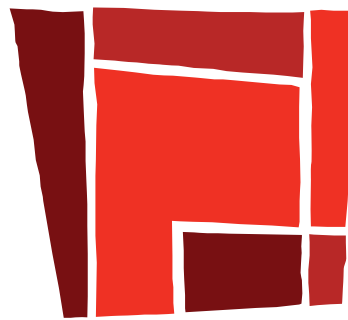


50 State Review on Opioid Related Policy



ARIZONA DEPARTMENT
OF HEALTH SERVICES

azhealth.gov/opioid



ARIZONA DEPARTMENT OF HEALTH SERVICES

August 18, 2017

Dear Fellow Arizonan,

In the United States, the opioid crisis has been firmly established as a national epidemic. Every day across our country lives are being lost and torn apart as a result of the deleterious effects caused by opioid misuse, abuse, overdose, and death.

Calls to action are being declared by individuals, communities, states, and national stakeholders. Collaboration and alignment among stakeholders has resulted in the implementation of numerous policy recommendations, statutory actions, public health interventions, and various other initiatives to address the opioid crisis.

Arizona has joined in this effort by establishing itself as a catalyst for change in developing and implementing a comprehensive public health approach to successfully tackle the complexities present within the opioid epidemic landscape.

Governor Doug Ducey's June 5, 2017 *Declaration of Emergency and Notification of Enhanced Surveillance Advisory* further solidified Arizona's resolve in enhancing and strengthening Arizona's opioid response activities so that we can effectively halt and begin to reverse the impact the opioid epidemic is having in our state.

Very shortly after the Governor's *Declaration*, the Arizona Department of Health Services initiated its Health Emergency Operations Center to establish an agency-wide response to implement Governor Ducey's requirements. One of the requirements was to "*provide a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.*"

The *Arizona 50 State Review on Opioid Related Policy* is intended to assist partners and decision-makers in determining what additional programmatic and policy actions may be necessary as Arizona moves forward with its opioid initiatives.

We hope that the *Arizona 50 State Review on Opioid Related Policy* is a helpful resource and adds value to the conversation on how best to address, and hopefully solve, the opioid crisis in Arizona and the United States.

Sincerely,

A handwritten signature in black ink that reads "Cara M. Christ MD".

Cara M. Christ, MD, MS
Director

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

Methodology

The development of the *Arizona 50 State Review on Opioid Related Policy* was a group effort. A team of Arizona Department of Health Services staff representing the Bureau of Epidemiology and Disease Control, Office of Injury Prevention, and Bureau of Tobacco and Chronic Disease worked collaboratively to produce the document and reference materials.

An exhaustive literature review was conducted to gather relevant and meaningful information to support discussion of each of the sixteen indicators included in the *Arizona 50 State Review on Opioid Related Policy*. Over 3,000 pages of text representing federal and state guidance documents, state task force publications, academic articles, federal, state, and local laws, administrative rules, and stakeholder contributions were reviewed. Information was then categorized by topic to provide a high level picture of what opioid intervention initiatives were taking place across the country.

Each topic was allowed 1-2 pages of text to provide readers with a quick glance of what the current national landscape looks like, what strategies and initiatives may have shown positive impacts on reducing opioid morbidity and mortality, and what strategies and activities Arizona is currently engaged in compared to other states.

Utilization of the Arizona 50 State Review

Due to the volume of documents that were available for review and the timeline in which the *Arizona 50 State Review on Opioid Related Policy* was developed, the authors were only able to provide the reader with a very high-level representation of the vast amount of effort taking place across the country to address the opioid epidemic.

Determining associative or causal relationships between interventions and the impact they are having on improving outcomes falls beyond the scope of this document. Furthermore, the large majority of work being done on a national scale to address this issue has been developed and implemented very recently. As a result, research and subsequent findings investigating the relationship between resources allocated to the crisis and outcomes produced are likely not going to be observed for some time.

However, the *Arizona 50 State Review on Opioid Related Policy* does represent an open door for stakeholders to walk through to explore more broadly and deeply the nuance, complexity, and opportunity there is to work together to create, implement, and sustain impactful policies and interventions to defeat the opioid epidemic we now face.

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SUMMARY OF ARIZONA INDICATORS

MEDICAL PRACTICE INDICATORS	
	Does Arizona Currently Have in Place?
Are there laws in place that target pill mills?	No
Are there laws in place to regulate pain clinics?	No
Are there laws in place supporting informed consent, including pain management agreements?	No
Does the state have any best practices or guidelines in place that encourage the use of non-opioid alternatives for the treatment of chronic pain?	Yes
PRESCRIPTION INDICATORS	
	Does Arizona Currently Have in Place?
Was a state Task Force created in response to the opioid epidemic?	Yes
Has the Task Force developed a list of recommendations to help guide future initiatives related to the state's response to the opioid epidemic?	Yes, See Appendix A
Has the state developed opioid prescribing guidelines?	Yes
Are there laws in place that limit initial opioid prescriptions?	No
Does the state have an operational Prescription Drug Monitoring Program (PDMP)?	Yes
Are there laws in place to require use of state PDMP?	Yes, effective October 16, 2017

PRESCRIPTION INDICATORS (cont.)

Are there laws in place that permit access to the PDMP to assigned delegates?	Yes
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EMERGENCY INDICATORS

	Does Arizona Currently Have in Place?
Are there laws in place to expand Naloxone access?	Yes
Does the state have a Naloxone Good Samaritan Law in place?	No
Has your jurisdiction issued any executive or administrative orders or declarations that provide emergency powers needed for response to the opioid epidemic?	Yes
Has your jurisdiction/agency officially activated its Emergency Operations Center for the Opioid Crisis?	Yes

REPORTING INDICATORS

	Does Arizona Currently Have in Place?
Are there laws in place to require the reporting of drug overdose cases?	No
Are there laws in place that require the reporting of Neonatal Abstinence Syndrome (NAS) cases?	No

PREVENTION, TREATMENT & EDUCATION INDICATORS	
Does the state fund or require substance abuse prevention programs for children and youth?	Does Arizona Currently Have in Place? Yes, but not required
Are there laws in place to support referral to treatment including utilization of SBIRT and MAT?	No
Are there laws in place that require opioid abuse prevention curriculum be developed and incorporated into academic programs for medical, dental, and nursing students?	No
Are there laws in place that require all medical providers to complete continuing education coursework related to opioid prescribing/ chronic pain management?	No

MEDICAL PRACTICE INDICATORS

Pill Mills

3 states, Florida, Texas, and Kentucky have implemented opioid misuse, abuse, and overdose laws, policies, or initiatives labeled “pill mill” laws. Regulations of pill mills are similar to regulations of pain clinics, but these three states have adopted greater regulatory and punitive policies to eliminate pain clinics that operate outside of medical and ethical boundaries.

A pill mill is a “pain management clinic whose providers operate outside the boundaries of standard medical practice by prescribing large quantities of opioids and other controlled substances with minimal medical oversight” (CDC, 2012).

Practices from Other States

In 2011, Florida governor signed into law an anti-pill mill bill (HB 7095), championed by Attorney General Pam Bondi. This bill specifically toughened criminal and administrative penalties targeting doctors and clinics engaged in prescription drug trafficking. The bill also established standards of care for physicians prescribing narcotics, required physicians making narcotic prescriptions to register with the Department of Health, and banned physicians from dispensing the most abused narcotics. Lastly, the bill also strengthened oversight of pharmacies and wholesale distributors and strengthened the effectiveness of the prescription drug database by speeding up the time data must be entered.¹

In 2009, Texas’s pill mill legislation required all pain management clinics to be certified by the state medical board on a biennial basis and to be owned or operated by a licensed physician. Furthermore, clinic owners must be physically present at least one-third of operating hours and must personally review at least one-third of all patient files. Lastly, pain management clinic owners must regularly verify qualifications and licensure of all employees.² Failure to comply with the law may result in revoking physicians’ licensure.

In 2012, Kentucky passed a pill mill law that introduced “restrictions on pain management clinics, strict new limits on prescribing controlled substances, and increased reporting requirements for practitioners using Kentucky’s ‘KASPER’ electronic controlled substances monitoring system.”³ HB 1 also requires each pain management facility to be owned only by licensed physicians and to be operated by a certified pain management specialist (whether the owner or his or her designee).

¹ <http://www.myfloridalegal.com/newsrel.nsf/newsreleases/9AD68A6580FA8DFD852578A400499E5E>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4976392/>

³ <http://www.taftlaw.com/news/publications/detail/941-new-kentucky-pill-mill-bill-places-new-restrictions-on-pain-management-facilities-and-controlled-substances-prescribing>

Impact: How has law, policy, or initiative improved outcomes in other states?

A 2016 article published in *Drug and Alcohol Dependence* presented an observational cohort study of Texans' (1) average morphine equivalent dose (MED) per transaction; (2) aggregate opioid volume; (3) number of opioid prescriptions; and (4) quantity of opioid pills dispensed before versus after the passage of Texas's pill mill legislation. This study found Texas's pill mill law was associated with modest declines (8.1-24.3%) in average MED per transaction, monthly opioid volume, monthly number of opioid prescriptions, and monthly quantity of opioid pills dispensed.⁴

A 2015 *JAMA* study of Florida's Prescription Drug Monitoring Program (PDMP) and pill mill laws (jointly) found they were associated with modest decreases in opioid prescribing and use. Specifically, "Florida's laws were associated with statistically significant declines in opioid volume (2.5 kg/mo, $P < .05$, > equivalent to approximately 500 000 5-mg tablets of hydrocodone bitartrate per month) and morphine milligram equivalent (MME) per transaction (0.45 mg/mo, $P < .05$, > without any change in days' supply. Twelve months after implementation, the policies were associated with approximately a 1.4% decrease in opioid prescriptions, 2.5% decrease in opioid volume, and 5.6% decrease in MME per transaction. Reductions were limited to prescribers and patients with the highest baseline opioid prescribing and use."⁵

Arizona: Current State and Recommendations

To date, Arizona does not have any laws or specific guidance on the regulation of pill mills.

⁴ <https://stacks.cdc.gov/view/cdc/40739/Email>

⁵ <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2429105>

Regulation of Pain Clinics

10 states, Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, Ohio, Tennessee, Texas, and West Virginia have implemented laws that regulate pain management clinics. All ten states require that every pain management clinic/facility have an owner or medical director to oversee its operations, and most states mandate that the owner or medical director meet certain requirements.

5 of these states, Florida, Kentucky, Louisiana, Tennessee, and West Virginia restrict prescribing and dispensing of controlled substances in pain management clinics/facilities.⁶

Practices from Other States⁷

Florida prohibits anyone except physicians from dispensing any medications on the premises of a pain management clinic. “Physicians, physician assistants, and advanced practice nurses are required to perform a physical examination of the patient on the same day that the physician prescribes a controlled substance and, if the physician prescribes more than a 72-hour dose of a controlled substance, the physician must document in the record the reason for prescribing that quantity.” (NAMSDL, 2016).

Kentucky law requires that each physician who will prescribe or dispense controlled substances to patients at a pain management facility shall successfully complete a minimum of ten hours of Category I continuing medical education in pain management during each registration period throughout the employment agreement with the facility.

In Louisiana, clinics must verify the identity of each patient who is seen and treated for chronic pain management and who is prescribed a controlled substance. Prescriptions for controlled substances may have a maximum quantity of a 30-day supply and shall not be refillable. On each visit to a pain clinic which results in a prescription for a controlled substance, the patient shall be personally examined by a pain specialist.

No pain management clinic or practitioner working at a pain management clinic in Tennessee shall be permitted to dispense controlled substances. The clinic or practitioner may provide, without charge, a sample of a Schedule IV or V controlled substance in a quantity limited to an amount that is adequate to treat the patient for a maximum of 72 hours or a sample of a non-narcotic Schedule V substance in a quantity limited to an amount adequate to treat the patient for a maximum of 14 days. If any practitioner

⁶ <http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

⁷ <http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

prescribes controlled substances for the treatment of chronic non-malignant pain, the practitioner must document in the patient's record the reason for prescribing that quantity.

Finally, in West Virginia a person may not dispense any medication, including a controlled substance, on the premises of a pain management clinic unless he or she is a physician or pharmacist licensed in West Virginia. Prior to dispensing, the physician must check the prescription monitoring program and at every patient examination thereafter or a minimum of every 90 days. Clinics may not dispense to any patient more than a 72-hour supply of a controlled substance. A physician, physician assistant, certified registered nurse anesthetist, or advanced nurse practitioner shall perform a physical examination of the patient on the same day the physician initially prescribes, dispenses, or administers a controlled substance to the patient and at least four times a year thereafter.⁸

Impact: How has a law, policy, or initiative improved outcomes in other states?

With only a handful of states having specific laws regulating pain management clinics there is little confirmatory evidence of the impact these laws have on reducing opioid misuse, abuse, and death. However, there are a few examples that suggest pain clinic regulatory laws are effective (Haegerich et al., 2014) but that in order to determine effectiveness more states will need to enact and enforce pain clinic laws and conduct research to measure the extent to which legislation improves outcomes (Rutkow, Vernick, & Alexander, 2017).

Arizona: Current State and Recommendations

To date, Arizona does not have any laws or specific guidance on the regulation of pain clinics.

⁸ <http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

Informed Consent, Patient Pain Management Agreements

26 states have implemented informed consent agreement laws, recommendations, or guidelines.

Practices from Other States

Alabama, Arizona, Delaware, Florida, Georgia, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming all have laws, quasi-regulatory requirements, or prescribing guidelines that mandates or includes informed consent for opioid treatment.

Informed consent consists of obtaining from a patient their acknowledgement of the potential risks and benefits associated with taking opioid medications and the responsibility of the patient when taking opioid prescription medications.

[Appendix B](#) (Davis, 2017) provides additional detail for all states that currently have informed consent laws, recommendations, or guidelines in place.

Practice Impact: How has law, policy, or initiative improved outcomes in other states?

Currently, there is a dearth of published evidence demonstrating the relationship between laws that require informed consent and individual health outcomes.

Arizona: Current State and Recommendations

Arizona currently includes informed consent within the Arizona Opioid Prescribing Guidelines and in the recently issued emergency rules for health care institutions.

In response to the Governor's Declaration of Emergency and after obtaining an exception from the rulemaking moratorium established by Executive Order 2017-02, the Department has amended the rules in 9 A.A.C. 10, Article 1 for licensed health care institutions through emergency rulemaking. The new rules require licensed health care institutions to:

- Establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment;
- Include specific processes related to opioids in a health care institution's quality management program; and
- Notify the Department of the death of a patient from an opioid overdose.

Specifically, the new rules require that healthcare institutions obtain informed consent from the patient or the patient's representative prior to prescribing an opioid. The consent must include potential risks, adverse reactions, complications, and medication interactions associated with the use of opioids, including risks associated with concurrent use of an opioid and a benzodiazepine. The consent must also include information on alternatives to a prescribed opioid.

Non-Opioid Chronic Pain Management

11 states have laws or guidelines in place that encourage the use of non-opioid alternatives for the treatment of chronic pain.

Practices from Other States

The Centers for Disease Control and Prevention *Chronic Pain Guidelines*⁹ and National Safety Council recommendations¹⁰ highlight and underscore the need to utilize alternative non opioid pharmacologic therapies to treat chronic pain. Physical therapy, occupational therapy, water therapy, acupuncture, yoga, T'ai Chi and massage have all been recognized as effective interventions to reduce the effects of and to effectively treat chronic pain. NSAID combination therapy (200 mg of ibuprofen combined with 500 mg of acetaminophen) is also recommended as a preferred alternative to prescribing an opioid¹¹ for treating chronic pain.

Impact: How has law improved outcomes in other states?

Arizona, California, Alaska, Colorado, Arkansas, Alabama, Connecticut, and Delaware have developed chronic pain guidelines that include providing alternatives to opioids for treating chronic pain. Ohio, Oregon, and Vermont have implemented laws allowing Medicaid recipients access to acupuncture, a non-pharmacotherapy form of pain management¹². Other states' task forces have also recommended employing a variety of alternative approaches to treating chronic pain.

Frank et al. (2017), "systematically reviewed the evidence on the effectiveness of strategies to reduce or discontinue long-term opioid therapy prescribed for chronic pain and the effect of dose reduction or discontinuation of long-term opioid therapy on important patient outcomes." Frank found that alternatives for treating chronic pain with non-pharmacologic and self-management strategies are effective and consistent with current best practice for management of chronic pain. Frank also recommended a need for higher quality research to continue if the relationship between implementing alternative methodologies for treating chronic pain and improvement in patient outcomes is to be realized.

Arizona: Current State and Recommendations

In 2016, the Arizona Substance Abuse Taskforce provided Recommendation Number 18 providing specific guidance regarding alternatives to opioids: "*Educate providers, health plans, and the general public about effective alternative pain management modalities for acute and chronic pain in order to decrease the use of opioids and unintended addiction.*" (p. 8).

⁹ https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

¹⁰ National Safety Council. (2016) Prescription Nation 2016: Addressing America's Drug Epidemic.

¹¹ <https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>

¹² <https://www.integrativepractitioner.com/whats-new/news-and-commentary/evidence-opens-medicaid-oregon-acupuncture/>

In May 2017, the Arizona Department of Health Services held a chronic pain summit to launch a public health initiative focused on promoting awareness of self-management strategies and non-opioid alternatives to treating chronic pain.

PRESCRIPTION INDICATORS

Opioid/Prescription Drug Task Force

37 states have created a state Task Force in response to the opioid epidemic.

30 states have a Task Force which developed a list of recommendations to help guide future initiatives.

Practices from Other States

As of 2017, 37 states have created multi-agency task force groups to assess the current state of the opioid epidemic and to establish a coordinated statewide response to reducing death and injury caused by opioid misuse and abuse. Of these states, 30 task force groups have also developed recommendations to guide next steps for combating prescription drug misuse and abuse. While most of these recommendations were developed within the past two years, some states have recommendations that were established as early as 2013. While specific task force recommendations tend to vary based on the needs of the state; there are similarities that exist as well. A review of existing task force documents revealed that many states recommend the following actions:

- Expanding prevention efforts to continue raising public awareness regarding the dangers of prescription drug misuse and abuse.
- Establishing new education and training requirements for healthcare providers related to safe opioid prescribing practices, pain management, and addiction.
- Improving the functionality of state Prescription Monitoring Programs
- Increasing access to naloxone
- Enhancing access to substance abuse treatment services, including the continued expansion of medication assisted treatment services

[Appendix C](#) provides links to state-specific detail regarding task force actions.

Impact: How has law improved outcomes in other states?

With the majority of state task forces being implemented very recently, empirical evidence suggests that the initiatives states are employing to address the opioid crisis are effective. However, given the very short existence of the task forces that have been implemented, very little scientific evidence has been collected to measure the impact task forces and their subsequent activities are having on reducing maladies caused by opioid misuse, abuse, overdose, and death.

Arizona: Current State and Recommendations

In 2016, the Arizona Substance Abuse Taskforce provided 104 separate recommendations ([see Appendix A](#)) to address various components of substance abuse in Arizona, including the opioid epidemic.

In addition to the Arizona Substance Abuse Taskforce, the Arizona Substance Abuse Partnership (ASAP)¹³ has played a central role in supporting initiatives targeting substance abuse, misuse, and overdose. Authorized by Executive Order 2013-05, amending and superseding Executive Order 2007-12, ASAP serves as the single statewide council on substance abuse prevention, enforcement, treatment, and recovery efforts. The Arizona Substance Abuse Partnership is chaired by the Maricopa County Attorney and vice-chaired by the Director of the Governor’s Office of Youth, Faith and Family and is composed of representatives from state governmental bodies, federal entities, and community organizations.

The Prescription Drug Core Group, a subcommittee of the Arizona Substance Abuse Partnership, convened in 2012 and created the Arizona Misuse & Abuse Prescription Drug Initiative with a set of five strategies and a toolkit for action at the state and community levels.

In the fall of 2016, the Governor’s Goal Council 3 on Health chose reducing opioid overdose deaths as its breakthrough project. Starting June 2017, sub-groups were convened to make recommendations and work on improvement actions targeting illicit opioid supply, prescription opioid supply, demand, youth prevention, treatment, and death.

¹³ <http://substanceabuse.az.gov/substance-abuse/arizona-substance-abuse-partnership>

Opioid Prescribing Regulations and Guidelines

33 states have prescribing requirements enforceable by law.

23 states have developed opioid prescribing guidelines.

18 states have developed guidelines by exercising their rule-making or quasi-regulatory¹⁴ authority.

Current Status across the US

The majority of US states have prescribing laws in place. Review of examples from a handful of states finds that, in general, most state laws provide guidance on prescribing within an emergency department or office setting that includes: outlining specific limits on number of prescriptions a prescriber can write for any patient, number of pills prescribed per patient, MME limits, and number of days a prescription can be written before a refill is required. Some states also include requirements for checking a prescription drug monitoring database and laws specific to Medicaid recipients.

For example, Alabama's Administrative Code § 540-X-4-.08 (2013), includes performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, conducting a periodic review of the opioid treatment, and maintaining a complete medical record of the patient's treatment. Physicians are not to fear disciplinary action if opioids are prescribed for legitimate purposes and within accepted medical knowledge and practice. Alabama's Administrative Code § 560-X-16-.20 (2014) limits the number of outpatient pharmacy prescriptions to four brand names and five total drugs per month per adult recipient for all Medicaid recipients. In no case can total prescriptions exceed ten per month per recipient.

Appendix B (Davis, 2017) provides a state-by-state overview of current laws, regulations, and guidelines.

Impact: How has law improved outcomes in other states?

A review of 13 opioid prescribing guidelines for chronic pain by Teryl K. Nuckols and her colleagues (2014) found that all of the guidelines contained the following opioid risk mitigation strategies: "upper dosing thresholds; cautions with certain medications; attention to drug–drug and drug–disease interactions; and use of risk assessment tools, treatment agreements, and urine drug testing. Frank et al. (2017), "systematically reviewed the evidence on the effectiveness of strategies to reduce or discontinue long-term opioid therapy prescribed for chronic pain and the effect of dose reduction or discontinuation of long-term opioid therapy on important patient outcomes." Frank found that alternatives for treating chronic pain with non- pharmacologic and self-management strategies are

¹⁴ *Quasi-regulatory* refers to situations where agencies may develop or enact guidance, rules, or regulations that may not be supported by statute.

effective and consistent with current best practice for management of chronic pain. Frank also recommended a need for higher quality research to continue if the relationship between implementing alternative methodologies for treating chronic pain and improvement in patient outcomes is to be realized.

Arizona: Current State and Recommendations

Arizona has developed and made widely available the *Arizona Opioid Prescribing Guidelines*¹⁵, *Arizona's Emergency Department Prescribing Guidelines*¹⁶, *Arizona Guidelines for Dispensing Controlled Substances*¹⁷; all of which are embedded and disseminated through the *Rx Drug Misuse and Abuse Initiative Toolkit (Strategy 2)*¹⁸.

In addition, in response to the Governor's Declaration of Emergency, ADHS has amended the rules for licensed health care institutions through emergency rulemaking. The new rules require licensed health care institutions to:

- Establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment consistent with the Arizona Opioid Prescribing Guidelines or national opioid prescribing guidelines, such as those issued by the Centers for Disease Control and Prevention;
- Include specific processes related to opioids in a health care institution's quality management program; and
- Notify the Department of the death of a patient from an opioid overdose.

The new rules include conducting a physical exam of the patient; checking the state's Controlled Substances Prescription Monitoring Program; conducting a substance abuse risk assessment; explaining alternatives to an opioid; and obtaining informed consent.

Finally, Recommendations 23 through 31 provided by the Arizona Substance Abuse Task Force acknowledge and support the need for continued development and implementation of prescribing and education guidance for practitioners and the public.

¹⁵ www.azhealth.gov/opioidprescribing

¹⁶ www.azhealth.gov/opioidprescribing

¹⁷ www.azhealth.gov/opioidprescribing

¹⁸ www.RethinkRxabuse.org

Prescribing Limits

12 states have laws in place that limit the initial amount of opioids medical professionals can prescribe.

Current Status of US States

Over the past year, 12 states have passed laws or agency rules limiting the initial amount of opioids practitioners can prescribe. These states are Connecticut, Delaware, Indiana, Kentucky, Maine, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Vermont. Of these states, New Jersey limited first fill prescriptions to 5 days while 10 states limited first fill prescriptions to 7 days. Kentucky recently passed a 3 day limit for controlled substances prescribed for acute pain. Maryland, Rhode Island, and Vermont enacted laws or adopted rules to limit morphine milligram equivalents (MME) below 100 MME within 30 days. Ohio is adopting administrative rules to limit MME to no more than 30 MME per day for acute pain. The Virginia Board of Medicine adopted several regulations in 2017, including requiring a prescriber treating acute pain with opioids to begin with short-acting opioids. Some states also require physicians to enter into a pain management agreement with a patient, prescribe non-opioid medications for chronic pain, and limiting daily pill counts¹⁹.

In addition, several states introduced legislation in 2017 limiting initial opioid prescription limits. States include Georgia, Hawaii, Montana, Oregon, and Washington.

Impact: How has law improved outcomes in other states?

In 2016, CDC published their *Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*²⁰. To date, there is a dearth of state-level literature that presents evidence demonstrating associations between the development and implementation of prescribing guidelines and reductions in opioid misuse, abuse, and overdose. However, Dowell, Haegerich, and Chou (2016) and others demonstrate the need to determine the relationship between prescribing limits, prescribing behavior, and patient outcomes.

Arizona: Current State and Recommendations

Governor Doug Ducey issued an executive order limiting initial opioid prescriptions to 7 days for AHCCCS members and state employees and their families on the state's health insurance plan. The order went into effect in April 2017.

Arizona published *Arizona Opioid Prescribing Guidelines* in 2014²¹ and is currently revising this edition to reflect recent evidence and feedback from Arizona practitioners and public health professionals. This initiative aligns with Recommendation Number 26 provided by the Arizona Substance Abuse Taskforce.

¹⁹ <http://www.astho.org/StatePublicHealth/A-Look-at-State-Legislation-Limiting-Opioid-Prescriptions/2-23-17/>

²⁰ <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1er.pdf>

²¹ <http://www.azhealth.gov/opioidprescribing>

Prescription Drug Monitoring Program (PDMP)

49 states have an operational PDMP.

36 states have laws in place to require use of state PDMP.

44 states have laws in place that allow delegates to use the PDMP.

Practices from Other States

Prescription Drug Monitoring Programs (PDMP) have emerged as a leading intervention adopted by states to address the opioid epidemic. Up until July, 2017, all states, with the exception of Missouri had an operational PDMP system in place. However, a recent executive order issued by Missouri Governor, Eric Greitens now directs the Missouri Department of Health and Senior Services to create a PDMP for this state as well²².

Despite evidence showing the effectiveness of PDMPs in reducing prescription drug related death and injury (Patrick, Fry, Jones, & Buntin, 2014). PDMPs remain underutilized leaving states unable to reap the full benefits of this system. A national survey conducted in 2014 found that while 72% of primary care physicians were aware of the state's PDMP system, only 53% of those surveyed reported using it, with the two main barriers to use being that it was too time consuming, and lacked ease of access (Rutkow et al., 2015).

While several states have put legislation in place that requires the use of the state PDMP system by prescribers, the integration of PDMPs with Electronic Health Records (EHR) and Health Information Exchange (HIE) systems has also been identified as a best practice for increasing PDMP utilization by minimizing technical challenges and making access to prescribing information more readily available to healthcare professionals²³.

Impact: How has law improved outcomes in other states?

Past research has shown PDMPs to be an effective tool to monitor prescribing behavior (Katz et al., 2010). CDC highlights examples from Florida, New York, and Tennessee to illustrate the association between the enactment of state-level PDMP policy enactments and changes in prescribing behavior²⁴.

Florida²⁵

- 2010 Action: Regulated pain clinics and stopped health care providers from dispensing prescription opioid pain relievers from their offices, in combination with establishing a PDMP.
- 2012 Result: Saw more than 50% decrease in oxycodone overdose deaths.

²² <http://www.astho.org/StatePublicHealth/Prescription-Drug-Monitoring-Program-Legislation-Update/7-20-17/>

²³ <http://www.astho.org/Rx/Brandeis-PDMP-Report/>

²⁴ <https://www.cdc.gov/drugoverdose/policy/successes.html>

²⁵ <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm>

- These changes might represent the first documented substantial decline in drug overdose mortality in any state during the previous ten years.

New York²⁶

- 2012 Action: Required prescribers to check the state's PDMP before prescribing opioids.
- 2013 Result: Saw a 75% drop in patients' seeing multiple prescribers for the same drugs.

Tennessee²⁷

- 2012 Action: Required prescribers to check the state's PDMP before prescribing painkillers.
- 2013 Result: Saw a 36% decline in patients' seeing multiple prescribers for the same drugs.

Arizona: Current State and Recommendations

In 2007, Arizona established its Controlled Substances Monitoring Program (CSPMP)²⁸. Every medical practitioner who is issued a medical license pursuant to title 32 and who possesses an Arizona registration under the controlled substances act (21 United States Code sections 801 through 904) must have a current controlled substances prescription monitoring program registration issued by the board and be granted access to the program's central database tracking system.

Following the passage of S.B. 1023, beginning the later of October 1, 2017, or 60 days after the statewide health information exchange has integrated the CSPMP into the exchange, a medical practitioner, before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient, shall obtain a patient utilization report regarding the patient for the preceding twelve months from the controlled substances prescription monitoring program's central database tracking system at the beginning of each new course of treatment and at least quarterly while that prescription remains a part of the treatment.

Medical practitioners are not required to obtain a patient utilization report from the central database tracking system pursuant to subsection H of this section if any of the following applies:

- The patient is receiving hospice care or palliative care for a serious or chronic illness.
- The patient is receiving care for cancer, a cancer-related illness or condition or dialysis treatment.
- A medical practitioner will administer the controlled substance.

²⁶http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf

²⁷http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf

²⁸ <http://www.azleg.gov/viewDocument/?docName=http://www.azleg.gov/ars/36/02606.htm>

- The patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility.
- The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient.
- The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for a patient who has suffered an acute injury or a medical or dental disease process that is diagnosed in an emergency department setting and that results in acute pain to the patient. An acute injury or medical disease process does not include back pain.
- The medical practitioner is prescribing no more than a five-day prescription and has reviewed the program's central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period.

By complying with S.B. 1023, Section J, a medical practitioner acting in good faith, or the medical practitioner's employer, is not subject to liability or disciplinary action arising solely from either:

- Requesting or receiving, or failing to request or receive, prescription monitoring data from the program's central database tracking system.
- Acting or failing to act on the basis of the prescription monitoring data provided by the program's central database tracking system.

The Arizona Substance Abuse Task Force Recommendation Number 25 calls for the continued enhancement of the PDMP to become more robust and user- friendly. This should be accomplished through continued efforts to integrate the PDMP into existing Electronic Health Records and Health Information Exchange systems across the state.

EMERGENCY INDICATORS

Naloxone Access

50 states have laws in place to expand naloxone access.

Practices from Other States

Every state in the Union has laws in place to expand access to naloxone. However, there is variation among states regarding the extent to which immunity is provided to prescribers, dispensers and lay administrators. Differences among states are also observed with respect to whether or not friends, family, and other community members can distribute and possess naloxone and if prescribing naloxone by a third party with or without a standing order is permitted²⁹.

Impact: How has law improved outcomes in other states?

Evidence has shown that communities with higher access to naloxone and overdose training have significantly lower opioid overdose rates than those that do not (Walley et al., 2013).

Arizona: Current State and Recommendations

As of May 17, 2017, Arizona has a number of laws providing expanded access to naloxone as reflected in Table 1 and the text below.

Table 1. Characteristics of Arizona’s Naloxone Access Laws³⁰

Immunity: Prescribers			Immunity: Dispensers			Immunity: Lay Administrators	
Civil	Criminal	Disciplinary	Civil	Criminal	Disciplinary	Civil	Criminal
-	Yes	Yes	-	Yes	Yes	Yes	-
Lay Distribution and Possession				Prescribing Permitted			
Lay Distribution	Possession without prescription		3 rd Party		Standing Order		
*	-		Yes		Yes		

Note: Citations: Ariz. Rev. Stat. Ann. § 32-1979; Ariz. Rev. Stat. Ann § 36-2266; Ariz. Rev. Stat. Ann. § 36-22667. * State law permits naloxone to be prescribed to “a community organization that provides services to persons who are at risk of an opioid-related overdose” but does not permit those organizations to further distribute the medication. Ariz. Rev. Stat. Ann. § 36-2266(A).

[AZ Rev Stat § 32-1979 \(2016\)](#) allows a pharmacist to dispense without a prescription, according to protocols adopted by the board, to a person who is at risk of experiencing an opioid-related overdose or to a family member or community member who is in a position to assist that person. Arizona Department of Health Services Director Dr. Cara Christ issued a standing order on June 9, 2017 for dispensing naloxone.

²⁹ https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf

³⁰ https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf

[AZ Rev Stat § 36-2266 \(2016\)](#) allows health care providers with prescribing authority to prescribe or dispense, directly or by a standing order, naloxone to a person who is at risk of experiencing an opioid-related overdose, to a family member of that person, to a community organization that provides services to persons who are at risk of an opioid-related overdose or to any other person who is in a position to assist a person who is at risk of experiencing an opioid-related overdose.

[AZ Rev Stat § 36-2228 \(2015\)](#) allows law enforcement officers or Emergency Medical Care Technician (EMTs) to administer naloxone to a person if they believe the person is suffering from an opioid-related overdose. The law requires a standing order for naloxone be issued by a physician or nurse practitioner, and requires training on proper administration of naloxone prior to being able to administer naloxone.

Currently, AHCCCS and ADHS are funding naloxone education and distribution throughout Arizona.

Recommendation Number 37 provided by the Arizona Substance Abuse Task Force states:

1. Increase[ing] access to the overdose antidote naloxone (Narcan™).
2. Conduct a needs assessment regarding the distribution of naloxone kits in Arizona and create strategies to support harm reduction.
3. Conduct community overdose education and prevention programs and distribute naloxone overdose prevention kits. Distribution must be accompanied with appropriate training on how to recognize the signs of an overdose, when and how to administer naloxone, the importance of calling 911, and how to administer rescue breathing until 911 first responders arrive.

Recommendation Number 38 provided by the Arizona Substance Abuse Task Force states:

1. Promote greater use of naloxone, especially in populations that are prone to fatal overdose such as people getting out of jail or prison, veterans, and individuals leaving the emergency department or a treatment program.

Good Samaritan Law

40 states have a Naloxone Good Samaritan Law.

Current Status across the United States

As of May, 2017, 40 states and the District of Columbia have passed an overdose Good Samaritan law that provides some protection from arrest or prosecution for individuals who report an overdose in good faith³¹ (Davis, Chang, Carr, & Hernandez-Delgado, 2017).

For states with Good Samaritan laws, legal protections may provide immunity (arrest, charge, prosecution³².) for controlled substance possession, paraphernalia, and other violations (protective or restraining order; pretrial, probation, or parole conditions). Other legal protections may include considering reporting as a mitigating factor and if reporting could result in civil forfeiture.

Impact: How has law improved outcomes in other states?

An evaluation of Washington State's 911 Good Samaritan law by Caleb J. Banta and his colleagues (2011) revealed, "88% of opiate users indicated that now that they were aware of the law they would be more likely to call 911 during future overdoses. 62% of police surveyed said the law would not change their behavior during a future overdose because they would not have made an arrest for possession anyway, 20% were unsure what they would do, and 14% said they would be less likely to make such an arrest." Banta and his colleagues (2013) also reported in their assessment of the implementation of the Good Samaritan law in Washington State that, "Most police and paramedics surveyed believed it was important for police to be at the scene of an overdose to help ensure the safety of medical personnel. This finding is important in light of concerns expressed locally and in the research literature about the presence of police at the scene of an overdose. Importantly, just a third of police felt it was important to be at the scene of an overdose to enforce laws."

Measuring the long-term effects of Good Samaritan law on reductions in opioid-related deaths has yet to occur. It is recommended that research efforts continue in order to pair anecdotal, qualitative reports with rigorous evidence-based analysis to become better able to assess the impact Good Samaritan laws have on reducing opioid overdose and death.

Arizona: Current State and Recommendations

Along with Iowa, Idaho, Kansas, Maine, Missouri, Oklahoma, South Carolina, Texas, and Wyoming, Arizona does not have any Good Samaritan laws. A next logical step for Arizona would be to review laws currently on the books in other states to identify which laws, or components of laws might be best applied in Arizona and the extent to which the benefits of enacting Good Samaritan laws in Arizona outweigh possible risks.

³¹ <http://pdaps.org/dataset/overview/good-samaritan-overdose-laws/58caa647d42e073a0b9ab804>

³² https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf

Emergency Response Activities

6 states have issued any executive or administrative orders or declarations that provide emergency powers needed to respond to the opioid epidemic.

3 states have activated their Emergency Operations Center for the Opioid Crisis.

Current State Status

Alaska, Arizona, Colorado, Florida, Georgia, Louisiana, Maryland, New Hampshire, Utah, and Virginia have issued an executive or administrative order or declaration that provides emergency powers needed to respond to the opioid crisis. The majority of executive and administrative powers included standing orders to allow entities, with or without medical direction, to distribute naloxone and implementing training for first responders and community to safely administer naloxone³³.

Practice Impact: How has law improved outcomes in other states?

Since the majority of emergency declarations have occurred within the past few years (Massachusetts, 2014; Arizona, 2017), it will very likely take a number of years to be able to determine the extent to which the provision of emergency powers impacted opioid outcomes.

Arizona: Current State and Recommendations

On June 5, Governor Doug Ducey issued a Declaration of Emergency and Notification of Enhanced Surveillance Advisory³⁴ that included 5 deliverables:

1. Within seven days of the order, provide consultation to the Governor on identifying and recommending the necessary elements for an Enhanced Surveillance Advisory
2. Initiate emergency rule making with the Arizona Attorney General's Office in order to develop rules for opioid prescribing and treatment within health care institutions
3. Develop guidelines to educate healthcare providers on reasonable prescribing practices
4. Develop and provide training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations
5. Provide a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.

³³ <http://www.astho.org/StatePublicHealth/Emergency-Declarations-and-Opioid-Overdose-Prevention/6-8-17/>

³⁴ <http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/opioid-emergency-declaration.pdf>

REPORTING INDICATORS

Opioid Overdose Reporting

3 states have laws or regulations in place to require the reporting of drug overdose.

Practices from Other States

Currently, New Mexico, Rhode Island, and Texas have laws or regulations in place that require drug overdoses to be reported.

New Mexico requires all drug overdoses to be reported within 24 hours to the Department of Health (N.M. Code R. § 7.4.3³⁵). Rhode Island utilized its Department of Health's rulemaking authority to require, "*health care professionals and hospitals...to report all opioid overdoses or suspected overdoses to the Department within a forty-eight (48) hour time period.*³⁶"

Texas requires mandatory reporting under § 97.3 of the Texas Administrative Code and § 161.042 of the Health and Safety Code. Reporting entities and individuals who report in good faith are provided civil and criminal liability protections.

Impact: How has law improved outcomes in other states?

Very little is yet known regarding the relationship between required overdose reporting and lowering of the incidence and prevalence of opioid overdose and overdose deaths. However, collecting and tracking overdose data can guide public policy, prevention, and intervention efforts.

Arizona: Current State and Recommendations

Governor Ducey's Executive Order Enhanced Surveillance Advisory includes a requirement to report within 24 business hours to the Arizona Department of Health Services³⁷:

- suspected opioid overdoses;
- suspected opioid deaths;
- naloxone doses administered in response to suspected overdoses;
- naloxone doses dispensed by pharmacists; and
- Neonatal Abstinence Syndrome.

In addition, new emergency rules for licensed health care institutions require reporting of a patient's death within one working day if the death may be related to an opioid prescribed, ordered, or administered as part of treatment.

³⁵ <http://164.64.110.239/nmac/parts/title07/07.004.0003.htm>

³⁶ <http://www.sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7738.pdf>

³⁷ <http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/opioid-faqs-reporting.pdf>

Neonatal Abstinence Syndrome (NAS)

9 states have laws in place that require the reporting of Neonatal Abstinence Syndrome.

Practices from Other States

Georgia, Indiana, Kentucky, Louisiana, Ohio, South Carolina, Tennessee, Texas, and Virginia currently have laws in place requiring NAS to be reported. Montana supports voluntary reporting and New Hampshire allows their Child Protection Services agency to require anyone suspected of child abuse or neglect to undergo drug testing.

In Georgia, reports are required to be provided to the Department of Health within 7 days of identification³⁸ whereas in Kentucky, reporting is required at the time of diagnosis. In Louisiana, notification of NAS to the Department of Child and Family Services, “*shall not constitute a report of child abuse or parental neglect, nor shall it require prosecution for any illegal action.*” Many states, including Alaska, Connecticut³⁹, Florida⁴⁰, Massachusetts, and Illinois⁴¹ have utilized their opioid and Neonatal Abstinence Syndrome task forces and advisory committees to recommend NAS as a reportable incident.

Impact: How has law improved outcomes in other states?

Long-term developmental outcomes related to NAS are limited⁴². However, including NAS as a reportable condition greatly improves the timeliness of providing in utero and postnatal treatment to affected neonates. Reporting is also very likely to assist public health officials in identifying if specific populations or geographic areas are disproportionately affected by conditions that may contribute to higher incidence and prevalence of NAS.

Arizona: Current State and Recommendations

Governor Ducey’s enhanced surveillance declaration includes NAS as a reportable condition⁴³. Referrals of NAS to the Department of Child Safety continue to be required as directed by A.R.S. 13-3620. On September 12, 2016, the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs published their *Guidelines for Identifying Substance-Exposed Newborns*⁴⁴. The Arizona Substance Abuse Taskforce dedicated Recommendations 87 through 104 to address and expand NAS initiatives in Arizona.

³⁸ <https://dph.georgia.gov/NAS>

³⁹ http://www.ct.gov/dph/lib/dph/publications/family_health/nas_fact_sheet_2016.pdf

⁴⁰ [http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/\\$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf](http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf)

⁴¹ <http://www.dph.illinois.gov/sites/default/files/publications/publications-owh-nas-report-ga-042816.pdf>

⁴² <https://www.cdc.gov/cdcgrandrounds/pdf/archives/2016/august2016.pdf>

⁴³ <http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/faqs-neonatal-abstinence-syndrome.pdf>

⁴⁴ http://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/high-risk/sen_guidelines.pdf

EDUCATION, PREVENTION & TREATMENT INDICATORS

Programs for Children and Youth

States support the implementation of substance use disorder interventions among children and youth. However, specific strategies and initiatives being implemented among states vary widely.

Current status of Interventions across the US

States support the implementation of a variety of substance use disorder interventions among children and youth. However, determining the exact number of states and number and type of programs states are implementing is challenging due to the sheer number of programs that are available to states.

Within the school-setting, we know that the majority of schools across the U.S. require instruction on substance abuse prevention. The Centers for Disease Control and Prevention conducted the National School Health Policies and Practices Study in 2014, and found that 66.7 percent of middle schools and 86.9 percent of high schools require that students receive instruction on alcohol or other drug use prevention.

Longitudinal research has demonstrated that there are individual, family, school and community risk and protective factors that influence an individual's likelihood to use drugs and/or alcohol. Risk and protect factors have implications for the types of policies and prevention program that are likely to be effective in differing age, ethnic and socio-economic demographics. Prevention interventions are often classified into three categories: universal, selective and indicated depending on the risk of substance use the target population presents. While more research is need to determine the most effective mix of these interventions, it is often encouraged for communities to provide multiple levels of prevention programs.

There are multiple repositories of evidence-based prevention programs. One such repository is SAMHSA's National Registry of Evidence-based Programs and Practices⁴⁵(NREPP). According to this registry, there are 132 interventions specific to providing children and youth with substance use disorder prevention and substance use disorder treatment education. In 2016, the U.S. Surgeon General released *Facing Addiction In America*, in which, 600 programs were reviewed and the top 42 prevention programs were categorized based on the target population's age.⁴⁶

At the state level, there have been several federal and state grant opportunities that support the work of community organizations. Such programs include but are not limited to Drug Free Communities and the Strategic Prevention Framework, which have been implemented across multiple states with varying levels of success. These programs have historically received support from federal and state-level grant funding and technical

⁴⁵ <https://www.samhsa.gov/nrepp>

⁴⁶ <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>

assistance. Most of these programs are designed to empower community coalitions and non-profits to assess the community need, identify appropriate community and school-based interventions, and measure the outcome of the prevention intervention.

Outside of the U.S., a promising model has emerged out of Iceland where they saw significant decreases in past 30-day use among 16-year olds in alcohol consumption (from 42% to 7%), smoking (from 23% to 3%) and marijuana consumption (from 17% to 5%) use over a ten year period. The program worked by engaging communities, government and providers to provide youth alternative activities to drug use from 3- 6 p.m. The program has expanded into multiple European countries.

Arizona: Current State and Recommendations

ARS 15-712 permits, but doesn't require, the instruction on the harmful effects of narcotic drugs, marijuana, date rape drugs, and other dangerous drugs in grades 4-12. The statute also allows instruction to include the harmful effects of drugs on a human fetus in grades 6-12.

Currently, federal Substance Abuse Block Grant funds are being utilized by the Governor's Office of Youth, Faith and Family to implement school-based programs targeting middle and high school youth. Additional prevention programming is funded through sources such as the SAMHSA's Partnership for Success grant, CDC Prescription for States, federal Drug Free Communities grant, and the Arizona Parent's Commission on Drug Education and Prevention, and implemented by a variety of community-based coalitions, non-profits, and county health departments.

The Arizona Substance Abuse Task Force provided several recommendations specific to children and youth.

- Recommendation Number 2
Increase funding to support prevention and early intervention activities. Investing in evidence-based prevention and early intervention improves public safety and decreases dollars spent on incarceration and long-term treatment.
- Recommendation Number 6
Engage children and adolescents in building social skills, character, and coping skills, so they have the tools needed to decline when offered substances.
- Recommendation Number 7
Engage youth to take the lead in educating their peers about the consequences of drug use by connecting them with education and supportive resources such as "Safe Talk for Teens."

- Recommendation Number 8
Thoroughly train teens to deliver peer-to-peer prevention and early intervention messages through evidence-based programs. Address vaping (inhaling substances through e-cigarettes and other devices) as part of these programs.
- Recommendation Number 9
Encourage use of the websites substanceabuse.az.gov, overcomeawkward.org, and ivegotsomethingbetter.org and ReThinkRxAbuse.org
- Recommendation Number 10
Scale prevention programs throughout Arizona in schools to develop drug-free school cultures.
- Recommendation Number 11
Investigate if the Adolescent ASAM (American Society of Addictive Medicine) Screening & Assessment Tool is the most efficacious tool for use in adolescents as well as the most cost effective option for the State.
- Recommendation Number 12
Support the GOYFF's plan to build a Youth Treatment Locator.
- Recommendation Number 13
Disseminate drug abuse prevention/resource toolkits to schools, primary care providers, faith based groups, parent groups, and others who interact with young people.
- Recommendation Number 16
Support efforts to improve the screening and treatment of mental illness, and to screen and treat mental illness at earlier ages.
- Recommendation Number 33
Scale the "Healthy Families – Healthy Youth" substance abuse prevention pilot and ensure its availability to all 7th grade students, parents, and faculty in the state.
- Recommendation Number 34
Engage the Arizona Board of Education to consider a mandate that substance abuse be a part of the required health curriculum.
 - a. *Utilize specialists and peers to assist in the delivery of evidence-based curricula.*
 - b. *Develop school-based drug prevention programming that builds drug-free culture.*
 - c. *As a part of the required health curriculum, prescreen for potential substance use precursors using the Adverse Childhood Experiences (ACEs) questionnaire and screen for substance abuse using the adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) process.*

Referral and Access to Substance Abuse Treatment

Nearly all states have implemented laws, policies, or initiatives specific to improve referral and access to pain specialists and, or substance abuse treatment. Few states have specific guidance on providing SBIRT and MAT.

Furthermore, as of 2005, 29 states required state-funded providers to use the American Society of Addiction Medicine (ASAM) comprehensive treatment criteria to create personalized plans of care for individuals. The ASAM criteria uses a multi-dimensional assessment to guide the selection of services, which include early intervention, outpatient services, intensive outpatient/partial hospitalization services, residential/inpatient service, and medically-managed intensive inpatient services. Several states have created SAMSHA-grant funded initiatives to create SBIRT programs. Since 2003 SAMHSA has funded 15 State Cooperative Agreement grants for SBIRT programs.⁴⁹

Practices from Other States

State regulatory and purchasing policies may create barriers to MAT. A 2013 Medicaid report found while agencies in every state covered buprenorphine and at least 28 states covered all three MAT medications, many states have implemented policies that restrict their availability. “Between 2011 and 2013, at least 48 states required prior authorization for buprenorphine; at least 34 states imposed quantity limits on buprenorphine and at least 11 states imposed lifetime limits. Comparatively, only 13 states required prior authorization for methadone and 12 states required prior authorization for naltrexone. No state set a lifetime limit on either methadone or naltrexone.¹⁴⁰ Restricting access to legitimate buprenorphine treatment may increase illicit use; difficulty accessing buprenorphine treatment was found to be the most common risk factor associated with diversion.”⁵⁰

In Massachusetts, the Gloucester Police Department developed a voluntary, no-arrest program that provides direct referral for drug detoxification and rehabilitation treatment. This program was featured recently featured in the New England Journal of Medicine for its successful outcomes. Police officers in the program collect demographic information from the participant, call treatment centers to identify a facility for placement, ensure participant’s transportation to the treatment center, and assign a volunteer Samaritan for emotional support if the process takes over a few hours.⁵¹

⁴⁹ <https://www.integration.samhsa.gov/clinical-practice/sbirt>

⁵⁰ <http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

⁵¹ <http://www.nejm.org/doi/full/10.1056/NEJMc1611640>

In Griswold, Connecticut, state police teamed with the state department to begin the CRISIS Initiative (Connection to Recovery through Intervention, Support and Initiating Services) in June 2017. The project includes a full-time clinical social worker attached to an officer troop in Griswold and a mobile outreach team that can provide round-the-clock intervention services.⁵²

In Kentucky, the state department runs a toll-free treatment referral line, called Operation UNITE, for anyone seeking assistance with drug addiction as well as family members in need of support. Staff is available 8-5 M-F to help callers learn about available treatment programs in the region and next steps to enter such programs.⁵³

In New Mexico, the state health department works with the University of New Mexico's School of Medicine to run a teleconsultation program, Project ECHO (Extension for Community Healthcare Outcomes) to increase provider training and build treatment capacity for substance use disorders in rural areas. The program connects healthcare providers in rural areas with specialists at a central hub via teleconferencing technology to provide support in patients' care management. The model has spread to other states, including one multi-state collaborative that supports addiction treatment at federally qualified health centers."⁵⁴

Impact: How has law, policy, or initiative improved outcomes in other states?

While evidence-based medicine strongly supports the efficacy of MAT in treating opioid use disorder, there is less evidence supporting SBIRT and MAT state-wide initiatives. According to SAMHSA, MAT services are most effective when combined with other behavioral therapies such as counseling to address both the behavioral and physiological components of substance use disorders. "Patient advocates and academics argue that state policies limiting the use MAT may do more harm than good, especially when accounting for the societal cost of untreated addiction. Studies suggest states can strike a balance between rigid utilization." management policies that make it more difficult to receive care and unfettered access.

In 2008, the Massachusetts Medicaid Agency implemented a targeted prior authorization policy that required increasingly frequent prior authorization for prescribing higher doses of buprenorphine, ranging from no prior authorization requirement for doses of 16 mg/day or less up to monthly prior authorization for doses of 32 mg/day or more. As a result, the percentage of individuals receiving dosages beyond the FDA's recommended dose fell from 16.5 to 4.1 percent. Cost savings to the state were minimal, as decreased dosages may have increased the rate of relapse for individuals already receiving buprenorphine, but lowering the availability of higher doses did not negatively affect individuals beginning MAT and may have reduced diversion."⁵⁵

⁵² <http://www.courant.com/community/griswold/>

⁵³ <http://odcp.ky.gov/Pages/Treatment-Resources.aspx>

⁵⁴ <http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

⁵⁵ <http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

Arizona: Current State and Recommendations

AHCCCS reimburses three FDA approved medications for MAT: methadone, buprenorphine, and naltrexone. No prior authorization is required for use of these medications for opioid replacement therapy, and there are no restrictions on the duration of treatment for MAT for AHCCCS members.

The Arizona Substance Abuse Task Force's 2016 report strongly supports the implementation of Recommendation 77 through 86 to provide education, training, and capacity to provide necessary treatment, referral, SBIRT, and MAT services in Arizona.

Examples of Arizona Substance Abuse Task Force Recommendations:

77. Increase the number of providers who are trained and licensed to provide MAT in Arizona.

79. Create a system of needs assessments for detoxification services, identify gaps, and increase capacity as needed so that appropriate levels of residential detox, inpatient detox, and outpatient detox services are readily available throughout Arizona.

80. Encourage the use of evidence-based tools to help determine whether residential, inpatient, or outpatient detoxification is the best choice for a given individual, followed by appropriate assessment and treatment.

83. Create targeted strategies for MAT for special populations, for example, individuals involved with the Department of Corrections, pregnant women, Native American communities, and rural communities.

85. Support the efforts of the Industrial Commission of Arizona to prevent future opioid addiction among Worker's Compensation beneficiaries and to obtain treatment for individuals who already have SUD.

86. Continue to seek federal grant monies to support prevention, early intervention, and treatment efforts in Arizona.

Continuing Medical Education & Medical Training

5 states have laws in place that *require* all medical providers to complete continuing education coursework related to opioid prescribing and chronic pain management.

0 states have a laws in place that require opioid abuse prevention curriculum be developed and incorporated into academic programs for medical, dental, and nursing students.

The National Perspective

Forty-six states and the District of Columbia require physicians to obtain periodic CME as a condition of maintaining their license to practice medicine⁵⁶. As of December 2015, 23 states require at least some physicians to receive training in pain management or controlled substance prescribing as a condition of obtaining or renewing their license to practice medicine or to specialize in pain management (Davis & Carr, 2016).

The characteristics of these laws vary across states in such attributes as the types of physicians who are required to receive training, the duration and frequency of the training, and the subjects covered. Only five states (CT, IA, MD, SC, and TN) require all or nearly all physicians to obtain periodic CME on such topics as pain management, controlled substance prescribing, or substance use disorders.

In all states with such requirements, they represent a small fraction of the total required CME hours. For example, Connecticut requires that physicians obtain 50 CME hours every two years, but only one CME hour in pain management and controlled substance prescribing every six years. Similarly, Maryland requires all physicians to obtain 50 CME hours every two years, of which only one must be relevant to pain management, proper prescribing, or substance use disorders (Davis & Carr, 2016).

Regarding providing required education on pain and pain management in medical and health profession curricula, Mezei and Murinson (2011) found that of the 104 medical schools they surveyed, only 4 reported having a required pain course and only 16 offered a designated pain elective. Following recent pressure placed on the medical school community as a result of the opioid crisis, medical schools across the United States are beginning to revise their curricula to reflect a need for pain and pain management training in the undergraduate medical school environment⁵⁷. The literature is very unclear what changes, if any, have been made to revise training in other medical and veterinary education training programs. However, a recent offering by John Loeser and Michael Schatman (2017) underscores and highlights the need to include pain and pain management as an absolute requirement for undergraduate and post-medical school training.

⁵⁶ <http://www.medscape.org/public/staterequirements>

⁵⁷ <https://www.medpagetoday.com/publichealthpolicy/medicaleducation/56025>

Impact: How has law improved outcomes in other states?

In 2012, New Mexico passed SB 215⁵⁸ requiring all health care licensing boards to mandate CME training in the treatment of chronic pain. Shortly thereafter, the New Mexico Medical Board (NMMB) developed Rule 16.10.14, requiring physicians and physician assistants to complete 5 hours of CME in pain and addiction between November 1, 2012, and June 30, 2014. Additionally, the NMMB mandated that all physicians and physician assistants sign up with the New Mexico Board of Pharmacy PMP and check the PMP each time a new prescription for chronic opioids is written and every 6 months thereafter (Katzman et al., 2014).

From 2012-2013, a reduction in the quantity of opioid medications prescribed was observed following passage of legislation and rule. Total MME decreased as did MME per prescription. High-dose prescriptions decreased, low-dose prescriptions increased. Prescribing limits were not included in the statutory or rulemaking text.

Arizona: Current State and Recommendations

Currently, Arizona does not statutorily require CME. However, several professional licensing boards are currently updating rules to require CME at the request of Governor Doug Ducey. Free CME about opioid prescribing is available online.

Recommendation Number 24, from The Arizona Substance Abuse Task Force Substance Abuse Recommendations report (2016) states, “Require and expand prescriber education regarding opioid use for pain management. Standardized resources for Arizona providers should include information on the dangers of prescribing opioids, SB 1283, and the CSPMP database, and recent federal legislation. These resources should be available online.”

Recommendation Number 28 states, “Engage medical schools, dental schools, veterinarian schools, and higher education programs for nurse practitioners and physician assistants to increase required curricula on substance abuse prevention and treatment.”

Arizona CME Recommendation: Consider statutorily requiring 5 hours of CME that reflects guidance provided in Recommendation Number 24. Consider including New Mexico’s SB 215⁵⁹ language that includes: a basic awareness of the epidemic of chronic pain as well as opioid abuse, addiction, and diversion; management of pain with non-opioid medications; safer opioid prescribing; identification and management of patients at risk for addiction; and, current state and federal rules and regulations including rules regarding use of the prescription monitoring program.⁶⁰

Arizona Medical and Health Professions Recommendation: Follow guidance provided in Recommendation 28 to increase pain management content in medical and nursing schools.

⁵⁸ Relating to Pain Management; Amending the Pain Relief Act; Changing the Name and Composition of the Pain Management Advisory Council; Requiring Continuing Education for Non-Cancer Pain Management, SB 215. 50th Leg., 2nd Sess., N.M. (2012).

⁵⁹ <https://www.nmlegis.gov/sessions/12%20Regular/bills/senate/SB0215.html>

⁶⁰ New Mexico Prescription Monitoring Program. Available at: <http://www.nmpmp.org>.

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Resources by Topic

Naloxone

https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf

Good Samaritan Laws

<http://pdaps.org/dataset/overview/good-samaritan-overdose-laws/58caa647d42e073a0b9ab804>

https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf

Neonatal Abstinence Syndrome (NAS)

<https://dph.georgia.gov/NAS>

http://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/high-risk/sen_guidelines.pdf

http://www.ct.gov/dph/lib/dph/publications/family_health/nas_fact_sheet_2016.pdf

[http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/\\$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf](http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf)

<http://www.dph.illinois.gov/sites/default/files/publications/publications-owh-nas-report-ga-042816.pdf>

<https://www.cdc.gov/cdcgrandrounds/pdf/archives/2016/august2016.pdf>

<http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/faqs-neonatal-abstinence-syndrome.pdf>

Prescribing Monitoring Program (PDMP)

<http://www.astho.org/StatePublicHealth/Prescription-Drug-Monitoring-Program-Legislation-Update/7-20-17/>

<http://www.astho.org/Rx/Brandeis-PDMP-Report/>

<https://www.cdc.gov/drugoverdose/policy/successes.html>

Emergency Response

<http://www.astho.org/StatePublicHealth/Emergency-Declarations-and-Opioid-Overdose-Prevention/6-8-17/>

<http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/opioid-emergency-declaration.pdf>

Non-Opioid Pain Management

https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

National Safety Council. (2016) Prescription Nation 2016: Addressing America's Drug Epidemic.

<https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>

<https://www.integrativepractitioner.com/whats-new/news-and-commentary/evidence-opens-medicaid-oregon-acupuncture/>

Prescribing Guidelines

www.azhealth.gov/opioidprescribing

<http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

Informed Consent

<http://preventopioidabuse.org/>

Please see [Appendix B](#).

Medical Education and Continuing Education

<http://www.medscape.org/public/staterequirements>

<https://www.medpagetoday.com/publichealthpolicy/medicaleducation/56025>

Relating to Pain Management; Amending the Pain Relief Act; Changing the Name and Composition of the Pain Management Advisory Council; Requiring Continuing Education for Non-Cancer Pain Management, SB 215. 50th Leg., 2nd Sess., N.M. (2012).

<https://www.nmlegis.gov/sessions/12%20Regular/bills/senate/SB0215.html>

New Mexico Prescription Monitoring Program. Available at: <http://www.nmpmp.org>.

Treatment

<https://www.integration.samhsa.gov/clinical-practice/sbirt>

<http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

<http://www.nejm.org/doi/full/10.1056/NEJMc1611640>

<http://www.courant.com/community/griswold/>

<http://odcp.ky.gov/Pages/Treatment-Resources.aspx>

<http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

<http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

Practice Management

<http://www.myfloridalegal.com/newsrel.nsf/newsreleases/9AD68A6580FA8DFD852578A400499E5E>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4976392/>

<http://www.taftlaw.com/news/publications/detail/941-new-kentucky-pill-mill-bill-places-new-restrictions-on-pain-management-facilities-and-controlled-substances-prescribing>

<https://stacks.cdc.gov/view/cdc/40739/Email>

<http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2429105>

<http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

Programs for Children and Youth

<http://legacy.nreppadmin.net/SearchResultsNew.aspx?s=b&q=early+childhood+intervention>

<http://legacy.nreppadmin.net/ViewIntervention.aspx?id=201>

<http://substanceabuse.az.gov/substance-abuse/meeting-body/arizona-substance-abuse-task-force-coalition-leading-substance-abuse>

[http://substanceabuse.az.gov/sites/default/files/files/substance abuse task force final 0.pdf](http://substanceabuse.az.gov/sites/default/files/files/substance%20abuse%20task%20force%20final%200.pdf)

<https://www.samhsa.gov/nrepp>

<https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>

APPENDIX B

State-by-State Summary of Opioid Prescribing Regulations and Guidelines

This document was developed by and used by permission from:
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Southeastern Region Office & the National Health Law Program

State-by-State Summary of Opioid Prescribing Regulations and Guidelines

	Requirements with the force of law	Quasi-regulatory guidelines	Advisory Guidelines
Alabama	-Ala. Admin Code § 560-X-16-.20 (2014); -Ala. Admin Code § 540-X-4-.09 (2013)	N/A	N/A
Alaska	N/A	N/A	Pending
Arizona	N/A	N/A	AZ Opioid Prescribing Guidelines
Arkansas	Ark. Code Ann § 20-7-703 (2015); Executive Order 2016-06 (2016)	N/A	AR Emergency Department Opioid Prescribing Guidelines
California	N/A	Guidelines for Prescribing Controlled Substances for Pain	N/A
Colorado	DHCPF Opioid Prescribing Policy	N/A	Joint Policy for Prescribing and Dispensing Opioids
Connecticut	-Conn. Gen. Stat. Ann. § 21a-254(9) (2015); -Conn. Gen. Stat. Ann § 17a-714a (2016)	N/A	CT Emergency Department Opioid Prescribing Guidelines
Delaware	Del Admin. Code C.S.A. 9.0 (2017)	N/A	-Guidelines for the Use of Controlled Substances for the Treatment of Pain; -DE Emergency Department Opioid Prescribing Guidelines
Florida	N/A	FL Boards of Medicine and Osteopathic Medicine's General Policies on Opioid Prescribing	N/A
Georgia	Ga. Comp. R. & Regs. 360-3-.06 (2013)	N/A	N/A
Hawaii	N/A	N/A	Emergency Department Opioid Prescription Guidelines

	Requirements with the force of law	Quasi-regulatory guidelines	Advisory Guidelines
Idaho	N/A	Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain	N/A
Illinois	N/A	N/A	N/A
Indiana	844 Ind. Admin. Code 5-6-3 (2014)	N/A	N/A
Iowa	Iowa Admin. Code § 653-13.2 (2016)	N/A	N/A
Kansas	N/A	Joint Policy Statement on the Use of Controlled Substances for the Treatment of Pain	N/A
Kentucky	-201 Ky. Admin. Regs. 9:260 (2013) - Ky. Rev. Stat. Ann. § 218A.205(3)(b) (2017)	Guidelines for the Use of Controlled Substances in Pain Treatment	N/A
Louisiana	La. Stat. Ann. § 40:978 (2015)	N/A	N/A
Maine	-02-373 Me. Code R. 21 § II (2012); -32 Me Rev. Stat. Ann. § 3300-F (2016); -22 Me. Rev. Stat. Ann. § 7253 (2016)	N/A	N/A
Maryland	Md. Code Ann., Health Occ. § 1-223 (2017)	N/A	MD Emergency Department Opioid Prescribing Guidelines
Massachusetts	Mass. Ann. Laws ch. 94C, § 19D (2016)	Prescribing Practices Policies and Guidelines	MHA Guidelines for Emergency Department Opioid Management
Michigan	N/A	Guidelines for the Use of Controlled Substances for the Treatment of Pain	N/A

	Requirements with the force of law	Quasi-regulatory guidelines	Advisory Guidelines
Minnesota	Minn. R. 5221.6110 (2015)	Joint Statement on Pain Management	N/A
Mississippi	Miss. Admin. Code 30-17-2640:1.7 (2012)	N/A	N/A
Missouri	N/A	Guidelines for the Use of Controlled Substances for the Treatment of Pain	N/A
Montana	N/A	N/A	Statement on the Use of Controlled Substances in the Treatment of Intractable Pain
Nebraska	N/A	Guidelines for the Use of Controlled Substances for the Treatment of Pain	N/A
Nevada	Nev. Rev. Stat. Ann. § 639.23507 (2015)	N/A	NHA Guidelines for Controlled Substance Prescriptions
New Hampshire	N.H. Code Admin. R. Med. 502 (2016); N.H. Rev. Stat. Ann. § 318-B:39 (2016)	Board of Medicine Guidelines for Pain Management	N/A
New Jersey	-N.J. Admin. Code § 13:35-7.6 (2011); -N.J. Rev. Stat. § 45:1-46.1(a) (2015); -N.J. Stat. Ann. §§ 24:21-15.2 and 45:9-22.19 (2017)	N/A	NJ Senate Resolution No. 60 (2016)
New Mexico	N.M. Code R. § 16.10.14.10 (2014)	N/A	NMHA Recommended Opioid Risk-Reduction Strategies and Prescribing Guidelines in NM Emergency Departments
New York	-N.Y. Pub. Health §3334-a(2) (2013); -N.Y. Pub. Health § 3331(5) (2016)	N/A	NYC Emergency Department Discharge Opioid Prescribing Guidelines
North Carolina	N/A	Policy for the Use of Opioids for the Treatment of Pain	N/A

	Requirements with the force of law	Quasi-regulatory guidelines	Advisory Guidelines
North Dakota	N/A	N/A	Safe Prescribing Tips for Opioids
Ohio	-Ohio Admin. Code 4731-11-11 (2015); -Pending	N/A	-Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines; -Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic Non-Terminal Pain 80 mg of MED “Trigger Point”; -Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments
Oklahoma	-Okla. Stat. Ann. Tit. 63, § 2-302(M) (2010); -OHCA’s Opioid Analgesic Quantity Limits	N/A	-OK Emergency Department and Urgent Care Clinic Opioid Prescribing Guidelines; -Opioid Prescribing Guidelines for OK Health Care Providers in the Office-Based Setting
Oregon	N/A	N/A	-Oregon Pain Guidance Treatment Guidelines; -Oregon Opioid Prescribing Guidelines
Pennsylvania	35 Pa. Cons. Stat. § 872.5	-PA Guidelines on the Use of Opioids to Treat Chronic Non-Cancer Pain; -PA Emergency Department Pain Treatment Guidelines; -PA Guidelines on the Use of Opioids in dental Practice	N/A
Rhode Island	-R.I. Admin. Code 31-2-6:3.0 (2014); -1956 R.I. Gen. Laws Ann. § 21-28-3.20 (2016)	N/A	N/A
South Carolina	SCDHHS’s Required Use of SCRIPTS	Pain Management Guidelines	N/A

	Requirements with the force of law	Quasi-regulatory guidelines	Advisory Guidelines
South Dakota	N/A	Model Policy for the Use of Controlled Substances for the Treatment of Pain	N/A
Tennessee	-Tenn. Code Ann. § 53-11-308 (2013); -Tenn. Code Ann. § 53-10-310 (2016)	N/A	Clinical Practice Guidelines for Outpatient Management of Chronic Non-Malignant Pain
Texas	22 Tex. Admin. Code § 170.3 (2007)	N/A	N/A
Utah	Utah Code Ann. §§ 58-37-6(7)(f)(iii) and 58-37f-304(2) (2017)	N/A	UT Clinical Guidelines on Prescribing Opioids for Treatment of Pain
Vermont	-Vt. Stat. Ann. Tit. 18, § 4289(d) (2014); -VDH's Rule Governing the Prescribing of Opioids for Pain; -VDH's Prescription Monitoring System Rule	Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain	Opiate Prescribing Guidelines for VT Emergency Departments
Virginia	Va. Code Ann. § 54.1-2522.1 (2015)	N/A	-Medical Society of Virginia's Guidelines for the Use of Opioids in the Management of Chronic Non-Cancer Pain; -Guidance on the Use of Opioid Analgesics in the Treatment of Chronic Pain; -VA Hospital Emergency Department Opioid Prescribing Guidelines
Washington	Wash. Admin. Code § 246-919-850 (2011);	N/A	-WA Emergency Department Opioid Prescribing Guidelines; -Interagency Guidelines on Prescribing Opioids for Pain
West Virginia	W. Va. Code Ann. § 60a-9-5a (2014)	N/A	Guidance for the Use and Prescribing of Opioids in Emergency Departments

	Requirements with the force of law	Quasi-regulatory guidelines	Advisory Guidelines
Wisconsin	Wis. Stat. Ann. § 961.385 (2016)	WI Medical Examining Board Opioid Prescribing Guidelines	N/A
Wyoming	N/A	WY Health Care Licensing Boards' Uniform Policy for the Use of Controlled Substances in the Treatment of Pain	N/A

Alabama

Requirements with the force of law: [Ala. Admin. Code § 540-X-4-.08 \(2013\)](#).

In 2013, the Alabama Board of Medical Examiners amended its guidelines for the use of controlled substances for treating pain. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient’s treatment.

Link to the guidelines:

<http://www.alabamaadministrativecode.state.al.us/docs/mexam/540-X-4.pdf>

Requirements with the force of law: [Ala. Admin. Code § 560-X-16-.20 \(2014\)](#).

Effective October 1, 2013, Alabama’s Medicaid Agency limits the number of outpatient pharmacy prescriptions to four brand names and five total drugs per month per adult recipient. In no case can total prescriptions exceed ten per month per recipient.

Link to the rule: <http://www.alabamaadministrativecode.state.al.us/docs/med/560-X-16.pdf>

Alaska

Advisory Guidelines: The Alaska Opioid Policy Task Force, within the Alaska Department of Health and Social Services, has conducted several community meetings to discuss potential opioid prescription guidelines and will provide recommendations to the governor and Legislature in November 2016.

For more information, see <http://dhss.alaska.gov/AKOpioidTaskForce/Pages/default.aspx>.

Arizona

Advisory Guidelines: [Arizona Opioid Prescribing Guidelines](#)

Released in November 2014, these are a “voluntary consensus set of guidelines that promote best practices for prescribing opioids for acute and chronic pain.” The guidelines were endorsed by a number of state organizations, including the Arizona Medical

Association, the Arizona Hospital and Healthcare Association, and the Arizona Nurses Association.

Summary of guidelines:

- Opioid medications should only be used for treatment of acute pain when the pain severity warrants that choice, and non-opioid pain medications or therapies do not provide adequate pain relief.
- When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed.
- When opioid medications are prescribed for acute pain, patient should be counseled that:
 - Sharing with others is illegal.
 - Medications should be stored securely.
 - Medications should be disposed of properly when the pain has resolved to prevent non-medical use of medications.
 - Opioids are intended for short-term use only.
 - Driving or operating machinery should be avoided if a patient is sedated or confused while using opioids.
- Long acting opioids should not be used for treatment of acute pain, except in select opioid tolerant patients, and limited situations.
- The continued use of opioids should be considered carefully, including assessing the potential for misuse.
- The Arizona Controlled Substances PMP should be checked prior to prescribing opioids and periodically if renewing opioid prescriptions.
- A comprehensive medical and pain related evaluation that includes assessing for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.
- The provider should assess for risk of misuse, addiction, or adverse effects, and perform risk stratification before initiating opioid treatment.
- Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal directed trial lasting 30-90 days should be the starting point.
- The provider should obtain and document informed consent including discussion of risks, benefits, and conditions under which opioids are prescribed or discontinued.
- Clinicians treating patients with opioids for chronic pain should obtain and review past records when possible.
- Clinicians should consider consultation, when available, for patients with: complex pain conditions, serious co-morbidities including mental illness, a history or evidence of current drug addiction or abuse, patients who are pregnant or breastfeeding.
- An opioid treatment trial should be discontinued if the goals are not met or at any point if the risks outweigh the benefits or if dangerous or illegal behaviors are demonstrated.
- COT should be used in the lowest possible doses to achieve treatment goals. Opioid related adverse events increase with doses >50-100 mg of morphine equivalent

dose per day (MEDD) and reaching these doses should trigger a re-evaluation of therapy.

- Combined use of opioids and benzodiazepines should be avoided if possible.

Link to guidelines: <http://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf>

Requirements with the force of law: Executive Order 2016-06

On October 24, 2016, Governor Doug Ducey issued an executive order limiting all initial prescriptions of opioids to no more than a seven-day dose. The order only applies to situations in which the state is the payer, specifically for Medicaid beneficiaries and state employees enrolled in the state health insurance plan.

Link to the Executive Order:

http://azgovernor.gov/sites/default/files/prescription_opioid_initial_fill_limitation_e.o.0.pdf

Arkansas

Requirements with the force of law: Ark. Code Ann. § 20-7-703 (2015).

This law requires Arkansas hospitals with an emergency department to adopt guidelines concerning prescribing of opioids in the emergency department. The guidelines must address treatment of chronic pain and acute pain; limits on amounts or duration of opioid prescriptions; and identification of situations where opioid prescriptions should be discouraged or prohibited.

Link to the statute: <http://law.justia.com/codes/arkansas/2015/title-20/subtitle-2/chapter-7/subchapter-7/section-20-7-703>

Advisory Guidelines: Arkansas Emergency Department Opioid Prescribing Guidelines

Intended to help EDs reduce the inappropriate use of opioid analgesics while preserving the vital role of the ED to treat patients with emergent medical conditions, these ED prescribing guidelines were adopted by the Arkansas Department of Health, the Arkansas Hospital Association, and the Arkansas Medical Society, among others.

Specific guidelines:

- One medical provider should provide all opioids to treat a patient's chronic pain.
- The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
- Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
- Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
- EDs are encouraged to use the Arkansas PDMP on appropriate patients.
- Physicians should send patient pain agreements to local EDs and work to include a plan for pain treatment in the ED.

- EDs are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.
- EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.
- The administration of Deme-rol® (Meperidine) in the ED is discouraged.
- For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary opioid prescriber or pharmacy.
- The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.
- Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.
- ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

Link to guidelines:

<http://www.arkhospitals.org/Misc.%20Files/Arkansas%20Emergency%20Department%20Opioid%20Prescribing%20Guidelines.pdf>

California

Quasi-regulatory guidelines: Guidelines for Prescribing Controlled Substances for Pain

These guidelines were adopted by the Medical Board of California in November 2014 with the purpose of helping physicians improve outcomes of patient care to prevent overdose deaths due to opioid use. The guidelines recommend that physicians proceed cautiously (yellow flag warning) once the Morphine Equivalent Dose (MED) reaches 80 mg/day. When higher doses are contemplated, referral to a specialist is recommended.

Link to guidelines: http://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf

Colorado

Advisory Guidelines: Joint Policy for Prescribing and Dispensing Opioids

In October 2014, the Colorado Department of Regulatory Agencies (DORA), in collaboration with the Colorado Dental Board, the Colorado Medical Board, the State Board of Nursing, and the State Board of Pharmacy, issued the Joint Policy for Prescribing and Dispensing Opioids. The Policy recommended limiting opioid prescriptions to 90 days in duration, 120 MME, or certain formulations such as transdermal or long-acting preparations.

Link to guidelines:

http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/Colorado_Joint%20Bd_Policy%20for%20Prescribing%20and%20Dispensing%20Opioids.pdf

Requirements with the force of law:

- In August 2014, the Colorado Department for Health Care Policy and Financing (DHCPF), which administers the state's Medicaid program, adopted the recommendations of the Joint Policy and started limiting short-acting oral opioid prescriptions to a maximum of four tablets a day or 120 tablets per 30 days.

For more information, see

<https://www.colorado.gov/pacific/sites/default/files/Stakeholder%20communication%20regarding%20new%20short-acting%20opioid%20policy.pdf>

- In February 2016, the DHCPF began limiting long-acting opioid prescriptions to a maximum of 300 MME per day. The Department also announced that the short-acting opioid policy would continue to be in effect.

For more information, see

<https://www.colorado.gov/pacific/sites/default/files/MME%20Policy%20Update%20-%20University.pdf>

Connecticut

Advisory Guidelines: Connecticut Emergency Department Opioid Prescribing Guidelines

In January 2015, the Connecticut Hospital Association and the Connecticut College of Emergency Physicians issued joint guidelines to “to assist emergency medical personnel (EMPs) in addressing the care needs of persons who come to the Emergency Department (ED), and who have a chronic pain condition that may involve the use of opioids.”

Specific guidelines include:

- The ED should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.
- ED opioid prescriptions for acute injuries should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In most cases, this should not exceed thirty (30) pills.
- ED patients should be asked about a history of current substance abuse prior to prescribing opioids for acute pain. Opioids should be prescribed with great caution in the context of a substance abuse history.
- EMPs generally should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
- EMPs generally should not provide replacement doses for Methadone or Suboxone, but special consideration may be given in the event of natural disasters or other exigent circumstances.
- EMPs generally should not prescribe long-acting opioids (e.g. Oxycontin, Fentanyl patches, and methadone) for acute pain management.
- EMPs should exercise caution when considering prescribing opioids for ED patients in situations in which the identity of the individual cannot be verified.

Link to guidelines: <http://csms.org/wp-content/uploads/2015/02/Opioid-Guidelines-FINAL-1 20 2015.pdf>

Requirements with the force of law: Conn. Gen. Stat. Ann. § 21a-254(9) (2015)

In 2015, Connecticut passed a law to require prescribers of opioids to review the patient’s record on the state’s prescription monitoring program before initiating prescribing a controlled substance. The statute provides as follows:

Prior to prescribing greater than a seventy-two-hour supply of any controlled substance to any patient, the prescribing practitioner or such practitioner's authorized

agent shall review the patient's records in the electronic prescription drug monitoring program established pursuant to this subsection.

Link to the CT's amended controlled substance statute:

<https://www.cga.ct.gov/2015/TOB/h/pdf/2015HB-06856-R00-HB.pdf>

Requirements with the force of law: Conn. Gen. Stat. Ann. § 17a-714a (2016)

On May 27, 2016, the Governor of Connecticut signed HB 5053 into law to expand the state's effort to combat the opioid epidemic. The new law includes a provision to limit the prescribing of opioid drugs by:

- prohibiting, for adult patients, an initial prescription of opioid drugs for longer than seven days
- prohibiting, for minor patients, any prescriptions of opioid drugs for longer than seven days and requiring the prescriber to discuss the risks associated with the drug with the patient
- allowing, for both adult and minor patients, a prescriber to give more than a seven-day supply of opioid drugs if, in the prescriber's professional medical judgement, the acute or chronic pain condition requires it and requires the prescriber to note such condition in the medical record

For more information, see

http://portal.ct.gov/Departments and Agencies/Office of the Governor/Press Room/Press Releases/2016/05-2016/Gov_Malloy_Signs_Comprehensive_Bill_Combating_Opioid_Abuse_and_Launches_Strategic_Plan_to_Tackle_Addiction/

For the language of the statute, see <https://www.cga.ct.gov/2016/ACT/pa/2016PA-00043-R00HB-05053-PA.htm>

Delaware

Requirements with the force of law: Del. Admin. Code C.S.A. 4.0 (2017)

In January 2017, the Delaware Department of State issued new regulations to address the problem of opioid prescription abuse and misuse. The new regulations limit opioid prescribing practices in the following ways:

- For an acute injury or procedure, a practitioner can prescribe a maximum initial seven-day supply of an opioid medication before additional steps are required.
- For minors, practitioners are barred from issuing an opioid prescription for longer than seven days and are required to discuss the reasons for why an opioid prescription is necessary with the minor's parents.
- Prescribing beyond a seven-day supply or for additional prescriptions after the first seven-day supply, the practitioner will be required to check the patient's prescription history in the State's PMP along with obtaining informed consent from the patient for risks of such things as potential addiction, abuse, misuse, and risks of life-threatening respiratory depression and accidental overdose, which can be fatal.

- For patients being treated for chronic pain, practitioners will be required to check the state's PMP and administer a urine drug screening at least twice a year while receiving chronic treatment with opioid medications. The practitioner must also consider and discuss alternative treatment options with a patient, and conduct a risk assessment to identify patients that are or may be at risk for dependence or misuse of a prescribed opioid. A signed treatment agreement will also be required for these patients.

For the language of the rule, see:

<http://regulations.delaware.gov/AdminCode/title24/Uniform%20Controlled%20Substances%20Act%20Regulations.shtml>

Advisory Guidelines: Guidelines for Use of Controlled Substances for the Treatment of Pain
The Medical Society of Delaware issued advisory guidelines for prescribing opioids to treat pain. Recommendations include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to guidelines:

<http://www.medicalsocietyofdelaware.org/Portals/1/PMP/Guidelines%20for%20Controlled%20Substances%20for%20treatment%20of%20Pain%20April%202013.pdf>

Advisory Guidelines: Delaware Emergency Department Opioid Prescribing Guidelines
Intended to help EDs reduce the inappropriate use of opioid analgesics while preserving the vital role of the ED to treat patients with emergent medical conditions, these ED prescribing guidelines were adopted by the Medical Society of Delaware.

Specific guidelines:

- One medical provider should provide all opioids to treat a patient's chronic pain.
- The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
- Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
- Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
- EDs are encouraged to use the Arkansas PDMP on appropriate patients.
- Physicians should send patient pain agreements to local EDs and work to include a plan for pain treatment in the ED.
- EDs are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.
- EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.

- The administration of Deme-rol® (Meperidine) in the ED is discouraged.
- For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary opioid prescriber or pharmacy.
- The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.
- Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

Link to guidelines:

https://www.acep.org/uploadedFiles/ACEP/Membership/Sections_of_Membership/qips/articles/Delaware%20Emergency%20DepartmentOpioid%20Prescribing%20Guidelines%20Revised%201221....pdf

Florida

Quasi-regulatory guidelines: Florida State Opioid Prescribing Policy

The Florida Boards of Medicine and Osteopathic Medicine adopted a policy for the prescribing of opioids that set the standard of care for the state. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the policy: http://fapmmmed.net/State_Opioid_Prescribing_Policy.pdf

Georgia

Requirements with the force of law: Ga. Comp. R. & Regs. 360-3-.06 (2013)

The Georgia Composite Medical Board issued regulations to establish the appropriate standard of care with respect to the prescribing of controlled substances in 2013.

Requirements include:

- Physicians cannot delegate the dispensing of controlled substances to unlicensed person.
- When initially prescribing a controlled substance for the treatment of pain or chronic pain, a physician shall have a medical history of the patient, a physical examination of the patient shall have been conducted, and informed consent shall have been obtained.
- In the event of a documented emergency, a physician may prescribe an amount of medication to cover a period of not more than 72 hours without a physical examination.
- When a physician is treating a patient with controlled substances for pain or chronic pain for a condition that is not terminal, the physician shall obtain or make a diligent effort to obtain any prior diagnostic records relative to the condition for which the controlled substances are being prescribed and shall obtain or make a diligent effort to obtain any prior pain treatment records.

- When a physician determines that a patient for whom he is prescribing controlled scheduled substances is abusing the medication, then the physician shall make an appropriate referral for treatment for substance abuse.
- When prescribing a Schedule II or III controlled substance for 90 consecutive days or greater for the treatment of chronic pain arising from conditions that are not terminal or patients who are not in a nursing home or hospice, a physician must have a written treatment agreement with the patient and shall require the patient to have a clinical visit at least once every three months, while treating for pain, to evaluate the patient's response to treatment.
- The requirement of a visit at a minimum of once every three months can be waived and the clinical visit be at least once per year if the doctor determines there is a substantial hardship and documents such hardship in the patient's record or if the morphine equivalent daily dose ("MEDD") is 30 mg. or less.

Link to the guidelines: <http://rules.sos.state.ga.us/GAC/360-3-06>

Hawaii

Advisory Guidelines: [Emergency Department Opioid Prescription Guidelines](#)

With the purpose of ensuring and protecting the appropriate use of prescription opioid medications, while attempting to reduce opioid abuse and diversion in the state, the Hawaii Chapter of the American College of Emergency Physicians adopted the following guidelines for the prescribing of opioid medications in emergency departments:

- Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.
- If opioid analgesics are prescribed, use the lowest possible safe and effective dose.
- Prescribe short courses of opioid analgesics for acute pain. Most patients require no more than three days of medication.
- Avoid prescribing long-acting or controlled-release opioid analgesics.
- Consider accessing Hawaii's PMP for information on the patient's controlled substance prescription history before providing opioid prescriptions. To assess for opioid abuse or addiction, consider using targeted history or validated screening tools.
- Consider risk factors for respiratory depression and use caution when prescribing opioid analgesics to patients being treated with benzodiazepines or other opioids.
- Avoid administering intravenous or intramuscular opioid analgesics for acute exacerbations of chronic pain.
- One medical provider should provide all opioid medications to treat a patient's chronic pain.
- Avoid providing replacement prescriptions for controlled substances that were lost, destroyed, or stolen. Replacement doses of methadone should not be provided in the emergency department.
- Attempt to coordinate the care of patients who frequently seek care in the ED among emergency, primary care, and specialty providers. Primary care and pain management physicians should make patient pain agreements accessible to local emergency departments and work to include a plan for pain treatment in the ED.

- Provide information about the risks of opioid analgesics, including overdose and addiction, along with information about proper storage and disposal to those receiving a prescription.
- Hospitals are required by law to provide a medical screening examination to determine if a patient has an emergency medical condition. The law does not require physicians to use opioid analgesics to treat pain.

Link to guidelines:

<http://www.hawaiiacep.org/uploadedFiles/Hawaii/Opioid%20Guidelines%20Final.pdf>

Idaho

Quasi-regulatory guidelines: Idaho Board of Medicine Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain

In September 2013, the Idaho Board of Medicine adopted a new policy regarding the use of opioids for treating chronic pain. The policy included guidelines like:

- The medical record should document the presence of one or more recognized medical indications for prescribing an opioid analgesic. Such an evaluation should be completed before a decision is made as to whether to prescribe an opioid analgesic.
- Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse should be part of the initial evaluation and should be completed prior to a decision as to whether to prescribe opioid analgesics.
- Where available, the state PDMP should be consulted to determine whether the patient is receiving prescriptions from any other physicians.
- Safer alternative treatments should be considered before initiating opioid therapy for chronic, non-malignant pain. Opioid therapy should be presented to the patient as a therapeutic trial for a defined period of time (usually no more than 90 days). A decision to continue opioid therapy beyond the trial period should reflect a careful evaluation of benefits versus adverse events and/or potential risks.
- Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs.

Link to guidelines:

<https://bom.idaho.gov/BOMPortal/BOM/PDF%20FORMS/ModelPolicyUseofOpioidAnalgesicsinTreatmentofChronicPain.pdf>

For more information, see:

https://www.idmed.org/idaho/assets/files/AM2016/DuBose_Addt.pdf

Illinois

No data found.

Indiana

Requirements with the force of law: 844 Ind. Admin. Code 5-6-3 (2014)

In September 2014, the Indiana Medical Licensing Board adopted a rule that regulates physicians engaged in the practice of pain management prescribing.

Summary of requirements:

- The rule only applies if a patient has been prescribed:
 - more than 60 opioid containing pills a month for more than three consecutive months;
 - a morphine equivalent dose of more than 15mg per day for more than three consecutive months;
 - a transdermal opioid patch for more than three consecutive months;
 - tramadol, but only if the patient's tramadol dose reaches a morphine equivalent dose of more than 60mg per day for more than three consecutive months; or
 - a hydrocodone extended release medication that is not in abuse deterrent form.
- Physicians must perform an initial evaluation, discuss the risks and benefits of opioids, review a treatment agreement, schedule periodic visits, run a PDMP report at the outset of an opioid treatment plan and annually thereafter, and order drug testing as necessary.
- When a patient's opioid dose reaches 60 mg MED/day, a face to face review of the treatment plan and patient evaluation must be scheduled, including consideration of a referral to a specialist.
- If treatment continues with an MED of more than 60 mg/day, the physician must develop a revised assessment and treatment plan for ongoing treatment, if the physician continues to provide ongoing opioid treatment.

For the language of the rule, see <http://www.ismanet.org/pdf/legal/FinalRule102516.pdf>

For a summary of the rule, see

<http://www.ismanet.org/pdf/legal/IndianaPainManagementPrescribingFinalRuleSummary.pdf>

Iowa

Requirements with the force of law: [Iowa Admin. Code § 653-13.2 \(2016\)](#)

In September 2016, the Iowa Medicine Board adopted an amendment to the regulations concerning the management of chronic pain. The new rule requires opioid-prescribing physicians to adhere to the CDC guidelines when prescribing opioids for chronic pain to patients 18 years of age and older.

For the language of the amendment, see

https://medicalboard.iowa.gov/iowa_code/proposed%20rules/pdf/ARC%202535C%20-%20Chapter%2013%20CDC%20Guidelines%20for%20Prescribing.pdf

For more information, see

<http://www.medicalboard.iowa.gov/Board%20News/2016/Press%20release%20-%20Board%20adds%20CDC%20guideline%20on%20opioid%20prescribing%20to%20lis>

[t%20of%20resources%20for%20physicians%20who%20treat%20chronic%20pain%20-%20%20August%2029%202016.pdf](#)

Kansas

Quasi-regulatory guidelines: [Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain](#)

In June 2002, the Kansas Boards of Healing Arts, Nursing, and Pharmacy issued a joint statement describing what the Boards considered to be the best practices for prescribing opioids to treat acute pain. Recommendations include performing a patient assessment before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the Joint Statement:

http://www.ksbn.org/positionstatements/joint_policy_statement.pdf

Kentucky

Requirements with the force of law: [201 Ky. Admin Regs. 9:260 \(2013\)](#)

In 2013, the Kentucky Board of Medical Licensure adopted new Professional Standards for the Prescribing or Dispensing of Controlled Substances in different situations. Some of these requirements include:

- Obtaining an appropriate medical history relevant to the medical complaint, including a history of present illness
- Obtaining and review a KASPER (Kentucky's PDMP) 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;
- After examining the benefits and risks of prescribing or dispensing a controlled substance to the patient, including non-treatment or other treatment, make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified;
- 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;
- 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
- Explain to the patient how to safely use and properly dispose of any unused controlled substance.

Similar requirements were adopted for opioid prescribing in other situations, including long-term opioid therapy and opioid prescribing in emergency departments.

Link to the statute: <http://www.lrc.state.ky.us/kar/201/009/260.htm>

Link to statute summary:

http://kbl.ky.gov/hb1/Documents/Summary%20of%20201%20KAR%209_260.pdf

Quasi-regulatory guidelines: Guidelines for the Use of Controlled Substances in Pain Treatment

The Kentucky Board of Medical Licensure issues advisory guidelines for prescribing opioids to treat acute pain. Recommendations include performing a patient evaluation before prescribing opioids (including analyzing the patient's KASPER report), obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment

Link to the guidelines: <http://www.kentucky.com/latest-news/article40998984.ece/BINARY/Kentucky%20Board%20of%20Medical%20Licensure's%20guidelines%20for%20the%20use%20of%20controlled%20substances%20in%20pain%20treatment>

Requirements with the force of law: Ky. Rev. Stat. Ann. § 218A.205(3)(b) (2017)

In 2017, Kentucky enacted an act to limit prescriptions of opioid prescriptions to a three-day supply. The act prohibits practitioners from issuing a prescription for a Schedule II substance for more than three days if the prescription is intended to treat pain as an acute medical condition. The following exceptions apply:

- The practitioner believes that more than a three-day supply is necessary to treat the patient's pain as an acute medical condition and the practitioner documents the condition and the lack of alternative options;
- Prescription issued to treat chronic pain;
- Prescription issued to treat pain associated with a cancer diagnosis;
- Prescription issued as part of a narcotic treatment program;
- Prescription issued to treat pain following a major surgery or the treatment of significant trauma;
- The substance is dispensed or administered directly to an ultimate user in an inpatient setting;
- Any additional treatment scenario deemed medically necessary by the state licensing board in consultation with the Kentucky Office of Drug Control Policy

Link to the enacted act:

<http://www.lrc.ky.gov/recorddocuments/bill/17RS/HB333/bill.pdf>

Louisiana

Requirements with the force of law: La. Stat. Ann. § 40:978 (2015)

In 2015, Louisiana amended its controlled substances statute to limit opioid prescriptions to ten (10) days if the prescribing physician is not licensed by the state of Louisiana and the drug prescribed is a Schedule II or Schedule III opioid derivative. In 2016, the statute was again amended to add an exception to this requirement for diagnosis of cancer or terminal illness.

Link to the amended statute: <http://law.justia.com/codes/louisiana/2014/code-revisedstatutes/title-40/rs-40-978>

Maine

Requirements with the force of law: 02-373 Me. Code R. 21 § II (2012)

In 2013, the Maine Boards of Osteopathic Licensure, Licensure in Medicine, Dental Examiners, Nursing, and Podiatric Medicine issued a joint statement on the use of controlled substances for treatment of pain. The regulations were adopted as part of the Maine Code of Rules and include performing a patient evaluation before prescribing opioids (including analyzing the patient's PDMP record), obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment

Link to the regulations:

<https://www1.maine.gov/osteo/administrative/chaptertwentyone.pdf>

Requirements with the force of law: 32 Maine Rev. Stat. Ann. § 3300-F (2016)

In 2016, the Main Legislature amended the state's statute related to professional licensing to adopt the following limitations on prescribers' practices: a licensed physician whose scope of practice includes prescribing opioid medication may not prescribe:

- To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents (MME) of opioid medication per day;
- To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 MME of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 MME of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 MME of opioid medication per day;
- On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain.
- On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain.

Exceptions to these requirements include 1) when prescribing opioid medication for pain associated with active and aftercare cancer treatment, palliative care, end-of-life and hospice care, and medication-assisted treatment (MAT); and 2) when directly ordering or administering benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility, or a residential care facility.

Link to the statute: <https://legislature.maine.gov/legis/statutes/32/title32sec3300-F.html>

Requirements with the force of law: 22 Maine Rev. Stat. Ann § 7253 (2016)

The legislature also added a provision to the state's Controlled Substances Prescription Monitoring Act that requires, upon initial prescription of a benzodiazepine or an opioid medication to a person and every 90 days for as long as that prescription is renewed, a prescriber to check prescription monitoring information for records related to that person. This provision takes effect on January 1, 2017.

Link to the statute: <https://legislature.maine.gov/legis/statutes/22/title22sec7253.html>

Maryland

Advisory Guidelines: Maryland Emergency Department Opioid Prescribing Guidelines

In September 2015, the Maryland Hospital Association, in conjunction with the Maryland Chapter of the American College of Emergency Physicians, developed opioid prescribing guidelines to be used in emergency departments in the state. The guidelines include:

- Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing, or who actively have, substance use disorders.
- When possible, ED providers, or their delegates, should consult the Maryland Prescription Drug Monitoring Program (PDMP) before writing an opioid prescription.
- Hospitals should develop a process to share the ED visit history of patients with other providers and hospitals that are treating the patients by using CRISP, Maryland's health information exchange.
- For acute exacerbations of chronic pain, the ED provider should attempt to notify the patient's primary opioid prescriber or primary care provider of the visit and the medication prescribed.
- ED providers should not provide prescriptions for controlled substances that were lost, destroyed, or stolen. Further, ED providers should not provide doses of methadone or buprenorphine for patients in a treatment program, unless the dose is verified with the treatment program and the patient's ED evaluation and treatment has prevented them from obtaining their scheduled dose.
- Unless otherwise clinically indicated, ED providers should not prescribe long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches, and methadone.
- When opioid medications are prescribed, the ED staff should counsel the patient:
 - to store the medications securely, not share them with others, and dispose of them properly when their pain has resolved;
 - to use the medications only as directed for medical purposes; and
 - to avoid using opioids and concomitant sedating substances due to the risk of overdose.
- As clinically appropriate and weighing the feasibility of timely access for a patient to appropriate follow-up care and the problems of excess opioids in communities, ED providers should prescribe no more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than three days.

Link to the guidelines: <http://www.mhaonline.org/docs/default-source/Resources/Opioid-Resources-for-Hospitals/maryland-emergency-department-opioid-prescribing-guidelines.pdf?sfvrsn=2>

Requirements with the force of law: Md. Code Ann., Health Occ. § 1-223 (2017)

Since 2017, Maryland provides that, “on treatment for pain, a health care provider, based on the clinical judgment of the health care provider, shall prescribe: (1) the lowest effective dose of an opioid; and (2) a quantity that is no greater than the quantity needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance [...].” The following circumstances are exempted:

- Opioid prescribed for a substance-related disorder;
- Opioid prescribed for pain associated with a cancer diagnosis;
- Opioid prescribed for pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or
- - opioid prescribed for chronic pain

Link to the enacted bill: <http://mgaleg.maryland.gov/2017RS/bills/hb/hb1432T.pdf>

Massachusetts

Quasi-regulatory guidelines: Prescribing Practices Policies and Guidelines

In 2015, the Massachusetts Board of Registration in Medicine amended its prescribing guidelines to address the opioid epidemic. The Board adopted the Massachusetts Medical Society’s Opioid Therapy and Physician Communication Guidelines. The guidelines include directions for opioid therapy for acute pain and chronic pain.

Summary of guidelines for acute pain:

- Physicians must be familiar with and follow the requirements of the law and regulations on use of the prescription monitoring program prior to initiating opioid treatment.
- Patients should be screened or assessed for pregnancy, personal or family histories of substance use disorder, mental health status, or relevant behavioral issues.
- Physicians prescribing opioids should inform their patients about the cognitive and performance effects of these prescriptions.
- When clinically indicated, opioids should be initiated as a short-term trial to assess the effects and safety of opioid treatment on pain intensity, function, and quality of life. In most instances, the trial should begin with a short-acting opioid medication.
- The starting dosage should be the minimum dosage necessary to achieve the desired level of pain control and to avoid excessive side effects.
- Duration should be short term with possible partial fill prescriptions or short term, low dosage sequential prescription approaches considered.
- Concurrent prescriptions should be reviewed, including paying close attention to benzodiazepines and other medications that may increase the risks of harm associated with opioid use.
- Patients should be counseled to store the medications securely, never share with others, and properly dispose of unused and expired prescriptions.

Summary of guidelines for chronic pain:

- Threshold for Considering Pain Chronic:
 - The MMS supports a duration of treatment of 90 days, consistent with the, rather than morphine equivalents to trigger these guidelines.
 - This time period should trigger a face-to-face reevaluation of the treatment provided to date, its long-term efficacy, and risks of continued opioid therapy.
- A detailed reevaluation of the patient's history and a physical should be done as soon as possible after the 90-day threshold is reached.
- The physician should do a risk of substance abuse assessment (the physician should consider the use of appropriate baseline urine drug testing if the risk assessment or other evidence indicates there may be issues with use of other drugs).
- The physician should tailor a diagnosis and treatment plan with functional goals at the initial 90-day threshold visit and every 60 to 90 days thereafter

Link to the Board's guidelines: <http://www.mass.gov/eohhs/docs/borim/policies-guidelines/policy-15-05.pdf>

Link to the MMS's guidelines: [http://www.massmed.org/Advocacy/Key-Issues/Opioid-Abuse/Opioid-Therapy-and-Physician-Communication-Guidelines-\(pdf\)/](http://www.massmed.org/Advocacy/Key-Issues/Opioid-Abuse/Opioid-Therapy-and-Physician-Communication-Guidelines-(pdf)/)

Advisory Guidelines: Massachusetts Hospital Association Guidelines for Emergency Department Opioid Management

The MHA Substance Use Disorder Prevention and Treatment Task Force developed opioid prescribing guidelines to be used in emergency departments in the state. The guidelines include:

- Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing substance use disorders.
- When possible, ED providers, or their delegates, should consult the Maryland PDMP before writing an opioid prescription.
- Hospitals should develop a process to share the ED visit history of patients with other providers and hospitals that are treating the patients by using CRISP, Maryland's health information exchange.
- For acute exacerbations of chronic pain, the ED provider should attempt to notify the patient's primary opioid prescriber or primary care provider of the visit and the medication prescribed.
- ED providers should not provide prescriptions for controlled substances that were lost, destroyed, or stolen. Further, ED providers should not provide doses of methadone or buprenorphine for patients in a treatment program, unless the dose is verified with the treatment program.
- Unless otherwise clinically indicated, ED providers should not prescribe long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches, and methadone.

- When opioid medications are prescribed, the ED staff should counsel the patient:
 - to store the medications securely, not share them with others, and dispose of them properly when their pain has resolved;
 - to use the medications only as directed for medical purposes; and
 - to avoid using opioids and concomitant sedating substances due to the risk of overdose.
- ED providers should prescribe no more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than three days.

Link to the guidelines:

<https://www.mhalink.org/AM/Template.cfm?Template=/CM/ContentDisplay.cfm&ContentID=50511&FusePreview=True&WebsiteKey=a3f1ffe-a9f6-4b95-a06a-a551e90c7801>

Requirements with the force of law: Mass. Ann. Laws ch. 94C, § 19D (2016)

In March 2016, Massachusetts adopted opioid prescribing limitations. The limitations do not apply to medications designed for the treatment of substance abuse or opioid dependence. The requirements of the new law are:

- When issuing a prescription for an opiate to an adult patient for outpatient use for the first time, a practitioner shall not issue a prescription for more than a 7-day supply. A practitioner shall not issue an opiate prescription to a minor for more than a 7-day supply at any time and shall discuss with the parent or guardian of the minor the risks associated with opiate use and the reasons why the prescription is necessary.
- If, in the professional medical judgment of a practitioner, more than a 7-day supply of an opiate is required to treat the adult or minor patient's acute medical condition or is necessary for the treatment of chronic pain management, pain associated with a cancer diagnoses or for palliative care, then the practitioner may issue a prescription for the quantity needed to treat such acute medical condition, chronic pain, pain associated with a cancer diagnosis or pain experienced while the patient is in palliative care. The condition triggering the prescription of an opiate for more than a 7-day supply shall be documented in the patient's medical record and the practitioner shall indicate that a non-opiate alternative was not appropriate to address the medical condition.

Link to the statute:

<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section19D>

Michigan

Quasi-regulatory guidelines: Guidelines for the Use of Controlled Substances for the Treatment of Pain

In 2002, the Michigan Boards of Medicine and Osteopathic Medicine & Surgery adopted its guidelines for the prescribing of controlled substances for the treatment of pain. The guidelines, which do not have the force of law, include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is

determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment

Link to the guidelines:

[https://www.michigan.gov/documents/mdch MI guidelines 91795 7.pdf](https://www.michigan.gov/documents/mdch_MI_guidelines_91795_7.pdf)

Minnesota

Quasi-regulatory guidelines: Joint Statement on Pain Management

In 2015, the Minnesota Boards of Medical Practice, Nursing, and Pharmacy updated their Joint Statement on Pain Management to "add guidance regarding appropriate prescribing with emphasis on the critical balance between pain management and the potential misuse of controlled substance medications."

Summary of guidelines:

- Consistently and thoroughly assess all patients for pain. Conduct a comprehensive risk assessment and review all medications and therapies from all sources.
- Utilize the Minnesota PMP prior to prescribing or dispensing controlled substances in an effort to identify additional prescribers and medications to inform decision making.
- Collaborate using a multi-disciplinary approach to identify all treatment options including pharmacologic and non-pharmacologic modalities. Consider the integration of non-medication and multi-modality therapeutic approaches.
- Consider non-opioid alternatives and start patients on the lowest effective dose when initiating pharmacologic therapy. Carefully consider the risks associated with the combination of an opioid and benzodiazepine.
- Obtain informed consent and consider a written treatment agreement and monitoring plan to promote adherence to the treatment plan and goals. Provide the patient with information regarding the benefits and risks of opioid therapy.
- Conduct urine drug screening, as appropriate.
- Educate patients about the safe use, storage, and disposal of opioid medications as well as the consequences for misuse or illegal use of prescribed medications.
- Re-evaluate and document the patient's pain, functionality, and response to treatment using consistent and developmentally appropriate tools. Make adjustments as needed and exercise increased clinical vigilance for patients using high-dose opioids.
- Direct patients in need of substance use disorder evaluations or treatment to appropriate providers, when applicable.
- Consider equipping patients at risk of an overdose with an opioid antagonist.
- Develop safe and effective strategies for discontinuing chronic opioid therapies.

Link to the guidelines:

https://mn.gov/boards/assets/Joint%20Statement%20on%20Pain%20Management%202015_tcm21-90718.pdf

Requirements with the force of law: Minn. R. 5221.6110 (2015)

Under Minnesota regulations, before prescribing long-term opioids, practitioners are required to:

- Affirm that the patient cannot maintain functions of daily life without the medication, doesn't have somatic symptoms disorder, doesn't have a history of failure to comply with treatment, and doesn't have substance abuse disorder;
- Ensure that all other pain management options have been exhausted;
- Determine whether the following circumstances are present, and whether they constitute contraindications for long-term opioid use: history of respiratory depression, pregnancy or planned pregnancy, history of substance abuse, suicide risk, poor impulse control, and regular engagement in unsafe activity for a patient on opioids;
- Complete a scientific assessment to determine the patient's risk for abuse;
- Explain the potential consequences and complications of long-term opioids to the patient;
- Enter into a written contract with the patient that includes a provision for drug testing at the doctor's discretion.

Link to the rule: <https://www.revisor.mn.gov/rules/?id=5221.6110>

Mississippi

Requirements with the force of law: [Miss. Admin. Code 30-17-2640:1.7 \(2012\)](#)

In 2012, the Mississippi Board of Medical Licensure adopted a new rule for the prescribing of controlled substances to treat chronic (non-terminal) pain. The rule includes, among others, the following requirements:

- No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is nontherapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.
- No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions
- Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.

This statute provides exceptions for situations such as emergency treatment and treatment in hospitals to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of a condition other than addiction.

Link to the regulations:

http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/Mississippi%20Medical%20Board%20Regulations_1.pdf

Missouri

Quasi-regulatory guidelines: [Guidelines for the Use of Controlled Substances for the Treatment of Pain](#)

In 2007, the Missouri Board of Healing Arts issued guidelines on prescribing of controlled substances to “clarify the Boards’ position on pain control, to alleviate physician uncertainty and to encourage better pain management.” The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient’s treatment.

Link to the guidelines:

http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/MO_CSGUIDE_0.pdf

Montana

Advisory Guidelines: [Statement on the Use of Controlled Substances in the Treatment of Intractable Pain](#)

In 2002, the Montana Board of Medical Examiners issued a statement on the use of opioids and other controlled substances for the treatment of pain. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient’s treatment.

Link to the statement:

<http://indianapainsociety.org/fileuploads/OpioidPolicies/MontanaMedicalBoardOpioidGuidelines.pdf>

Nebraska

Quasi-regulatory guidelines: [Guidelines for the Use of Controlled Substances for the Treatment of Pain](#)

On June 17 2016, the Nebraska Board of Medicine and Surgery reaffirmed its guidelines for the prescribing of opioids to treat pain. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient’s treatment.

Link to the guidelines:

<http://dhhs.ne.gov/publichealth/Licensure/Documents/GuidelinesForUseOfContSubst.pdf>

Nevada

Requirements with the force of law: [Nev. Rev. Stat. Ann. § 639.23507 \(2015\)](#)

Since 2015, Nevada requires prescribers of controlled substances to obtain a patient utilization report regarding the patient from the prescription monitoring program before initiating a prescription for a controlled substance. This requirement is triggered if 1) the patient is a new patient of the practitioner, or 2) the prescription is for more than 7 days

and is part of a new course of treatment for the patient. By reviewing the patient utilization report, the practitioner must assess whether the prescription for the controlled substance is medically necessary.

Link to the statute: <https://www.leg.state.nv.us/nrs/NRS-639.html#NRS639Sec23507>

Advisory Guidelines: Nevada Hospital Association Guidelines for Controlled Substance Prescriptions

In February 2016, the NHA adopted guidelines for hospitals to address the misuse of controlled substance prescriptions. The guidelines establish best practices for prescribers and pharmacists for screening and prescribing controlled substances and opioid antagonists in a hospital emergency department or practitioners discharging an in-patient to home.

Link to NHA's press release:

[https://nvha.net/News/Docs/2016 News Release.PMP and Opioids.pdf](https://nvha.net/News/Docs/2016%20News%20Release.PMP%20and%20Opioids.pdf) (the guidance document is currently unavailable online)

New Hampshire

Quasi-regulatory guidelines: Board of Medicine Guidelines for Pain Management

The New Hampshire Board of Medicine adopted voluntary guidelines for physicians prescribing opioids to treat pain. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the guidelines: <https://www.nh.gov/medicine/aboutus/pain.htm>

Requirements with the force of law: N.H. Rev. Stat. Ann. § 318-B:39 (2016)

This law requires prescribers to query the prescription drug monitoring program when prescribing schedule II, III, and IV opioids for the management or treatment of pain and then periodically (at least twice per year), except when controlled medications are to be administered to patients in a health care setting, and when treating acute pain associated with serious traumatic injury, post-surgery, or with an acute medical condition for no more than 30 days.

Requirements with the force of law: N.H. Code Admin. R. Med. 502 (2016)

The New Hampshire Board of Medicine's new requirements for physicians who prescribe opioids went into effect on January 1, 2017. First, the new rule requires physicians to query the prescription drug monitoring program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient's pain and then periodically and at least twice per year. Physicians are exempted from this requirement when controlled medications are to be administered to patients in a health care setting, or when treating

acute pain associated with serious traumatic injury, post-operatively, or with an acute medical condition for no more than 30 days. The requirements also limit doses of opioids prescribed in emergency settings to a maximum of seven days. The rule includes requirements for both acute pain treatment and chronic pain treatment.

Requirements for acute pain treatment include:

- Conduct and document a physical examination and history;
- Consider the patient's risk for opioid misuse, abuse, or diversion and prescribe for the lowest effective dose for a limited duration;
- Document the prescription and rationale for all opioids;
- Ensure that the patient has been provided information that contains the following:
 - Risk of side effects, including addiction and overdose resulting in death;
 - Risks of keeping unused medication;
 - Options for safely securing and disposing of unused medication;
 - Danger in operating motor vehicle or heavy machinery

Requirements for chronic pain treatment include:

- Conduct and document a history and physical examination;
- Conduct and document a risk assessment, including, but not be limited to, the use of an evidence-based screening tool;
- Document the prescription and rationale for all opioids;
- Prescribe for the lowest effective dose for a limited duration;
- Utilize written informed consent that explains the following risks associated with opioids:
 - Addiction;
 - Overdose and death;
 - Physical dependence;
 - Physical side effects;
 - Hyperalgesia;
 - Tolerance; and
 - Crime victimization;
- Create and discuss a treatment plan with the patient.
- Utilize a written treatment agreement that is included in the medical record, and specifies conduct that triggers the discontinuation or tapering of opioids;
- Document the consideration of a consultation with an appropriate specialist in the following circumstances:
 - When the patient receives a 100 mg morphine equivalent dose daily for longer than 90 days;
 - When a patient is at high risk for abuse or addiction; or
 - When a patient has a co-morbid psychiatric disorder;
- Require periodic review and follow-up at least every 4 months;
- Require random and periodic urine drug testing at least annually for all patients using opioids for longer than 90 days;
- The prescriber may forego the requirements for a written treatment agreement and for periodic drug testing for patients:

- Who are residents in a long-term, non-rehabilitative nursing home facility where medications are administered by licensed staff; or
- Who are being treated for episodic intermittent pain and receiving no more than 50 dose units of opioids in a 3-month period.

Link to the rule: <https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf>

New Jersey

Requirements with the force of law: N.J. Admin. Code § 13:35-7.6 (2011)

This rule imposes the following limits on the prescribing of controlled substances:

- When prescribing, dispensing or administering controlled substances, a practitioner shall ensure that a patient's medical history has been taken and physical examination accomplished, including any history of substance abuse and the nature, frequency and severity of any pain.
- With respect to Schedule II controlled substances, a practitioner shall not authorize a quantity calculated to exceed 120 dosage units or a 30-day supply, whichever is less.
- A practitioner may exceed the 120 dosage unit or 30-day supply limitations for Schedule II controlled substances in the following circumstances:
 - For the 120 dosage unit limitation, the practitioner follows a plan designed to achieve effective pain management, which has been tailored to the needs of a patient who is suffering pain from cancer, intractable pain or terminal illness.
 - With regards to the 30-day supply limitation, a practitioner may prescribe the use of an implantable infusion pump which is utilized to achieve pain management for patients suffering from cancer, intractable pain or terminal illness. A prescription for such an implantable infusion pump may provide up to a 90-day supply, as long as the physician evaluates and documents the patient's continued need at least every 30 days; and
 - With regards to the 30-day supply limitation, a practitioner may prescribe multiple prescriptions authorizing a patient to receive a total of up to a 90-day supply of a Schedule II controlled dangerous substance provided that.
- When controlled substances are continuously prescribed for management of pain for three months or more, the practitioner:
 - Shall review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain and the patient's progress toward treatment objectives;
 - Shall remain alert to problems associated with physical and psychological dependence; and
 - Shall periodically make reasonable efforts, unless clinically contraindicated, to stop the use of the controlled substance, decrease the dosage, try other drugs such as nonsteroidal anti-inflammatories, or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence.
- A practitioner managing pain in a patient with a history of substance abuse shall exercise extra care by way of monitoring and possible consultation with addiction specialists.

- The practitioner shall keep accurate and complete patient records.

Link to the statute:

http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/NJ_mbreg3_0.pdf

Requirements with the force of law: N.J. Rev. Stat. § 45:1-46.1(a)(1) (2015)

Since 2015, New Jersey requires prescribers to access prescription monitoring information before prescribing opioids and other controlled substances to a patient. The statute provides as follows:

[A] practitioner or other person who is authorized by a practitioner to access prescription monitoring information [...] shall access prescription monitoring information the first time the practitioner or other person prescribes a Schedule II controlled dangerous substance to a new patient for acute or chronic pain. In addition, for any prescription of a Schedule II controlled dangerous substance for a new or current patient for acute or chronic pain, [...] a practitioner or other authorized person shall access prescription monitoring information on a quarterly basis during the period of time the patient continues to receive such prescriptions.

Link to the statute: <http://law.justia.com/codes/new-jersey/2015/title-45/section-45-1-46.1/>

Resolutions: New Jersey Senate Resolution No. 60 (2016)

The New Jersey Senate Resolution No. 60 “urge[d] the State Board of Medical Examiners to adopt the CDC Guideline for Prescribing Opioids for Chronic Pain, United States 2016 in order to improve patient safety, educate patients about the risks and benefits of opioid use as a pain management treatment, and reverse the cycle of opioid pain medication misuse that is contributing to the opioid overdose epidemic in New Jersey.” As of October 2016, the CDC guidelines have yet to be adopted by the New Jersey Board of Medical Examiners.

Link to the resolution: ftp://www.njleg.state.nj.us/20162017/SR/60_I1.PDF

Requirements with the force of law: N.J. Stat. Ann. §§ 24:21-15.2 and 45:9-22.19 (2017)

In 2017, New Jersey enacted one of the most aggressive acts to prevent opioid overdoses. Beginning May 2017, the state will limit the initial prescriptions of opioid to treat acute or chronic pain to a five-day supply. The prescriber must also (1) take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history; (2) conduct, as appropriate, and document the results of a physical examination; (3) develop a treatment plan, with particular attention focused on determining the cause of the patient's pain; (4) access relevant prescription monitoring information under the state's PDMP. Subsequent prescriptions of Schedule II controlled substances must be limited to a maximum of 30-day supply.

Link to the enacted act: <http://www.njleg.state.nj.us/2016/Bills/PL17/28 .PDF>

New Mexico

Advisory Guidelines: New Mexico Hospital Association-Recommended Opioid Risk-Reduction Strategies and Prescribing Guidelines in New Mexico Emergency Departments
The NMHA Behavioral Health Task Force developed opioid prescribing guidelines to be used in emergency departments in the state. The guidelines include:

- Hospital ED personnel should develop a process to screen for substance misuse and abuse that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing, or who actively have, substance use disorders.
- Hospital ED personnel should develop a process to document an appropriate pain assessment as well as a reason pain medication was denied to meet CMS standards for pain assessment and treatment; the patient should receive this information too.
- EDs should develop processes to facilitate appropriate provider or provider delegate consultations of the NM PMP prior to writing opioid prescriptions.
- Hospitals should support timely implementation and the use of the ED Information Exchange to reduce risk associated with frequent ED visits and potential for multiple narcotic or benzodiazepine prescriptions.
- Hospitals should support processes for ED provider notification of a patient's primary opioid prescriber or primary care provider when prescriptions for acute exacerbations of chronic pain are made.
- ED providers and hospital-based pharmacies should be encouraged to prescribe nasal naloxone and provide education to at-risk patients (e.g., patients on high dose/quantity narcotic prescriptions, patients with accidental prescription or illicit narcotic overdoses, etc.) and their families/friends.

Link to the guidelines: <http://nmhanet.org/files/Documents/Emergency-Medicine-Controlled-Substance-Administration-and-Prescribing-Guidelines.pdf>

Requirements with the force of law: N.M. Code R. § 16.10.14.10 (2014)

Since 2014, New Mexico requires physicians to obtain a patient PMP report for the previous twelve months before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III, or IV. This provision is triggered if the patient is a new patient of the practitioner (in which situation a patient PMP report for the previous twelve months shall only be required when drugs are prescribed for a period greater than 10 days). Moreover, during the continuous use of opioids by established patients a PMP report shall be requested and reviewed a minimum of once every six months.

Link to the statute: <http://164.64.110.239/nmac/parts/title16/16.010.0014.htm>

New York

Advisory Guidelines: NYC Emergency Department Discharge Opioid Prescribing Guidelines
In 2013, the New York City Department of Health and Mental Hygiene released guidelines to provide recommendations for opioid analgesic prescribing to patients being discharged from EDs. The guidance includes the following recommendations:

- Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.

- Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.
- Prescribe no more than a short course of opioid analgesics for acute pain. Most patients require no more than three days.
- To assess for opioid misuse or addiction, prescribers can access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients' controlled substance prescription history.
- Avoid initiating treatment with long-acting or extended-release opioid analgesics.
- Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, nonpharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.
- Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.
- Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one-to two-day supply.
- Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/ addiction, as well as safe storage and proper disposal of unused medications.

Link to the guidelines: <https://www1.nyc.gov/assets/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf>

Requirements with the force of law: N.Y. Pub. Health § 3334-a(2) (2013)

Since 2013, the State of New York requires physicians to access the state's prescription monitoring program before initiating a controlled substance treatment. The statute provides as follows:

Every practitioner shall consult the prescription monitoring program registry prior to prescribing or dispensing any controlled substance [...], 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

Link to the statute: <http://law.justia.com/codes/new-york/2015/pbh/article-33/title-4/3343-a/>

Requirements with the force of law: N.Y. Pub. Health § 3331(5) (2016)

In 2016, the New York Legislature amended the state's controlled substances statute to include a provision that limits the doses of opioids physicians are allowed to prescribe. Opioid prescriptions are limited to seven days for first time users for treatment of acute pain. Practitioners can issue refills after subsequent consultations that they deem appropriate up to a 30-day supply. Finally, the new act requires regulations to articulate circumstances where one-time prescription between 30 and 90 days is warranted.

Link to the enacted act:

http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10727&term=&Summary=Y&Actions=Y&Memo=Y&Text=Y

North Carolina

Quasi-regulatory guidelines: [Policy for the Use of Opiates for the Treatment of Pain](#)

In June 2014, the North Carolina Medical Board issued guidelines for the use of opioids in treating pain. The guidelines include, among others:

- Patient evaluation and risk stratification should be performed before initiating opioid treatment.
- Information from the North Carolina Controlled Substance Reporting System (NCCSRS) should be part of every patient's initial evaluation and subsequent monitoring program.
- Development of opioid treatment plan and goals should be established before initiating opioid treatment.
- Physicians should obtain informed consent and written agreement before prescribing opioids.
- Safer alternative treatments including non-pharmacologic and minor interventions and first line pharmacotherapy with over the counter medications, non-steroidal anti-inflammatory drugs, and acetaminophen should be considered before initiating opioid therapy.
- When the decision to use an opiate has been made, it should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with specified evaluation points.
- The Board expects physicians who prescribe opiates to help insure that naloxone is readily available to patients who are identified as being at risk of an opiate overdose
- When initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient and titrated to affect while monitoring for complications. Opioid therapy should begin with a short acting drug and rotate to a long acting/extended release if indicated. A decision to continue opioid therapy beyond the trial period should reflect a careful evaluation of benefits, adverse events, and potential risks.
- The physician should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of activities.
- Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs.

Link to the guidelines:

[http://www.ncmedboard.org/images/uploads/other_pdfs/Policy for the Use of Opiates for the Treatment of Pain June 4 2014.pdf](http://www.ncmedboard.org/images/uploads/other_pdfs/Policy_for_the_Use_of_Opiates_for_the_Treatment_of_Pain_June_4_2014.pdf)

North Dakota

Advisory Guidelines: [Safe Prescribing Tips for Opioids](#)

The North Dakota Department of Human Services issued tips for safe opioid prescribing practices in their Medicaid Pharmacy Program Quarterly Newsletter. Some of the recommendations include:

- Individualize treatment.
- Consider long-acting preparations.
- When opioids are used to treat chronic pain, they should be considered one portion of a multimodal treatment plan. The treatment plan should acknowledge that the patient is likely to benefit from a range of therapies, both pharmacologic and non-pharmacologic.
- In patients with chronic pain, opioid therapy should be considered after the patient has tried and failed non-opioid therapy as well as non-pharmacologic pain therapy.
- Educate patients and get a written treatment agreement
- Refer patients with complicated cases to a specialist.
- Random urine drug screening may be important, even before an opioid is prescribed. This can be an important part of the patient history as it can screen for the presence of illegal drugs, unreported prescribed medications, or unreported alcohol use prior to starting therapy
- Consider tamper-resistant products. The tamper-resistant products should be considered in all patients and not just those exhibiting potential abuse behaviors.

Link to the recommendations:

http://www.hidesigns.com/assets/files/ndmedicaid/newsletters/ND%20newsletter1_rev.pdf

Ohio

Advisory Guidelines: Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines

In April 2012, the Ohio Department of Health, in collaboration with the Ohio Hospital Association, the Ohio State Pharmacists Association, among others, issued guidelines for the prescribing of opioids in emergency and acute care settings.

Specific guidelines:

- OOCs for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, clinical examination, and risk for addiction.
 - Doses of OOCs for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
 - Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCs prescription from another provider within the last month.
 - IV Demerol (Meperidine) for acute or chronic pain is discouraged.
- Emergency medical clinicians will not routinely provide:
 - Replacement prescriptions for OOCs lost, destroyed or stolen.
 - Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.

- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).
- Prior to making a final determination regarding whether a patient will be provided a prescription for OPCS, the emergency clinician or facility:
 - Should search the Ohio Automated Rx Reporting System (OARRS) or other prescription monitoring programs, per state rules.
 - Reserves the right to perform a urine drug screen or other drug screening.
- Prior to making a final determination regarding whether a patient will be provided a prescription for an OPCS, the emergency clinician should consider the following options:
 - Contact the patient’s routine provider who usually prescribes their OPCS.
 - Request a consultation from their hospital’s palliative or pain service (if available), or an appropriate sub-specialty service.
 - Perform case review or case management for patients who frequently visit the emergency/ acute care facilities with pain-related complaints.
 - Request medical and prescription records from other hospitals, provider’s offices.
 - Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OPCS.
- Except in rare circumstances, prescriptions for OPCS should be limited to a three-day supply.
- Each patient leaving the emergency/acute care facility with a prescription for OPCS should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and the appropriate storage and disposal of these medications at home.

Link to the guidelines: <http://www.healthy.ohio.gov/-/media/HealthyOhio/ASSETS/Files/edguidelines/EGs-no-poster.pdf?la=en>

Advisory Guidelines: Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain 80 mg of Morphine Equivalent Daily Dose (MED) “Trigger Point”

In October 2013, the Ohio Opiate Action Team (part of the Governor’s cabinet), issued recommendations for the treatment of chronic, non-terminal pain with opioids.

Specific guidelines:

- Providers should first consider non-pharmacologic and non-opioid therapies. Providers should exercise the same caution with tramadol as with opioids.
- Providers must avoid Long-Term and Co-Prescribing.
- Providers should avoid starting a patient on long-term opioid therapy when treating chronic pain. Providers should also avoid prescribing benzodiazepines with opioids.
- Providers treating chronic, non-terminal pain patients who have received opioids equal to or greater than 80 mg MED for longer than three continuous months should strongly consider doing the following:
 - Reestablish informed consent, including providing the patient with written information on the potential adverse effects of long-term opioid therapy.

- Review the patient’s functional status and documentation,
 - Review the patient’s progress toward treatment objectives for the duration of treatment.
 - Utilize OARRS as an additional check on patient compliance.
 - Reconsider having the patient evaluated by one or more other providers who specialize in the treatment of the area, system, or organ of the body perceived as the source of the pain.
- For providers treating acute exacerbation of chronic, nonterminal pain, clinical judgment may not trigger the need for using the full array of reassessment tools.

Link to the guidelines:

<http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Chronic-Pain.pdf>

Requirements with the force of law: Ohio Admin. Code 4731-11-11 (2015)

Since 2015, the Ohio State Medical Board requires physicians to obtain and review an OARRS report to help determine if it is appropriate to prescribe an opioid analgesic, benzodiazepine, or reported drug to a patient unless one of the following exceptions apply:

- The reported drug is prescribed or personally furnished to a hospice patient in a hospice care program or any other patient diagnosed as terminally ill;
- The reported drug is prescribed for administration in a hospital, nursing home, or residential care facility;
- The reported drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days;
- The reported drug is prescribed or personally furnished for the treatment of cancer or another condition associated with cancer; and
- The reported drug is prescribed or personally furnished to treat acute pain resulting from a surgical or other invasive procedure or a delivery.

Link to the statute: <http://codes.ohio.gov/oac/4731-11-11v1>

Advisory Guidelines: Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments

In 2016, the Ohio Opiate Action Team issued recommendations for the prescribing of opioids for treatment of acute pain outside of emergency rooms.

Specific guidelines:

- Assessment and Diagnosis of Patient Presenting with Pain. A specific diagnosis should be made, when appropriate, to facilitate the use of an evidence-based approach to treatment.
- Upon determining the symptoms fit the definition of acute pain, both the provider and patient should discuss the risks/benefits of pharmacologic therapy.
- Non-pharmacologic therapies should be considered as first-line therapy for acute pain.
- Non-opioid medications should be used with non-pharmacologic therapy.
- Reserve opioids for acute pain resulting from severe injuries or medical conditions, surgical procedures, or when non-opioid options are ineffective or contraindicated.

- Appropriate risk screening should be completed (e.g. age, pregnancy, high-risk psychosocial environment, personal or family history of substance use disorder).
- Provide the patient with the least potent opioid to effectively manage pain. A morphine equivalence chart should be used if needed.
- Prescribe the minimum quantity needed with no refills based on each individual patient, rather than a default number of pills.
- Consider checking Ohio Automated Rx Reporting System (OARRS) for all patients who will receive an opiate prescription
- Avoid long-acting opioids (e.g. methadone, oxycodone ER, fentanyl).
- Use caution with prescribing opioids with patients on medications causing central nervous system depression (e.g. benzodiazepines and sedative hypnotics) or patients known to use alcohol.
- Discuss with the patient a planned wean off opioid therapy, concomitant with reduction or resolution of pain.
- Discuss proper secure storage and disposal of unused medication to reduce risks to the patient and others.
- Remind the patient that it is both unsafe and unlawful to give away or sell opioid medication, including unused or leftover medication.

Link to the guidelines:

<http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf>

Link to the Ohio Guidelines Factsheet:

<http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/20160112-GCOAT-Prescribing-Guidelines-Summary.pdf>

Requirements with the force of law: *Adoption by professional boards pending*

In March 2017, Gov. Kasich announced that the Ohio Medical Board, together with the Boards of Pharmacy, Dentistry, and Nursing, will be adopting new regulations implementing limits on opioid prescribing. In general:

- Practitioners may prescribe no more than seven days of opiates for adults;
- Practitioners may prescribe no more than five days of opiates for minors;
- The total morphine equivalent dose (MED) of a prescription for acute pain cannot exceed an average of 30 MED per day;
- Health care providers can prescribe opiates in excess of the new limits only if they provide a specific reason in the patient's medical record.
- Prescribers will be required to include a diagnosis or procedure code on every controlled substance prescription, which will be entered into Ohio's PDMP, OARRS.

The new limits do not apply to opiates prescribed for cancer, palliative care, end-of-life/hospice care or medication-assisted treatment for addiction.

Link to the announcement:

<http://www.pharmacy.ohio.gov/Documents/Pubs/NewsReleases/2017/New%20Limits%20on%20Opioid%20Prescribing.pdf>

[20on%20Prescription%20Opiates%20Will%20Save%20Lives%20and%20Fight%20Addiction.pdf](#)

Link to FAQ on the new rules:

<http://www.pharmacy.ohio.gov/Documents/Pubs/Special/ControlledSubstances/New%20Limits%20on%20Prescription%20Opiates%20for%20Acute%20Pain%20-%20Frequently%20Asked%20Questions.pdf>

Oklahoma

Requirements with the force of law: Okla. Stat. Ann. tit. 63, § 2-302(M) (2010)

Since 2010, Oklahoma requires physicians who prescribe methadone to check the patient's record at the state's prescription monitoring program (PMP). The statute provides as follows:

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.

Link to the statute: <http://law.justia.com/codes/oklahoma/2015/title-63/section-63-2-302/>

Advisory Guidelines: Oklahoma Emergency Department (ED) and Urgent Care Clinic (UCC) Opioid Prescribing Guidelines

In 2013, an interdisciplinary group of health care practitioners in Oklahoma, that included the Oklahoma Board of Nursing, the Oklahoma State Medical Association, the Oklahoma Department of Mental Health and Substance Abuse Services, among others, published a set of recommendations for physicians and other providers prescribing opioids for treating acute and chronic pain in office-based settings.

- Consider opioid medications for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.
- When administering or prescribing opioids, it is suggested that health care providers start with the lowest possible effective dose for the management of pain.
- When prescribing opioids for acute pain, prescribe no more than a short course, except in special circumstances. Most patients require opioids for no more than three days of pain control, with a maximum of 30 pills in most cases.
- Providers should query the Oklahoma PMP for patients presenting with acute pain, prior to prescribing opioid medication.
- In patients who routinely take opioids for chronic pain, it is ideal that one health care provider provide all opioid prescriptions. When an exception occurs and another provider deems it necessary to prescribe opioids, Oklahoma PMP data should be reviewed, and only enough pills prescribed, if indicated, to last until the office of the patient's primary opioid prescriber opens.
- Health care providers should not provide replacement prescriptions for lost, destroyed or stolen controlled substances.
- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, suboxone, and methadone) should not be prescribed from the ED/UCC.

- The emergency health care provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.
- The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.
- Use caution when prescribing opioid medications to patients currently taking benzodiazepines and/or other opioids.
- Provide information about opioid medications to patients receiving an opioid prescription, such as the risks of overdose and addiction.
- Health care providers are encouraged to consider non-pharmacological therapies and/or referral to specialists for follow-up, as clinically appropriate.

Link to the guidelines:

<http://www.okoha.com/Images/OHADocs/Patient%20Safety/Opioid%20Guidelines/Oklahoma ED Guidelines FINAL%20with%20logos%20v2.pdf>

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

In September 2014, an interdisciplinary group of health care practitioners in Oklahoma, that included the Oklahoma Board of Nursing, the Oklahoma State Medical Association, the Oklahoma Department of Mental health and Substance Abuse Services, among others, published a set of recommendations for physicians and other providers prescribing opioids for treating acute and chronic pain in office-based settings.

Specific guidelines for treating acute pain:

- Opioids should only be used for treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies will not provide adequate pain relief.
- Providers should query the Oklahoma Prescription Monitoring Program (PMP) for patients presenting with acute pain, prior to prescribing an opioid medication. In circumstances where a patient's pain is resulting from an objectively diagnosed disease process or injury, a provider may prudently opt not to review the Oklahoma PMP.
- When opioids are prescribed for treatment of acute pain, the number of doses dispensed 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.
- When opioids are prescribed for treatment of acute pain, the patient should be counseled to store the medications securely and never to share with others.
- Long duration-of-action opioids (e.g., methadone, buprenorphine, fentanyl, extended release oxycodone, and morphine) are rarely indicated for treatment of acute pain.
- The use of opioids should be re-evaluated carefully, including assessing the potential for abuse, if persistent pain suggests the need to continue opioids. Health care providers should query the Oklahoma PMP as part of this re-evaluation process.
- Health care providers should generally not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

Specific guidelines for treating chronic pain:

- Alternatives to opioid treatment should be tried, or previous attempts documented, before initiating opioid treatment.
- A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain.
- The health care provider should screen for risk of abuse or addiction before initiating opioid treatment.
- Prior to the initial prescribing of opioid medications, health care providers should query the Oklahoma Prescription Monitoring Program (PMP).
- When opioids are used for the treatment of chronic pain, a written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function.
- 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 goals should be scheduled during the period when the dose of opioids is being adjusted. During this period and until the patient is clinically stable and judged to be compliant with therapy, it is recommended that the health care provider check the Oklahoma PMP more frequently.
- 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 Oklahoma PMP should be queried at least once per year for patients receiving opioid treatment for chronic pain.
- Opioid treatment should be discontinued if adverse effects outweigh benefits or if aberrant, dangerous, or illegal behaviors are demonstrated.
- Health care providers should generally not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.
- The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.
- Long-acting opioids should only be prescribed by health care providers familiar with their indications, risks, and need for careful monitoring.
- When opioids are prescribed for treatment of chronic pain, the patient should be counseled to store the medications securely and never to share with others.

Link to the guidelines:

https://www.ok.gov/health2/documents/UP_Oklahoma_Office_Based_Guidelines.pdf

Requirements with the force of law: Opioid Analgesic Quantity Limits

In November 2014, the Oklahoma Health Care Authority (OHCA), which administers the state's Medicaid program, implemented a quantity limit on coverage of short-acting opioid prescription. Chronic opioid analgesic quantity limits apply to short-acting opioid therapies greater than 10 days. This is triggered when a member receives a prescription greater than 10-day supply and the quantity is greater than four per day. For therapies determined to be long-term (greater than 10-day supply), the maximum quantity that will be reimbursed is four dosage units per day.

Link to OHCA's opioid prescribing policy:

<https://www.okhca.org/providers.aspx?id=11146>

Oregon

Advisory Guidelines: [Oregon Pain Guidance Pain Treatment Guidelines](#)

In 2016, the Oregon Pain Guidance, a group of physicians, nurse practitioners, pharmacists, and other health care providers, updated its guidance for physicians prescribing opioids to treat pain. The updated guidelines endorsed and incorporated the CDC's 12 recommended guidelines and incorporated guidelines from the Washington state AMDG guidelines. The guidelines include, among others, the following axioms:

Guidelines for acute pain:

- For most injuries and minor procedures (e.g., dental extraction, sports injuries), prescribe no more than a three-day supply or 10 doses of a short-acting opioid.
- For more severe injuries (e.g., fractures), prescribe no more than a seven-day supply of a short-acting opioid.
- Do not prescribe extended-release opioids for acute pain.

Guidelines for chronic conditions with acute pain flares

- Do not use opioids for acute flares of non-specific musculoskeletal pain, headaches, or fibromyalgia.
- For acute flares of other chronic conditions (e.g., osteoarthritis, sickle cell anemia), limit prescribing to a three-day supply of a short-acting opioid. In rare instances, up to a seven-day supply may be appropriate.
- Check the state Prescription Drug Monitoring Program (PDMP) with any first opioid prescription.

Guidelines for subacute (6–12 weeks) opioid use and transition to chronic opioid therapy (>12 weeks)

- Don't start long-term use of opioids without a visit devoted to evaluation of suitability of long-term opioid use and discussion of all opioid risks and realistic benefits.
- Use non-opioid alternatives (non-opioid analgesics, graded exercise, cognitive behavioral therapy, mindfulness, and relaxation techniques).
- Unless opioid use has resulted in clinically meaningful improvement in pain and function (at least 30% improvement documented with validated instruments), discontinue prescribing.
- If opioid use results in clinically meaningful improvement in pain and function, use best-practice screenings for opioid-related risks. Assess signs of prescription opioid-use disorder by asking the patient or family members about history of substance abuse.
- At every prescribing visit for opioids, the total opioid dose should be recorded using an online calculator and measures of pain and function using brief validated instruments.

Guidelines for chronic opioid use (>12 weeks)

- Do not prescribe chronic opioids for non-specific musculoskeletal pain, headache or fibromyalgia.

- Do not combine opioids with benzodiazepines, muscle relaxants, or sedative hypnotics.
- Repeat PDMP check and urine drug screen (UDS) periodically, based on risk.
- Avoid exceeding 90 mg/day MED. For patients with one or more risk factors (e.g., history of substance-use disorder, tobacco users, mental health disorders, cannabis-use disorder), do not prescribe more than 50 mg/day MED.
- Non-pharmacological alternatives to opioids should be used and incented for most chronic-pain conditions
- Periodically ask if the patient would like to consider trying a gradual opioid taper to reduce dose or discontinue use.
- MED calculators (not all of which agree with each other) can help you determine the dosage equivalency of one opioid when compared to another. It is wise to use MED calculations very conservatively and use 25 to 50% of the calculated dose when switching between opioids.

Link to the guidelines: http://professional.oregonpainguidance.org/wp-content/uploads/sites/2/2014/04/OPG_Guidelines_2016.pdf

Advisory Guidelines: Oregon Opioid Prescribing Guidelines

In January 2017, the Oregon Opioid Prescribing Guidelines Task Force adopted the CDC Guideline for Prescribing Opioids for Chronic Pain as the foundation for opioid prescribing for Oregon. The Task Force also adopted several additional guidelines specific to the state, including recommending that prescribers consult the state's PDMP before prescribing opioids.

Link to the guidelines:

<https://www.oregon.gov/obnm/rules/opioidprescribingguidelines.pdf>

In May 2017, the Oregon Legislature passed HB 2114, which requires health care professional boards in the state to provide notice about the Oregon Opioid Prescribing Guidelines to practitioners regulated by each board not later than January 1, 2018.

Link to the enacted bill:

<https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2114>

Pennsylvania

Quasi-regulatory guidelines: [Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Non-Cancer Pain](#)

In July 2016, the Pennsylvania Board of Medicine voted to adopt guidelines published in 2014 for the prescribing of opioids for non-cancer-related pain.

Summary of guidelines:

- Before initiating chronic opioid therapy, conduct and document a history, including documentation and verification of current medications, and a physical examination.
- Opioids should rarely be used as a sole treatment modality. Rather, opioids should be considered as a treatment option within the context of multimodality therapy.

- When starting chronic opioid therapy, provider should discuss the risks and benefits associated with treatment, so that the patient can make an informed decision.
- Initial treatment with opioids should be considered by clinicians and patients as a therapeutic trial to determine whether chronic opioid therapy is appropriate.
- Patient's opioid selection, initial dosing, and dose adjustments should be individualized according to the patient's health status, previous exposure to opioids, response to treatment, and predicted or observed adverse events.
- Caution should be used in patients also taking benzodiazepines.
- Clinicians should carefully consider if doses above 100 mg/day of oral morphine or its equivalent are indicated.
- Clinicians should reassess patients on chronic opioid therapy periodically and as warranted by changing circumstances.
- Clinicians should carefully monitor patients for aberrant drug-related behaviors.

Link to the guidelines:

<http://www.ddap.pa.gov/Document%20Library/Prescriber%20Guidelines%20on%20the%20Use%20of%20Opioids%20to%20Treat%20Chronic%20Noncancer%20Pain.pdf>

Quasi-regulatory guidelines: Pennsylvania Emergency Department (ED) Pain Treatment Guidelines

In July 2016, the Pennsylvania Board of Medicine voted to adopt guidelines published in 2014 for the prescribing of opioids in EDs.

Summary of guidelines:

- Discharge prescriptions should be limited to the amount needed until follow-up and typically should not exceed seven days.
- When selecting a medication for pain control the provider should consider non-opioid medications as alternative or concurrent therapy.
- When opioids are indicated, the provider should choose the lowest potency opioid necessary to relieve the patient's pain.
- An ED provider should only dispense the amount of opioid medication needed to control the patient's pain until they are able to access a pharmacy.
- ED providers should not prescribe long acting opioid agents, such as morphine or methadone, unless coordinated with outpatient provider
- The patient should not receive opioid prescriptions for chronic or recurrent pain from multiple providers.
- Upon development of a controlled substances database in Pennsylvania, ED providers should access it as indicated.
- ED providers should not replace lost or stolen prescriptions for controlled substances.
- ED providers should not fill prescriptions for patients who run out of pain medications.
- Patients whose behavior raises the provider's concern for addiction should be encouraged to seek detoxification assistance.

Link to the guidelines:

<http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/PA%20Guidelines%20Emergency%20Department.pdf>

Quasi-regulatory guidelines: Pennsylvania Guidelines on the Use of Opioids in Dental Practice

In July 2016, the Pennsylvania Board of Dentistry voted to adopt guidelines published in 2014 for the prescribing of opioids in to relive dental pain.

Summary of guidelines:

- Before initiating pain therapy, conduct and document a medical history, including documentation and verification of current medications, and a physical examination.
- Clinicians should administer non-steroidal anti-inflammatory drugs (NSAIDs), as first-line analgesic therapy, unless contraindicated.
- Clinicians should consider the use of local anesthetic techniques.
- If an opioid is to be administered, the dose and duration of therapy should be for a short period of time, and for conditions that typically are expected to be associated with more severe pain.
- When opioids are indicated, the provider should choose the lowest potency opioid necessary to relieve the patient's pain.
- Long-acting opioids or extended-release preparations are contraindicated for the treatment of acute procedural pain.
- The provider should assess the risk for drug-drug interactions before prescribing analgesics.
- Opioids should not be administered in combination with benzodiazepines or other centrally acting sedating medications.
- Care should be used when prescribing opioid combination product medications, to ensure that the total dose of acetaminophen does not exceed 3,000 mg/day in adults.
- Upon development of a controlled substances database by the state of Pennsylvania, providers should access the database as indicated.
- Unless the clinician has training and experience in the use of opioids for the treatment of non-cancer pain, long acting or extended-release opioids should not be prescribed
- A patient whose behavior raises concern for the presence of a substance use disorder should be encouraged to seek evaluation and possible treatment for this condition through his or hers primary medical care provider.
- In general, it is not proper to prescribe opioids absent a face-to-face patient evaluation.
- Providers should provide patients with instructions on safe disposal of unused medications, including opioids.

Link to the guidelines:

https://www.pamedsoc.org/PAMED_Downloads/opioid_dental_prescribing_guidelines3_13_15.pdf?utm_source=PDF&utm_medium=web&utm_campaign=DentalGuidelines

Requirements with the force of law: 35 Pa. Cons. Stat. § 872.8 (2016)

In 2016, the Pennsylvania Assembly amended the state statute that requires prescribers to check the state's PDMP before prescribing controlled substances to also require prescribers to query the system each time a patient is prescribed an opioid. The statute reads as follows:

(a) System query — A prescriber shall query the system:

- (1) for each patient the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a baseline and a thorough medical record;
- (2) if a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs; or
- (3) each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.

(a.1) Query not required – If a patient has been admitted to a licensed health care facility or is in observation status in a licensed health care facility, the prescriber does not need to query the system after the initial query [...] as long as the patient remains admitted to the licensed health care facility or remains in observation status in a licensed health care facility.

Requirements with the force of law: 35 Pa. Cons. Stat. § 52A03 (2016).

Pennsylvania also amended its laws regulating opioid prescribing to minors in 2016. The amended statute prohibits prescriber from prescribing more than a seven-day supply of a controlled substance containing an opioid to a minor.

Link to the enacted act language:

<http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2016&sessInd=0&act=125>

Requirements with the force of law: 35 Pa. Cons. Stat. § 873.3 (2016).

As with minors, Pennsylvania also now prohibits prescribers from prescribing more than a seven-day supply of opioids to persons receiving care in emergency departments.

Link to the enacted act language:

<http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2016&sessInd=0&act=122>

Link to the language of the enacted statute:

<http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2015&sessInd=0&billBody=S&billTyp=B&billNbr=1202&pn=2199>

Rhode Island

Requirements with the force of law: R.I. Admin. Code 31-2-6:3.0 (2014)

In March 2015, the Rhode Island Department of Health amended the Rules and Regulations for Pain management, Opioid Use, and the Registration of Distributors of Controlled Substances to update the minimum requirements for prescribing opioids for pain management. The updated requirements include:

- The practitioner shall obtain, evaluate and document the patient's health history and physical examination in the health record prior to treating for chronic pain.

- Prescribing opioids for an acute injury shall be for a reasonable duration consistent with community standards for the pain that is being treated
- If prescribing opioids, the practitioner will advise patients specifically about adverse risks of taking alcohol or other psychoactive medications, tolerance, dependence, addiction overdose or death if acute or long term use.
- The PMP shall be reviewed prior to starting any opioid.
- Chronic pain patients who receive opioid medication(s) shall have a written patient treatment agreement which shall become part of their medical record.
- Periodic reviews, including an in-person visit, shall take place at intervals not to exceed twelve months.
- For patients the practitioner is maintaining on continuous opioid therapy for pain for six months or longer, the practitioner shall review information from the PMP at least every twelve months.
- The consideration, and documentation of consideration, for consultation threshold for adults is 120 milligrams morphine equivalent dose per day (MED) (oral). In the event a practitioner prescribes a dosage amount that meets or exceeds the consultation threshold of 120 milligrams MED (orally) per day, a consideration of consultation with a Pain Medicine Physician is required, and must be documented in the medical record.
- For patients on long-acting opioids, including methadone, practitioners shall monitor use closely, especially upon initiation and following any dose increases.
- Patients who receive long-acting opioid medication(s) on a long term basis (ninety (90) days or greater) shall have a written patient treatment agreement, which shall become part of their medical record.

Link to the regulations:

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/8003.pdf>

Requirements with the force of law: 1956 R.I. Gen. Laws Ann. § 21-28-3.20 (2016)

Since June 28, 2016, Rhode Island requires physicians to consult the state's PMP prior to prescribing opioids. The statute also limits the dosing of opioids for acute pain management of outpatient adults to 30 MME daily for up to a 20 doses. The law provides as follows:

(b) The prescription-monitoring program shall be reviewed prior to starting any opioid. A prescribing practitioner [...] shall review the prescription-monitoring program prior to refilling or initiating opioid therapy with an intrathecal pump. For patients the prescribing practitioner is maintaining on continuous opioid therapy for pain for three (3) months or longer, the prescribing practitioner shall review information from the prescription-monitoring program at least every three (3) months. [...]

(c) The director of health shall develop regulations for prescribing practitioners on appropriate limits of opioid use in acute pain management. Initial prescriptions of opioids for acute pain management of outpatient adults shall not exceed thirty (30) morphine milligram equivalents (MMEs) total daily dose per day for a maximum total of twenty (20) doses, and, for pediatric patients, the appropriate opioid dosage maximum per the department of health.

Link to the language of the approved bill:

<http://webserver.rilin.state.ri.us/BillText/BillText16/SenateText16/S2823Aaa.pdf>

South Carolina

Quasi-regulatory Guidelines: Pain Management Guidelines

In 2009, the South Carolina Board of Medical Examiners approved guidelines for the use of controlled substances for treatment of pain. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the guidelines:

<http://www.llr.sc.gov/POL/medical/index.asp?file=Policies/MEPAIN.HTM>

Requirements with the force of law: Required Use of the South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS)

Since April 1, 2016, the South Carolina Department of Health and Human Services (SCDHHS) requires that providers verify Medicaid members' controlled substance prescription history before issuing prescriptions for opioids. Failure to consult the South Carolina Reporting and Identification Prescription Tracking System (SCRIPTS) database may result in loss of Medicaid payments for the office visit during which the prescription was given. For Medicaid members treated chronically with controlled substances, SCDHHS will require that SCRIPTS be consulted at the initiation of therapy and at least every 90 days thereafter. The new policy exempts the following situations from the requirement:

- Issuance of less than a five-day supply of a controlled substance.
- Issuance of controlled substance prescription to a Medicaid member enrolled in hospice.
- Instances where a controlled substance is administered by a licensed health care provider.

Link to SCDHHS's bulletin on the new policy:

<https://www.scdhhs.gov/sites/default/files/SCRIPTS%20Bulletin-%20%28v15%29%20w%20CLS%20signature.pdf>

South Dakota

Quasi-regulatory guidelines: Model Policy for the Use of Controlled Substances for the Treatment of Pain

In 2004, the South Dakota State Board of Medical and Osteopathic Examiners issued guidelines on the prescribing of controlled substances for treating pain. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse

or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the guidelines:

http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/SD_model.pdf

Tennessee

Requirements with the force of law: Tenn. Code Ann. § 53-11-308 (2013)

In 2013, the Tennessee Legislature amended its controlled substances statute to add limitations to the prescribing of opioids. The amended statute prohibits dispensing of prescriptions for any opioids or benzodiazepines in quantities greater than a 30-day supply. The statute also requires prescribers of opioids, benzodiazepines, barbiturates, or carisoprodol to patients who are in chronic, long-term drug therapy for 90 days or longer to consider mandatory urine testing.

Link to the statute: <http://law.justia.com/codes/tennessee/2014/title-53/chapter-11/part-3/section-53-11-308>

Advisory Guidelines: Clinical Practice Guidelines for Outpatient Management of Chronic Non-Malignant Pain

In 2014, the Tennessee Department of Health issued guidelines for the prescribing of opioids to treat chronic non-malignant pain. The guidelines include recommendations regarding patient evaluation prior to initiating the opioid treatment and recommendations as to the proper dosing of opioid that should be prescribed. Some of the guidelines include:

- A patient should be prescribed a maximum of four doses of a short-acting opioid per day.
- Prescribers who are not pain medicine specialists shall not prescribe methadone for a chronic pain condition.
- Prescribers shall not prescribe buprenorphine in the form of oral or sublingual buprenorphine for chronic pain condition.
- Benzodiazepines should be generally avoided in combination with opioid therapy.
- When the opioid dose reaches 120mg MEDD and the benzodiazepines are being used for mental health purposes, the provider shall refer to a mental health professional to assess necessity of benzodiazepine medication.
- Buprenorphine/naloxone combinations shall be avoided for chronic pain.
- The initiation of opioids should be presented to the patient as a therapeutic trial.
- When initiating opioid therapy, the lowest dose of opioids should be given to an opioid naïve patient and then titrated to effect.
- Informed consent for the use of opioids in treating pain must be obtained prior to initiating treatment.
- Providers must continually monitor the patient for signs of abuse, misuse or diversion.
- All chronic opioid therapy should be handled by a single provider or practice.
- Opioids should be used at the lowest effective dose. A provider should not use more than one short-acting opiate concurrently.

- Patients on opioid doses of 120mg MEDD or greater should be referred to a pain specialist for a consultation and/or management.
- Providers must continually monitor the patient for signs of abuse, misuse or diversion.
- ED physicians should keep the specialist and the primary care provider informed about changes in a patient's condition and any emergent incidents or conditions.
- Opioids are to be discontinued when the risks, side effects, lack of efficacy or presence of medication or aberrant behavior outweigh the benefits.

Link to the guidelines:

<https://www.tn.gov/assets/entities/health/attachments/ChronicPainGuidelines.pdf>

Requirements with the force of law: Tenn. Code Ann. § 53-10-310 (2016)

Since 2013, providers in Tennessee are required to check the state's controlled substance database or have a healthcare practitioner delegate check the database before prescribing or dispensing a controlled substance if the healthcare practitioner is aware or reasonably certain that a person is attempting to obtain a Schedule II-V controlled substance, which includes, among other, opioids and benzodiazepines.

Texas

Requirements with the force of law: 22 Tex. Admin. Code § 170.3 (2007)

In 2007, the Texas Medical Board adopted regulations with regards to treating pain with controlled substances. The guidelines set the appropriate standard of care in those situations and have been amended twice, in 2014 and 2016. The guidelines include performing a patient evaluation before prescribing opioids (including reviewing prescription data and history related to the patient contained in the state's prescription drug monitoring program (PDMP)), obtaining informed consent from the patient for opioid treatment, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the regulation:

[https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&ptloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=9&ch=170&rl=3](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&ptloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=9&ch=170&rl=3)

Utah

Advisory Guidelines: Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

In 2009, the Utah Department of Health adopted recommended guidelines for physicians prescribing opioids for treating pain.

Summary of guidelines for Opioid Treatment for Acute Pain

- Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies will not provide adequate pain relief.
- When opioid medications are prescribed, the number dispensed should be no more than the number of doses needed based on the usual duration of pain..

- When opioid medications are prescribed for treatment of acute pain, the patient should be counseled to store the medications securely, to not share with others, and to dispose of medications properly when the pain has resolved.
- Long duration-of-action opioids should not be used for treatment of acute pain,
- Methadone is rarely if ever indicated for treatment of acute pain.
- The use of opioids should be reevaluated carefully, including assessing the potential for abuse, if persistence of pain suggests the need to continue opioids.

Summary of guidelines for Opioid Treatment for Chronic Pain:

- A comprehensive evaluation should be performed before initiating opioid treatment.
- Alternatives to opioid treatment should be before initiating opioid treatment.
- The provider should screen for risk of abuse or addiction before initiating treatment.
- When opioids are to be used for treatment of chronic pain, a written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function.
- The patient should be informed of the risks and benefits and any conditions for continuation of opioid treatment.
- Opioid treatment for chronic pain should be initiated as a treatment trial, usually using short-acting opioid medications.
- Regular visits with evaluation of progress against goals should be scheduled during the period when the dose of opioids is being adjusted (titration period).
- Once a stable dose has been established (maintenance period), regular monitoring should be conducted at face-to-face visits.
- Continuing opioid treatment after the treatment trial should be a deliberate decision that considers the risks and benefits of chronic opioid treatment for that patient.
- An opioid treatment trial should be discontinued if the goals are not met and opioid treatment should be discontinued at any point if adverse effects outweigh benefits.
- Clinicians treating patients with opioids for chronic pain should maintain records documenting the evaluation of the patient, treatment plan, etc.
- Clinicians should consider consultation for patients with complex pain conditions, patients with serious co-morbidities including mental illness, patients who have a history or evidence of current drug addiction or abuse.
- Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use, and who are prepared to conduct the necessary careful monitoring.

Link to the guidelines:

<http://www.health.utah.gov/prescription/pdf/guidelines/final.04.09opioidGuidlines.pdf>

Requirements with the force of law: Utah Code Ann. §§ 58-37-6(7)(f)(iii) and 58-37f-304(2) (2017)

In 2017, Utah enacted a law to limit the number of days for which an opioid may be prescribed. Prescribers can prescribe up to a 7-day supply for an acute condition. If the prescriber determines that a higher dose is needed in the case of prescriptions issued for a

surgery, the prescriber must not prescribe a dose exceeding a 30-day supply. The law exempts pharmacists from verifying that a prescription is in compliance with these requirements. The enacted law also requires prescribers to check the PDMP database for information about the patient when prescribing more than a 3-day supply of opioids for the first time, unless the prescription is for post-surgical treatment and is a 30-day or less supply.

Link to the enacted legislation: <https://le.utah.gov/~2017/bills/static/HB0050.html>

Vermont

Requirements with the force of law: Vt. Stat. Ann. tit. 18, § 4289(d) (2014)

Since 2014, Vermont law requires health care providers to query the Vermont Prescription Monitoring System (VPMS) with respect to an individual patient's record in all the following circumstances:

- At least annually for patients who are receiving ongoing treatment with an opioid or controlled substance;
- When starting a patient on an opioid or controlled substance for non-palliative long-term pain therapy of 90 days or more;
- The first time the provider prescribes an opioid or controlled substance written to treat chronic pain; and
- Prior to writing a replacement prescription for an opioid or controlled substance.

In 2016, the Vermont Legislature amended the statute to direct the state's Commissioner of Health to adopt rules on prescribing opioids after consulting with the Controlled Substances and Pain Management Advisory Council, which may include number and time limits on pills prescribed.

For the enacted legislation, see

<http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT173/ACT173%20As%20Enacted.pdf>

Quasi-regulatory guidelines: Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

In 2014, the Vermont Board of Medical Practice updated its policy on the use of opioids for treating chronic pain to incorporate the latest best practices and new developments in the healthcare profession regarding the safe and effective use of controlled substances to treat pain.

Summary of guidelines:

- For every patient, the initial work-up should include a systems review and relevant physical examination, as well as laboratory investigations
- Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse should be completed prior to a decision as to whether to prescribe opioid analgesics
- The decision to initiate opioid therapy should be a shared decision between the physician and the patient.
- If opioids are prescribed, the patient (and possibly family members) should be counseled on safe ways to store and dispose of medications

- Safer alternative treatments should be considered before initiating opioid therapy for chronic, nonmalignant pain.
- Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with evaluation points.
- When initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient. It is generally suggested to begin opioid therapy with a short acting opioid and consider rotating to a long-acting/extended release opioid only if indicated.
- Physician should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of function
- Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs

Link to the guidelines:

[http://healthvermont.gov/hc/med board/documents/opioid pain treatment policy.pdf](http://healthvermont.gov/hc/med%20board/documents/opioid_pain_treatment_policy.pdf)

Advisory Guidelines: Opiate Prescribing Guidelines for Vermont Emergency Departments
 In 2014, Vermont ED Directors issued a consensus statements outlining their recommended guidelines for prescribing opioids in EDs. The guidelines include:

- Providers are encouraged to review the Vermont Prescription Monitoring System (VPMS) prior to treating or prescribing opiates for patients with high risk features.
- Any patient receiving parenteral narcotics should be appropriately monitored with inclusion of either pulse oxymetry or capnography.
- Patients presenting to the acute care setting requesting rapid escalation of treatment for chronic pain or requesting parenteral administration of opiates should be considered to be at high risk for injury or abuse.
- A urine drug screen may be considered prior to initiating treatment.
- Concurrent use of non-prescribed controlled or illegal substances is considered to be a risk factor for overdose or abuse.
- Long-acting opiates including fentanyl patch, MS Contin, and OxyContin should generally not be initiated by acute care providers.
- Acute care providers should only prescribe scheduled doses of long-acting opiates as part of an established outpatient plan for chronic pain management.
- Due to low safety margin, drug interaction and risk of seizure, IV Demerol (meperidine) for treatment of acute or chronic pain is discouraged.
- Acute care providers should not prescribe replacements for narcotics that have been lost, stolen, or destroyed or continuation of treatment for patients who have run out of narcotics early or while their usual provider is off duty.
- Providers should not provide replacement doses of Suboxone, Subutex or methadone.
- Acute care providers should not initiate outpatient treatment for chronic pain using long-acting opiate preparations
- Three days is the recommended maximum duration for treatment prescribed from the acute care setting, depending on the condition and clinical judgment.

- All patients prescribed an opiate should be assessed for potential drug interactions which could potentiate the respiratory depression effects.

Link to the guidelines:

<http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/Senate%20Health%20and%20Welfare/Bills/S.201/W~Dr.%20Mark%20Depman~Opioid%20Prescribing%20Guidelines~1-27-2016.pdf>

Requirements with the force of law: Rule Governing the Prescribing of Opioids for Pain Effective July 2017, Department of Health regulations limit the initial dose of opioids a physician can prescribe to 7 days. The rule also incorporates previous prescribing guidelines including:

- The prescriber shall conduct and document a medical and physical examination as part of the patient's medical record when prescribing opioids for chronic pain
- The prescriber shall evaluate and document benefits and relative risks, including the risk for misuse, abuse, diversion, addiction, or overdose, for the individual patient of the use of opioids prior to writing an opioid prescription for chronic pain.
- Prior to prescribing an opioid for the treatment of chronic pain, the prescriber shall consider and document in the patient's medical record:
 - Non-opioid alternatives up to a maximum recommended by the FDA, including non-pharmacological treatments;
 - Trial use of the opioid;
 - Any applicable requirements to query the Vermont Prescription Monitoring System
 - That the prescriber has asked the patient if he or she is currently, or has recently been, dispensed methadone from an OTP or prescribed and taken any other controlled substance.
- For patients prescribed opioids for 90 days or more for chronic pain, the prescriber shall receive a signed Informed Consent from the patient.
- The prescriber shall consider referring a patient for a consultation with an appropriate specialist when the patient is not meeting the goals of treatment despite escalating doses of controlled substances or when the patient is at high risk for substance misuse, abuse, diversion, addiction, or overdose as determined by the patient's history or a screening.
- Prior to prescribing a dose of opioids, or a combination of opioids, that exceeds 120 MED/day the prescriber of opioids to treat chronic pain shall document in the patient's medical record:
 - A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen;
 - The potential for the use of non-opioid and non-pharmacological alternatives for treating pain;
 - A functional status examination of the patient;

- A review of the patient’s agreement and informed consent, making any necessary revisions, including pill counts and directly observed urine testing to monitor adherence and possible use of other substances;
- An assessment of any co-morbid conditions affected by treatment with opioids. This may be best conducted by a mental health or addictions professional.

Link to the rule:

http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_opioids-prescribing-for-pain.pdf

Requirements with the force of law: Vermont Prescription Monitoring System Rule

In August 215, the Vermont Department of Health issued a rule to implement the state’s statute that requires physicians to query the VPMS before prescribing opioids for treating pain.

Summary of situations when prescribers of opioids are required to query the VPMS:

- The first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat pain when such a prescription exceeds 10 pills or the equivalent;
- When starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more;
- Prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance;
- At least annually for patients who are receiving ongoing treatment (treatment without meaningful interruption) with an opioid Schedule II, III, or IV controlled substance;
- The first time a provider prescribes a benzodiazepine;
- When a patient requests an opioid prescription or a renewal of an existing prescription for pain from an Emergency Department or Urgent Care prescriber if the prescriber intends to write a prescription for an opioid;
- With the exception of prescriptions written from an OTP, prior to prescribing buprenorphine or a drug containing buprenorphine to a Vermont patient for the first time and at regular intervals thereafter, and:
 - At regular intervals thereafter, but no less than twice annually; and
 - No fewer than two times annually thereafter; and
 - Prior to writing a replacement prescription.
- In the case of an OTP, prior to prescribing buprenorphine, methadone, or a drug containing buprenorphine to a Vermont patient for the first time, and:
 - Annually thereafter; and
 - Any other time that is clinically warranted.
- Prior to prescribing buprenorphine or a drug containing buprenorphine that exceeds the dosage threshold approved by the Vermont Medicaid Drug Utilization Review Board and published in its Preferred Drug List, prescribers must receive prior approval from the Chief Medical Officer or Medical Director of the Department of Vermont Health Access or designee

Link to the rule:

http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_vpms-20170701.pdf

Virginia

Advisory Guidelines: Medical Society of Virginia's Guidelines for the Use of Opioids in the Management of Chronic Non-Cancer Pain

The Medical Society of Virginia adopted recommendations for physicians treating chronic, non-cancer-related pain prescribing opioids. The guidelines include performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the guidelines: <http://www.druglibrary.net/schaffer/asap/virginia1.htm>

Quasi-regulatory guidelines: Guidance on the Use of Opioid Analgesics in the Treatment of Chronic Pain

In 2013, the Virginia Board of Medicine updated its guidelines on the use of opioid analgesics to treat pain by adopting the Federation of State Medical Board's new guidelines. The guidelines include:

- 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.
- Treatment of a patient who has a history of substance use disorder should, if possible, involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up as needed).
- The state PDMP should be consulted to determine whether the patient is receiving prescriptions from any other physicians.
- Safer alternative treatments should be considered before initiating opioid therapy for chronic, non-malignant pain. Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with specified evaluation points.
- The physician should regularly review the patient's progress. When possible, information about the patient's response to opioid therapy should be obtained from family members or other close contacts, and the state PDMP.
- Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs.

Link to the guidelines: <http://www.dhp.virginia.gov/medicine/guidelines/85-24.pdf>

Requirements with the force of law: Va. Code Ann. § 54.1-2522.1 (2015)

Since 2015, Virginia law requires prescribing physicians to request information from the state's PMP at the time of initiating a new course of treatment to a human patient that includes the prescribing of opioids anticipated to last more than 14 consecutive days. This information should be used for the purpose of determining what, if any, other covered

substances are currently prescribed to the patient. The following situations are exempted from this requirement:

- The opioid is prescribed to a patient currently receiving hospice or palliative care;
- The opioid is prescribed to a patient as part of treatment for a surgical or invasive procedure and such prescription is not refillable;
- The opioid is prescribed to a patient during an inpatient hospital admission or at discharge;
- The opioid is prescribed to a patient in a nursing home or a patient in an assisted living facility that uses a sole source pharmacy;
- The PMP is not operational or available due to a temporary technological or electrical failure or natural disaster; or
- The prescriber is unable to access the PMP due to emergency or disaster and documents such circumstances in the patient's medical record.

Effective July 2019, however, this requirement will be as follows:

Prescribers [...] 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 at the onset of treatment to last more than 90 consecutive days, request information from the [PMP] for the purpose of determining what, if any, other covered substances are currently prescribed to the patient.

Link to the statute: <http://law.lis.virginia.gov/vacode/title54.1/chapter25.2/section54.1-2522.1/>

Advisory Guidelines: Virginia Hospital Emergency Department Opioid Prescribing Guidelines

In January 2016, the Virginia Hospital & Healthcare Association's Board of Directors produced recommendations for setting general standards of care on opioid prescribing in Virginia's EDs. The guidelines include:

- A provider outside the ED should provide all opioids to treat any patient's chronic pain.
- Administering intravenous or intramuscular opioids in the ED for the relief of acute exacerbation of chronic pain is generally discouraged.
- Prescriptions for opioids from the ED should be written for the shortest duration appropriate. This generally should be for no more than three days.
- Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse.
- When patients present with acute chronic pain, it is recommended that a summary of the ED care is communicated to the primary opioid prescriber or primary care provider.
- ED providers should not dispense prescriptions for controlled substances that were lost, destroyed, stolen, or finished prematurely.
- ED providers, or their designees, are encouraged to consult Virginia's PMP before writing opioid prescriptions for acutely painful conditions.
- ED providers, in general, should not provide replacement doses of methadone or buprenorphine for patients participating in an opioid treatment program.

- ED providers should not prescribe long-acting or controlled release opioids, such as oxycodone, fentanyl patches, or methadone.
- ED providers are strongly discouraged from prescribing buprenorphine products.

Link to the guidelines: <http://vacep.org/wp-content/uploads/2016/06/VHHA-VACEP-Opioid-Guidelines.pdf>

Washington

Requirements with the force of law: Wash. Admin. Code § 246-919-850 (2011)

In 2011, the Washington Department of Health adopted a rule regulating the prescribing of opioids for pain treatment. Some of the prescribing requirements include:

- For patients who are stable involving non-escalating daily doses of 40 mg MED/day or less, periodic reviews shall take place annually.
- Mandatory consultation threshold for adults is 120 mg MED/day (oral).
- In the event a physician prescribes a dosage that meets or exceeds the consultation threshold, a consultation with a pain management specialist is required.
- The physician shall document each mandatory consultation.
- Recommended that a practitioner not prescribe more than an average of MED of 120 mg without either the patient demonstrating improvement in function or without first obtaining a consultation from a pain management expert.

Link to the regulation: <http://apps.leg.wa.gov/documents/laws/wsr/2011/12/11-12-025.htm>

Advisory Guidelines: Washington Emergency Department Opioid Prescribing Guidelines

In 2012, the Washington State Medical Association, the Washington State Hospital Association, the American College of Emergency Physicians, Washington Chapter, and the Emergency Nurses Association, Washington State Council, adopted recommendations for physicians prescribing opioids in EDs in Washington state. The guidelines include:

- One medical provider should provide all opioids to treat a patient's chronic pain.
- The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
- Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
- Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
- EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.
- The administration of Demerol® (Meperidine) in the ED is discouraged.
- For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary opioid prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.

- Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.
- ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

Link to the guidelines:

<http://www.maineacep.org/uploadedFiles/Maine/edopioidabuseguidelinesfinal.pdf>

Advisory Guidelines: Interagency Guidelines on Prescribing Opioids for Pain

In 2015, the Washington State Agency Medical Directors Group (AMDG) approved the third and current version of its guidelines for prescribing opioids for treating pain. The guidelines are divided into four phases of treatment.

Acute Phase (0-6 weeks):

- Check the state's Prescription Monitoring Program (PMP) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain:

- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2-3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

Subacute phase (6-12 weeks):

- Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if planning to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks):

- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient's risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

Link to the guidelines:

<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

Link to the guidelines' summary: http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf

West Virginia

Requirements with the force of law: W. Va. Code Ann. § 60a-9-5a (2014)

Since 2014, West Virginia law requires physicians to check the state PMP before prescribing opioids. The statute provides:

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 [...] 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. [...]

Link to the statute: <http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=60a&art=9#09>

Pursuant to this statute, several professional boards have adopted regulations requiring prescribers to check the state's PMP before prescribing opioids:

Board of Dentistry: [W. Va. Code R. §§ 5-10-3.2 – 5-10-3.6 \(2014\)](#)

Board of Medicine: [W. Va. Code R. §§ 11-10-3.2 – 11-10-3.5 \(2014\)](#)

Board of Examiners for Registered Nurses: [W. Va. Code R. §§ 19-14-3.2 – 19-14-3.6 \(2014\)](#)

Board of Osteopathic Medicine: [W. Va. Code R. §§ 24-7-3.2 – 24-7-3.5 \(2014\)](#)

Advisory Guidelines: [Guidance for Use and Prescribing of Opioids in Emergency Departments](#)

In November 2015, the West Virginia Hospital Association adopted guidance for the prescribing of opioids in EDs across the state.

Summary of guidelines:

- One medical provider should provide all opioids to treat a patient's chronic pain.
- A prescription for a controlled substance should not be given to a patient without a government issued photo ID.
- The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
- Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
- Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
- Emergency medical providers should not provide replacement doses of methadone for patients in a methadone program without consultation with the program.
- The ED will not prescribe or dispense suboxone.
- Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
- Prescriptions for opioids from the ED for acute injuries will cover the shortest appropriate time. If the emergency provider does elect to provide pain medication for chronic pain, it will be enough to cover until the next business day.
- Hospital ED providers should consult the West Virginia Controlled Substance Automated Prescription program (CSAPP) before writing a controlled substance prescription.

Link to the guidelines: <http://www.wvha.org/getmedia/94a27c11-c3d5-4709-9c7c-8e29378c58ee/Opioid-Guidelines-Toolkit.pdf.aspx>

Requirements with the force of law: In October 2016, the Office of the Governor of West Virginia announced that the state's Department of Health and Human Resources will adopt the guidelines on opioid prescribing issued by the CDC. The state intends to implement these guidelines to reduce the opportunity for opioid overuse and abuse while preserving access to necessary drugs.

For more information, see <http://www.wvgazettemail.com/news-health/20161018/wv-to-follow-cdc-guidelines-for-prescribing-opioids>

Wisconsin

Quasi-regulatory guidelines: Wisconsin Medical Examining Board Opioid Prescribing Guideline

In June 2016, the Wisconsin Medical Examining Board adopted guidelines to help providers make informed decisions about acute and chronic pain treatment with the use of opioids. The guidelines excluded patients who are in cancer treatment, palliative care, or end-of-life care.

Summary of guidelines:

- In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth.
- Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid.
- Opioids should not necessarily be the first choice in treating acute or chronic pain.
- Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy.
- Patients should not receive opioid prescriptions from multiple physicians.
- Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.
- Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the ED or urgent care setting.
- Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations.
- Prescribing of opioids is not encouraged in patients concurrently taking benzodiazepines or other respiratory depressants.
- Opioids should be prescribed in the lowest effective dose.
- If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented. Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged.

- The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use.
- During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks.
- During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.
- Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk.

Link to the guidelines:

http://dsps.wi.gov/Documents/Board%20Services/Other%20Resources/MEB/MEB_Guidelines.pdf

Requirements with the force of law: Wis. Stat. Ann. § 961.385(cs) (2016)

Effective April 2017, Wisconsin law requires a practitioner to review a patient's records under the state's PMP before the practitioner issues an opioid prescription order for the patient.

This requirement does not apply under the following circumstances:

- The patient is receiving hospice care.
- The prescription order is for a number of doses that is intended to last the patient 3 days or less and is not subject to refill.
- The monitored prescription drug is lawfully administered to the patient.
- Due to emergency, it is not possible for the practitioner to review the patient's records under the PMP before the practitioner issues a prescription order for the patient.
- The practitioner is unable to review the patient's records under the PMP because the digital platform for the program is not operational or due to other technological failure if the practitioner reports that failure to the board.

Link to the statute: <https://docs.legis.wisconsin.gov/statutes/statutes/961/III/385>

Wyoming

Quasi-regulatory guidelines: Wyoming Health Care Licensing Boards' Uniform Policy for the Use of Controlled Substances in the Treatment of Pain

In February 2009, the Wyoming Board of Medicine adopted the state's licensing boards' Uniform Policy on the use of controlled substance to treat pain. The guidelines include performing a patient assessment before prescribing opioids, obtaining informed consent from the patient for opioid treatment, requiring a written agreement outlining patient responsibilities if the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, conduct periodic review of the opioid treatment, and maintain a complete medical record of the patient's treatment.

Link to the guidelines:

http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/WY_joint.pdf

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APPENDIX C

Arizona Substance Abuse Taskforce Resources and Links

US Health Departments, Opioid Task Force, and Opioid-Prescription Drug Intervention Recommendations

State	Link to Health Department	Link to Task Force (if available)	Link to Recommendations (if available)
AL	http://www.alabamapublichealth.gov/	N/A	N/A
AK	http://dhss.alaska.gov/Pages/default.aspx	http://dhss.alaska.gov/AKOpioidTaskForce/Pages/default.aspx	http://dhss.alaska.gov/AKOpioidTaskForce/Documents/AOPTF-Recommendations-1-19-17.pdf
AZ	http://www.azdhs.gov/	http://substanceabuse.az.gov/substance-abuse/meeting-body/arizona-substance-abuse-task-force-coalition-leading-substance-abuse	http://substanceabuse.az.gov/sites/default/files/files/substance_abuse_task_force_final_0.pdf
AR	http://www.health.arkansas.gov/Pages/default.aspx	http://www.arkansashouse.org/committees/838/TASK%20FORCE%20ON%20SUBSTANCE%20ABUSE%20TREATMENT%20SERVICES	N/A
CA	https://www.cdph.ca.gov/	https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/ACB/Pages/StatewidePrescriptionOpioidMisuseandOverdosePreventionWorkgroup.aspx	https://archive.cdph.ca.gov/Documents/CAOpioidPreventionStrategies06272016.pdf
CT	http://www.ct.gov/dph/site/default.asp	N/A	http://www.ct.gov/dmhas/lib/dmhas/publications/core_initiative10.6.16.pdf
DE	http://www.dhss.delaware.gov/dhs	http://dhss.delaware.gov/dhss/dph/pdachome.html	http://dhss.delaware.gov/dhcc/files/o

State	Link to Health Department	Link to Task Force (if available)	Link to Recommendations (if available)
	s/dph/index.html		piodpresentation_03022017.pdf
FL	http://www.floridahealth.gov/	http://myfloridalegal.com/pages.nsf/Main/CFC9846F8D7790FC85257A10004AE67E	http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/\$file/Statewide Task Force on Prescription Drug Abuse and Newborns Final Report.pdf
GA	https://dph.georgia.gov/	N/A	http://www.senate.ga.gov/sro/Documents/StudyComments/StudyCommentsRpts/OpioidsAppendix.pdf
HI	http://health.hawaii.gov/	N/A	N/A
ID	http://healthandwelfare.idaho.gov/	N/A	N/A
IL	http://www.dph.illinois.gov/	http://www.dph.illinois.gov/topics-services/prevention-wellness/prescription-opioids-and-heroin/illinois-plan	N/A
IN	http://www.in.gov/isdh/	http://www.in.gov/bitterpill/about.html	http://www.in.gov/bitterpill/files/FINAL%20Four%20Years%20In%20Action%20Report%20-%20OAG%20Coverchange%20final.pdf

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IA	https://idph.iowa.gov/	N/A	N/A
KS	http://www.kdheks.gov/	N/A	N/A
KY	http://chfs.ky.gov/	https://odcp.ky.gov/Pages/About-Us.aspx	N/A
LA	http://www.dhh.louisiana.gov/	http://www.dhh.louisiana.gov/index.cfm/page/2581	N/A
ME	http://www.maine.gov/dhhs/	http://www.maine.gov/legis/opla/OpioidTaskForce.htm	http://www.maine.gov/legis/opla/OTFFINALInterimReportrevised51517.pdf
MD	http://msa.maryland.gov/msa/mdmanual/16dhmh/html/16agenph.html	http://governor.maryland.gov/ltgovernor/home/heroin-and-opioid-emergency-task-force/reports/	https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/12/Heroin-Opioid-Emergency-Task-Force-Final-Report.pdf
MA	http://www.mass.gov/eohhs/	http://www.mass.gov/eohhs/gov/commissions-and-initiatives/opioid-addiction/opioid-working-group/	http://www.mass.gov/eohhs/docs/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf

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MI	http://www.michigan.gov/mdhhs/	http://www.michigan.gov/snyder/0,4668,7-277-73341-364552--,00.html	https://www.michiganprosecutor.org/files/PAAM/External/Prescription_Drug_and_Opioid_Task_Force_Report_504140_7.pdf
MN	https://mn.gov/dhs/	https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/opioid-work-group/	https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/opioid-work-group/#5
MS	http://www.msdc.state.ms.us/	http://www.sos.ms.gov/Education-Publications/ExecutiveOrders/1388.pdf	N/A
MO	https://www.mo.gov/health/public-health/	https://governor.mo.gov/news/archive/governor-greitens-takes-action-address-opioid-epidemic	N/A
MT	http://dphhs.mt.gov/	N/A	N/A
NE	http://dhhs.ne.gov/Pages/default.aspx	N/A	N/A
NV	http://dpbh.nv.gov/	http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Programs/ClinicalSAPTA/Docs/Final%20Summit%20Report.pdf	http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Programs/ClinicalSAPTA/State%20of%20Nevada%20Plan%20to%20Reduce

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			e%20Prescription%20Drug%20Abuse.pdf
NH	http://www.dhhs.nh.gov/	http://www.dhhs.nh.gov/dcbcs/bdas/documents/state-response-opioid-crisis.pdf	http://1viuw040k2mx3a7mwz1lwva5.wpengine.netdna-cdn.com/wp-content/uploads/2017/03/Governors-Commission-Mid-Yr-report-final.pdf
NJ	http://www.state.nj.us/health/	N/A	http://gcada.nj.gov/policy/master/documents/2014_TaskForce_Report.pdf
NM	https://nmhealth.org/	N/A	https://www.google.com/url?sa=t&rc=t=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwihkYrZh8vVAhVII1QKHcVBD8MQFggnMAA&url=https%3A%2F%2Fwww.nmlegis.gov%2Ffics%2Fhandouts%2FCJRS%2520052814%2520Item%25202%2520HM14%2520Report.pdf&usg=AFQjCNGtZwx9mfWgl8JrQGd_CYtgL0Ow
NY	http://www.health.ny.gov/	https://www.ny.gov/programs/governor-cuomos-task-	https://www.gove

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	h.ny.gov/	force-combat-heroin	rnor.ny.gov/sites/governor.ny.gov/files/atoms/files/HeroinTaskForceReport_3.pdf
NC	http://publichealth.nc.gov/	https://www.ncdhhs.gov/opioids	https://ncdhhs.s3.amazonaws.com/s3fs-public/NC%20Opioid%20Action%20Plan%206-23-2017.pdf http://governorsinstitute.org/opioid/
ND	https://www.ndhealth.gov/		
OH	https://www.odh.ohio.gov/	http://fightingopiateabuse.ohio.gov/	http://fightingopiateabuse.ohio.gov/initiatives
OK	https://www.ok.gov/health/	https://www.ok.gov/health/Protective_Health/Injury_Prevention_Service/Drug_Overdose/Opioid_Prescribing_Guidelines/index.html	https://www.ok.gov/health2/documents/UP_Rx_Abuse_Prevention_State_Plan_2016.pdf
OR	http://www.oregon.gov/oha/PH/pages/index.aspx	http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/index.aspx	http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/prescription-drug-overdose-state-plan.pdf

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PA	http://www.health.pa.gov/Pages/default.aspx#.WYticdKGNOQ	http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Pages/default.aspx#.WYtijtKGNOQ	
RI	http://www.health.state.ri.us/	http://preventoverdoseri.org/	http://preventoverdoseri.org/our-action-plan/
SC	http://www.scdhec.gov/	http://www.dhec.sc.gov/Health/Opioids/	
SD	https://doh.sd.gov/	https://doh.sd.gov/news/Opioid.aspx	https://doh.sd.gov/documents/news/OpioidEvaluationDraft.pdf
TN	https://www.tn.gov/health	http://www.tncoalitions.org/	https://www.tn.gov/health/topic/pdo-resources
TX	http://www.dshs.texas.gov/		
UT	https://health.utah.gov/	new task force formed in 2017	http://www.health.utah.gov/vipp/topics/prescription-drug-overdoses/
VT	http://www.healthvermont.gov/	http://www.healthvermont.gov/alcohol-drugs/professionals/resources-patients-and-providers	http://www.healthvermont.gov/scorecard-opioids
VA	http://www.vdh.virginia.gov/	http://www.vdh.virginia.gov/commissioner/opioid-addiction-in-virginia/	http://www.vdh.virginia.gov/data/op

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			ioid-overdose/
WA	http://www.doh.wa.gov/	http://www.doh.wa.gov/YouandYourFamily/PoisoningandDrugOverdose/OpioidMisuseandOverdosePrevention	http://stopoverdose.org/docs/StateODResponsePlan2017.pdf
WV	http://www.dhhr.wv.gov/Pages/default.aspx	http://governorssubstanceabusetaskforceswv.com/	http://governorssubstanceabusetaskforceswv.com/resources.php
WI	https://www.dhs.wisconsin.gov/	https://www.dhs.wisconsin.gov/opioids/index.htm	https://hope.wi.gov/Documents/ReportOnCombatingOpioidAbuse.pdf
WY	https://health.wyo.gov/	https://health.wyo.gov/publichealth/prevention/substanceabuseandsuicide/opioid-information-wyoming/	https://health.wyo.gov/publichealth/prevention/substanceabuseandsuicide/opioid-information-wyoming/opioid-abuse-data-resources/