INFORMATION ON NEW LAW TO PREVENT AND TREAT OPIOID ADDICTION
(Signed by the Governor February 15, 2017; Regulations Pending)

Effective Date
While the law has an effective date of 90 days after signing (May 16, 2017), emergency regulations were promulgated in line with the law. These regulations took effect March 2017. We advise that members change their opioid prescribing practices to comply with the law immediately.

Pill Limits
The law states that a practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a five-day supply for treatment of acute pain. There are no exceptions to this rule, not even for post-operative pain treatment. The rule applies to scheduled or unscheduled opioids, but does NOT dictate what constitutes a 5 day supply. Any prescription for acute pain shall be for the lowest effective dose of immediate-release opioid drug.

The law restates current regulations on pain management by requiring the following:

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 focus on determining the cause of the patient’s pain; and
4. Access relevant prescription monitoring information under the Prescription Monitoring Program.

The law allows subsequent prescriptions, up to a 25 day supply, no less than four days after the initial 5 day prescription if needed. *There may be practical difficulties for patients being able to access appointments for this additional supply. As such, keep in mind that current regulations allow pharmacies, in the case of an emergency situation, to dispense a controlled substance listed in Schedule II upon receiving oral authorization of a prescribing individual practitioner, provided that:

1. The quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency period, not to exceed 72 hours (dispensing beyond the emergency period must be pursuant to a written prescription signed by the prescriber);
2. The prescription shall be immediately reduced to writing by the pharmacist and shall contain all information required by law, except for the signature of the prescriber;
3. Within seven days after authorizing an emergency oral prescription, the prescriber shall cause a written prescription for the emergency quantity prescribed (not to exceed the amount for a 72-hour period) to be delivered to the dispensing pharmacist. In addition to conforming to the current requirements, the prescription shall have written on its face “Authorization for Emergency Dispensing,” and the date of the oral order. The written prescription may be delivered to the pharmacist in person or by mail, postmarked within the seven-day period.

Informed Consent
Prior to issuing the initial prescription of a Schedule II controlled dangerous substance or any other opioid prescription drug in a course of treatment for acute or chronic pain, and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient, the risks associated with the drugs being prescribed, including but not limited to:

1. the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;
2. the reasons why the prescription is necessary;
3. alternative treatments that may be available; and
4. risks associated with the use of the drugs being prescribed, specifically that: opioids are highly addictive, even when taken as prescribed; there is a risk of developing a physical or psychological dependence on the controlled dangerous substance; and the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

*For unemancipated minors under age 18, this discussion must be documented for each Schedule II opioid prescription, not just the first and third.

The practitioner shall include a note in the patient’s medical record that the patient or the patient’s parent or guardian, as applicable, to document the discussion.

Pain Agreements
Pain management agreements must be written contracts or agreements executed between a practitioner and a patient, prior to the commencement of treatment for chronic pain using a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug.

The pain management agreement must:
1. Prevent the possible development of physical or psychological dependence in the patient;
2. Document the understanding regarding the patient’s pain management plan;
3. Establish the patient’s rights in association with treatment, and the patient’s obligations in relation to the responsible use, discontinuation of use, and storage of Schedule II controlled dangerous substances, including any restrictions on the refill of prescriptions or the acceptance of Schedule II prescriptions from practitioners;
4. Identify the specific medications and other modes of treatment, including physical therapy or exercise, relaxation, or psychological counseling, that are included as part of the pain management plan;
5. Specify the measures the practitioner may employ to monitor the patient’s compliance, including but not limited to random specimen screens and pill counts; and
6. Delineate the process for terminating the agreement, including the consequences, if the practitioner has reason to believe that the patient is not complying with the terms of the agreement.

When a Schedule II controlled dangerous substance or any other prescription opioid drug is continuously prescribed for three months or more for chronic pain, the practitioner shall:
1. 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 and document the review results;
2. Assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with physical and psychological dependence and document the results of that assessment;
3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or dependence and document with specificity the efforts undertaken;
4. Review the Prescription Drug Monitoring information; and
5. Monitor compliance with the pain management agreement and any recommendations that the patient seek a referral.
Exceptions to pill limits, informed consent and pain agreement requirements
The law does not apply to a prescription for a patient in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long term care facility, or to any medications that are prescribed in the treatment of substance abuse or opioid dependence (medication assisted treatment).

Continuing Education Mandate
As a condition of biennial registration, all physicians must complete one credit of educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. This requirement will take effect in the 2017-2019 cycle. Resources are forthcoming.

The only other CME mandate carve out of the 100 biennial hours required is 2 hours of End of Life education every two years. See http://www.njconsumeraffairs.gov/bme/Pages/End-of-Life-Care.aspx.

Definitions
“Acute pain” means pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time. “Acute pain” does not include chronic pain, pain being treated as part of cancer care, hospice or other end of life care, or pain being treated as part of palliative care.

“Initial prescription” means a prescription issued to a patient who:
   (1) Has never previously been issued a prescription for the drug or its pharmaceutical equivalent; OR
   (2) Was previously issued a prescription for the drug or its pharmaceutical equivalent, but not in the past year.

When determining whether a patient was previously issued a prescription for a drug or its pharmaceutical equivalent, the practitioner shall consult with the patient and review the patient’s medical record and prescription monitoring information.

“Practitioner” means a medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, physician assistant, certified nurse midwife, or advanced practice nurse, acting within the scope of practice of their professional license pursuant to Title 45 of the Revised Statutes.

Addiction treatment
The law increases addiction treatment coverage by requiring insurers to provided unlimited benefits for inpatient or outpatient treatment and guarantees medically necessary coverage for 6 months without prior authorization. It also states that the benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

Prescription Insurance Coverage
The law allows insurers to pro rate the patient cost for an opioid if only a 5 or 25 day amount is prescribed. But, the law also allows the insurers to collect payment for the full 30 day supply up front, so patients will not likely see any cost reductions if they only obtain a 5 day supply.

Report patient access issues as a result of this law to MSNJ by emailing info@msnj.org. Visit www.msnj.org/drugabuse for other important information.