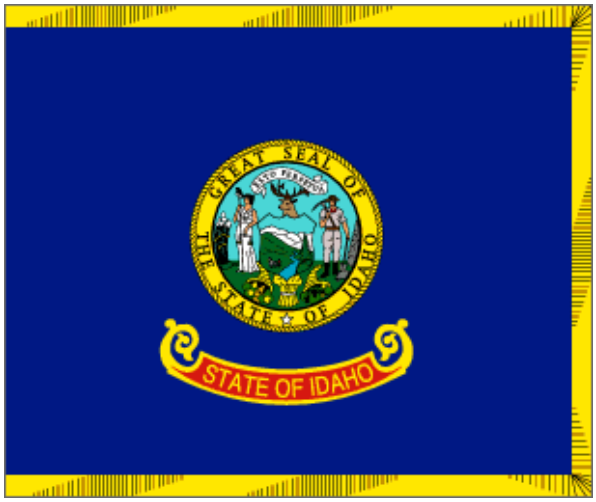
Prescribing and Dispensing Profile

Idaho



Research current through November 2015.

This project was supported by Grant No. G1599ONDCP03A, 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.

NAMSDL
National Alliance for Model State Drug Laws

Schedule II Prescribing Limitations (not related to pain clinics)

Schedule II prescriptions may only be dispensed on the written prescription of a practitioner

- May be dispensed on the oral prescription of a practitioner in an emergency
  - Emergency situation is one in which the prescriber determines that the administration of the controlled substance is necessary for proper treatment of the patient, that no appropriate alternative is available, including administration of a drug that is not a Schedule II substance, and that is it not reasonably possible for the prescriber to provide a written prescription
  - Quantity dispensed must be limited to the amount adequate to treat the patient for the duration of the emergency
  - Must be promptly reduced to writing
  - Written prescription must be provided to the pharmacist within 7 days
- May be dispensed on the faxed prescription of a practitioner in the following circumstances:
  - For direct administration to patients by certain methods
  - For the resident of a long term care facility or hospice patient

A physician may issue and pharmacy may fill multiple prescription drug orders, written on the same day, that allow the patient to receive up to a 90-day supply of a Schedule II substance

- Prescriber must provide written instructions on each order indicating the earliest date on which the pharmacy can fill each prescription

Schedule II prescriptions shall not be filled or dispensed more than 90 days after the date of issue

Schedule II prescriptions must be maintained separately from other prescription records

Schedule II prescriptions may not be refilled

Schedule III, IV and V Prescribing Limitations (not related to pain clinics)

Schedule III and IV prescriptions may only be dispensed on the written or oral prescription of a practitioner

Schedule V substances shall not be distributed or dispensed for other than a medical purpose

Schedule III – V prescriptions must be maintained in a separate file or in a form that is readily retrievable

Schedule III – V prescriptions shall not be filled or refilled more than six months after originally written or refilled more than five times unless renewed by the practitioner

Miscellaneous Prescribing/Dispensing Requirements

A pharmacist may refill a prescription for a patient when the prescriber is not available for authorization if:

- In the professional judgment of the pharmacist, a situation exists that threatens the health or safety of the patient
- Only sufficient medication should be provided, consistent with dosage instructions, to maintain the prescribed treatment until, at the earliest possible opportunity, the issuing or alternative prescriber is contacted for further renewal instructions

Prescription drug orders must include at least the following:

- Name and address of patient
- Date issued
- Drug name, strength, quantity, and dosage form
- Directions for use
- Name, address, and DEA registration number of prescriber
- Prescriber's signature

Prescribing/Dispensing Limitations for Dentists

No separate statutes or regulations related to prescribing and dispensing limitations for dentists.

Prescribing/Dispensing Limitations for Optometrists

Optometrists may be granted a certification to prescribe, administer, and dispense therapeutic pharmaceutical agents if:

- S/he has successfully passed the "treatment and management of ocular disease" section of the optometrist examination or an equivalent
- Is the holder of a certificate for the use of diagnostic pharmaceutical agents
- Has completed such appropriate additional educational and clinical experience requirements as shall be established by the state

Pain Clinic/Pain Management Regulations

No specific statutes or regulations identified.

Training or Education Requirements or Recommendations for Practitioners who Prescribe or Dispense Controlled Substances

Optometrists who are certified to prescribe, administer, or dispense therapeutic pharmaceutical agents must attend 12 hours of continuing education every year in courses involving ocular pharmacology and/or advanced ocular disease

Medical Marijuana or Controlled Substances Therapeutic Research Program Provisions

No specific statutes or regulations identified.

PMP Requirements for Mandatory Registration and Access

All prescribers, except veterinarians, shall register with the prescription monitoring program

Patient Referral to Treatment

No specific statutes or regulations identified.

Board Guidelines

Idaho Board of Medicine Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain

Policy is intended to encourage physicians to be knowledgeable about the best clinical practices regarding the prescribing of opioids and be aware of associated risks

- Inappropriate treatment of pain includes:
  - Non-treatment
  - Inadequate treatment
  - Overtreatment
  - Continued use of ineffective treatments

Responsibility for appropriate pain management

- Physicians should be knowledgeable about assessing patients' pain and function and familiar with methods of managing pain
- Physicians should understand and comply with federal and state requirements for prescribing opioids
  - When federal law differs from state law, the more stringent rule is the one that should be followed
- Board will consider opioids for pain management to be for a legitimate medical purpose if it is based on sound clinical judgment and current best clinical practices, is appropriately documented, and is of demonstrable benefit to the patient
  - To be within the usual course of professional practice:
    - A legitimate physician-patient relationship must exist
    - Prescribing or administration of medications should be appropriate to the identified diagnosis, should be accompanied by careful follow up monitoring of the patient's response to treatment as well as his or her safe use of prescribed medications, and should demonstrate that the therapy has been adjusted as needed, as well as documentation of appropriate referrals as needed

Board Guidelines, cont'd.

Guidelines

- Physicians must understand the relevant pharmacologic and clinical issues in the use of analgesics for the treatment of pain, and carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient
- The medical record should document the presence of one or more recognized medical indications for prescribing an opioid analgesic and reflect an appropriately detailed patient evaluation
  - Evaluation should be completed prior to deciding to prescribe an opioid analgesic
  - Nature and extent of the evaluation depends upon the type of pain and the context in which it occurs
    - Assessment of pain typically includes nature and intensity of the pain, past and current treatments, underlying or coexisting disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning
  - Initial work-up should include a systems review and relevant physical examination as well as laboratory investigations as indicated
  - Social and vocational assessments can be useful
  - Assessment of patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse should also be part of the initial evaluation
  - All patients should be screened for depression or other mental disorders
  - Treatment of a patient with a history of substance use disorder should include consultation with an addiction specialist, if possible, before opioid therapy is initiated
    - Patients with an active addiction should not be initiated on opioid therapy until they are in an established treatment/recovery program or alternatives are established, such as co-management with an addiction professional
  - Physicians are encouraged to be knowledgeable about the treatment of addiction
  - If possible, patient evaluation should include information from family members and/or significant others
    - Where available, the state PMP should be consulted to determine whether a patient is receiving prescriptions from any other physicians and the results from the PMP should be documented in the record
- Treatment goals include:
  - Reasonably attainable improvement in pain and function
  - Improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety
  - Avoidance of unnecessary or excessive use of medications
- Treatment plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered

Board Guidelines, cont'd.

- Physician should discuss the risks and benefits of the treatment plan with the patient
  - Use of a written informed consent and treatment agreement is recommended
    - Informed consent documents typically address:
      - Potential risks and anticipated benefits of chronic opioid therapy
      - Potential side effects
      - Likelihood that tolerance to and physical dependence on the medication will develop
      - Risk of drug interactions, over-sedation, impaired motor skills, and opioid misuse, dependence, addiction, and overdose
      - The limited evidence as to the benefit of long-term opioid therapy
      - Physician's prescribing profiles and expectations, including the number and frequency of refills, as well as the physician's policy on early refills and replacement of lost or stolen medications
      - Specific reasons for which drug therapy may be discontinued or changed
    - Treatment agreements typically outline the joint responsibilities of the physician and patient and typically discuss:
      - The goals of treatment, in terms of pain management, restoration of function, and safety
      - Patient's responsibility for safe medication use
      - Patient's responsibility to obtain prescriptions from one physician or practice
      - Patient's agreement to periodic drug testing
      - Physician's responsibility to be available or to have a covering physician available to care for unforeseen problems and to prescribe scheduled refills
- Generally, safer alternatives should be considered before initiating opioid therapy
  - Opioid therapy should be presented as a trial or test for a definite period of time with specified evaluation points
- Physician should monitor patient's progress regularly, including any new information about the etiology of the pain or the patient's overall health and level of function
  - At each visit, the results of drug therapy should be monitored by assessing the 5 A's, which involve:
    - A determination of whether the patient has experienced a reduction in pain (Analgesia)
    - Has demonstrated improvement in level of function (Activity)
    - Whether there are significant Adverse effects
    - Whether there is evidence of Aberrant substance-related behaviors
    - Mood of the individual (Affect)
  - Continuation, modification, or termination of drug therapy should be contingent on the physician's evaluation of:
    - Evidence of the patient's progress toward treatment objectives
    - Absence of substantial risks or adverse events
- Periodic drug tests should be performed
  - Test results that suggest opioid misuse should be discussed with the patient
  - Evidence of misuse of prescribed opioids demands prompt intervention by the physician. Patient behaviors that require such intervention include:
    - Recurrent requests for refills
    - Multiple reports of lost or stolen prescriptions
    - Obtaining controlled substances from multiple sources without the physician's knowledge
    - Intoxication or impairment
    - Pressuring or threatening behaviors

Board Guidelines, cont'd.

- Treating physician should seek a consultation with or refer a patient to a pain, psychiatry, addiction, or mental health specialist as needed
- Physician and patient should discuss discontinuation or modification of drug therapy at regular intervals
- Physicians should keep accurate and complete medical records that include:
  - Copies of the signed informed consent and treatment agreement
  - Patient's medical history
  - Results of physical examination and all laboratory tests
  - Results of risk assessment, including the results of any screening instruments used
  - Description of treatments provided
  - Instructions to patient, including discussion of risks and benefits
  - Results of ongoing monitoring of patient progress
  - Notes on evaluations by and consultations with specialists
  - Any other information used to support the initiation, continuation, revision, or termination of treatment and steps taken in response to any aberrant medication use behaviors
  - Authorization for release of information to other treatment providers