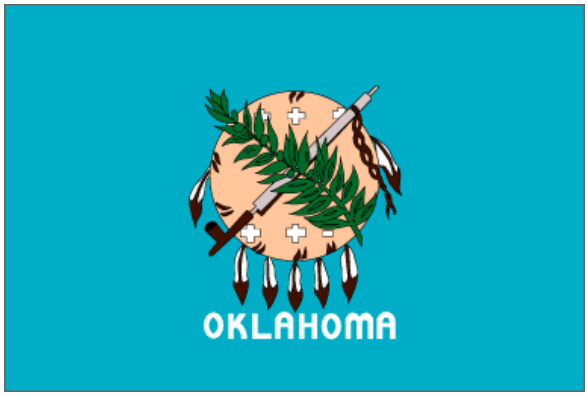
Prescribing and Dispensing Profile

Oklahoma



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 substances may only be dispensed on the written prescription of a practitioner

- May be dispensed on the oral prescription of a practitioner in an emergency situation
  - Must be promptly reduced to writing
  - The quantity prescribed and dispensed must be limited to an amount adequate to treat the patient during the emergency period
  - If the prescriber is not known to the pharmacist, the pharmacist must make a reasonable effort to determine that oral authorization came from a registered practitioner using his/her phone number as listed in the telephone directory and/or other good faith effort to ensure his/her identity
  - In an emergency situation, reasonable effort must be made to determine the identity of the person picking up the prescription if that person is not known to the pharmacist
  - The prescriber shall cause a written prescription to be delivered to the pharmacy within 72 hours
- May be dispensed on the faxed prescription of a practitioner in the following circumstances:
  - For home infusion pharmacies
  - Patients in long term care facilities

A written prescription for a Schedule II substance becomes invalid 30 days after the date of issuance

Schedule II prescriptions shall be maintained a separate file from other prescriptions

Schedule II prescriptions may not be refilled

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

Schedule III and IV substances may only be dispensed on the written, faxed, electronic, or oral prescription of a practitioner

- Oral prescriptions shall be promptly reduced to writing

Schedule III and IV prescriptions may not be filled or refilled more than six months after originally issued or refilled more than five times unless renewed by the practitioner

- A written or oral prescription for any product containing hydrocodone with another active ingredient shall not be refilled

Schedule V substances may not be distributed or dispensed other than for a legitimate medical or scientific purpose

Schedule III – V prescriptions shall be kept in a separate file from other prescriptions

Schedule V prescriptions may be refilled the number of times expressly authorized by the prescriber

Schedule V prescriptions may not be refilled more than six months after the date of issuance

Miscellaneous Prescribing/Dispensing Requirements

Practitioner may dispense a controlled dangerous substance listed in Schedule II in the course of his or her professional practice without a prescription

A physician may dispense controlled dangerous substances if s/he registers annually with the appropriate licensing board as a dispenser

- Physician is exempt from that requirement if:
  - The prescriber furnishes professional samples in the original packaging
  - No charge is made to the patient
  - An appropriate record is entered in the patient's chart

It is unprofessional conduct for a physician to prescribe a drug or treatment without sufficient examination and establishment of a valid physician-patient relationship

- A physician-patient relationship includes a medically appropriate, timely-scheduled, face-to-face encounter with the patient except as follows:
  - Providers covering the practice of another provider may approve refills of previously ordered medications if they have access to the medical file of the patient
  - Hospice medical directors may initiate prescriptions based on requests from licensed health care providers and information from hospice records
  - Providers ordering appropriate medications for persons with laboratory-proven sexually transmitted diseases and persons who have been in contact with certain infectious diseases
  - Licensed healthcare providers providing medical immunizations, which may be implemented by standing orders and/or policies
  - Licensed providers ordering opioid antagonists

Prescriptions shall contain the following information:

- Date of issuance
- Full name and address of patient
- Name, dosage, strength, and quantity of controlled substance
- Directions for use
- Signature of prescriber
- Number of refills

Prescribing/Dispensing Limitations for Dentists

Dentists may prescribe controlled dangerous substances if s/he has complied with the registration requirements and registers annually with the appropriate licensing board as a dispenser

Prescribing/Dispensing Limitations for Optometrists

Optometrists may prescribe dangerous drugs and controlled substances except those included in Schedules I and II

- Must annually register with the appropriate licensing board as a dispenser
- May prescribe hydrocodone or hydrocodone-containing drugs regardless of schedule for a period not to exceed a five day supply and the issuance of refills for such substances following a sufficient physical exam of the patient

Pain Clinic/Pain Management Regulations

Controlled dangerous substances have useful and legitimate medical and scientific purposes and are necessary to maintain the health and general welfare of the people of Oklahoma

- Principles of quality medical practice dictate that the people of Oklahoma have access to appropriate and effective pain relief
  - The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity and costs associated with untreated or inappropriately treated pain
  - Physicians are encouraged to view effective pain management as part of quality medical practice for all patients with pain
- If, in the judgment of the physician, appropriate pain management warrants a high dosage of controlled substances and the benefit of the relief expected outweighs the risk of the high dosage, the physician may administer such a dosage, even if its usage may increase the risk of death, so long as it is not also furnished for the purpose of causing, or the purpose of assisting in causing, death

The board has adopted the following criteria when evaluating a physician's treatment of pain, including the use of controlled substances:

- A medical history and physical examination must be obtained, evaluated, and documented in the medical record
  - Medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse
  - Medical record should also document one or more medical indications for the use of controlled substances
- Written treatment plan that outlines the objectives that will be used to determine treatment success, such as pain relief and improved function, and should indicate whether further diagnostic evaluations or other treatments are planned
  - Physician should adjust drug therapy after treatment begins to meet the individual needs of the patient
  - Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which pain is associated with physical and psychosocial impairment
- Physician should discuss the risks and benefits of the use of controlled substances with the patient
  - Patient should receive prescriptions from one physician and one pharmacy when possible
  - Physicians should consider the use of a written treatment agreement that outlines the responsibilities of the patient, including:
    - Drug screens when requested
    - Number and frequency of all refills
    - Reasons for which drug therapy may be discontinued

Pain Clinic/Pain Management Regulations, cont'd.

- Physician should periodically review the course of treatment and any new information about the etiology of the pain or the patient's state of health
  - Satisfactory response to treatment may be indicated by patient's decreased pain, increased level of function or improved quality of life
  - If patient's progress is unsatisfactory, physician should assess the appropriateness of continued drug therapy
- Physician should be willing to refer the patient, as needed, for additional evaluation and treatment in order to achieve treatment objectives
- Medical records should be accurate and complete and include the following:
  - Medical history and physical exam
  - Diagnostic, therapeutic, and laboratory results
  - Evaluations, consultations, and follow-up evaluations
  - Treatment objectives
  - Discussion of risks and benefits
  - Informed consent
  - Treatments
  - Medications
  - Instructions and agreements
  - Periodic reviews

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

No specific statutes or regulations identified.

Medical Marijuana or Controlled Substances Therapeutic Research Program Provisions

No specific statutes or regulations identified.

PMP Requirements for Mandatory Registration and Access

Prior to prescribing or authorizing for a refill, if 108 days have passed prior to the previous access and check, of opiates, synthetic opiates, semisynthetic opiates, benzodiazepines, or carisoprodol to a patient of record, registrants or members of their medical or administrative staff, shall be required until October 31, 2020 to access the information in the PMP to assess medical necessity and possibility that the patient may be unlawfully obtaining prescription drugs

Each registrant that prescribes, administers, or dispenses methadone shall be required to check the PMP

Patient Referral to Treatment

No specific statutes or regulations identified.

Board Guidelines

Emergency Department and Urgent Care Clinic Opioid Prescribing Guidelines

The following recommendations are based on the expert opinion of numerous physicians and other health care providers and are not intended to replace sound clinical judgment:

- Consider opioid medications only when the severity of the pain is reasonably assumed to warrant their use
- Start with the lowest possible dose
- When prescribing for acute pain, prescribe no more than a short course, except in special circumstances
  - Most patients require opioids for no more than three days with a maximum of 30 pills in most cases
- Providers should query the PMP unless pain is resulting from an objectively diagnosed disease process or injury, when a clinician may opt not to review the PMP
- In patients suspected of opioid addiction, abuse, or diversion, providers should check the PMP and perform SBIRT if indicated
- In patients who routinely take opioids for the treatment of pain, opioids should ideally be provided by one health care provider with rare exception
  - In those circumstances, the provider should check the PMP and provide the patient with only enough pills to last until the patient's primary opioid prescriber's office opens
- Health care providers should not provide replacement prescriptions for lost, destroyed, or stolen controlled substances
- Long acting or controlled release opioids should not be prescribed from the emergency department or urgent care center
- For exacerbations of chronic pain, the provider should attempt to notify the patient's primary opioid prescriber and should only prescribe enough pills to last until the primary opioid prescriber's office opens
  - If the patient's primary opioid prescriber is contacted and approves further opioids, a limited prescription from the ED/UCC may be provided to last until the patient is able to see their primary opioid prescriber
  - Only enough pain medication should be prescribed to last until the patient can contact their primary prescriber, with a maximum of a three day supply of opioids
  - If the primary opioid provider cannot be reached, the PMP should be queried and the provider should confirm that recent opioid prescriptions reported by the PMP match what the patient reports
  - If the PMP reveals opioid prescriptions from multiple providers, the provider should not prescribe an opioid
  - No opioids should be prescribed if the patient misrepresents
- Administration of IV or intramuscular opioids for the relief of exacerbations of pain is discouraged
- Use caution when prescribing opioids to patients currently taking benzodiazepines and/or other opioids
- Provide information regarding risks and benefits and proper storage and disposal
- Providers are encouraged to consider non-pharmacological therapies and/or referral to specialists for follow-up, as clinically appropriate
- The use of opioids is not required when treating patients for pain

Board Guidelines, cont'd.

Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting

Opioid treatment for acute pain

- Should only be used when the severity of the pain warrants that choice after determining that other non-opioid medications or therapies will not provide adequate relief
- Providers should query the PMP prior to prescribing an opioid medication except in circumstances where the pain is resulting from an objectively diagnosed disease process or injury
- The number of doses prescribed should be no more than the number of doses needed based on the usual duration of pain severe enough to require opioids for that condition
- Patients should be counseled to store medications securely and never share with others
- Long duration opioids are rarely indicated for the treatment of acute pain
- Use of opioids should be re-evaluated carefully, including assessing the potential for abuse, if persistent pain suggests the need to continue opioids beyond the anticipated time period of acute pain treatment for that condition
- Providers should query the PMP as part of this process
- Providers generally should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed

Opioid treatment for chronic pain

- Alternatives to opioid treatment should be tried, or previous attempts documented, prior to initiating opioid treatment
- A comprehensive evaluation should be performed
  - For pain patients transferring to a new physician, opioids generally shouldn't be prescribed until the records from the previous physician have been reviewed or the previous provider has been notified of the transfer
- Provider should screen for the risk of abuse or addiction
- Provider should query the PMP prior to initially prescribing opioids
- A written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function
  - One provider should coordinate a patient's comprehensive care plan and provide all opioid prescriptions required
- Patient should be informed of the risks, benefits, and terms for continuation of opioid treatment, ideally using a written and signed treatment agreement
- Opioids should be initiated as a short term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life
- Regular visits for evaluation of progress toward treatment goals should be scheduled during the period when opioid dosing is being adjusted
  - It is recommended that the provider check the PMP more frequently during this period
- Once a stable dose has been established, regular monitoring should be conducted at face-to-face visits during which treatment goals, analgesia, activity, adverse effects, and aberrant behaviors are monitored
  - The PMP should be queried at least once per year

Board Guidelines, cont'd.

- Periodic reviews should be conducted to reassess the need for continued opioid treatment, weaning whenever possible
- Treatment should be discontinued if adverse effects outweigh benefits or if aberrant, dangerous, or illegal behaviors are demonstrated
- Providers should maintain records documenting:
  - Patient evaluation
  - Treatment plan
  - Discussion of risks and benefits
  - Informed consent
  - Treatments prescribed
  - Results of treatment
  - Any aberrant behavior observed
- Providers should consider consultation for patients with complex pain conditions, serious comorbidities and mental illness, a history or evidence of current drug addiction or abuse, or when the provider is not confident of his/her ability to manage the treatment
- Providers should generally not provide replacement prescriptions for lost, stolen, or destroyed prescriptions
- Administration of IV or intramuscular opioids for the relief of exacerbation of chronic pain is discouraged
- Opioids should only be prescribed by providers familiar with their indications, risks, and need for careful monitoring
- Patients should be counseled to store the medications securely and never to share with others