when the patient has prescription insurance);

(b) a pharmacist receives an opiate prescription requesting the dispensing of opiates from a prescription is-sued 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);

(c) providing opiates for a patient that is receiving chronic pain management prescriptions.

(2) After obtaining an initial prescription monitoring 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 prescription monitoring reports and other states' reports for that patient. The pharmacist shall document the review of these reports.

(3) In the 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 a report.

(4) A prescription for an opiate written for a patient in a long term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness is exempt from Subsection D of 16.19.29.8 NMAC. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner. The pharmacist shall document whether the patient is “terminally ill” or an “LTCF patient”.

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Code of New Mexico Rules (2014)
Title 16. Occupational and Professional Licensing
Chapter 21. Podiatrists
Part 9. Management of Pain with Controlled Substances

16.21.9. MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

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16.21.9.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the New Mexico board of podiatry in requiring participation in the PMP is to assist practitioners in balancing the promotion of the safe use of controlled substances for the provision of medical care and services with the need to impede illegal and harmful activities involving these pharmaceuticals.

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A. A podiatrist who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A podiatrist shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when one of the following situations exists:

(1) the patient is a new patient of the podiatrist, in which situation a patient PMP report for the previous 12 months shall only be required when Schedules II, III, and IV drugs are prescribed for a period greater than 10 days; and

(2) during the continuous use of opioids by established patients a PMP shall be requested and reviewed a minimum of once every six months.

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New York

Public Health Law § 3343-a
10 ADC 80.63

McKinney's Consolidated Laws of New York Annotated (2014)
Public Health Law
Chapter 45. Of the Consolidated Laws
Article 33. Controlled Substances
Title IV. Dispensing to Ultimate Users

§ 3343-a. Prescription monitoring program registry

...

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:

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(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.

...

Compilation of Codes, Rules and Regulations of the State of New York (2014)
Title 10. Department of Health
Chapter II. Administrative Rules and Regulations
Subchapter K. Controlled Substances
Part 80. Rules and Regulations on Controlled Substances
Prescribing and Dispensing Controlled Substances.

Section 80.63. Prescribing

...

(c) (1) Prior to prescribing for or dispensing to a patient any controlled substance listed on schedule II, III, or IV of section 3306 of the Public Health Law, every practitioner shall consult the prescription monitoring program registry for the purpose of reviewing that patient's controlled substance history. The patient's controlled substance history shall be obtained from the prescription monitoring program registry no more than 24 hours prior to the practitioner prescribing or dispensing any controlled substance to that patient. A practitioner shall document such consultation in the patient's medical chart or, if the practitioner does not consult the prescription monitoring program registry, the

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practitioner shall document in the patient's medical chart the reason such consultation was not performed. Such documentation shall include the specific exception listed in paragraph (2) of this subdivision.

(i) When such consultation is not performed due to circumstances specified in subparagraph (2)(vii) of this subdivision, the practitioner shall further document in the patient's medical chart the conditions, occurrences, or circumstances that caused such consultation in a timely manner to be unreasonable. Such documentation shall include a description of the barrier(s) to accessing the registry, and the efforts made by the practitioner to contact other designees.

(ii) When such consultation is not performed due to circumstances specified in subparagraph (2)(viii) of this subdivision, the practitioner shall further document in the patient's medical chart a description of the circumstances supporting the practitioner's conclusion that consultation of the registry would adversely impact the patient's ability to obtain a prescription in a timely manner and the relationship between that delay and the patient's medical condition.

(2) The duty to consult the prescription monitoring program registry shall not apply to:

(i) veterinarians;

(ii) a practitioner dispensing pursuant to Public Health Law section 3351(3);

(iii) a practitioner administering a controlled substance, as defined in Public Health Law section 3302(2);

(iv) a practitioner prescribing or ordering a controlled substance pursuant to Public Health Law section 3342(1) for a patient of an institutional dispenser as defined by Public Health Law section 3302 for use on the premises of, or during an emergency transfer from, the institutional dispenser;

(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 Public Health Law section 4002;

(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 Public Health Law section 3343-a, 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 circumstances under which consultation of the registry would, as determined by the practitioner, result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient, provided that the quantity of the controlled substance does not exceed a five-day supply if the controlled substance were used in accordance with the directions for use;

(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 defined in section 80.64 of this Part. In the instance of a temporary technological or electrical failure, a practitioner shall, without undue delay, seek to correct any cause for the failure that is reasonably within his or her control; or

(x) a practitioner to whom the commissioner has granted a waiver from the requirement to consult the registry. A waiver may be issued by the commissioner based upon a showing by a practitioner that his or her ability to consult the registry in accordance with this section is unduly burdened by:

(a) technological limitations that are not reasonably within the control of the practitioner; or

(b) other exceptional circumstance demonstrated by the practitioner. The practitioner's showing shall include a sworn statement of facts detailing the circumstances in support of a waiver, and should be accompanied by any and all other information which would be relevant to the commissioner's determination. As part of the application for a waiver, the practitioner shall also provide any information which would tend to negate the need for a waiver. A waiver shall be granted by the commissioner for a specified period of time, but in no event for more than one year. Subsequent waivers shall be applied for in the same manner and shall be subject to the same requirements as the original waiver. A practitioner who has been granted a waiver shall notify the department in writing within five business days upon gaining the capability to consult the prescription monitoring program registry. Without regard to the original expiration date, the waiver granted to the practitioner shall terminate within a reasonable period of time as determined by the department, allowing for the practitioner to make accommodations to begin consulting the prescription monitoring program registry.

(3) A practitioner may authorize a designee to consult the prescription monitoring program registry on his or her behalf, provided that 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. A practitioner may only appoint a designee if:

(i) such designee is located in the state of New York when accessing the prescription monitoring program registry;

(ii) the designee is employed by the same professional practice or is under contract with such practice. For purposes of this subparagraph, professional practice shall include, but not be limited to, an institutional dispenser where the designating practitioner is employed, under contract, or otherwise has privileges or authorization to practice;

(iii) the practitioner takes reasonable steps to ensure or has actual knowledge that such designee is sufficiently competent in the use of the registry and that such designee is aware of and conforms to all relevant Federal and State privacy statutes;

(iv) 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 the practitioner remains responsible for any breach of confidentiality; and

(v) the practitioner selects and maintains all active designees authorized to access the prescription monitoring program registry in a format acceptable to the department. Upon a designee's relinquishment or termination of employment or authorization as a designee, a designating practitioner shall immediately notify the department, in a fashion deemed appropriate by the commissioner, of the revocation of the designee's authorization to access the prescription monitoring program registry on the designating practitioner's behalf.

(4) 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. A pharmacist may designate another pharmacist or a pharmacy intern as defined by section 6806 of the Education Law to consult the prescription monitoring program registry on the pharmacist's behalf, provided that:

(i) such designee is located in the state of New York when accessing the prescription monitoring program registry and is employed by the same pharmacy or is under contract with such pharmacy; and

(ii) the designating pharmacist selects and maintains all active designees authorized to access the prescription monitoring program registry in a format acceptable to the department. Upon relinquishment or termination of employment or authorization as a designee, a designating pharmacist shall immediately notify the department, in a fashion deemed appropriate by the commissioner, of the revocation of the designee's authorization to access the prescription monitoring program registry on the designating pharmacist's behalf.

(d) (1) No controlled substance prescription shall be issued prior to the examination of the patient by the practitioner except as otherwise permitted by this subdivision.

(2) Once the initial examination has been completed, the frequency and necessity for future examinations prior to prescribing, either for the same acute or chronic condition, will be made by the practitioner utilizing generally accepted medical standards, including taking into account the drug to be prescribed and the patient's condition, history and disposition toward the use of controlled substances.

(3) In the temporary absence of the initial prescriber, an authorized practitioner may issue a controlled substance prescription for a patient as part of a continuing therapy if the practitioner: (i) had direct access to the patient's medical records and such records warrant continued controlled substance prescribing, or (ii) had direct and adequate consultation with the initial prescriber, who assures the necessity of continued controlled substance prescribing and with which the practitioner concurs. If the patient record is not available, the practitioner shall document the activity for his or her own record and shall transmit to the initial prescriber the prescription information. The initial prescriber shall include the prescription information in the patient's record.

(4) A practitioner may prescribe a controlled substance to his or her patient after review of the patient's record if the record contains the result of an examination performed by a consulting physician or hospital and such record warrants the prescribing.

(5) If a patient develops a new condition that would warrant the issuance of a prescription for a controlled substance, a practitioner may issue such prescription prior to performing an examination if: (i) the prescribing practitioner has a previously established practitioner/patient relationship with the patient; and (ii) an emergency exists; and (iii) the prescription does not exceed a 5 day supply as determined by the directions for use. An emergency means that the immediate administration of the drug is necessary for the proper treatment of the patient and that no alternative treatment is available. If the practitioner prescribes such substance orally, the practitioner must comply with the requirements of section 80.68 and section 80.70 of this Part.

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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.

Further, the North Carolina Medical Board issued a Position Statement regarding their policy for the use of controlled substances for the treatment of pain which states that physicians treating patients for pain should intermittently check the Controlled Substance Reporting Service for all patients.

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North Dakota

ADC 75-09.1-10-10

North Dakota Administrative Code (2014)
Title 75. Department of Human Services
Article 75-09.1. Substance Abuse Treatment Programs
Chapter 75-09.1-10. Licensing and Treatment Standards for Opioid Treatment Programs

75-09.1-10-10. Opioid treatment program administrative organization and responsibilities.

1. Each opioid treatment program shall develop a referral and consultative relationship with a network of agencies and providers capable of providing primary and specialty services for the range of behavioral difficulties, psychiatric comorbid conditions, medical complications, and communicable diseases that may be part of a patient's treatment needs. Any information exchanged across this network must facilitate treatment and protect patient privacy, consistent with the Health Insurance Portability and Accountability Act, and title 42, Code of Federal Regulations, part 2.
2. Each opioid treatment program shall create a written statement of its mission and goals for patient care.
3. An opioid treatment program shall maintain individualized personnel files as a record of employment. These files must contain employment and credentialing data, employment application data, date of employment, updated licensing and credentialing data, detailed job descriptions, performance evaluations, and appropriate training records.
4. An opioid treatment program shall require a criminal history record investigation as set forth under section 75-09.1-01-17 for an employee prior to allowing the employee to work with either adult or adolescent patients.
5. An opioid treatment program shall complete outcomes and data reports as requested by the division.
- 6. An opioid treatment program shall utilize the prescription drug monitoring program at least monthly for each patient.**

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Ohio

ADC 4729-5-20

§ 4731.055 (eff. until Apr. 1, 2015)

§ 4731.055 (eff. Apr. 1, 2015)

ADC 4731-11-11

§ 4715.302 (eff. until Apr. 1, 2015)

§ 4715.302 (eff. Apr. 1, 2015)

ADC 4715-6-01

§ 4723.487 (eff. until Apr. 1, 2015)

§ 4723.487 (eff. Apr. 1, 2015)

ADC 4723-9-12

§ 4725.092 (eff. until Apr. 1, 2015)

§ 4725.092 (eff. Apr. 1, 2015)

§ 4729.162

§ 4730.53 (eff. until Apr. 1, 2015)

§ 4730.53 (eff. Apr. 1, 2015)

ADC 4723-6-21.4

ADC 4725-16-04

ADC 4730-2-10

Baldwin's Ohio Administrative Code (2014)

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;

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- (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 (2014)
Title XLVII. Occupations--Professions
Chapter 4731. Physicians; Limited Practitioners
State Medical Board

§ 4731.055 Review of patient information available through drug database

<Text of Section Effective Until April 1, 2015>

(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 under division (A)(5) of section 4729.80 of the Revised Code.

(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4731. Physicians; Limited Practitioners
State Medical Board

§ 4731.055 Review of patient information available through drug database

<Text of Section Effective April 1, 2015>

(A) As used in this section:

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(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) Except as provided in divisions (C) and (E) of this section, a physician shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine, or personally furnishing a complete or partial supply of such a drug, as part of a patient’s course of treatment for a particular condition:

(1) Before initially prescribing or furnishing the drug, the physician or physician’s delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the physician practices primarily in a county of this state that adjoins another state, the physician or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient’s course of treatment for the condition continues for more than ninety days after the initial report is requested, the physician or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the physician shall assess the information in the report. The physician shall document in the patient’s record that the report was received and the information assessed.

(C) Division (B) of this section does not apply in any of the following circumstances:

(1) A drug database report regarding the patient is not available, in which case the physician shall document in the patient’s record the reason that the report is not available.

(2) The drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days.

(3) The drug is prescribed or personally furnished for the treatment of cancer or another condition associated with cancer.

(4) The drug is prescribed or personally furnished to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill.

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(5) The drug is prescribed or personally furnished for administration in a hospital, nursing home, or residential care facility.

(6) The drug is prescribed or personally furnished to treat acute pain resulting from surgical or other invasive procedure or a delivery.

(D) With respect to prescribing or personally furnishing any drug that is not an opioid analgesic or a benzodiazepine but is included in the drug database pursuant to rules adopted under section 4729.84 of the Revised Code, the state medical board shall adopt rules 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 under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) 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 (2014)
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.

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(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4715. Dentists; Dental Hygienists
Disciplinary Action; Prohibitions

§ 4715.302 Review of patient information available through drug database

<Text of Section Effective Until April 1, 2015>

(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 under division (A)(5) of section 4729.80 of the Revised Code.

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(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4715. Dentists; Dental Hygienists
Disciplinary Action; Prohibitions

§ 4715.302 Review of patient information available through drug database

<Text of Section Effective April 1, 2015>

(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) Except as provided in divisions (C) and (E) of this section, a dentist shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine, or personally furnishing a complete or partial supply of such a drug, as part of a patient’s course of treatment for a particular condition:

(1) Before initially prescribing or furnishing the drug, the dentist or the dentist’s delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the dentist practices primarily in a county in this state that adjoins another state, the dentist or delegate shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient’s course of treatment for the condition continues for more than ninety days after the initial report is requested, the dentist or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the dentist shall assess the information in the report. The dentist shall document in the patient’s record that the report was received and the information was assessed.

(C)(1) Division (B) of this section does not apply if a drug database report regarding the patient is not available. In this event, the dentist shall document in the patient’s record the reason that the report is not available.

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(2) Division (B) of this section does not apply if the drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days.

(D) With respect to prescribing or personally furnishing any drug that is not an opioid analgesic or a benzodiazepine but is included in the drug database pursuant to rules adopted under section 4729.84 of the Revised Code, the state dental board shall adopt rules that establish standards and procedures to be followed by a dentist regarding the review of patient information available through the drug database under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) 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 (2014)
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.

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(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.

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(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4723. Nurses
Certificates to Prescribe

§ 4723.487 Review of patient information available through drug database

<Text of Section Effective Until April 1, 2015>

(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 registered 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 under division (A)(5) of section 4729.80 of the Revised Code.

(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4723. Nurses
Certificates to Prescribe

§ 4723.487 Review of patient information available through drug database

<Text of Section Effective April 1, 2015>

(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) Except as provided in divisions (C) and (E) of this section, an advanced practice registered nurse holding a certificate to prescribe issued under this chapter shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine as part of a patient’s course of treatment for a particular condition:

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(1) Before initially prescribing the drug, the nurse or the nurse's delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the nurse practices primarily in a county of this state that adjoins another state, the nurse or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient's course of treatment for the condition continues for more than ninety days after the initial report is requested, the nurse or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the nurse shall assess the information in the report. The nurse shall document in the patient's record that the report was received and the information assessed.

(C) Division (B) of this section does not apply if in any of the following circumstances:

(1) A drug database report regarding the patient is not available, in which case the nurse shall document in the patient's record the reason that the report is not available.

(2) The drug is prescribed in an amount indicated for a period not to exceed seven days.

(3) The drug is prescribed for the treatment of cancer or another condition associated with cancer.

(4) The drug is prescribed to a hospice patient in a hospice care program, as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill.

(5) The drug is prescribed for administration in a hospital, nursing home, or residential care facility.

(D) With respect to prescribing any drug that is not an opioid analgesic or a benzodiazepine but is included in the drug database pursuant to rules adopted under section 4729.84 of the Revised Code, the board of nursing shall adopt rules that establish standards and procedures to be followed by an advanced practice registered 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 under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) 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 (2014)
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;

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(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4725. Optometrists; Dispensing Opticians
State Board of Optometry

§ 4725.092 Review of patient information available through drug database

<Text of Section Effective Until April 1, 2015>

(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 under division (A)(5) of section 4729.80 of the Revised Code.

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

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§ 4725.092 Review of patient information available through drug database

<Text of Section Effective April 1, 2015>

(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) Except as provided in divisions (C) and (E) of this section, an optometrist holding a therapeutic pharmaceutical agents certificate shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine, or personally furnishing a complete or partial supply of such a drug, as part of a patient’s course of treatment for a particular condition:

(1) Before initially prescribing or furnishing the drug, the optometrist or optometrist’s delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the optometrist practices primarily in a county of this state that adjoins another state, the optometrist or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient’s course of treatment for the condition continues for more than ninety days after the initial report is requested, the optometrist or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the optometrist shall assess the information in the report. The optometrist shall document in the patient’s record that the report was received and the information assessed.

(C)(1) Division (B) of this section does not apply if a drug database report regarding the patient is not available. In this event, the optometrist shall document in the patient’s record the reason that the report is not available.

(2) Division (B) of this section does not apply if the drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days.

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(D) With respect to prescribing or personally furnishing any drug that is not an opioid analgesic or a benzodiazepine but is included in the drug database pursuant to rules adopted under section 4729.84 of the Revised Code, the state board of optometry shall adopt rules 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 under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) 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 (2014)
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 under division (A)(6) of section 4729.80 of the Revised Code.

(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4730. Physician Assistants

§ 4730.53 Review of patient information available through drug database

<Text of Section Effective Until April 1, 2015>

(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

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holds a certificate to prescribe issued under this chapter regarding the review of patient information available through the drug database under division (A)(5) of section 4729.80 of the Revised Code.

(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 (2014)
Title XLVII. Occupations--Professions
Chapter 4730. Physician Assistants

§ 4730.53 Review of patient information available through drug database

<Text of Section Effective April 1, 2015>

(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) Except as provided in divisions (C) and (E) of this section, a physician assistant holding a certificate to prescribe issued under this chapter shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine as part of a patient’s course of treatment for a particular condition:

(1) Before initially prescribing or furnishing the drug, the physician assistant or physician assistant’s delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the physician assistant practices primarily in a county of this state that adjoins another state, the physician assistant or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient’s course of treatment for the condition continues for more than ninety days after the initial report is requested, the physician assistant or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the physician assistant shall assess the information in the report. The physician assistant shall document in the patient’s record that the report was received and the information assessed.

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(C) Division (B) of this section does not apply in any of the following circumstances:

(1) A drug database report regarding the patient is not available, in which case the physician assistant shall document in the patient's record the reason that the report is not available.

(2) The drug is prescribed in an amount indicated for a period not to exceed seven days.

(3) The drug is prescribed for the treatment of cancer or another condition associated with cancer.

(4) The drug is prescribed to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill.

(5) The drug is prescribed for administration in a hospital, nursing home, or residential care facility.

(D) With respect to prescribing any drug that is not an opioid analgesic or a benzodiazepine but is included in the drug database pursuant to rules adopted under 4729.84 of the Revised Code, the state medical board shall adopt rules 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 under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) 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 (2014)
4123 Workers' Compensation Bureau
Chapter 4123-6. Health Partnership Program (HPP)

4123-6-21.4 Coordinated services program

The bureau, or a self-insuring employer with a point-of-service adjudication system, may establish a coordinated services program (CSP) that requires an injured worker to obtain prescription medications reimbursed by the bureau or self-insuring employer from a single designated pharmacy and/or prescriber.

(A) Placement in a CSP.

(1) The bureau or self-insuring employer with a point-of-service adjudication system may review an injured worker for possible placement in a CSP if a review of his or her claim indicates the injured worker meets one or more of the following criteria:

(a) Use of three or more different prescribers to obtain prescriptions of the same or comparable medications per three month time frame;

(b) Receipt of prescription drugs from more than two different pharmacies per three month time frame;

(c) Monthly receipt of three or more prescriptions including refills for drugs identified by therapeutic drug class as a narcotic analgesic per three month time frame;

(d) Monthly receipt of more than two concurrent narcotic analgesics in the same therapeutic drug class per three month time frame;

(e) Monthly receipt of more than two narcotic analgesics in the same therapeutic drug class, more than one benzodiazepine, and more than one sedative-hypnotics per three month time frame.

(2) Upon identification of an injured worker meeting one or more of the criteria identified in paragraphs (A)(1)(a) to (A)(1)(e) of this rule, the bureau or self-insuring employer with a point-of-service adjudication system shall obtain a physician review of the injured worker's most recent twelve months history of prescription medications reimbursed by the bureau or self-insuring employer.

(3) If, based on this physician review, the bureau or self-insuring employer with a point-of-service adjudication system determines that the injured worker's utilization of prescription medications during this period was at a frequency or in an amount that was not medically necessary or appropriate under the criteria set forth in paragraphs (B)(1) to (B)(3) of rule 4123-6-16.2 of the Administrative Code, or was potentially unsafe, the bureau or self-insuring employer may place the injured worker in a CSP.

(4) Notwithstanding paragraphs (A)(1) to (A)(3) of this rule, if the bureau or self-insuring employer with a point-of-service adjudication system determines that an injured worker has been convicted of or pled guilty to an offense under Chapter 2925. of the Revised Code or any other criminal offense related to the misuse of drugs, the bureau or self-insuring employer may place the injured worker in a CSP.

(5) Placement in a CSP shall be for an initial period of eighteen months. The bureau or self-insuring employer with a point-of-service adjudication system may place the injured worker in the CSP for additional eighteen month periods in accordance with paragraph (A)(6) of this rule.

(6) The bureau or self-insuring employer with a point-of-service adjudication system may evaluate an injured worker's medication utilization at the conclusion of each eighteen month

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period in the CSP. If the bureau or self-insuring employer determines that the injured worker's medication utilization continues to meet the criteria set forth in paragraphs (A)(1) to (A)(4) of this rule, the bureau or self-insuring employer may place the injured worker in the CSP for an additional eighteen month period.

(7) If an injured worker placed in the CSP enters a nursing home, residential care/assisted living facility, or hospice program, the injured worker shall be released from the CSP. If the injured worker is subsequently discharged from the nursing home, residential care/assisted living facility, or hospice program during the CSP period, the bureau or self-insuring employer with a point-of-service adjudication system may place the injured worker back into the CSP.

(B) Selection of designated pharmacy and/or prescriber.

(1) An injured worker placed into a CSP pursuant to paragraph (A)(3) or (A)(4) of this rule shall be given the opportunity to select a designated pharmacy from a list of participating pharmacies maintained by the bureau or self-insuring employer. If an injured worker fails to select a designated pharmacy, or selects a designated pharmacy that is unable or unwilling to accept the injured worker, the bureau or self-insuring employer may select a designated pharmacy for the injured worker.

(2) An injured worker placed in a CSP pursuant to paragraph (A)(3) or (A)(4) of this rule may only change from one designated pharmacy to another in the following circumstances:

(a) The designated pharmacy becomes inaccessible to the injured worker due to relocation or incapacity of the injured worker or closing of the designated pharmacy,

(b) The designated pharmacy chooses to no longer participate in the CSP or to provide services to the injured worker in accordance with paragraph (D)(4) of this rule.

(c) The injured worker requests to be assigned to another designated pharmacy due to personal preference. Not more than one change due to personal preference shall be approved in a rolling twelve-month period.

(3) An injured worker placed in the CSP pursuant to paragraph (A)(4) of this rule shall be given the opportunity to select a designated prescriber from among those bureau certified providers who meet the definition of physician under paragraph (D) of rule 4123-6-01 of the Administrative Code. If an injured worker fails to select a designated prescriber, or selects a designated prescriber that is unable or unwilling to accept the injured worker, the bureau or self-insuring employer may select a designated prescriber for the injured worker.

(4) An injured worker placed in a CSP pursuant to paragraph (A)(4) of this rule may only change from one designated prescriber to another in the following circumstances:

(a) The designated prescriber becomes inaccessible to the injured worker due to relocation or incapacity of the injured worker or closing of the designated prescriber's practice,

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(b) The designated prescriber chooses to no longer provide services to the injured worker,

(c) The injured worker requests to be assigned to another designated prescriber due to personal preference. Not more than one change due to personal preference shall be approved in a rolling twelve-month period.

(5) All requests for change of designated pharmacy or designated prescriber must be submitted in writing to the bureau or self-insuring employer.

(C) Operation of the CSP.

(1) An injured worker placed in a CSP pursuant to paragraph (A)(3) or (A)(4) of this rule must obtain covered prescription medications from the injured worker's designated pharmacy. During the period the injured worker is placed in the CSP, the bureau or self-insuring employer shall deny reimbursement for prescription medications obtained from a pharmacy other than the injured worker's designated pharmacy, except in cases of emergency as set forth in paragraph (C)(2) of this rule.

(2) Emergency prescription fills shall be allowed in the following situations:

(a) The injured worker is unable to get to his or her designated pharmacy,

(b) The injured worker's designated pharmacy does not have the prescribed medication in stock.

(3) Emergency prescription fills shall be limited to a four-day supply. Records of dispensing for emergency prescription fills are subject to review by the bureau.

(4) An injured worker placed in a CSP pursuant to paragraph (A)(4) of this rule must obtain all prescriptions for covered medications from the injured worker's designated prescriber. During the period the injured worker is placed in the CSP, the bureau or self-insuring employer shall deny reimbursement for prescriptions written by providers other than the injured worker's designated prescriber, except:

(a) In cases of emergency as defined in paragraph (O) of rule 4123-6-01 of the Administrative Code;

(b) With prior authorization, prescriptions written by a specialist in cases where the injured worker has been referred to a specialist for care.

(D) Pharmacies participating in the bureau's CSP.

(1) The bureau shall maintain a list of pharmacies participating in the bureau's CSP that are eligible for selection by an injured worker as a designated pharmacy. To participate in the bureau's CSP, a pharmacy must meet the following criteria:

(a) The pharmacy must be enrolled with the bureau and have a signed agreement with the bureau's pharmacy benefits manager.

(b) The pharmacy must enter into a CSP agreement with the bureau.

(2) Pharmacies participating in the bureau's CSP agree to perform the following monitoring activities:

(a) For each injured worker in the bureau's CSP for whom the pharmacy is the designated pharmacy, the pharmacy shall conduct a bimonthly review of the injured worker's OARRS report from the Ohio board of pharmacy (or a similar automated prescription monitoring report from the injured worker's state of residence).

(b) The pharmacy shall notify the injured worker's prescribing physician of any critical findings discovered in the report. Critical findings are indications of any prescription related activity that could cause harm to the patient, including but not limited to:

(i) Duplication of therapy,

(ii) Excessive doses of concurrent medications,

(iii) Potential drug interactions or potentiation of side effects.

(c) The pharmacy shall notify BWC in writing whenever reports are made under paragraph (D)(2)(b) of this rule.

(d) BWC may request quarterly documentation of the pharmacy's monitoring activities under paragraphs (D)(2)(a) to (D)(2)(d) of this rule.

(3) Pharmacies participating in the CSP may receive compensation from the bureau under the CSP agreement for services provided as part of the CSP.

(4) Pharmacies participating in the bureau's CSP may terminate their CSP agreement with the bureau and discontinue their participation in the bureau's CSP at any time upon not less than thirty days written notice to the bureau. Pharmacies participating in the bureau's CSP may discontinue providing services to an individual injured worker at any time upon not less than thirty days written notice to the bureau, the injured worker, and the injured worker's authorized representative.

(5) The bureau may terminate the CSP agreement of a pharmacy participating in the bureau's CSP in accordance with the terms of the CSP agreement.

(E) Pharmacies participating in a self-insuring employer's CSP.

(1) A self-insuring employer with a point-of-service adjudication system who establishes a CSP shall maintain a list of pharmacies participating in the self-insuring employer's CSP that are eligible for selection by an injured worker as a designated pharmacy. The list of participating pharmacies shall cover a geographic area sufficient to provide the self-insuring employer's injured workers with reasonable access to pharmacy providers.

(2) Pharmacies participating in a self-insuring employer's CSP shall provide not less than thirty days written notice to an injured worker and the injured worker's authorized representative prior to discontinuing services to the injured worker.

(F) Disputes.

(1) Decisions by the bureau regarding an injured worker's placement in the bureau's CSP, assignment of a designated pharmacy or designated prescriber, or denial of an injured worker's request for change of designated pharmacy or designated prescriber may be appealed to the industrial commission in accordance with section 4123.511 of the Revised Code.

(2) Decisions by a self-insuring employer regarding an injured worker's placement in the self-insuring employer's CSP, assignment of a designated pharmacy or designated prescriber, or denial of an injured worker's request for change of designated pharmacy or designated prescriber shall indicate that the injured worker has the right to request a hearing before the industrial commission.

Baldwin's Ohio Administrative Code Annotated (2014)

4725 Optometry Board

Chapter 4725-16. Controlled Substances

4725-16-04 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.
- (c) Other non-controlled dangerous drug products as listed in rule 4729-37-02 of the Administrative Code in the definitions as (A)(5)(b).

(B) If an optometrist believes or has reason to believe that a patient may be abusing or diverting drugs, the optometrist 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 optometrist 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;**

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(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) An optometrist 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 optometrist has reason to believe that the treatment will be required on a protracted basis; and

(2) At least once annually, thereafter.

(D) An optometrist 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, an optometrist 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 Administrative Code Annotated (2014)
4730 Physician Assistants
Chapter 4730-2. Prescriptive Authority

4730-2-10. 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 tramadol.

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

(1) To assist in this determination, the physician assistant 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 drug 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 use 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; and

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

(C) A physician assistant prescribing 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 assistant has reason to believe that the treatment will be required on a protracted basis; and

(2) At least once annually, thereafter.

(D) A physician assistant 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, the physician assistant 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.

(G) Review of the physician assistant's compliance with this rule shall be included as an activity in the quality assurance plan required by division (F) of section 4730.21 of the Revised Code.

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Oklahoma

63 § 2-302

Oklahoma Statutes Annotated (2014)

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-

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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 warehouse, or an employee thereof, whose possession of any controlled dangerous substance is in the usual course of such carrier's or warehouse'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 [FN1] 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.

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Rhode Island

ADC 46-1-13:45.0

West's Rhode Island Administrative Code (2014)
Title 46. Mental Health Retardation & Hospitals Department
Division 1. General
Rule 13. Rules and Regulations for the Licensing Behavioral Healthcare Organizations
Part VI. Services and Programs

46-1-13:45.0. Opioid Treatment Programs

This section applies to all public or private opioid treatment and maintenance programs. These programs must also comply with all applicable sections of the General Regulations and with 42 CFR Part 8 (DHHS/SAMHSA, DEA Regulations), and Rhode Island General Laws section 21-28-1 et seq. (Uniform Controlled Substance Act), Rhode Island General Laws section 21-28.2-1 et seq. (Drug Abuse Control Act), Rhode Island General Laws section 21-28.3-1 et seq. (Drug Abuse Reporting System), Rhode Island General Laws section 5-19-1 et seq. (Pharmacy Statute), and Rhode Island State Methadone Authority. Programs shall reference the State Methadone Treatment Guidelines/ TIP1 (Treatment Improvement Protocol Series/CSAT) and Buprenorphine Treatment Guidelines.

...

45.4.5 A physical health assessment, including a medical history and physical examination, shall be completed within the first twenty-four (24) hours of a person's admission to the program.

A. This assessment shall include: an assessment of the possibility of: infectious diseases, including HIV, TB, Viral Hepatitis and sexually transmitted diseases; pulmonary, liver, and cardiac abnormalities; dermatological and neurological consequences of addiction; and possible concurrent surgical problems.

B. The assessment shall include laboratory tests, the results of which must be returned no later than fourteen (14) days after admission. The licensee shall ensure that such laboratory tests are completed by licensed facilities which shall comply with all applicable federal and state laboratory licensure and certification requirements. The laboratory tests shall include the following:

1. Tests to determine liver function;
2. Complete blood count and lipid panel; and
3. Screening test for syphilis.

C. If the Medical Director determines that laboratory tests are not clinically indicated at the time of admission, this justification shall be documented in the patient record.

D. Programs are required to check Department of Health's Prescription Monitoring Program for each new admission.

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45.16 OTP's shall develop policies and procedures that ensure compliance with federal and state regulations before take-home medication privileges are granted. **In addition, prior to advancement to a new take-home phase, programs are required to check the Department of Health's Prescription Monitoring Program.** The policies and procedures shall, at a minimum, include the following:

45.16.1 The following treatment schedule shall be implemented:

A. At least a two (2) month probationary period with daily doses of medication ingested under appropriate supervision. During this time the individual must satisfactorily meet all requirements of the program. In the event that a program is closed on a Sunday or Holiday during a patient's two (2) month probationary period, if the patient meets the criteria established by the program and approved by the State Opioid Treatment Authority, the patient may receive one (1) take-home during this period. Written closure requests to the State Opioid Treatment Authority (as required in section 45.3 of these regulations) shall also include written de-tailed plans containing: patient inclusion/exclusion criteria, patient notification, diversion control, a documented history of take-home safety, and the submission of exception requests. Documentation of appropriateness shall be noted in the patient record.

B. During the first ninety (90) days of take-home privileges, the take-home supply shall be limited to a single dose each week. The individual shall ingest all other doses under appropriate supervision.

C. During the second ninety (90) days, the take-home supply shall be limited to two (2) doses per week.

D. During the third ninety (90) days, the take-home supply shall be limited to three (3) doses per week with no more than two (2) consecutive days supply of medication.

E. After one (1) year the individual may be permitted to reduce attendance to two (2) visits weekly and may be given no more than three (3) consecutive days supply of medication.

F. After two (2) years, the individual may be permitted to reduce program attendance to once weekly and may receive no more than six (6) days take-home supply of medication.

G. After three (3) years, the individual may be permitted to reduce program attendance to two (2) visits monthly and receive no more than a fourteen (14) day supply of medication.

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H. After four (4) years, the individual may be permitted to reduce program attendance to once monthly. OTPs are required to inform the State Opioid Treatment Authority of all individuals advanced to this take-home phase.

45.16.2 In an emergency situation or severe illness, individuals may be given up to ten (10) days supply of medication based on the judgment of the OTP physician.

45.16.3 Prior to the initiation of take-home privileges, the following shall be confirmed and documented:

A. The individual shall receive instructions regarding safety. Such instructions shall include but not be limited to, child safety measures and the storage of medications.

B. The individual shall obtain an agency approved locked box for storage of take-home medication.

45.16.4 Take-home containers shall be labeled with the following:

A. Individual's name;

B. Name and amount of medication;

C. Directions for use, including route of administration;

D. Date issued and date medication is to be taken;

E. Program name and address;

F. Program's telephone number.

45.16.5 Childproof caps shall be used on all take-home bottles of opioid replacement medication.

45.16.6 The OTP physician shall document in the treatment record the rationale for authorizing take-home privileges.

45.16.7 The individuals shall return all take-home containers on their next day of Program attendance. Prior to the person's receiving his or her subsequent dose, bottles shall be inspected to ensure that they are coming from the appropriate person during the appropriate time-period.

45.16.8 The agency shall have a policy regarding the non-return of take-home bottles that includes the inter-ventions to be taken. Should there be a violation of this policy, the documentation required for each incident shall include the following:

A. The person's treatment history at the agency

B. Reason for damage to the label on the container or the person's inability to produce the container

C. Number of repeated occurrences.

45.16.9 Take-home privileges are not allowed during long or short-term opioid detoxification.

45.16.10 Take-home privileges may be revoked by the OTP physician with the rationale documented in the person's treatment record.

45.16.11 Individuals may contest a revocation of take-home privileges through the Concern and Complaint Resolution Procedure.

45.16.12 An OTP must maintain a Diversion Control Plan to ensure quality care while minimizing the diversion of an opioid replacement medication from treatment to illicit use. The plan shall include, but not be limited to, the following:

A. Clinical and administrative continuous monitoring

B. Problem identification, correction, and prevention

C. Accountability to the person and to the community

45.16.13 When buprenorphine is given as a take-home medication, the medically indicated formulation shall be used.

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Tennessee

§ 53-10-310

ADC 1140-11-.06

ADC 1200-34-01-.07

ADC 0940-05-42-.07

ADC 0940-05-42-.15

ADC 0940-05-42-.17

West's Tennessee Code Annotated (2014)

Title 53. Food, Drugs and Cosmetics

Chapter 10. Legend Drugs

Part 3. Tennessee Prescription Safety Act of 2012

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

<Text of section effective until July 1, 2016.>

(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 healthcare 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 when 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 part.

(e)(1) All prescribers or their designated healthcare 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.

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(2) Before dispensing, a dispenser shall have the professional responsibility to check the database or have a healthcare 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 (1) 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 healthcare 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-day treatment period and does not allow a refill;

(E) The controlled substance is prescribed for administration directly to a patient during the course of inpatient or residential treatment in a hospital or nursing home licensed under title 68 or a mental health hospital licensed under title 33.

(f) Each appropriate licensure board shall promulgate rules pursuant to the Uniform Administrative Procedures Act, 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 healthcare 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.

Tennessee Rules and Regulations (2014)

1140. Board of Pharmacy

Chapter 1140-11. Controlled Substance Monitoring Database

1140-11-.06 PRESCRIBER AND DISPENSER RESPONSIBILITIES (EFFECTIVE APRIL 1, 2013).

(1) All prescribers or their designated healthcare practitioner's extenders, unless otherwise exempted by T.C.A. Title 53, Chapter 10, part 3, shall check the database prior to prescribing one of the controlled substances identified below in paragraph (3) to a human patient at the beginning of a new episode of treatment and shall check the database for the human patient at least annually when that prescribed controlled substance remains part of treatment.

(2) Before dispensing, a dispenser shall have the professional responsibility to check the database or have a healthcare 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 T.C.A. § 53-11-402.

(3) The controlled substances which trigger a check of the database pursuant to paragraph (1) above include, but are not limited to, all opioids and benzodiazepines.

(4) Prescribers are not required to check the database before prescribing or dispensing one of the controlled substances identified in paragraph (3) above or added to that list by the Committee if one (1) 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 healthcare facility;

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

Tennessee Rules and Regulations (2014)

1200. Department of Health, Department of Environment and Conservation, and Department of Finance and Administration

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:**

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- (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.

Tennessee Rules and Regulations (2014)
0940. Department of Mental Health and Developmental Disabilities
0940-05. Office of Licensure
Chapter 0940-05-42. Minimum Program Requirements for Non-Residential Opioid Treatment
Program Facilities

0940-05-42-.07 SERVICE RECIPIENT RECORD REQUIREMENTS.

...

(2) The Facility shall document that the following assessments are completed prior to the development of the Individualized Program Plan (IPP).

(a) Screening. The sources and methods of verification shall have been recorded in the prospective service recipient's case folder. The screening process shall include:

1. Verification, to the extent possible, of a prospective service recipient's identity, including name, address, date of birth and other identifying data.
2. Drug history and current status, including determination and substantiation, to the extent possible, of the duration of substance dependence, determination by medical examination performed by a program physician of dependence on opium, morphine, heroin or any derivative or synthetic drug of that group, and determination of current Diagnostic and Statistical Manual (DSM) diagnosis.
3. Medical history, including past and family medical history, HIV status, pregnancy, a six-month history of prescriber medications, over-the-counter medications used frequently, and the patterns of specific usage of alcohol or other drugs for the past 30 days, and active medical problems.
- 4. Verification of other prescribed controlled medications through the PMP.**
5. Psychiatric history and current mental status exam.
6. Within 14 days of admission, physical assessment and laboratory tests, including drug screens, HIV status, if the prospective service recipient consents to be tested, pregnancy, sexually transmitted diseases, Mantoux tuberculosis tests, Hepatitis C, and others as directed by the SOTA.
7. Pregnancy tests for females at admission and at least annually thereafter, unless otherwise indicated.
8. Determination if the prospective service recipient needs special services, such as treatment for alcoholism or psychiatric services, and determination that the Facility is capable of addressing these needs either directly or through referral.

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9. If a prospective service recipient is 18 years of age or older, verification of dependence on opium, morphine, heroin or any derivative or synthetic drug of that group for a period of two years or verification of one year of opioid dependence and one documented unsuccessful attempt at clinical treatment. If clinically appropriate, the program physician may waive these dependency and detoxification requirements for service recipients released from penal institutions (within six months after release), for pregnant service recipients with a verified pregnancy and for previously treated service recipients.

10. If a prospective service recipient is under 18 years of age, verification of two documented unsuccessful attempts at detoxification within a twelve month period. Additionally, no person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian or responsible adult designated by the SOTA consents in writing to such treatment.

...

Tennessee Rules and Regulations (2014)

0940. Department of Mental Health and Developmental Disabilities

0940-05. Office of Licensure

Chapter 0940-05-42. Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities

0940-05-42-.15 MEDICATION MANAGEMENT.

...

(c) Take-home doses of methadone or buprenorphine shall be handled in accordance with applicable rules of the Substance Abuse and Mental Health Administration or other applicable federal agency.

1. All requests for take-home exceptions shall be reviewed and approved by the SOTA and any other applicable federal agency.

2. The Facility shall check the PMP database prior to requesting any take-home or dosing exceptions and shall submit this report to the SOTA with the exception request.

3. The Facility shall provide counseling prior to providing take-home doses to any service recipient. Progress notes in the service recipient's record shall document the counseling provided.

4. The Facility shall document in the service recipient's record the basis for approving "take-home" medication for the service recipient. The following criteria shall be considered in determining the service recipient's eligibility for "take-home" medications.

(i) Cessation of illicit drug use;

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- (ii) Regularity of program attendance;
- (iii) Length of time and level of treatment in medication therapy (ability to responsibly self-medicate);
- (iv) Absence of known recent criminal activity (especially drug dealing);
- (v) Absence of serious behavioral problems;
- (vi) Absence of abuse of drugs including excessive use of alcohol;
- (vii) Other special needs of the service recipient, such as split dosing, physical health needs, pain treatment, etc.;
- (viii) Capacity to safely store “take-home” medication within the service recipient's home;
- (ix) Stability of the home environment and social relationships;
- (x) Service recipient's work, school, or other daily-life activity schedule; and
- (xi) Hardship experienced by the service recipient in traveling to and from the Facility.

...

(h) The Facility shall check the PMP database upon admission of the service recipient, at least every six months to determine if controlled substances other than methadone are being prescribed for the service recipient, and thereafter as clinically indicated. The service recipient's record shall include documentation of the check of the PMP database and the date upon which it occurred.

...

Tennessee Rules and Regulations (2014)
0940. Department of Mental Health and Developmental Disabilities
0940-05. Office of Licensure
Chapter 0940-05-42. Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities

0940-05-42-.17 DRUG SCREENS.

...

(17) The Facility shall access the PMP:

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- (a) Upon admission of a service recipient;**
- (b) Before the initial administration of methadone or other treatment in an opioid treatment program;**
- (c) After any positive drug test for prescription medication;**
- (d) Every six months to determine if controlled substances other than methadone are being prescribed for the service recipient. The service recipient's record shall include documentation of the check of the PMP database and the date upon which it occurred; and**
- (e) Each PMP access shall confirm that the service recipient is not seeking prescription medication from multiple sources.**

...

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Vermont

18 § 4289

18 § 4290

ADC 12-5-102:2

Sec. 13 (S.B. 295)

West's Vermont Statutes Annotated (2014)

Title Eighteen. Health

Part 5. Foods and Drugs

Chapter 84A. Vermont Prescription Monitoring System

§ 4289. Standards and guidelines for health care providers and dispensers

(a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of chronic pain and for other medical conditions to be determined by the licensing authority. The standards developed by the licensing authorities shall be consistent with rules adopted by the Department of Health.

(b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS by November 15, 2013.

(2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the Commissioner of Health shall notify the applicable licensing authority and the provider by mail of the provider's registration requirement pursuant to subdivision (1) of this subsection.

(3) The Commissioner of Health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection.

(c) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS.

(d) Health care providers shall query the VPMS with respect to an individual patient in the following circumstances:

(1) at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance;

(2) when starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more;

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(3) the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and

(4) prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title.

(e) The Commissioner of Health shall, after consultation with the Unified Pain Management System Advisory Council, adopt rules necessary to effect the purposes of this section. The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS when a patient requests renewal of a prescription for an opioid Schedule II, III, or IV controlled substance written to treat acute pain.

(f) Each professional licensing authority for dispensers shall adopt standards, consistent with rules adopted by the Department of Health under this section, regarding the frequency and circumstances under which its respective licensees shall:

(1) query the VPMS; and

(2) report to the VPMS, which shall be no less than once every seven days.

(g) Each professional licensing authority for health care providers and dispensers shall consider the statutory requirements, rules, and standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care.

West's Vermont Statutes Annotated (2014)
Title Eighteen. Health
Part 5. Foods and Drugs
Chapter 84A. Vermont Prescription Monitoring System

§ 4290. Replacement prescriptions and medications

(a) As used in this section, “replacement prescription” means an unscheduled prescription request in the event that the document on which a patient's prescription was written or the patient's prescribed medication is reported to the prescriber as having been lost or stolen.

(b) When a patient or a patient's parent or guardian requests a replacement prescription for a Schedule II, III, or IV controlled substance, the patient's health care provider shall query the VPMS prior to writing the replacement prescription to determine whether the patient may be receiving more than a therapeutic dosage of the controlled substance.

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(c) When a health care provider writes a replacement prescription pursuant to this section, the provider shall clearly indicate as much by writing the word “REPLACEMENT” on the face of the prescription. The health care provider shall document the writing of the replacement prescription in the patient's medical record.

West's Vermont Administrative Code (2014)
Title 12. Agency of Human Services
Subtitle 5. Department of Health
Division of Alcohol and Drug Abuse Programs
Rule 102. Medication Assisted Therapy for Opioid Dependence Rules

12-5-102:2. OPIOID TREATMENT APPROVAL RULES

...

8. Avoiding Multiple Program Enrollments

Reasonable measures will be taken to prevent patients from enrolling in treatment provided by more than one clinic or individual practitioner. Use of the Vermont Prescription Monitoring System (VPMS) is required.

...

Sec. 13. VPMS Query; Rulemaking

The Secretary of Human Services shall adopt rules requiring:

(1) All Medicaid participating providers, whether licensed in or outside Vermont, who prescribe buprenorphine or a drug containing buprenorphine to a Vermont Medicaid beneficiary to query the Vermont Prescription Monitoring System the first time they prescribe buprenorphine or a drug containing buprenorphine for the patient and at regular intervals thereafter. Regular intervals shall exceed the requirements for other Schedule III pharmaceuticals, and queries shall be done prior to prescribing a replacement prescription. The rules shall also include dosage thresholds, which may be exceeded only with prior approval from the Chief Medical Officer of the Department of Vermont Health Access or designee.

(2) All providers licensed in Vermont who prescribe buprenorphine or a drug containing buprenorphine to a Vermont patient who is not a Medicaid beneficiary to query the Vermont Prescription Monitoring System for the first time they prescribe buprenorphine or a drug containing buprenorphine for the patient and at regular intervals thereafter. Regular intervals shall exceed the requirements for other Schedule III pharmaceuticals,

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and queries shall be done prior to prescribing a replacement prescription. The rules shall also include dosage thresholds.

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Virginia

§ 54.1-2522.1 (eff. July 1, 2015)

West's Annotated Code of Virginia (2014)

Title 54.1. Professions and Occupations

Subtitle III. Professions and Occupations Regulated by Boards Within the Department of Health Professions

Chapter 25.2. Prescription Monitoring Program

§ 54.1-2522.1. Requirements of Prescribers.

<Text of section effective July 1, 2015>

A. Any prescriber who is licensed in the Commonwealth to treat human patients and is authorized pursuant to §§ 54.1-3303 and 54.1-3408 to issue a prescription for a covered substance shall be registered with the Prescription Monitoring Program by the Department of Health Professions upon filing an application for licensure or renewal of licensure, if the prescriber is not already registered.

B. Prescribers registered with the Prescription Monitoring Program shall, at the time of initiating a new course of treatment to a human patient that includes the prescribing of benzodiazepine or an opiate anticipated to last more than 90 consecutive days and for which a treatment agreement is entered into, request information from the Director for the purpose of determining what, if any, other covered substances are currently prescribed to the patient. In addition, any prescriber who holds a special identification number from the Drug Enforcement Administration authorizing the prescribing of controlled substances approved for use in opioid addiction therapy shall, prior to or as a part of execution of a treatment agreement with the patient, request information from the Director for the purpose of determining what, if any, other covered substances the patient is currently being prescribed. Nothing in this section shall prohibit prescribers from making additional periodic requests for information from the Director as may be required by routine prescribing practices.

C. The Secretary of Health and Human Resources may identify and publish a list of benzodiazepines or opiates that have a low potential for abuse by human patients. Prescribers who prescribe such identified benzodiazepines or opiates shall not be required to meet the provisions of subsection B. In addition, a prescriber shall not be required to meet the provisions of subsection B if the course of treatment arises from pain management relating to dialysis or cancer treatments.

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Washington

ADC 296-20-03035

ADC 296-20-03056

ADC 388-877B-0440

Washington Administrative Code (2014)

Title 296A. (Ch. 1-59) Labor and Industries, Department of

Chapter 296-20. Medical Aid Rules

Opioids for Noncancer Pain

296-20-03035. Checking the prescription monitoring program data base.

Checking the prescription monitoring program is recommended before prescribing opioids for new injuries. **Providers must check the prescription monitoring program data base, if available, and document before prescribing opioids in the subacute phase and repeat during chronic opioid therapy at intervals according to the worker's risk category as described in the agency medical directors' group's guideline.**

Any provider performing a preoperative evaluation for elective surgery in workers on chronic opioid therapy should also check the prescription monitoring program data base and document as part of a treatment plan for post-surgical pain management.

Washington Administrative Code (2014)

Title 296A. (Ch. 1-59) Labor and Industries, Department of

Chapter 296-20. Medical Aid Rules

Opioids for Noncancer Pain

296-20-03056. Opioid authorization requirement for the subacute phase (6-12 weeks).

Before the department or self-insurer authorizes payment for opioids beyond the acute phase, the provider must perform and document the following:

- Verify that the worker had clinically meaningful improvement in function and pain with the use of opioids in the acute phase.
- If indicated, use a validated instrument to screen the worker for comorbid psychiatric conditions (e.g., depression, anxiety, or post traumatic stress disorder) which may impact the response to opioid treatment.
- Verify that the worker has no contraindication to the use of opioids.

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- **Access the state's prescription monitoring program data base, if available, to ensure that the controlled substance history is consistent with the prescribing record and the worker's report.**

- Use a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of opioid use disorder.

- Administer a baseline urine drug test to verify the absence of cocaine, amphetamines, alcohol, and nonprescribed opioids.

- Verify that the worker has no evidence of or is not at high risk for serious adverse outcomes from opioid use.

Washington Administrative Code (2014)

Title 388. Social and Health Services, Department of

Chapter 388-877B. Chemical Dependency Services

Section Four-Chemical Dependency-Opiate Substitution Treatment Services

388-877B-0440. Chemical dependency opiate substitution treatment services-Program physician responsibility.

An agency providing chemical dependency opiate substitution treatment services must ensure the program physician, or the medical practitioner under supervision of the program physician, performs and meets the following:

...

(3) A review must be completed by the department of health prescription drug monitoring program data on the individual:

(a) At admission;

(b) Annually after the date of admission; and

(c) Subsequent to any incidents of concern.

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West Virginia

§ 16-5H-4

§ 60A-9-5a

ADC 5-10-1

ADC 5-10-3

ADC 11-10-1

ADC 11-10-3

ADC 19-14-1

ADC 19-14-3

ADC 24-7-1

ADC 24-7-3

ADC 69-7-27

ADC 69-7-42

West's Annotated Code of West Virginia (2014)

Chapter 16. Public Health

Article 5H. Chronic Pain Clinic Licensing Act

§ 16-5H-4. Operational requirements

(a) Any person, partnership, association or corporation that desires to operate a pain management clinic in this state must submit to the director documentation that the facility meets all of the following requirements:

...

(7) A person may not dispense any medication, including a controlled substance, as defined by section one hundred one, article one, chapter sixty-a of this code, on the premises of a licensed pain management clinic unless he or she is a physician or pharmacist licensed in this state. **Prior to dispensing or prescribing controlled substances, as defined by section one hundred one, article one, chapter sixty-a of this code, at a pain management clinic, the treating physician must access the Controlled Substances Monitoring Program database maintained by the Board of Pharmacy to ensure the patient is not seeking controlled substances from multiple sources. If the patient receives ongoing treatment, the physician shall also review the Controlled Substances Monitoring Program database at each patient examination or at least every ninety days. The results obtained from the Controlled Substances Monitoring Program database shall be maintained with the patient's medical records.**

...

West's Annotated Code of West Virginia (2014)
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 (2014)
Title 5. West Virginia Board of Dental Examiners
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 5-10-1. General.

1.1. Scope. -- W. Va. Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving 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 licensed by the Board of Dental Examiners 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,

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nonmalignant pain but who are not suffering from a terminal illness, and that the information obtained shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W. Va. Code § 60A-9-5a.

West Virginia Code of State Rules (2014)

Title 5. West Virginia Board of Dental Examiners

Legislative Rule (Ser. 10)

Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 5-10-3. General Rules for Practitioners for Patients Not Suffering from a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner, or the practitioner's authorized agent, is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the 12 month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the access and any controlled substances reported to the CSMP within the 12 month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain, the CSMP shall be accessed by the current practitioner, or the practitioner's authorized agent, at least annually to determine whether the patient has obtained any controlled substances reported to the CSMP from any source other than the current practitioner within the 12 month period immediately preceding the access. The access and any controlled substances from any other source other than the current practitioner reported to the CSMP within such 12 month immediately preceding the access shall be then promptly documented in the

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patient's medical record, with rationale for continuing provision of the pain-relieving substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, or the practitioner's authorized agent, however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.6. Accessing the CSMP must occur prior to the provision of the controlled substance Provided, that if there is an equipment failure, electricity outage or other disaster or prevent that renders review of the CSMP impossible prior to provision of the required controlled substances and it is determined by the practitioner that providing a controlled substance is medically necessary, this determination of medical necessity shall be documented in the medical record and the controlled substance may be provided in a limited amount. The circumstances preventing the access to the CSMP prior to provision of the controlled substance shall be documented in the patient's medical record, and immediately upon having access restored the CSMP report shall be accessed, documented as described in this rule and the practitioner shall adjust patient care as needed, Provided further, that if a practitioner is unable to access the CSMP due to the unavailability of commercially affordable broadband coverage in a practitioner's area and it is determined by the practitioner that providing a controlled substances is medically necessary, this determination shall be documented in the medical record and the controlled substance may be provided in a limited amount. The practitioner shall access the CSMP through alternate means and document the treatment rendered and the practitioner shall adjust patient care as needed.

West Virginia Code of State Rules (2014)
Title 11. West Virginia Board of Medicine
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 11-10-1.General.

1.1.Scope.--W. Va. Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving 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

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Enforcement Administration registration identification number and licensed by the Board of Medicine 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, and that the inquiry and information obtained from such accessing shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W.Va. Code § 60A-9-5a.

West Virginia Code of State Rules (2014)
Title 11. West Virginia Board of Medicine
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 11-10-3. General Rules for Practitioners for Patients Not Suffering from a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the twelve (12) month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the date of access and any controlled substances reported to the CSMP within the twelve (12) month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record by the current practitioner, with rationale for provision of the pain-relieving controlled substance by the current practitioner.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain, the CSMP shall be accessed by the current practitioner at least annually to determine whether the patient has obtained any controlled substances reported to the CSMP from any source other than the current practitioner within the twelve (12) month period immediately

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preceding the date of access. The date of access and any controlled substances from any other source other than the current practitioner reported to the CSMP within such twelve (12) month period immediately preceding the date of access shall be then promptly documented in the patient's medical record by the current practitioner, with rationale for continuing provision of the pain-relieving substance by the current practitioner.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient's medical record by the current practitioner, with the date of access and rationale for provision of the pain-relieving controlled substance by the current practitioner.

West Virginia Code of State Rules (2014)

Title 19. West Virginia Board of Examiners for Registered Professional Nurses

Legislative Rule (Ser. 14)

Series 14. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 19-14-1. General.

1.1. Scope. -- W. Va. Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving 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 licensed 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, and that the information obtained shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W. Va. Code § 60A-9-5a.

West Virginia Code of State Rules (2014)

Title 19. West Virginia Board of Examiners for Registered Professional Nurses

Legislative Rule (Ser. 14)

Series 14. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 19-14-3. General Rules for Practitioners for Patients Not Suffering From a Terminal Illness.

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3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner, or the practitioner's authorized agent, is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the 12 month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the access and any controlled substances reported to the CSMP within the 12 month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner with a paper or electronic copy of the CSMP accessed report maintained in the patient medical record.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain, the CSMP shall be accessed by the current practitioner, or the practitioner's authorized agent, at least annually to determine whether the patient has obtained any controlled substances reported to the CSMP from any source other than the current practitioner within the 12 month period immediately preceding the access. The access and any controlled substances from any other source other than the current practitioner reported to the CSMP -within such 12 months immediately preceding the access shall be then promptly documented in the patient's medical record, with rationale for continuing provision of the pain-relieving substance by the current practitioner, with a paper or electronic copy of the CSMP accessed report maintained in the patient medical record.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, or the practitioner's authorized agent; however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a paper or electronic copy of the CSMP accessed report maintained in the patient medical record.

3.6. Accessing the CSMP must occur prior to the provision of the controlled substance Provided, that if there is an equipment failure, electricity outage or other disaster or event

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that renders review of the CSMP impossible prior to provision of the required controlled substances and it is determined by the practitioner that providing a controlled substance is medically necessary, this determination of medical necessity shall be documented in the medical record and the controlled substance may be provided in a limited amount. The circumstances preventing the access to the CSMP prior to provision of the controlled substance shall be documented in the patient's medical record, and immediately upon having access restored the CSMP report shall be accessed, documented as described in this rule and the practitioner shall adjust patient care as needed.

West Virginia Code of State Rules (2014)

Title 24. West Virginia Board of Osteopathic Medicine

Legislative Rule (Ser. 7)

Series 7. Practitioner Requirements for Controlled Substances Licensure and Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 24-7-1. General.

1.1. Scope. -- West Virginia Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving 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 licensed by the Board of Osteopathic Medicine 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, and that the information obtained shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W. Va. Code § 60A-9-5a. West Virginia Code § 60A-3-301 requires each department, board or agency which licenses or registers practitioners authorized to dispense controlled substances to promulgate rules relating to the registration and control of the dispensing of controlled substances within the state.

West Virginia Code of State Rules (2014)

Title 24. West Virginia Board of Osteopathic Medicine

Legislative Rule (Ser. 7)

Series 7. Practitioner Requirements for Controlled Substances Licensure and Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 24-7-3. General Rules for Practitioners for Patients Not Suffering from a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be

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suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the twelve-month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the access and any controlled substances reported to the CSMP within the twelve-month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic nonmalignant pain, the CSMP shall be accessed by the current practitioner at least annually to determine whether the patient has obtained any controlled substances reported to the CSMP from any source other than the current practitioner within the twelve-month period immediately preceding the access. The access and any controlled substances from any other source other than the current practitioner, reported to the CSMP within such twelve-month period immediately preceding the access shall be then promptly documented in the patient's medical record, with rationale for continuing provision of the pain-relieving substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

West Virginia Code of State Rules (2014)
Title 69. Department of Health and Human Resources
Legislative Rule (Ser. 7)
Series 7. Regulation of Opioid Treatment Programs

§ 69-7-27. Pre-Admission Assessment; Admission Criteria.

27.1. Each opioid treatment program shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment only after assessment by qualified personnel who have determined that the person meets the qualifications for admission.

27.2. Any person seeking admittance to the opioid treatment program shall undergo a pre-admission initial assessment in order to determine whether the person meets the criteria for admission to an opioid treatment program. The initial assessment, consisting of a physical examination and an intake screening, shall be conducted by the medical director, an approved program physician or a supervised physician extender. The initial assessment shall focus on the individual's eligibility and need for treatment and shall provide indicators for initial dosage level, if required and if admission is determined appropriate. The determination of admission eligibility shall be made using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental disorders (DSM-IV).

27.3. The initial physical examination shall include documentation of:

27.3.a. A brief physical examination;

27.3.b. The patient's immediately relevant health history (e.g., determination of chronic or acute medical conditions such as diabetes, renal disease, hepatitis, sickle cell anemia, tuberculosis, HIV exposure, sexually transmitted disease, chronic cardiopulmonary disease and pregnancy);

27.3.c. A determination of currently prescribed medications;

27.3.d. An evaluation of other substances of abuse;

27.3.e. Determination of current opioid dependence;

27.3.f. Determination of length of addiction;

27.3.g. A toxicology screen to determine immediate use of opiates;

27.3.h. An initial drug test and full toxicology screen to identify whether the patient is using other drugs, including opiates, methadone, amphetamines, cocaine, barbiturates, benzodiazepines, marijuana, or other drugs or substances as determined by community standards, regional variation or clinical indication (e.g., carisopodol); to determine whether the individual is opioid addicted; and to determine whether the patient is presently receiving methadone for an opioid addiction from another opioid treatment program;

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27.3.i. An inquiry to and report from the Controlled Substances Monitoring Program; and.

27.3.j. An inquiry whether the patient is enrolled in any other opioid treatment program.

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West Virginia Code of State Rules (2014)
Title 69. Department of Health and Human Resources
Legislative Rule (Ser. 7)
Series 7. Regulation of Opioid Treatment Programs

§ 69-7-42. Controlled Substances Monitoring Program Database.

42.1. Each opioid treatment program shall comply with policies and procedures developed by the designated state oversight agency and the West Virginia Board of Pharmacy to allow physicians treating patients through an opioid treatment program access to the Controlled Substances Monitoring Program database maintained by the West Virginia Board of Pharmacy.

42.2. Program physicians shall access the database:

42.2.a. At the patient's intake;

42.2.b. Before the administration of methadone or other treatment in an opioid treatment program;

42.2.c. After the initial thirty days of treatment;

42.2.d. Prior to any take-home medication being granted;

42.2.e. After any positive drug test; and

4.2.f. At each ninety-day treatment review.

42.3. The physician shall access the Controlled Substances Monitoring Program database in order to ensure that the patient is not seeking prescription medication from multiple sources. The results obtained from the database shall be maintained with the patient records.

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