News Laws Governing Controlled Substances (CS) for Administrators and Managers
AB 474 – effective Jan. 1, 2018

Weldon (Don) Havins, MD, JD, LLM (Health Law)
Professor and Director of Medical Jurisprudence
Professor of Ophthalmology
In-House Counsel
Touro University Nevada
DISCLOSURES

NO CONFLICTS TO DISCLOSE

Joe Hardy, MD, Professor, Touro University Nevada, is a Nevada State Senator, District 12

Weldon (Don) Havins, MD, JD is a Board Member of the Nevada Board of Medical Examiners

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Board postpones opioid regulations

Implementation delayed after complaints from doctors, lawyers at hearing

By Kimber Laux
Las Vegas Review-Journal

The Nevada Medical Board of Examiners is delaying implementation of a new opioid prescription law after dozens of doctors complained that the change is burdensome and enforcement is confusing.

Assembly Bill 474, which went into effect Jan. 1, requires Nevada licensing boards to create regulations that outline disciplinary actions to be taken against doctors who prescribe opioids in violation of the bill, which requires physicians to perform a risk assessment on patients before writing opioid prescriptions, limit initial prescriptions of the drugs to two weeks and get the patient's consent to random drug testing if the prescription is extended to a month.

Doctors have complained that the risk assessment takes too long and that patients are deterred from seeking help by the threat of random drug testing.

The board said it will create an “AB474 Working Group” to study the law, explore how it affects patients and medical providers and collaborate to develop “workable solutions” to the law’s requirements.

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Complaints of about 40 physicians, lawyers and others who argued during a Jan. 3 meeting that the draft disciplinary rules make unreasonable paperwork demands and do not specify what types of conduct could lead to penalties or revocation of medical licenses.

“We agreed based on comments at the workshop that we should pull back our efforts to implement the draft regulations” and focus instead on developing regulations that would be fair and amenable to licensees, board Executive Director Ed Cousineau said Friday.

“The board said in a statement it will create an “AB474 Working Group” to study the law, explore how it affects patients and medical providers and collaborate to develop “workable solutions” to the law’s requirements.

Cousineau said the board has not decided who will be in the working group and has no timeline for when the group will meet or when regulations will be submitted for review, but that it likely will be a six-month process. The board’s main priority, he said, is getting the appropriate parties involved in drafting the new regulations.

“There’s always someone who’s not going to get what they want,” Cousineau said.

The board has been drafting and revising the regulations contested at the Jan. 3 workshop since AB474 went into effect for administrative purposes in June.

“It wasn’t like we were sitting on it,” Cousineau said.

The board submitted the draft language at its quarterly meeting in September, received revisions from the Legislative Counsel Bureau in November and, because it had to wait 30 days to hold a public meeting, opted to conduct the workshop after the holidays, Cousineau said.

Once assembled by the board, the working group must propose new regulations to the board for its blessing and wait for the legislative committee’s approval to put them into law.

Gov. Brian Sandoval mentioned the bill’s turbulent enrollment during a National Governors Association panel discussion Friday.

“I sponsored legislation in the past two Legislatures to combat the opioid epidemic in Nevada. We lose a Nevadan every day because of this,” Sandoval said during the panel.

Sandoval said he understands physicians’ frustration with the law, but ultimately, doctors share the same goals as the legislators who wrote and passed AB 474: to curb the over-prescribing of opioids in Nevada.

“I still think that the legislation is incredibly important in terms of saving lives, and we’ll continue to work with the medical community to get them comfortable with this,” Sandoval said. “But this is the law, and it’s not going to change, and we’re going to ensure that there’s compliance with it.”

“It is going to take some time, but I think over time everyone is going to see it’s in the best interest of the patient,” Sandoval said.

Contact Kimber Laux at klaux@reviewjournal.com. Follow @lauxkimber on Twitter.
Controlled Substances

• Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules.

• Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.
Schedule II - Controlled Substances

- Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

- Examples of Schedule II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine, and hydrocodone.

- Examples of Schedule IIN stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®)

- Other Schedule II substances include: amobarbital, glutethimide, and pentobarbital.
Schedule III - Controlled Substances

- Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

- Examples of Schedule III narcotics include: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).

- Examples of Schedule IIIN non-narcotics include: benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.
Schedule IV - Controlled Substances

• Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

• Examples of Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).
AB 474 of 2017 – Sec. 3
effective Jan 1, 2018

- Cases of drug overdose or suspected overdose must be reported to the Chief Medical Officer by the provider of health care who knows of, or provided services to, the person.

- Any provider who willfully fails, neglects or refuses to comply is guilty of a misdemeanor and may be subject to an administrative fine of $1000 for each violation, as determined by the Board of Health.
Public Health - New Emergency Regulation

For the purpose of this regulation, a drug overdose or suspected drug overdose is reportable if the suspected drug is scheduled I, II, III, or IV per the United States Drug Enforcement Administration.

No later than 7 days from patient discharge, a provider of health care who knows of, or provides services to, a patient who has suffered or is suspected of having suffered a drug overdose shall report that fact to the Chief Medical Officer or his or her designee.
Public Health New Emergency Regulation

The name, address and telephone number of the health care provider making the report.

The name, address, and telephone number of the patient.

The occupation, employer, age, sex, race and date of birth of the patient.

The date of the overdose or suspected overdose.

Any laboratory results, including toxicology, that apply to the overdose or suspected overdose, as well as the description of the laboratory sampling method.

Disposition of the patient.

Previous known overdose(s) of the patient.

Patient pregnancy status.

International Classification of Disease (ICD) 10 Diagnosis Codes related to the overdose or suspected overdose.
Law enforcement or board investigator declaring exigent circumstances requires provider’s immediate production of medical records (at the time of the request); if MRs are out of State, 5 days. (Sec. 13)

Regular production of MRs by the custodian of MRs is 10 days (20 days if out of State).

See SB 291 (2017)
AB 474 of 2017 – all 6 Boards effective Jan 1, 2018

Each (of the six) Board shall, by regulation, require each practitioner certified or registered to dispense CS to complete 2 hours of training relating to the misuse and abuse of CS, the prescribing of opioids or addiction during each relicensure period. These CMEs may be used to satisfy 2 hours of any continuing education requirement.

(FYI, AB 105, effective July 1, 2017, requires 2 CME hours every four (4) years in suicide prevention.)
Licensee registered to dispense CS shall, each licensing cycle, complete at least 2 hours of Category I CME relating specifically to the misuse and abuse of CS, the prescribing of opioids or addiction.
NBOM Regulation 116-17

NAC 633.250:

Each osteopathic physician and PA, for licensure renewal, must attest he or she has completed 2 hours continuing education related to misuse and abuse of CS, the prescribing of opioids or addiction.

Each osteopathic physician shall complete 2 hours instruction on evidence-based suicide prevention and awareness every 4 years.
NBME Existing Mandate to Report Violations

**NRS 630.3062** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

6. **Failure to report any person** the licensee knows, or has reason to know, **is in violation of the provisions of this chapter or the regulations of the Board** within 30 days after the date the licensee **knows or has reason to know** of the violation.

**NRS 630.3062** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

3. **Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law** or knowingly or willfully obstructing or inducing another to obstruct such filing.
NRS 633.511(1) The grounds for initiating disciplinary action pursuant to this chapter are:

(p) Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

(o) Making or filing a report which the licensee knows to be false, failing to file a record or report that is required by law or knowingly or willfully obstructing or inducing another to obstruct the making or filing of such a record or report.
Before prescribing a CS (II, III, IV), a practitioner must consider the following factors, when applicable:

1. Whether there is reason to believe that the patient is not using the CS as prescribed or is diverting the CS for use by another person.
2. Whether the CS has had the expected effect on the symptoms of the patient.
3. Whether there is reason to believe that the patient is using other drugs, including alcohol, Schedule I CS or prescription drugs that:
   a. May interact negatively with the CS prescribed; or
   b. Have not been prescribed by a practitioner who is treating the patient.
Before prescribing a CS (II, III, IV), a practitioner must consider the following factors, when applicable:

4. The number of attempts by the patient to obtain an early refill of the prescription.

5. The number of times the patient has claimed that the controlled substance has been lost or stolen.

6. Information from the PMP that is irregular or inconsistent or indicates that the patient is inappropriately using a CS.

7. Whether previous blood or urine tests have indicated inappropriate use of CS by the patient.
Before prescribing a CS (II, III, IV), a practitioner must consider the following factors, when applicable:

8. The necessity of verifying that CS, other than those authorized under the treatment plan, are not present in the body of the patient.

9. Whether the patient has demonstrated aberrant behavior or intoxication.

10. Whether the patient has increased his or her dose of the CS without authorization by the practitioner.

11. Whether the patient has been reluctant to stop using the CS or has requested or demanded a CS that is likely to be abused or cause dependency or addiction.

12. Whether the patient has been reluctant to cooperate with any examination, analysis or test recommended by the practitioner.

13. Whether the patient has a history of substance abuse.
Before prescribing a CS (II, III, IV), a practitioner must consider the following factors, when applicable:

14. Any major change in the health of the patient, including, pregnancy, or any diagnosis concerning the mental health of the patient that would affect the medical appropriateness of prescribing the CS for the patient.

15. Any other evidence that the patient is chronically using opioids, misusing, abusing, illegally using or addicted to any drug or failing to comply with the instructions of the practitioner concerning the use of the CS.

16. Any other factor that the practitioner determines is necessary to make an informed professional judgment concerning the medical appropriateness of the prescription.
Forms

- 16 item CS Questionnaire
- Beck Depression Inventory
- Prescription Opioid Misuse Index questions
- COMM test
AB 474 – Sec 60, NRS 639.23507
PMP Mandate – Before prescribing

Practitioner must obtain a PMP utilization report on the patient before issuing an initial prescription for a CS (II, III, IV) and at least every 90 days thereafter.

The practitioner shall:

a. Review the PMP report to access whether the prescription for the CS is medically necessary, and

b. Determine whether the patient has been issued another prescription for the same CS for ongoing treatment; if so, the practitioner shall not prescribe the CS.
Each prescription for Controlled Substances (CS) II, III, and IV must include:

i. DEA number of the prescriber

ii. ICD 10 diagnosis

iii. Fewest number of days to consume the quantity of CS prescribed; number of refills, and

iv. Each state in which the patient to whom the CS was prescribed has resided or filled a prescription for CS II, III, or IV.

(see AB474 Sec. 7(e)(2); however, this is not required in sec. 61 of AB474 which amends NRS 639.2353 of the BOP statutes, but it is required in the prescription medication agreement nevertheless)
Controlled Substance (CS) NOT for Pain

- 16 considerations before prescribing
- Check the PMP (and every 90 days thereafter)
- Review the PMP report to access whether the prescription for the CS is medically necessary
- Determine whether the patient has been issued another prescription for the same CS for ongoing treatment; if so, the practitioner **shall not prescribe** the CS
- Prescription: ICD 10 Diagnosis code; DEA # is clear; Minimum # days, shortest period.
AB 474 of 2017

effective Jan 1, 2018 – Sec 53 & NRS 639.235(4), NRS 639.23911

Before issuing an initial prescription for CS (II, III, IV) for the treatment of pain, a practitioner must:

a. Have established a bone fide relationship with the patient

(a bona fide relationship between the patient and the person prescribing the controlled substance shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics, including, without limitation, through telehealth, within or outside this State or the United States by the person prescribing the controlled substances within the 6 months immediately preceding the date the prescription was issued)
Before issuing an initial prescription for CS (II, III, IV) for the treatment of pain, a practitioner must:

b. Perform an evaluation and risk assessment which must include:

1. Obtaining and reviewing a medical history
2. *Conducting a physical exam
3. *Make a good faith effort to obtain and review the MRs from any other provider who has provided care to the patient
   - practitioner shall document efforts to obtain such MRs
   - and the conclusions from reviewing these MRs
4. *Assess the mental health and risk of abuse, dependency and addiction of the patient
   - using methods supported by peer-reviewed scientific research and validated by a nationally recognized organization
Forms

- 16 item CS Questionnaire
- Beck Depression Inventory
- Prescription Opioid Misuse Index questions
- COMM test
Before issuing a prescription for a CS (II, III, IV) for the treatment of pain, a practitioner must:

c. Establish a preliminary diagnosis of the patient and a treatment plan tailored toward treating the pain of the patient and the cause of that pain;

d. *Document in the MR the reasons for prescribing the CS instead of an alternative treatment that does not require the use of a CS; and
e. Obtain **informed consent** to use a CS for the treatment of pain from:

i. The patient, if the patient is 18 years of age or older or legally emancipated and competent to give such consent;

ii. The parent or guardian of a patient who is less than 18 years of age and not legally emancipated; or

iii. The legal guardian of a patient of any age who has been adjudicated mentally incompetent.
*The **informed consent** must include information concerning:

1. potential risks and benefits of treatment using the CS
   - including if a form of the CS that is designed to deter abuse is available
   - the risks and benefits of using that form
2. proper use of the controlled substance
3. any alternative means of treating the symptoms of the patient and the cause of such symptoms
4. the important provisions of the treatment plan established for the patient
The **informed consent** must include:

5. the risks of dependency, addiction and overdose during treatment using the CS

6. methods to safely store and legally dispose of the CS

7. the manner in which the practitioner will address requests for refills of the prescription

8. if the patient is a woman between 15 and 45
   - the risks to a fetus of chronic exposure to CS during pregnancy
   - the risks of fetal dependency on the CS and neonatal abstinence syndrome
The **informed consent** must include:

**9. if the CS is an opioid**

- the availability of an opioid antagonist without a prescription, and
- if the patient is an unemancipated minor
  - the risks that the minor will abuse or misuse the CS or divert the CS for use by another person, and
  - ways to detect such abuse, misuse or diversion
INFORMED CONSENT FOR
CONTROLLED SUBSTANCE TREATMENT FOR PAIN

Nevada law requires a patient’s informed consent before a controlled substance can be initially prescribed to treat the patient’s pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries risks and may result in addiction and overdose.

I understand there are potential risks and benefits associated with the medication that I am being prescribed, and I agree to take the medication as directed and not to exceed the dosage as recommended by my practitioner.

My practitioner has discussed possible alternative treatments for my pain that do not include a controlled substance, along with the risks and benefits of the alternate medications or treatments.

It is our mutual decision that a controlled substance may be necessary to manage the treatment of my pain.

PROPER USE OF THE CONTROLLED SUBSTANCE

My practitioner has discussed how to properly use the controlled substance being prescribed, and I agree to take the medication as directed and not to exceed the dosage as recommended by my practitioner.

TREATMENT PLAN AND REFILLS

I have discussed my treatment plan with my practitioner, understanding that the overall treatment plan and goals of treatment is to use the minimum amount of controlled substance rather than to remove all pain.

I understand my practitioner’s protocol for addressing pain control if my usage of the medication, I may not be able to do this on my own.

I understand controlled substance medication is taken, or if the medication is not administered as directed, and if I am not taking the medication properly or my level of consciousness (including alcohol or other substances) is impaired, this may increase the risk of diversion of the controlled substance.

SAFE STORAGE AND DISPOSAL OF A CONTROLLED SUBSTANCE

It is my responsibility to store and dispose of controlled substances in an appropriate manner. I will store controlled substances in a secure place out of reach of children and other family members. To safely dispose of controlled substances, I agree to return the medications to a local pharmacy, a local police station, or I may safely dispose of them by dissolving the medication which may be available for purchase at a pharmacy.

FOR WOMEN IN THE AGES BETWEEN 15 AND 45

It is my responsibility to tell my practitioner if I am, or have reason to believe that I am pregnant, or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).

IF THE CONTROLLED SUBSTANCE IS AN OPIOID

Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone is available without a prescription at a Nevada pharmacy. I understand I can obtain this medication from a pharmacist at any time.

In addition to all of the above, there are increased risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person. I have been informed about ways to detect such abuse, misuse or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I provide consent for the prescription of controlled substances for the treatment of pain.

Patient Signature ___________________________ Patient name printed ___________________________ Date ________________

For a minor, or for a legal guardian:

Parent/Guardian ___________________________ Parent/Guardian name printed ___________________________ Date ________________
AB 474 of 2017
effective Jan 1, 2018 – Sec 52
Pain Treatment with a CS – including an opioid

For treatment of **acute pain**, shall not prescribe CS for more than **14 days** and, **if** the CS is **an opioid**, if patient has never been issued an opioid or it has been more than **19 days** since initial prescription for an opioid, prescription **may not exceed 90 MMEs per day**.
*If a practitioner prescribes a CS (II, III, IV) for the treatment of pain, the practitioner shall not issue more than one additional prescription that increases the dose of the CS unless the practitioner meets with the patient, in person or using telehealth, to reevaluate the treatment plan.
*If a practitioner intends to prescribe a controlled substance (II, III, IV) for more than 30 days for the treatment of pain, the practitioner must, not later than 30 days after issuing the initial prescription, enter into a prescription medication agreement with the patient, which must be:

Documented in the patient’s MRs; and updated at least once every 365 days while the patient is using the CS, or whenever a change is made to the treatment plan.
A **prescription medication agreement** must include:

a. The **goals of the treatment** of the patient
b. **Consent** of the patient to testing **to monitor drug use** when deemed medically necessary by the practitioner;
c. A requirement that the patient **take the CS only as prescribed**;
d. A **prohibition on sharing medication with any other person**;
Pain Treatment using a CS

A prescription medication agreement must include:

e. A requirement that the patient inform the practitioner:

i. Of any other CS prescribed to or taken by the patient;

ii. Whether the patient drinks alcohol or uses marijuana or any other cannabinoid while using the CS.

iii. Whether the patient has been treated for side effects or complications relating to the use of the CS, including whether the patient has experienced an overdose; and

iv. Each state in which the patient has previously resided or had a prescription for a CS filled;
A prescription medication agreement must include:

f. Authorization for the practitioner to conduct random counts of the amount of the CS in the possession of the patient;

g. The reason the practitioner may change or discontinue treatment of the patient using the CS; and

h. Any other requirements that the practitioner may impose.
Prescription Medication agreement

Name

PRESCRIPTION MEDICATION AGREEMENT FOR
CONTROLLED SUBSTANCE TREATMENT OF PAIN

Nevada law requires a patient to enter into a “Prescription Medication Agreement” to be continued for more than 30 days for treatment of pain. I understand I may experience side effects such as dizziness, drowsiness, and insomnia. Pain control is a complex and individualized process. I understand my responsibility, and that the treatment of pain with controlled substances can have profound effects on my life. The purpose of the agreement is to comply with the law and my practitioner comply with the law.

(Please initial within each numbered paragraph and sign below to indicate acceptance of this document.)

Regarding my treatment plan and be goals of the treatment, I will disclose to the appropriate use of a controlled substance.

_________ I have discussed my treatment plan with my practitioner and understand the overall treatment plan and goals of treatment possible alternative treatments for my pain and the substances and it is our mutual decision that continued treatment with more than 30 days may provide some benefit for the treatment of my pain.

_________ I understand that part of the goals of my pain management plan is to minimize or even discontinue the use of controlled substances. My practitioner will recommend tapering or discontinuing the use of the controlled substance. Some of these reasons may include, but are not limited to: improvements in symptoms by other means; the presence of development of adverse events associated with current use; the development of new or worsened adverse events; the development of new or increased medical conditions; and the practitioner’s recommendations. I hereby reaffirm my consent to monitor my use of controlled substances, to discontinue the use of controlled substances at any time, and to discontinue the use of controlled substances if the practitioner deems it appropriate or necessary, including, without limitation, testing as well as bringing my medications to the prescribing pharmacist to be counted.

_________ I reaffirm that I will take all prescribed controlled substance(s) as prescribed. I will not share my medications with any other person. I agree to inform my practitioner of any other controlled substances that I am taking or have been taking in the past 30 days, including any alcohol, tobacco, marijuana, or other controlled substances.

_________ I will immediately disclose to my practitioner of any alcohol consumed by me and of any marijuana products, including cannabinoids, I may use or consume while taking controlled substances for the treatment of my pain.

_________ I will disclose to my practitioner whether I have been treated for side effects or complications related to the use of the controlled substance, including whether I have experienced an overdose.

_________ I understand that Nevada state law requires me to provide a listing of every prescription for a controlled substance that I have previously used or had a prescription for a controlled substance filled in the 30 days prior to the date of the agreement. Below is a listing of such prescriptions:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

_________ I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and not to deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children, and I will dispose of unused medication appropriately.

_________ I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, dependence, and addiction.

_________ I understand that prescriptions will only be provided during scheduled office visits, and it is my responsibility to make sure that I have scheduled appointments for refills (typically 30 days in advance).

_________ I understand that my medication is my responsibility and if it is lost or stolen, medication may not be replaced until my next appointment, at the judgment of my prescriber.

_________ If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk for abuse, misuse, and addiction using validated tools. I agree to cooperate for these tests. If the test results indicate that I will also be required to undergo appropriate testing to determine evidence-based diagnosis for the cause of my pain. My practitioner may also refer me to a specialist for consultation or for further treatment.

I hereby authorize my practitioner to obtain records from other practitioners or clinics, and speak to other practitioners about my current or prior medical care.

_________ It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.

_________ I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies, investigation, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Occupational Licensing Boards.

I agree to fill my prescriptions only at one pharmacy, unless the medication is not available at that pharmacy or the cost of the medication is substantially better at another pharmacy. I will immediately notify my practitioner if I change or use another pharmacy.

My current pharmacy is:

________________________________________________________________________
Farmacy Name ___________________________ Pharmacy Phone Number ___________________________

Pharmacy Address

I understand that if I violate any part of this agreement, I may be denied prescriptions for controlled substances and I may be discharged from the clinic.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of this Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain.

Patient Signature ___________________________ Patient name printed ___________________________ Date _____________

Parent/Guardian ___________________________ Parent/Guardian name printed ___________________________ Date _____________

Touro University Nevada
AB 474 of 2017

effective Jan 1, 2018 – Sec 55

Pain Treatment using a CS

Before prescribing a CS (II, III, IV) to continue to treat pain for 90 days or more, a practitioner must:

a. *Require the patient to complete an assessment of the patient’s risk for abuse, dependency and addiction that has been validated through peer-reviewed scientific research;

b. Conduct an investigation, including appropriate hematological and radiological studies, to determine an evidence-based diagnosis for the cause of the pain;
Forms

• 16 item CS Questionnaire
• Beck Depression Inventory
• Prescription Opioid Misuse Index questions

• COMM test
Before prescribing a CS (II, III, IV) to continue to treat pain for **90 days or more**, a practitioner must:

c. Meet with the patient, in person or using telehealth, to review the treatment plan to determine whether continuation of treatment using the CS is medically appropriate; and

d. If the patient has been prescribed a dose of 90 MMEs or more of an **opioid** per day for 90 days or longer, consider referring the patient to a specialist
AB 474 of 2017
effective Jan 1, 2018 – Sec 52, NRS 639.2391
Pain Treatment using a CS

If practitioner prescribes more than 365 days of CS pain medication (II, III, IV) in 365 days practitioner in MR the reasons, or

for a larger quantity of CS (II, III, IV) than will be used in 90 days, the prescriber must document in the MR the reasons.
AB 474 of 2017
effective Jan 1, 2018 – Sec 55
Pain Treatment using an opioid

If the practitioner decides to continue to prescribe a dose of 90 MMEs or greater per day, the practitioner must develop and document in the patient’s MRs a revised treatment plan with must include an assessment of the increased risk for adverse outcomes.
Initial Prescription for CS for Pain

Same as not for pain, plus:

1. If acute pain, no more than 14 days and no more than 90 MMEs if opioid naïve

2. Bone fide relationship

3. Evaluation and risk assessment
   i. Medical history
   ii. Physical exam
   iii. Document good faith effort to review medical records, and conclusions from review of MRs
Initial Prescription for CS for Pain

iv. Access mental health and risk of abuse, dependency, and addiction with qualifying tests

4. Preliminary diagnosis and treatment plan to treat the patient’s pain and the cause of the patient’s pain

5. Document in the MR the reasons for prescribing the CS instead of an alternative treatment that does not require the use of a CS
Initial Prescription for CS for Pain

6. Obtain an **informed consent** to use a CS for the treatment of pain from the appropriate authority.

7. The informed consent must include the eight (8) required elements, plus, if an opiate, four (4) additional elements.

No more than one increase in the CS unless re-evaluation of treatment plan in-person or telehealth.
Prescription for CS for Pain > 30 days

Prescription Medication Agreement

- twelve (12) elements including States in which the patient has lived or has filled a prescription for controlled substances

- (no requirement in AB 474 to use the same pharmacy; FSMB Guidelines suggest this)
Prescription for CS for Pain > 90 days

a. Require the patient to complete an assessment of the patient’s risk for abuse, dependency and addiction that has been validated through peer-reviewed scientific research;

b. Conduct an investigation, including appropriate hematological and radiological studies, to determine an evidence-based diagnosis for the cause of the pain;

c. Meet with the patient in-person or telehealth, review treatment plan to determine if CS should be continued
Prescription for CS for Pain > 90 days
Sec. 55(1)(d); NRS 639.23913(1)(d)

- If the patient has been prescribed a dose of 90 MMEs or more of an opioid per day for 90 days or longer, consider referring the patient to a specialist.

- May not prescribe more than 365 days of CS pain medication (II, III, IV) in 365 days if patient adheres to the dose prescribed, unless justified in the patient's MR.
Thank God He Stopped Talking!!!
Board of Pharmacy (BOP) may access the PMP to identify any suspected fraudulent, illegal, unauthorized activity related to prescribing, dispensing, or use of a CS.

Discovered information shall be reported to law enforcement or licensing board.

Dispensing Licensees must present proof of authorization to access the PMP to be relicensed.
AB 474 of 2017
effective Jan 1, 2018 – all 6 Boards

Failure to comply with requirements of NRS 453.163, 453.164, 639.23507, and sections 52 to 58 of AB 474, and any regulations adopted by the BOP, subjects the licensee to licensure discipline.

Fraudulent, illegal, unauthorized or otherwise inappropriate prescribing, administering or dispensing of a CS subjects the licensee to licensure discipline.
If licensing Board Executive Director (ED) receives complaint from law enforcement, BOP, or any other source, that the licensee has:

- has issued a fraudulent, illegal, unauthorized or inappropriate CS prescription, or
- a pattern of such prescribing, or
- a patient (of the licensee) who has acquired, used or possessed a CS (II thru IV) as above, then:
AB 474 of 2017 – all 6 Boards effective Jan 1, 2018 – “review and evaluation”

- ED, or designee, must notify licensee as soon as practicable (may delay notification if criminal investigation ongoing)
- ED, or designee, reviews PMP licensee’s information
- The licensee is required to attest that licensee has complied with NRS 639.23507 (reviewed patient’s PMP and CS is medically indicated; confirm if ongoing treating CS not written by another prescriber) AND has complied with AB 474 sec. 52, 54, and 57 [and their codification in NRS].
AB 474 of 2017 – all 6 Boards

effective Jan 1, 2018

After “review and evaluation,” if ED determines that the licensee may have issued a fraudulent, illegal, unauthorized or inappropriate prescription, the ED, or designee, may refer for criminal prosecution & the Board must proceed as if a written complaint had been filed against the licensee.

After conducting an investigation and a hearing, if licensee is found guilty, the licensing Board must impose appropriate disciplinary action.
If the Board determines from investigation that the public health, safety, or welfare, of any patient is at risk of imminent or continued harm, the Board **may** summarily suspend licensee’s authority to prescribe CS (II, III, IV) pending a determination upon the conclusion of a hearing to consider a formal complaint against the licensee.
AB 474 of 2017 – all 6 Boards
effective Jan 1, 2018 – Sec 34

Such summary suspension may be issued by the Board, President of the Board, presiding officer of an investigative committee (IC) conducting the investigation or member of the Board who conducted the investigation. If IC chair or investigating member issues the summary suspension order, that person may not participate in any further proceedings related to the order.

The licensing Board must hold a hearing and render a decision concerning [whether to file] the formal complaint within 60 days of the summary suspension order for the Medical Board, Nursing Board, Podiatric Board, and Optometric Board, or within 180 days for Osteopathic Medical Board and Dental Board.
The licensing Board shall adopt regulations providing for disciplinary action against a licensee for inappropriately prescribing a CS (II, III, IV) or violation of Section 52 to 58 of AB 474, and any regulations of the BOP, to include additional continuing education concerning prescribing CS II, III, IV.
AB 474 of 2017
effective Jan 1, 2018 – Sec 58; NRS 630.23916

The BOP may adopt any regulations necessary or convenient to enforce the provisions of NRS 639.23507, and Sections 52 to 58 of AB 474. Such regulations may impose additional requirements concerning the prescription of CS II, III, IV for the treatment of pain.

A practitioner who violates any provision of this act or any furthering regulations is:

a. Not guilty of a misdemeanor; and [is]

b. Subject to professional discipline.