FAQ: "2 hour Opioid Prescribing Course" – Joshua Lenchus, DO, RPh, FACP (Updated: 7/5/2018)

1. **Question:** Is there any particular information regarding the drugs we prescribe for ADHD? My other question is the slide said this applies to those over 16 years of age. So do we need to do this for those under that age? **Answer:** The law was enacted to specifically address the use of opioids. Stimulant medications typically used for ADHD, while C-II controlled substances, do not fall under the aegis of acute pain treatment and are not opioids, hence the 3 day maximum prescription supply would not apply. That said, since they are controlled substances, the PDMP needs to be queried when a prescription for such is written, and the dispenser has a duty to enter the prescription into the PDMP. The dispensing of a controlled substance to a person under the age of 16 need not be reported to the PDMP. It is a listed exception.

2. **Question:** I was wondering what you know about how the government agency pharmacies (VA) will be affected by the new time limits for reporting to the PDMP (EFORSCE). I practice in Tampa and have a fair number of patients who fill Rxs at the VA. I very seldom see evidence of filling on EFORSCE done through the VA or McDill Air Force base. **Answer:** I noted no exception to the PDMP reporting because the patient was having their prescription filed in a VA. Perhaps, in the example noted below, patients are choosing to fill them elsewhere hence the lack of information identifying the VA as the dispenser. HB 21 specifically provides that employees of the United States Department of Veterans Affairs who provide health care services pursuant to such employment and who have the authority to prescribe or dispense controlled substances shall have access to the E-FORCSE database. VHA Directive 1306, issued October 19, 2016, requires VHA health care providers to query State Prescription Drug Monitoring Programs. Additionally, I spoke with a senior VA pharmacist who tells me that the filling of an opiate prescription is automatically entered into the PDMP so not exactly sure why one would explicitly not see those. I suggest speaking directly with a pharmacist at McDill or the local VA, the location at which the controlled substance is being dispensed.

3. I am registered with a PDMP--as CURES 2.0. Mainly I practice radiation oncology in California. I do maintain a Florida license -- and occasionally I do Local Tenens in Florida. Do I also need to register separately with E-FORCSE for my PDMP? If you are going to prescribe a controlled substance, specifically an opioid, in Florida, I would recommend registering on the EFORCSE website. It is free and easy, and can only be helpful. If not used, there is absolutely no harm in being registered. But, in the event that you need it, you are already registered.

4. I gather that anti-depressants do not need to be registered with the PDMP?? What about testosterone such as Estratest for female climacteric sx? As Ambien is a controlled substance, does that mean that only 3 Ambien may be given for insomnia? Antidepressants, as a general class, are not controlled substances, and therefore do not require checking the PDMP before prescribing or entering such at the time of dispensing. Testosterone is a controlled substance and, thus, the PDMP must be queried prior to the prescription thereof, regardless of the diagnosis. Finally, while zolpidem (Ambien) is a controlled substance (so the PDMP must be queried, and the dispenser must enter it into the PDMP), it is not an opioid used for acute pain treatment and is therefore not bound to a maximum 3 day supply.

5. Is Florida enforcing a maximum daily morphine equivalent starting in July, 2018? it appeared on his flowchart comparing cdc and other states who has. I am a pain specialist and have patients with chronic pain well over that morphine limit and need to prepare my patients. The law does not include a maximum daily morphine equivalent dose. This was included in the presentation to address why the CDC recommends such, and inform the physician as to the current state of implementing such across the country. On February 13, 2018, Governor Rick Scott declared the opioid epidemic a state of emergency in Florida. In response, the Agency for Health Care Administration implemented the following change to the Florida Medicaid program: Effective March 26, 2018, prescriptions for opioids for patients who are new to opioid treatment be limited to a maximum dose equivalent of 90 milligrams of morphine per day. Presently, this applies to Medicaid patients who are new to opioid treatment only.

6. I was surprised by the requirement for a narcan Rx for Schedule II prescriptions, but am unclear if that was for ALL schedule II Rx's or only for those patients with an ISS of 9 or greater. If it is only for those with an ISS of 9 or greater, what would be the temporal relationship to the actual injury? For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance listed in s. 893.03 or 21 U.S.C. s. 812 must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1). The law does not specify a temporal relationship between the injury and the prescription.

7. I am a primary care, Internal Medicine provider with office, Hospital and nursing home practice . I took your online course for opioid and controlled substances and have few questions:

(1) Does FMA reports this to CE Broker / medical License to satisfy mandatory new requirement Yes. Like other CME activities completed through the FMA, this course will be reported to CE Broker on your behalf.

(2) Does 3 day or 7 day new rule also apply to C- III to - V (example ambien, klonopin , restoril, tramadol etc.) The 3 and 7 day limits specifically apply to C-II opioid prescriptions.

(3) Do I need to check PDMP all time even for class 3 to 5. If they coming for renewal of ambien, klonopin or tramadol and I know them well can I document PDMP not checked as do not suspect any abuse. Every prescription for a controlled substance requires that the PDMP be queried. Every prescription for a controlled substance requires that the PDMP be queried, with the exception of non-opioid Schedule V controlled substances.

(4) I have big office Geriatrics population and lot of them are chronically on some form of controlled pain meds or benzodiazepine or sleeping aid . If for chronic pain can I write in Rx. (for non acute pain) and give 30 day supply. Most of them have no access to pain management or don't want to see pain management. Chronic pain is materially different than the acute pain focus of this legislation. There is no explicit limit on the duration of a prescription for chronic, nonmalignant pain.

(5) We also have lots of elderly patients in nursing homes and ALF who are chronically dependent on some form of pain med or benzodiazepines. Since they don't come in acute pain category can they be given meds long term. These places have no pain management or psychiatry all time. Do I keep writing Narcan for each and every Rx for even chronic pain, or it applies to acute pain only. It would be imperative to identify patients' pain as either acute; chronic, nonmalignant; malignant; etc. The requirement to concurrently prescribe an opioid antagonist (e.g., Narcan) is mandated if an opioid is being prescribed to treat acute pain related to trauma with an ISS (injury severity score) of 9 or greater.

(6) When I discharge a patient from hospital and write discharge acute pain C-II (example Percocet) for 3 day on hospital Rx. do I still check and document PDMP checked. This makes no sense as I work in a trauma hospital as well and if patient has been in hospital for many days post-surgery etc. and need 3 day or 7 day post hospital pain med on discharge, why need to do this extra work. Quite simply, any prescription for a controlled substance to be filled outside of the hospital requires a PDMP query by the prescriber or his/her designee.

8. I have a question related to the new controlled substance law from what I read three days Supply only applies to class two opioid. What about Tylenol number 3 which is a class 3 drug and tramadol which is a class 4 drug will those medications also be under the 3-day limit
   You are correct in that the 3 day prescription supply only applies to Schedule II opioids written for acute pain. Insofar as the agents you list above are not of that classification, they are not held to that limit.

9. My understanding is that I can only prescribe medications like hydrocodone with acetaminophen or Percocet for three days. That is correct, with limited exception up to a 7 day maximum for acute pain.

   If the patient still continues to complain of pain after the three days, then can I only have them use OTC medications such as ibuprofen/acetaminophen combination or can they be prescribed the pain medication for another three days? If you believe that their post-procedure acute pain requires an opioid prescription, and wish to prescribe up to the 7 day maximum, 3 things must occur: (1) In your professional judgment, you believe that more than a 3 day supply of the opioid is medically necessary to treat the patient's pain as an acute medical condition; (2) You indicate "ACUTE PAIN EXCEPTION" on the prescription; and (3) You adequately document in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3 day supply limit. Without explicitly recommending how you practice, I would suggest that the intention was not to simply have the patient return every 3 days for another opioid prescription, but rather to (a) decide whether or not an opioid was necessary at the outset; and (b) if so, evaluate the duration of such a prescription. If you feel that the patient requires an opioid, you may wish to consider whether 3 or 7 days (as described above) is satisfactory, but also think about the use of non-opioid analgesics as you mention.

   Do I also need to check the PDMP for every narcotic pain prescription written or just one time for each patient? A prescriber or dispenser (if you dispense medications from your office) or a designee must consult the PDMP to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This applies to all controlled substances except those non-opioids listed in Schedule V. This means that the PDMP must be queried each time a controlled substance prescription is written, yes.

Sometimes a patient may have multiple appointments for extractions or subsequent surgeries like implant placement Sometimes a patient has pain and infection prior to extractions. If I feel an antibiotic is warranted, I will prescribe that but now it seems that I should only prescribe the OTC analgesics for their pain and then the narcotic prescription after their extractions. Is that correct or can I prescribe a three day narcotic prescription with the antibiotic and then another three day prescription after their extractions? This sounds like a clinical decision. Acute pain is defined as the normal, predicted, physiological, and time-limited response to an adverse stimulus associated with surgery, trauma, or acute illness. The situation described sounds like the pain may be originating from the same stimulus, so you would be limited to a 3 day (or 7 day with exception) prescription supply. If, in your clinical judgment, the patient's pain can be addressed with non-opioid analgesics, that is likely the best route.

I just registered with e-Forcse. Is that what I log onto to check the PDMP? Congratulations; hopefully it was rather easy to do so. The website can be accessed by logging in at https://florida.pmpaware.net/login. From there, click on the pull down menu at the upper left hand corner and begin your search.

Can I place a poster or sign in each of my operatories that says something like Florida Law only allows a maximum three day prescription for pain medication. Additional pain prescriptions will not be written. (This way it can diffuse the patient who always think they need pain medication, but at least they will know that Florida Law prohibits additional prescribing). The law is silent on this, but you are free to do so if you choose.

10. Do you need to access the E-Forcse if you only prescribe less than 3 days of opioids. I am in the ER and for ankle pain or fractures etc. prescribe Vicodin 6 pills. Do I need to document accessing the database for something like this? Quite simply, the law states, "A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V of s. 893.03 or 21 U.S.C. 812." Therefore, regardless of the duration for which the prescription is written, the PDMP must be queried each and every time a controlled substance prescription is prescribed or dispensed.

11. Does a doctor have to query the PMDP each time they prescribe the controlled substance or can we use our designate? The short answer is yes; either you or your designee must query the PDMP for each and every controlled substance prescription. The law states, "A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V of s. 893.03 or 21 U.S.C. 812. "

    Can one write for 2, 3 day rx for a class 2 agent, adding the words "do not fill" to the 2nd rx? Our EMR has this ability and we have used it for college students for Adderall when living away from home. While not explicitly prohibited by this law, you may wish to consider several things. (1) does the patient's pain meet the definition of acute pain? (2) If so, in your professional opinion, does the patient require an opioid to adequately address the pain? (3) If so, would the patient best be served with a 3 day or 7 day course of therapy? If you think the patient would benefit from a 7 day course of therapy, and can address the stipulations thereof, you may consider writing a single prescription for 7 days, rather than post-dating a second prescription. As a reminder, the law requires the following for a 7 day supply: "1. The prescriber, in his or her professional judgment, believes that more than a 3-day supply of such an opioid is medically necessary to treat the patient's pain as an acute medical condition; 2. The prescriber indicates "ACUTE PAIN EXCEPTION" on the prescription; and 3. The prescriber adequately documents in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3- day supply limit established in this subsection."

    Do physicians have to see the patient to write for another 3 day rx for acute pain or can they have family member pick up after phone call to patient for "f/u" as condition makes it difficult to get in. The law delegates patient evaluation rules to the Board of Medicine. In your professional judgment, if you think it feasible to write the patient another prescription absent a follow up visit, that is within your purview.

12. Questions regarding the palliative care definition... Would someone with a prior history of failed back surgery qualify as palliative care? What about a spinal cord injury? Could you give us examples of palliative care besides connective tissue diseases? The law denotes an exception to the definition of acute pain, related to your inquiry, as follows, "Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury." The Boards of Medicine and/or Osteopathic Medicine may make a further determination as to what specific diseases qualify under this, but you may wish to consider the wording in the interim.

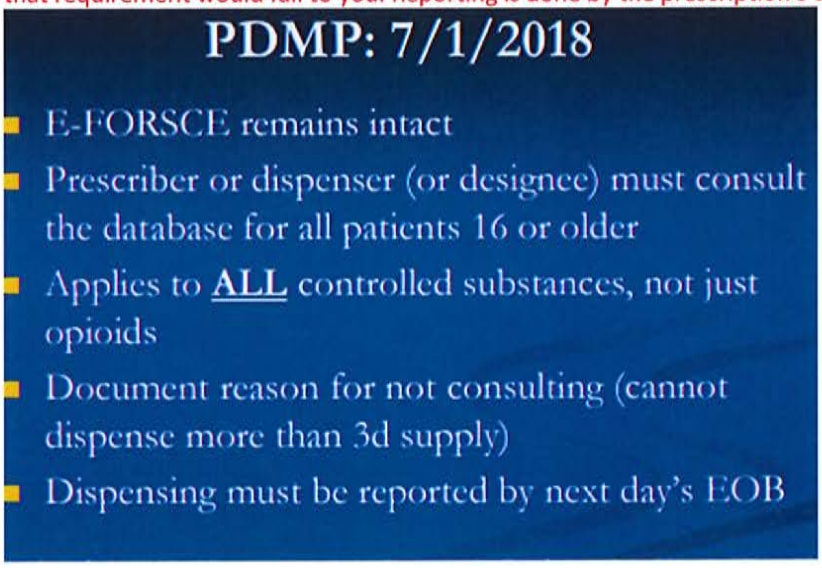
13. On E-forcse, what is the delegate management? I would have office personnel checking the E-forcse. Are they to be listed as users of E-forcse and how do they get listed if necessary? Thanks again.
The assignment of a designee is done by the prescriber or dispenser, who must accept ultimate responsibility for querying the PDMP as necessary. Please see the bottom of page 36 of the following document for further operational details: http://www.hidesigns.com/assets/files/flpdms/2016/FL_PDMP_Training_Guide_for_Practitioners_and_Pharmacists.pdf

14. I do not treat acute pain but have a number of patients with chronic neuropathic pain. How does this law change the narcotic treatment for those patients. I understand that I now have to write Non-acute pain on each Rx but can I prescribe a month's supply. The law does not materially change the prescribing of opioids for chronic nonmalignant pain, defined as, "pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery." Your examples below seem to fit that definition. You are correct insofar as the law stipulates, "For the treatment of pain other than acute pain, a practitioner must indicate "NONACUTE PAIN" on a prescription." Hence, because you are treating these patients for chronic nonmalignant pain, a one month's supply is allowed.

15. I have one question: How should we handle patients who are on chronic opioids for nonmalignant and nonfatal conditions such as RSD, failed back syndrome, etc, who are clearly benefiting from the medication and would suffer significant harm without it. Are there exceptions for these unfortunate patients? The law does not materially change the prescribing of opioids for chronic nonmalignant pain, defined as, "pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery." Your examples would appear to fit that definition. However, the law does stipulate, "For the treatment of pain other than acute pain, a practitioner must indicate "NONACUTE PAIN" on a prescription." Hence, because you are treating these patients for chronic nonmalignant pain, opioid prescriptions are not restricted to a 3 or 7 day supply and I would refer you to the rules governing chronic nonmalignant pain. These can be found at the following link: https://www.flsenate.gov/Session/Bill/2018/21/BillText/er/PDF, beginning with line 234 on page 10.

16. What is "EOB" in reference to? I copied a picture of the slide I am referring to below. EOB means "end of business"; I apologize for the abbreviation.

17. You said that previously pharmacist had 7 days time to report the dispensing of a controlled substance and now it seems that reporting is needed to be done within 24 hours, is that the job of the pharmacist or the physician prescribing the controlled substance? In my case i am in private practice and not dispensing subutex or methadone. The dispensing practitioner, whether physician or pharmacist, is required to enter such into the PDMP within 24 hours or by the end of the next day's business. For most, this will be mandated of the pharmacist as they dispense the medication, but there are physicians who have chosen to identify themselves as dispensing. If such agents were being dispensed from your office, that requirement would fall to you. Reporting is done by the prescription's dispenser, not its author.



18. I only prescribe these drugs occasionally for post op pain. I prescribe either Ultram, Percocet or Tylenol With codeine. With the new rule, I will need to prescribe these drugs for three Days only. Because you are prescribing these controlled substances for acute pain, yes, a 3 day supply is the maximum limit without satisfying the criteria necessary to prescribe up to a 7 day maximum supply. Note that tramadol is a C-IV agent and, therefore, not subject to the 3 - 7 day limit as are the other examples listed above. The law specifically imposes a limit on C-II opioid analgesics.

    I would like to know more about how to correctly prescribe Naltrexone or drugs to counter- act opioids. Is there a website to educate me on how to better prescribe these drugs and when that I can review? I am not very experienced with this drug. Excellent question. See the following link from the federal Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone. Additionally, I have attached the package insert (PI) for naltrexone in case you want more scientific information.

19. What do I do with an acute exacerbation of a chronic condition? For example, I have several arthritic patients who use intermittent narcotics for flares of chronic arthritis. A current prescription of 30 Vicodin may last 2 to 3 months. This fits in neither the acute pain (by definition), or really the chronic nonmalignant pain category as I am seeing it intended. Great question. I suppose the first question is to ascertain whether or not these patients require opioid analgesics to satisfactorily address their pain. If not, you could consider switching to non-opioid analgesics. If so, you are correct in that an acute exacerbation of a chronic issue would not fit the definition of acute pain per the law. However, you may wish to consider simply treating these patients under the aegis of chronic, non-malignant pain. This is defined as, "pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery." If, in your professional opinion, you believe that this is a sufficient umbrella encompassing the patients described above, such opioid analgesic prescriptions could be written for a longer supply duration, but monitoring would need to occur according to the chronic, non-malignant section of the law.

20. There is a category that I see little about in the rest of the law – (5)(b), on page 8. "NON-ACUTE PAIN." What does this mean, when is it used, why would I use it and how? Nonacute pain is used as a catch-all term "for the treatment of pain other than acute pain." This would encompass all other types of chronic pain, whether malignant or nonmalignant - anything that does not fit the definition of acute pain according to the law. It is also a helpful distinction for the dispensing pharmacist to have an idea as to the appropriate duration of the prescription supply. Recall that pharmacists have a corresponding responsibility in ensuring the validity of the prescription.

21. I will likely stop prescribing for my geriatric patients chronic opioid pain meds, and utilize NSAIDs and chronic PPIs (which are fraught with their own health issues). The non-acute pain category for a 3 to 7 day supply feels like it would be useful, and could be reasonably used for this situation up to 3 or 4x a year. Recall that there are other non-opioid analgesic options available that should be considered in light of the pain type. These include non-pharmacological and non-opioid pharmacological interventions. Rather than resorting to opioids for all types of pain, consider assessing the type and focusing on particular interventions that may work without the magnitude of side effects seen in the population you typically treat.

22. Do I or my staff my staff have to check the PDMP for every ESTABLISHED patient currently prescribed controlled substances, or does this just pertain to checking the PDMP before prescribing controlled substances to NEW PATIENTS? You are expected to either personally check or have a delegate check the PDMP prior to writing any controlled substance prescription – the status of the patient as new or established does not matter.

23. Other than the obvious of looking for doctor shopping, poly pharmacy use, compliance, diversion...is there another reason to review this information for patients? There is no specific thing you are expected to look for, nor is there a specific finding you are expected to act on – looking for the things you described would be appropriate.

24. Am I supposed to store printed reports for every single inquiry on the PDMP, or will there be an electronic paper trail behind the scenes on the PDMP website? I know not to keep the reports in the patient charts. If you print and store a report you must expunge it from your medical record within 2 years. When a prescription is filled under your DEA number the DOH will be able to determine if you checked the database as required.

25. What are dispensing limits for stimulants such as Adderall? and benzos? and do they require same E-FORSCE documentation? The law does not address dispensing limits for non-opioid analgesics, as the agents you mention above are not generally used to treat pain. However, they are both controlled substances. To that end, so long as they are being prescribed for a patient over the age of 16, the PDMP must be consulted. The law stipulates, "A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a non-opioid controlled substance listed in Schedule V."

26. I am a rheumatologist and I dohave a few- VERY few parients on Vicodin- and ultram- I realized ultram class 4 but vicodin class 2- how do I write for these scripts as I do have a few pts that are NOT surgical candidates BUT have CHRONIC deformities due to their CHRONIC RA/LUPUS- etc... IF I write for #60 {sixty} tabs - do I simply write PRN "RA pain"- also some with severe lumbar stenosis- do I write "PRN severe lumbar stenosis pain"???? It would appear that you are describing pain that would fit within the definition of chronic, non-malignant pain. According to the law, it "means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery." Hence, if, based on your professional opinion, you believe that 60 tablets is an appropriate amount to satisfactorily address the patient's pain, you may write for it.

    Despite not being used for acute pain, Vicodin is a C-II opioid,thus you would need to abide by the following, "For the treatment of pain other than acute pain, a prescriber must indicate "NONACUTE PAIN" on a prescription for an opioid drug listed as a Schedule II controlled substance." It is also advisable that you indicate the specific diagnosis being treated so I suggest writing "PRN rheumatoid arthritis pain," or "PRN severe lumbar stenosis pain," as relevant to the examples listed above.

    Finally, you may wish to consider whether or not switching to a non-opioid, or non-controlled substance may be a viable option for the treatment of some of these patients. Recall that ever prescription written for a controlled substance requires checking the PDMP.

    The certificate of exemption provision in HB 21 is administrative in nature. It does not change the current law regarding who has to register as a pain clinic. If you meet the definition of a pain clinic, but do not have to register because you fall under one of the exceptions, you will have to obtain a certificate of exemption by January 1, 2019.

    If Dr. Ropos does not (1) advertise in any medium for any type of pain-management services, or (2) prescribe opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain to a majority of his patients in a month, his practice does not meet the definition of a "pain-management clinic" and therefore he does not have to obtain a certificate of exemption.

27. Do I need to enter every prescription in all schedules into the state database? If so I would have to hire another employee just to do that. Those who dispense controlled substance prescriptions must enter such information into the PDMP. If you are registered as a dispensing physician, and dispense controlled substances out of your office to patients over the age of 16, you are responsible to enter data into the PDMP. Typically, prescribers are not dispensers. That role falls on the pharmacists who are required to enter the prescription's data into the PDMP so that future prescribers can query the system.

28. Could you send me the web address for the Training Guide.
    http://www.hidesigns.com/assets/files/flpdms/2016/FL_PDMP_Training_Guide_for_Practitioners_and_Pharmacists.pdf.

29. Do I need to enter every prescription in all schedules into the state database? If so I would have to hire another employee just to do that. Those who dispense controlled substance prescriptions must enter such information into the PDMP. If you are registered as a dispensing physician, and dispense controlled substances out of your office to patients over the age of 16, you are responsible to enter data into the PDMP. Typically, prescribers are not dispensers. That role falls on the pharmacists who are required to enter the prescription's data into the PDMP so that future prescribers can query the system.

30. Do I or my staff have to check the PDMP for every ESTABLISHED patient currently prescribed controlled substances, or does this just pertain to checking the PDMP before prescribing controlled substances to NEW PATIENTS? According to the law, a query of the PDMP must be made for every controlled substance prescription written, regardless of whether or not the patient is new or established. Specifically, the law stipulates, "A prescriber or dispenser or a designee of a prescriber or

dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V." So, for all controlled substance prescriptions you indicate above, despite not being opioid analgesics, the PDMP must be queried each and every time.

31. Other than the obvious of looking for doctor shopping, poly pharmacy use, compliance, diversion...is there another reason to review this information for patients? Although the explicit rationale for querying the PDMP is not described in the law, the objectives of doing so appear to be as you delineate above. More to the point, the information obtained from such a review should be considered when a physician prescribes a controlled substance. So, any data you would consider pertinent to informing such a decision so as to not feed into a situation of abuse or misuse would be material.

32. Am I supposed to store printed reports for every single inquiry on the PDMP, or will there be an electronic paper trail behind the scenes on the PDMP website? I know not to keep the reports in the patient charts. You need not print out the PDMP query, but rather can document that the PDMP has been queried and the information reviewed. Based on that information, you make the following treatment/management decisions. There is no existing boilerplate language of which I am aware that would attest to such a review of the PDMP information.

33. If a physician prescribes $\leq$3 days of any CS 2-5 opioid, would this physician still have to access the PMDP database and report? All of our physicians at Community Health Services ***do not*** manage chronic pain but do, at times, prescribe CS 2-5 opioids for acute pain conditions (non-cancer, terminal condition, pain treated with palliative care, or traumatic injury with ISS $\geq$ 9) and this question may come up at one of our future monthly primary care meetings. The PDMP must be queried each time a controlled substance prescription is written. This query can be done by the prescriber or his/her designee. The query must occur each and every time such a prescription is written.

34. I was surprised by the requirement for a narcan Rx for Schedule II prescriptions, but am unclear if that was for ALL schedule II Rx's or only for those patients with an ISS of 9 or greater. If it is only for those with an ISS of 9 or greater, what would be the temporal relationship to the actual injury? For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance listed in s. 893.03 or 21 U.S.C. s. 812 must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1). The law does not specify a temporal relationship between the injury and the prescription.

    From the bill:
    Section 3 (line 403)
    (6) EMERGENCY OPIOID ANTAGONIST.—For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance listed in s. 893.03 or 21 U.S.C. s. 812 must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1).

    s. 381.887(1) – Emergency Treatment for suspected opioid overdose.---

    (1) As used in this section, the term:
    (a) "Administer" or "administration" means to introduce an emergency opioid antagonist into the body of a person.
    (b) "Authorized health care practitioner" means a licensed practitioner authorized by the laws of this state to prescribe drugs.
    (c) "Caregiver" means a family member, friend, or person in a position to have recurring contact with a person at risk of experiencing an opioid overdose.
    (d) "Emergency opioid antagonist" means naloxone hydrochloride or any similarly acting drug that blocks the effects of opioids administered from outside the body and that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose.
    (e) "Patient" means a person at risk of experiencing an opioid overdose.
    (2) The purpose of this section is to provide for the prescription of an emergency opioid antagonist to patients and caregivers and to encourage the prescription of emergency opioid antagonists by authorized health care practitioners.
    (3) An authorized health care practitioner may prescribe and dispense an emergency opioid antagonist to a patient or caregiver for use in accordance with this section, and pharmacists may dispense an emergency opioid antagonist pursuant to such a prescription or pursuant to a non-patient-specific standing order for an autoinjection delivery system or intranasal application delivery system, which must be appropriately labeled with instructions for use. Such patient or caregiver is authorized to store and possess approved emergency opioid antagonists and, in an emergency situation when a physician is not immediately available, administer the emergency opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist.

(4) The following persons are authorized to possess, store, and administer emergency opioid antagonists as clinically indicated:
(a) Emergency responders, including, but not limited to, law enforcement officers, paramedics, and emergency medical technicians.
(b) Crime laboratory personnel for the statewide criminal analysis laboratory system as described in s. 943.32, including, but not limited to, analysts, evidence intake personnel, and their supervisors.
(5) A person, including, but not limited to, an authorized health care practitioner, a dispensing health care practitioner, or a pharmacist, who possesses, administers, prescribes, dispenses, or stores an approved emergency opioid antagonist in compliance with this section and s. 768.13 is afforded the civil liability immunity protections provided under s. 768.13.
(6)(a) An authorized health care practitioner, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of prescribing an emergency opioid antagonist in accordance with this section.
(b) A dispensing health care practitioner or pharmacist, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of dispensing an emergency opioid antagonist in accordance with this section.
(7) This section does not limit any existing immunities for emergency responders or other persons which are provided under this chapter or any other applicable provision of law. This section does not create a duty or standard of care for a person to prescribe or administer an emergency opioid antagonist.
History.—s. 2, ch. 2015-123; s. 1, ch. 2016-145; s. 1, ch. 2017-107.

35. Can you find out how it came about that you must prescribe an opioid antagonist to trauma patient with ISS of 9 or greater if you prescribe an opioid? Great question to which I do not know the answer. The following rationale is possible however. Trauma pain with an ISS of 9 or greater indicates injury to multiple organ systems. Insofar as this pain is likely to not significantly diminish over the course of 3 or 7 days, it was probably marked for exclusion from the definition of acute pain. Hence, it is highly likely that a physician would prescribe a fair amount of opioid analgesics, both in total daily dosage and duration of treatment. The affected patient would have enough supply to potentially overdose, so a concomitant prescription for an opioid antagonist was warranted lest this occur. That said, one could make the argument that an opioid antagonist should be prescribed for all patients with chronic, nonmalignant pain under the same rationale, yet this is not required.

    If a physician is on-call and at home, Friday night for example, and calls in a prescription for benzos but doesn't have access to the PDMP because the physician is not at the office, what happens/what is the protocol? Querying the PDMP can be done from any computer with internet access once the prescriber completes the free registration process. So, simply writing a prescription from home would not qualify as an acceptable exclusion for not checking the database.

    Does this law apply to physicians with DATA 2000 Waiver? With respect to his second question, the simple answer is yes. The requirement to check the PDMP applies to all DEA-certificate holding prescribers of controlled substances of schedule II-V (except non-opioid C-Vs), for patients aged 16 and older. There are no other exceptions, including a DATA waiver.

36. Amputation with non-active cancer (previous cancer patient in surveillance) ***This would not appear to be cancer-related pain, but rather the surgical procedure of an amputation would likely be classified as acute post-operative pain. Hence, the law would apply and the prescriber would be limited to a 3 day supply, unless justification exists to warrant up to a 7 day supply. If so, appropriate documentation is required.***
    Chronic back pain when NSAID's are ineffective however a Percocet a day keeps them pain free- nonactive cancer diagnosis ***This example would appear to fall under the definition of chronic, non malignant pain, so the 3-7 day limit is not applicable.*** Sickle cell management – covered? If so, documentation necessary to support opioid and ongoing success to keep them out of the ED ***this too would fall under the definition of chronic, non malignant pain.***
    Hemophilic management- covered? If so, documentation necessary to support opioid and ongoing success to keep them managed appropriately. ***Again, chronic, non malignant pain.***

37. I am a GI doctor I have a particular patient with short bowel syndrome secondary to Crohn's and multiple surgeries. I have given DTO (deodorized tincture of opium) to for year for treatment of diarrhea. It is no used as a pain treatment. He gets a month supply at a time. How does this fit in with the new narcotic law. BTW I also know his primary care also give him Codeine as additional treatment for diarrhea. It is quite a severe issue and he is on home IV fluid infusions to keep him hydrated and out of hospital. Without all this he ends up admitted with dehydration and metabolic acidosis. I can not just give him a 3 day supply every 3 days. Do I just write on the script this is for diarrhea and not for pain is there anyting else I need to do to comply with the law besides checking the eforce database. In the case described above, it would appear that

the condition does not meet the law's definition of acute pain, namely, "the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness." In fact, as you state, the C-II opioid is not being prescribed for pain at all, so it would also not appear to be defined as chronic, nonmalignant pain. To that end, the 3 - 7 day prescription limit would not be applicable, and you can continue to prescribe it according to your professional judgment. In light of the new law, you may wish to consider carefully documenting that the use of opium is related to the patient's chronic, unremitting, otherwise untreatable, diarrhea so there is no question about it being used for pain. Further, it may be helpful to document its specific use on the prescription so the dispensing pharmacist understands the chronicity of the treatment, and may be less likely to call it into question. Finally, you correctly state that the PDMP must be queried when writing a controlled substance prescription. I assume that this patient is over the age of 16 years. Note that regardless of the chronic treatment, the PDMP must be queried each and every time opium, as described in the case above, is prescribed for this patient.

38. With respect to HB 21, the opioid law, cancer is explicitly exempt from the definition of acute pain. And, chronic, nonmalignant pain would obviously not apply to those patients who are suffering from neoplastic pain, but would likely encompass those with pain related to sickle cell disease or hemophilia.

39. What are dispensing limits for stimulants such as Adderall? and benzos? and do they require same E-FORSCE documentation? The law does not stipulate prescribing limits for medications prescribed for diagnoses other than pain. As such, stimulants and benzodiazepines are not restricted any more than they were prior to the law. Note that Adderall is a C-II substance and therefore has no refills by law. Additionally, the prescription must be filled within one year of its original written date. Benzodiazepines are, by and large, C-IV substances. Their prescriptions must be filled within 6 months of the original date and are limited to a maximum of 5 refills during this time frame.
However, as all of the aforementioned agents are controlled substances, the PDMP must be queried each and every time a prescription is written for them (so long as the patient is age 16 or older), the same requirement as that of opioids written for acute pain - yes.

40. As far as a recommended method by the DEA to dispose of controlled substances I know throwing them away in the garbage is on the list as well as take back and flushing down the toilet. I know you said in the lecture that disposing of them in the trash is still not a completely safe way but it is still one of the options according to DEA, correct? If I were to rank them, take back programs would be first if this can be accomplished quickly so as not to stock pile medications. Next would be flushing them down the toilet as this option mitigates the ability of others to find, obtain, and ingest them.I mentioned these options in the talk, as well as disposal in the trash mixed with a non-palatable substance, under disposal alternatives for pharmaceuticals in general, but recommend flushing down the toilet for controlled substances.

    Also as far as acute pain for filling the prescription for more than 3 days, I know you said the exceptions are: Medical necessity; Acute pain exception option on prescription: Document acute condition with no alternative treatment. There was a question that included both medical necessary and acute pain exception as individual answer choices. I thought all three criteria must be met. In order to exceed the 3-day supply, and provide up to a 7-day maximum, three criteria must be satisfied, namely (1) in the prescriber's professional judgment, more than a 3-day supply is medically necessary to treat the acute pain; (2) "acute pain exception" must be indicated on the prescription; and (3) adequate documentation must be entered into the patient's medical record noting the acute medical condition and lack of alternative treatment justifying the deviation from the 3-day maximum. The CME test question to which you refer should be read a bit more carefully as it explicitly asks about what must be indicated on the face of the prescription. There is but a single correct answer to that question.

    Also for chronic nonmalignant pain is it correct that you can give more than 3 days up to seven days of class 2 under limited circumstances? The law does not change any of the requirements, permissible actions, or prohibitions related to chronic, nonmalignant pain except (1) prior to writing any controlled substance prescription, the PDMP must be queried each and every time; and (2) the phrase "nonacute pain" must be indicated on the prescription for a C-II opioid.

41. I am a dermatologist and I dispense hydroquinone, Latisse, and Retin a. I don't dispense any scheduled meds. When I registered for the Eforsce program...I registered as non-dispensing b/c I do not dispense scheduled drugs...is this correct? No, you must identify yourself as a dispensing physician within the PDMP and during the relicensure period. However, simply because you are a dispensing physician does not mean that you need to dispense anything, let alone those controlled substances that you do not currently.

    Next question... on our progress note can you comment what is needed to document... "the PDMP was accessed and a decision to prescribe "x" drug was made"... what pain scores or pain symptoms do we have to document along with the

PDMP line for acute pain... I occasionally write for someone with a big abscess or if I excise a large skin cancer/flap/graft. There is no boilerplate language for this. The Board of Osteopathic Medicine May promulgate such, but has not currently. Hence, you simply need to document that the PDMP was queried as this is material to your decision to prescribe opioids. What you wrote above appears to address the requirement. If you wish to include additional information to support your prescribing, you should.

42. I am a rheumatologist and I do have a few- VERY few patients on Vicodin- and ultram- I realized ultram class 4 but vicodin class 2- how do I write for these scripts as I do have a few pts that are NOT surgical candidates BUT have CHRONIC deformities due to their CHRONIC RA/LUPUS- etc... IF I write for #60 [sixty} tabs - do I simply write PRN "RA pain"- also some with severe lumbar stenosis- do I write "PRN severe lumbar stenosis pain"???? It would appear that you are describing pain that would fit within the definition of chronic, non-malignant pain. According to the law, it "means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery."Hence, if, based on your professional opinion, you believe that 60 tablets is an appropriate amount to satisfactorily address the patient's pain, you may write for it. Despite not being used for acute pain, Vicodin is a C-II opioid,thus you would need to abide by the following, "For the treatment of pain other than acute pain, a prescriber must indicate "NONACUTE PAIN" on a prescription for an opioid drug listed as a Schedule II controlled substance." It is also advisable that you indicate the specific diagnosis being treated so I suggest writing "PRN rheumatoid arthritis pain," or "PRN severe lumbar stenosis pain," as relevant to the examples listed above. Finally, you may wish to consider whether or not switching to a non-opioid, or non-controlled substance may be a viable option for the treatment of some of these patients. Recall that ever prescription written for a controlled substance requires checking the PDMP.

43. The statute says that a prescription may not exceed a 3-day supply. It does not say that you may not issue consecutive prescriptions. The legislative intent is clear that a physician, after reevaluating a patient once the 3-7 day period expires, may prescribe another 3-7 day course of medication. See the exchange between Rep. Boyd (the bill sponsor) and Rep. Pigman starting at the 11:22 mark of the House Health and Human Services Committee meeting on 2/21/18 (https://thefloridachannel.org/videos/2-21-18-house-health-human-services-committee/).

While we do not have a definitive answer on this issue from the Department of Health, given the wording of the statute and the clear legislative intent, I believe the answer to the question below is yes, you can prescribe a new 7-day supply of a CS II opioid for continued acute pain, provided that you again document the lack of alternative treatment options that justifies deviation from the 3-day supply limit.

44. We have a weight loss clinic here at my office where we dispense phentermine usually in a months worth. Do we need to check the e-force website every time we prescribe phentermine? Are we limited to 3 days worth? The law does not change the duration of a prescription written for a diagnosis other than acute pain. Hence, you are not limited to a 3 day prescription of phentermine, a C-IV agent. However, as it is a controlled substance, you, or your designee, are required to query the PDMP each and every time the prescription is written, yes.

When I write for narcotic prescriptions as I usually do for my surgical patients am I required to write an antagonist like narcan? The concomitant prescribing of an opioid antagonist, like naloxone, is required only for the treatment of pain related to a traumatic injury with an injury severity score of 9 or greater, when the patient is also prescribed a C-II controlled substance.

45. I am not clear about checking PDMP/eForsce. Do I check it for 3 day Rx' or just longer ones. I guess I'll go to eForsce to see if they explain how to use their site and information. Any clarification you can give me or just tell me eForsce explains would be adequate. The PDMP must be queried (checked) each and every time a controlled substance prescription (not just an opioid) is written, regardless of the length of said prescription. Please do not hesitate to contact me if I can be of further assistance.

46. I am licensed in Florida to practice medicine, however, I do not practice in Florida and my DEA is registered in New Jersey where I practice as a licensed physician. If I prescribe a scheduled drug to a NJ patient on my NJ Rx pad, must I consult E-FORSCE? Thank you for your question. The law, and its stipulations, including that of querying the PDMP, are applicable to the State of Florida. Hence, if you do not hold a DEA license in Florida, and do not prescribe controlled substances here, this would not be relevant to you. However, you must subscribe to whatever laws exist in the State of New Jersey.

47. Florida Opioid Prescription – New Rules

1. 3 day opioid limit
2. Up to 7 day supply can be written **IF**:
a. Medically necessary and documented on the chart
b. "Acute pain exception" is written on prescription
c. Document acute condition and lack of alternatives

NOTE THAT ALL 3 CRITERIA MUST BE MET to prescribe up to 7 days

3. Must search and review patient on Florida's **PDMP** PRIOR to writing prescription (**PDMP** - **P**rescription **D**rug **M**onitoring **P**rogram)
a. Failure to check the **PDMP**:
i. 1st offense:
1. Non-disciplinary citation from DOH
ii. 2nd offense:
1. Subject to discipline from respective board
iii. Willful malfeasance
1. 1st degree misdemeanor

4. Emergency Opioid antagonist - must be concomitantly prescribed for the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater when a C-II medication is prescribed.
5. 2 hour, board approved, CME by January 31, 2019 and each subsequent renewal
a. Failure to complete by deadline: No license renewal
6. Components of a legal controlled substance prescription
a. Legible printed/typed on counterfeit proof Rx
b. Date in textual form
c. Patient name & address
d. Name and strength of medication
e. Dispense amount in both textual and numeric format
f. Sig: directions should be legibly written out
g. Number of refills, if any
h. DEA number legibly written
i. Signature – ink or typed (no signature stamps)
j. Doctor office name and contact information (e.g. address, phone)

PLEASE ENSURE YOUR SITE HAS THE APPROPRIATE INFORMATION ON YOUR PRESCRIPTIONS

Does the above match the expectations? Yes, as revised

And, if you do not mind, two further questions:

1. When searching for the patient on the PDMP (given when the system is functioning with the ability to access), does this step need to be documented in the patient's chart? It is advisable to document that the PDMP was queried in the patient's chart. Some may consider writing something similar to "PDMP queried and information reviewed by prescriber or his/her designee; no adverse information identified." The law is silent on documentation language, but the query must be done each and every time a controlled substance prescription is written.

2. For item 4, when is an Emergency Opioid Agonist required to be prescribed? modified as above

51. The law, and its stipulations, including that of querying the PDMP, are applicable to the State of Florida. Hence, if you do not hold a DEA license in Florida, and do not prescribe controlled substances here, this would not be relevant to you. However, you must subscribe to whatever laws exist in the State of New Jersey. It is our position that if you have a Florida license, and are registered with the DEA to prescribe controlled substances, no matter in which state you are registered, you must take the Florida course. Thus since the Doctor has a Florida license, and is registered with the DEA in New Jersey, we believe he should take the course.

52. Within the provisions of HB 21, I have a question.

1. I have believed that my private practice is exempt from registration as a PMC due to either of these items in Florida Statute 458.3265:

. A clinic is wholly owned and operated by a physician multispecialty practice where one or more board eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of

Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

A clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

2. The Provisions of HB 21 go into effect on July 10, 2018, exemption process starts January 2019.
3. Since I do not know how the professional boards will interpret the changes to statute, I have started the application for PMC registration June 07, 2018. I do not know when this registration will complete.

QUESTION: Should I continue to work in my private pain medicine practice -- as Board Certified by the ACOFP, with a certification (CAQ) Pain Medicine -- before my PMC registration takes place at some indeterminant time in the future. If you were exempt from having to register as a pain management clinic prior to the passage of HB 21, you are still exempt. There were no changes made to the exemption categories. Effective **January 1, 2019**, however, you will have to apply for a certificate of exemption. You will not have to register as a pain clinic. The application for the certificate of exemption has to be on a form adopted by rule by DOH. They have not done so yet, and until they do, there is nothing for an exempt pain clinic to do.

53. Seeing your CME on new opioid prescription requirements and just hoping to clarify that for a prescription for a 3 day supply of opioids does not require accessing the PDMP, is that correct? No, that is not correct. According to the law, "A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V of s. 893.03 or 21 U.S.C. 812." Hence, so long as the prescription is being written for a controlled substance (aside from a nonopioid C-V agent) to a patient 16 years of age or older, the PDMP must be queried for each and every prescription, regardless of treatment duration.

54. The DOH Dispenser's Implementation Guide states that a "dispenser" is defined as a pharmacy, dispensing pharmacist, or dispensing healthcare practitioner. Since Dr. Tobon is a dispensing health care practitioner, even though he does not dispense controlled substances, he should register as such.

    According to the DOH, "ff a dispenser is permitted or licensed in the State of Florida, but does not dispense any controlled substances directly to Florida residents, they are not required to report to E-FORCSE. However, the dispenser must notify DOH in writing by completing a waiver form provided by DOH stating that it does not dispense controlled substances in the state.

55. I am a plastic surgeon who performs a lot of breast cancer reconstruction. The majority of my patients require opioids in the postoperative periods.

    I understand that we must query the E-Forsce website before writing a narcotic prescription. In addition to documenting in the medical record that this query was performed, is there any mechanism in place wherein the physician will be able to record proof that the query was performed? Such as, does the website generate a reference number or confirmation number that you can record in the medical record or written Rx that proves that you have done your due diligence? I am unaware of the PDMP generating a confirmation, or any other, number that a prescriber can use as evidence of a query. Further, there is no boilerplate language suggested in the law to document such. You may wish to consider something akin to "PDMP checked; no adverse information noted, XYZ (medication) to be prescribed." Really, it is simply about documenting that you checked the PDMP lest you do not, and do not document why you didn't.

    For patients at the hospital having in patient or out patient surgery, is the physician required to query the E-Forsce website before ordering a narcotic or controlled substance for treatment while at the hospital or surgical facility? Checking the PDMP is unnecessary for the ordering of controlled substances that are administered in the hospital, or

other facility. It is, however, required for the prescribing of controlled substances, including opioids, that are to be dispensed for future ingestion.Note the semantics as they are important here. Ordering and administering are done within a facility, and the law does not change what we can do in those situations. But, prescribing and dispensing are done for outpatients, and the law most certainly has mandates within this realm.

For postoperative patients who use there three day supply of opioid medication and return to your office or call in complaining of persistent pain, are you permitted to write a second Rx for another three day course of treatment? What protocol should be followed regarding that instance.? After determining that an opioid is most appropriate to treat the patient's acute post-operative pain, a prescription is written. In doing so, you should carefully consider whether a 3 or 7 day amount is necessary. If you believe the 7 day duration is needed, there are stipulations to do so. If after either, 3 or 7 days, the patient still has pain that requires further treatment with an opioid, another prescription can be written subsequent to rechecking the PDMP.

Is it a requirement that a physician and patient sign an agreement or informed consent about use of narcotics and controlled substances prior to prescribing? I have seen suggestion of this requirement elsewhere but it was not really discussed much in the lecture. I am looking for something that I can use with my patients when giving them prescriptions for their postoperative instruction. Including something official about FL DOH policies for patients and consumers. Sort of what they need to know. The law stipulates, "STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The applicable boards shall adopt rules establishing guidelines for prescribing controlled substances for acute pain, including evaluation of the patient, creation and maintenance of a treatment plan, **obtaining informed consent and agreement for treatment**, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations. Failure of a prescriber to follow such guidelines constitutes grounds for disciplinary action pursuant to s. 456.072(1)(gg), punishable as provided in s. 456.072(2)." To date, the Boards have yet to promulgate such rules, so it is advisable to have and document a conversation related to risks, benefits, and alternatives of opioid treatment, that the patient was afforded an opportunity to ask questions, you addressed them, and the patient verbalized understanding thereof.

56. While there is no boilerplate language suggested in the law, you may consider documenting that the PDMP was queried but no adverse information was noted, that an opioid would be prescribed for a treatment duration of X days, or something like that. Quite simply, you are advised to document that the PDMP was checked.

    Regarding the sharing of information with the patient, or incorporating the PDMP query in the medical record, there are two reasons for not doing so. First, section 893.055(5) states, "The following entities may not directly access information in the system, but may request information from the program manager or designated program and support staff." Subsection (f) states, "A patient...who submits a written and notarized request that includes..."

    Additionally, section 893.055(10) states, "Information in the prescription drug monitoring program's system may be released only as provided... The content of the system is intended to be informational only. Information in the system is not subject to discovery or introduction into evidence in an civil or administrative action..."

    The inclusion of information contained in the PDMP into the patient's medical record would, in fact, be discoverable and could not be redacted. Further, the patient must go through proper channels to obtain the information contained in the PDMP, rather than simply requesting his/her medical records from you. This is the reason why you simply need to document that the PDMP was queried but should not include the actual report.

57. Does this new law only pertain to opiods or all scheduled medications? The thrust of the law is in addressing opioid prescriptions for the treatment of acute pain, but there are sections that have been modified on other components.

    I am board certified in Internal Medicine and Bariatric Medicine. I do prescribe sleep aids and occasionally benzodiazepine. I do prescribe anti-obesity medications that are scheduled III, IV. (including phentermine, phendimetrazine, diethylpropion, Qsymia and Contrave). Can I provided my patients a 30 day supply of the above

medications? The 3 - 7 day limitation on treatment duration specifically applies to the treatment of acute pain with the use of opioids.

Do I have to check EFORCSE prior to each refill? The law stipulates, "A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V of s. 893.03 or 21 U.S.C. 812." Hence, checking E-FORCSE (PDMP) applies to each and every controlled substance prescription, not just those for opioids. That would include all of the agents you listed above.

58. It seems like there are 3 pains: 1.Acute 3 day 2.Acute 7 day with the additional prescribing requirements 3.Palliative/cancer. What happens to all the others—chronic non cancer nonpalliative pain? Do they all go to pain management clinics? You know where they are going to end up—in the ED. What are the laws around this group of patients? In fact, there is a fourth category, that of chronic, nonmalignant pain. There were no significant changes to the management of these patients except (1) you must document "nonacute pain" on the prescription, and (2) the PDMP must be queried each and every time a controlled substance prescription is written (except for nonopioid C-V agents). But, the duration of 3-7 days does not apply.

    Is the narcan prescription only required for ISS>9 7 day prescriptions? If the patient suffers from trauma-related pain, with an ISS of 9 or greater, and receives a prescription for a C-II controlled substance, a concomitant prescription must be written for an opioid antagonist, regardless of the duration of treatment.

    One of the guys I work with said there is some loophole for patients complaining of 10/10 pain and that we don't have to follow the same prescribing requirements. That seems hokey to me. Maybe he means acute in chronic pain? Do you know if any "loopholes"? I am unaware of any loopholes. Acute pain is clearly defined, as are its exceptions, and chronic, nonmalignant pain.

59. Your comprehension of the second issue is correct. "Nonacute pain" must be written on the prescription, the PDMP must be checked when each and every controlled substance prescription is written (except for nonopioid C-V agents), but otherwise there is no limitation to the duration as you noted below. A 7 day maximum for all patients is simply incorrect.

60. The law states, "A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V of s. 893.03 or 21 U.S.C. 812."

    So, yes - so long as the patient to whom you are prescribing is 16 years of age or older, you are required to check the PDMP for each and every controlled substance prescription written, not just for opioids.

61. How does this new law affect prescribing controlled substances in a hospital setting? There is a difference between prescribing and ordering. A prescription is intended for outpatient dispensing and use at a later time. Ordering reflects inpatient use and more immediate administration. Semantics, I know, but incredibly important difference here. The law does not affect the ordering of controlled substances in a hospital setting. A prescription (not an order) for a C-II opioid for acute pain that is not to be administered in the hospital but rather for use at a later time is limited to a 3-7 day supply.

    What does the law say about prescribing controlled substances after the initial 3 days supply run out? There are no specific limits in HB 21 on issuing new prescriptions after the expiration of the 3-7 day period. Statutory history and comments from the DOH support this position. While you are not prohibited from doing so per se, you should critically evaluate the ongoing clinical necessity of prolonged opioid treatment of acute pain.

62. The program was very clear with regard to prescribing opiates for acute pain in Florida including the definition of **acute pain**, the 3 day limit on C-II opioids and the 4 exceptions for 7 a day supply including Cancer, Terminal Care, Palliative Care and Traumatic Injury. Actually, these categories are exceptions to the definition of acute pain, hence the 3-7 day limit does not apply to patients with these afflictions.

    Are there any limitations on repeated prescriptions for 3 or 7 day periods? There are no specific limits in HB 21 on issuing new prescriptions after the expiration of the 3-7 day period. Statutory history and comments from the DOH support this position. While you are not prohibited from doing so per se, you should critically evaluate the ongoing clinical necessity of prolonged opioid treatment of acute pain.

    Do these rules apply in hospitals as well? The limits on prescribing C-II opioids apply only to prescriptions and do not apply when these substances are ordered and administered in a hospital. There is a material difference between ordering and administering medication in a hospital and prescribing and dispensing them in an outpatient environment. The law sought to address the latter. The limits do apply to prescriptions written in a hospital in which the C-II opioid will not be administered in the hospital.

    Your program covered the CDC guidelines for chronic pain treatment. However, I am somewhat unclear with the implications of the FL laws with regard to the prescribing of C-II opiates for **chronic pain conditions** other than Cancer, Terminal Condition & Palliative Care.

    One example might be an Orthopedic patient with neuropathic pain after injury that is chronic and requires a C-II opiate for subacute or chronic control but no longer has an Injury Severity Score of 9 or above. In this hypothetical, it is possible that the patient's pain would be better classified as chronic, nonmalignant pain and thus, not be subject to the 3-7 day limitation.

    Would a prescription need to be rewritten (no refills allowed) for 3 day supplies on a long term basis? If, at the time of opioid prescribing, one's clinical judgment supports a 7 day treatment duration, so long as the law's stipulations for so doing are met, such a prolonged treatment can be written. As mentioned above, if a 3-7 day course of opioids is insufficient to address a patient's acute pain, another prescription can be written. Note that the PDMP must be queried each and every time a controlled substance (of any class, not just opioids), prescription is written.

    Is there any limit to the number of rewritten prescriptions? As above, it would be highly irregular to continue to write opioid prescriptions to address one's acute pain for months. In that scenario, it is likely that the prescription would not be filled by the dispensing pharmacist due to the suspicion that the patient is being supplied a highly abused medication for a prolonged period of time. Pharmacists have a corresponding responsibility under Federal law to ensure that the prescription is written for a legitimate purpose. Months of treatment for acute pain would probably raise a red flag here.

63. Is it required for providers to chart that e-forcse was accessed? I understand the exception if the website is down, but in general if the website is working, do you have to document that it was accessed? HB 21 does not specifically require you to document in the medical records that you checked the database. However, from a best practices standpoint, it is advisable to document that the PDMP was queried and, if a controlled substance prescription is to be written, that nothing adverse was identified to preclude the prescription from being written.

    Also, as a side note, have you been able to find any limitation on days supply for "non-acute pain"? Just curious. There is no limitation on the prescription of a controlled substance for non-acute pain in the law. In fact, the rules governing the prescription of controlled substances for treating chronic, nonmalignant pain have not changed except to require the querying of the PDMP for every prescription, every time (with the exception of prescriptions for nonopioid Schedule V substances and prescriptions for children under 16)..

64. I have a few questions about opioid prescribing after reviewing your lecture. I am a plastic surgeon who performs a lot of breast cancer reconstruction. The majority of my patients require opioids in the postoperative periods.

    I understand that we must query the E-Forsce website before writing a narcotic prescription. In addition to documenting in the medical record that this query was performed, is there any mechanism in place wherein the physician will be able to record proof that the query was performed? Such as, does the website generate a reference

number or confirmation number that you can record in the medical record or written Rx that proves that you have done your due diligence? I am unaware of the PDMP generating a confirmation, or any other, number that a prescriber can use as evidence of a query. Further, there is no boilerplate language suggested in the law to document such. You may wish to consider something akin to "PDMP checked; no adverse information noted, XYZ (medication) to be prescribed." Really, it is simply about documenting that you checked the PDMP lest you do not, and do not document why you didn't.

For patients at the hospital having in patient or out patient surgery, is the physician required to query the E-Forsce website before ordering a narcotic or controlled substance for treatment while at the hospital or surgical facility? Checking the PDMP is unnecessary for the ordering of controlled substances that are administered in the hospital, or other facility. It is, however, required for the prescribing of controlled substances, including opioids, that are to be dispensed for future ingestion.Note the semantics as they are important here. Ordering and administering are done within a facility, and the law does not change what we can do in those situations. But, prescribing and dispensing are done for outpatients, and the law most certainly has mandates within this realm.

For postoperative patients who use there three day supply of opioid medication and return to your office or call in complaining of persistent pain, are you permitted to write a second Rx for another three day course of treatment? What protocol should be followed regarding that instance.? After determining that an opioid is most appropriate to treat the patient's acute post-operative pain, a prescription is written. In doing so, you should carefully consider whether a 3 or 7 day amount is necessary. If you believe the 7 day duration is needed, there are stipulations to do so. If after either, 3 or 7 days, the patient still has pain that requires further treatment with an opioid, another prescription can be written subsequent to rechecking the PDMP.

65. Is it a requirement that a physician and patient sign an agreement or informed consent about use of narcotics and controlled substances prior to prescribing? I have seen suggestion of this requirement elsewhere but it was not really discussed much in the lecture. I am looking for something that I can use with my patients when giving them prescriptions for their postoperative instruction. Including something official about FL DOH policies for patients and consumers. Sort of what they need to know. The law stipulates, "STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The applicable boards shall adopt rules establishing guidelines for prescribing controlled substances for acute pain, including evaluation of the patient, creation and maintenance of a treatment plan, **obtaining informed consent and agreement for treatment**, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations. Failure of a prescriber to follow such guidelines constitutes grounds for disciplinary action pursuant to s. 456.072(1)(gg), punishable as provided in s. 456.072(2)." To date, the Boards have yet to promulgate such rules, so it is advisable to have and document a conversation related to risks, benefits, and alternatives of opioid treatment, that the patient was afforded an opportunity to ask questions, you addressed them, and the patient verbalized understanding thereof.

66. I have some patients that undergo large spine surgeries.... these patients require narcotics for about 4-6 weeks, average, after a large spinal procedure.... so... how do I prescribe this quantity to this group of patients?

    If I only supply 7 days, this is not nearly enough... do I bring them back every 7 days and keep writing for 7 days at a time? It looks as though I am not to prescribe for longer than 14 days if I do it that way... do I do 7 days acute pain and then do "non acute" thereafter or non acute pain from surgery going forward? Help.. I get lost at this juncture... If you believe that the patient still requires opioid treatment for their acute, post-operative pain, then, yes, you could provide them a 7 day prescription (documenting appropriately to justify more than the 3 day limit), and write another prescription every 7 days until opioids are no longer needed. Note that the PDMP must be checked each and every time such a prescription is written, and an assessment should be made as to whether or not opioids are still necessary. This type of pain would not qualify as chronic, nonmalignant pain under the definition insofar as the post-operative pain you describe in the scenario above does not "...persist beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery."

Also, I read about applying for an exemption from the state if the clinic is purely a surgical practice... My PA and myself are the only practitioners in my clinic and I have an orthopaedic spine surgery practice with no partners that are non-surgical... would that make sense? Would that make sense to the state? You are referring to the section on pain management clinics. Indeed there is an exemption from registering as such but those clinics advertise for pain-management services, or have a majority of patients who are prescribed medications to treat chronic, nonmalignant pain. To that end, I do not believe that your clinic would qualify as a pain management clinic with exception due to the provision of primarily surgical services. The certificate of exemption provision in HB 21 is administrative in nature. It does not change the current law regarding who has to register as a pain clinic. If you meet the definition of a pain clinic, but do not have to register because you fall under one of the exceptions, you will have to obtain a certificate of exemption by January 1, 2019. To get a certificate of exemption, you will have to fill out a DOH approved form. DOH has not yet approved such a form – we will notify you via FMA News when such a form is available. Please note that obtaining a certificate of exemption does not exempt you from the provisions of HB 21 regarding the checking of the PDMP and the 3-7 day limit on prescribing Schedule II opioids for acute pain.

67. I'm a FOMA member and physician working in LTC facilities. I was told at a meeting With Pharmerica reps who told me the LTCs are exempt at this time. Now I have one facility who just sent me the bill with comments advising me to comply with all the new rules. I have some confusion and concerns as many LTC patients have been on these meds and connot partake in a "pain care plan", or understand weaning process. Can you give me guidance or direct me to someone who might have better understanding than me about this? It sounds like you are referring to the section of the law related to chronic, nonmalignant pain. Note that the law does not materially change prescriptions thereof except for two components. First, the PDMP must be queried before writing a controlled substance (not just opioids) prescription, and the phrase "nonacute pain" must be indicated on the prescription. However, these stipulations refer to outpatient prescriptions that will be dispensed, not orders written for administration to inpatients. With respect to the chronic, nonmalignant pain section, there are standards of practice reiterated in this law. As it is rather voluminous, you should search for 456.44(3) - Standards of practice for treatment of chronic nonmalignant pain. There, you should familiarize yourself with subsections (a) - (g). If the patient is unable to participate in his/her care plan, akin to other medical decisions, a surrogate can be spoken with.

68. Is there a time period prior to checking eforsce, before u write a prescription for opioids? For example if I have several surgery on a particular day and I will need to check eforsce before I give the patient a narcotic prescription, must I check eforsce day of prescription or can I check eforsce a week prior or a day prior? Thank you for the excellent question. In fact, the law is silent on the time frame in which the PDMP must be checked prior to prescribing or dispensing a controlled substance. That said, insofar as the PDMP query is intended to provide the prescriber with current information, it would seem advisable to check the database as close to the time at which the controlled substance prescription is written. The Board may promulgate additional rules delineating a more specific time frame in the near future.

69. I have no questions on acute pain, but if you could help me with chronic pain I would appreciate it. Are there any specific diagnosis accepted for chronic pain? Are there any restrictions for chronic pain? For patients with osteoarthritis not control with nsaid is there any limitations in prescribing tramadol? The law does not change your prescribing of controlled substances to treat chronic, nonmalignant pain, with two exceptions: (1) you must consult the PDMP before prescribing a controlled substance for a patient age 16 or older, except if prescribing a C-V nonopioid; and (2) you must indicate "NONACUTE PAIN" on a prescription for a C-II opioid (when being prescribed for chronic, nonmalignant pain). The duration limitation does not apply.

70. I, along with 5 other Florida licensed physicians work in VA primary care clinics in the West Palm Beach area as contractors. As contractors, we are subject to Florida law, while the VA follows Federal Law. So, this has raised a few questions:

    1. Schedule II opioids for acute pain are limited to 3 day supply (or 7 day exemption) and must be designated as "acute pain". If these prescription are filled at VA pharmacy, does this requirement still exist if ordered by a Florida licensed physician? Yes, although 3 day prescriptions need not otherwise be identified. 7 day prescriptions require

"ACUTE PAIN EXCEPTION" on the prescription. And, C-II opioid prescriptions written for other types of pain need to have "NONACUTE PAIN" indicated.

2. Schedule II opioids for chronic pain are to be designated as such on the prescription. Does this requirement exist if the medication is filled at VA pharmacy? Yes, as above, C-II opioid prescriptions written to treat chronic, nonmalignant pain, or pain other than acute pain, must include "NONACUTE PAIN" on the prescription.

3. Are schedule III and IV medications also restricted to a 3 day supply when prescribed for acute pain? No, the treatment duration limitation is specific for C-II opioids.

4. Under the new law PDMP must be checked prior to each controlled substance prescription. Must it be checked for each and every fill of the medication or only with each prescription? For instance, tramadol is allowed refills, so would PDMP only be checked with each new prescription or with each refill? As a prescriber, you are required to consult the PDMP before prescribing the controlled substance. This would occur on the first prescription. However, the dispenser is also required to consult the system before dispensing, hence each refill dispensed would result in a check of the PDMP by the dispenser, generally the pharmacist.

5. I am being told by VA that when the PDMP is queried, there are documentation requirements that must be entered into the VA electronic medical record and this would be expected of our physicians. The documentation would state either no prescription for controlled substances outside VA were found, or those controlled substances filled outside VA would be designated in the patient's medical record. If I recall, Florida law states that the findings of the PDMP cannot be part of the patient's medical record. If this is the case, how should the findings of the PDMP be documented by a Florida licensed physician? At the present time, when the PDMP needs to be queried, our physicians place a consult to VA pharmacy and a VA pharmacist checks the PDMP and documents the findings in the VA electronic medical record. The law is silent on boilerplate language that could, or should, be integrated into the patient's medical record as evidence of querying the PDMP. The specific information identified should not be entered into the patient's chart, but rather a general statement would be more advisable, like the ones mentioned above. Recall the purpose of the query is to ascertain the patient's controlled substance prescription and dispensing history, so generic statements reflecting such can be made. In the future, the Boards of Medicine and Osteopathic Medicine may devise statements expected to be included in the chart.

71. I had a question in regards to administration of testosterone in our office. How does this apply to the new regulations...(we provide the medication to the patient)? I suspect that you are not prescribing or dispensing testosterone for the treatment of pain. To that end, there is no duration limitation. Assuming that you are not dispensing the product, but are solely administering it, you are exempt from entering that information into the PDMP. If you are dispensing the product for use by the patient, other requirements apply, and they can be found under s. 893.055(3), beginning in the middle of page 92 of 205 of the law. Testosterone is not a Schedule II opioid, so would not be subject to the 3-7 day limit for that reason as well.

72. It seems that this presentation is geared towards those who practice in the outpatient realm. I could not tell how this applies to inpatients, nor did the statute you put up seem to distinguish the two. Do we have to check eforce on inpatients? Limit the number of days and quantities? Do we have to use pain assessment tools? How about for people who get meds for non pain related reasons (such as benzos for status epilepticus)? The focus of the law is on the outpatient prescription of C-II opioids for the treatment of acute pain. To that end, the PDMP need not be checked prior to the ordering of medications for inpatients. There is no duration limit for such patients according to the law (although your institution may have one). The use of pain assessment tools is not required for inpatients, but is probably good practice. The above applies to any and all controlled substances being ordered within the facility and administered to patients, for any diagnosis.

73. As essentially a stroke hospitalist, I deal with mostly aphasic and intubated patients with prolonged length of stays. I frequently don't even know their names (john does) or much about their background. I am being asked to do medicine reconciliation of "chronic" home meds on people that I have never met, but are often quite ill at the time .The requirement for medication reconciliation is not included in this law, and is beyond its scope, but has been promulgated, I believe, by the Federal Government related to meaningful use measures, Joint Commission standards, and National Patient Safety Goals.

In regards to supply limitations and need for indications, how does this apply to controlled substances prescribed for non pain related reasons? You gave only a few exceptions (vimpat, keppra, diarrhea something or other, I think another). Here is a blurb from a tipsheet we received from our administration...and here is an example I do not know how to rectify:

74. Patient needs 30 day supply benzodiazepine for their epilepsy/spasticity/anxiety (these are controlled substances), but this does not qualify as acute pain, chronic pain, or non acute pain- its not for an indication of pain at all, nor or are they even terminal conditions. As this diagnosis is unrelated to pain, the 3-7 day duration limitation is not applicable. However, the PDMP must be checked before prescribing a controlled substance for a patient age 16 years or older, except the C-V nonopioids. In your example above, if you are prescribing a benzodiazepine for outpatient use, the PDMP must be queried prior to doing so.
75. When discharging patients on a Controlled Substance or giving a patient a prescription for a Controlled Substance in clinic: After completing dose, route, and frequency in Epic, you will have to indicate one of the following for why you are prescribing a controlled substance:

    1) For "Acute Pain" – limit to a 3 day or less supply

    2) For "Acute Pain with exception" – exceed the 3 day limit, but no more than a 7 day supply

    a. You will need to document the "exception" in Epic

    3) For Non Acute Pain – no exception documentation is needed, but you are certifying the patient falls into one of the following categories (cancer, terminal condition, pain treated with palliative care, traumatic injury with injury severity score of 9 or higher)

    a. Opioid antagonist must be co-prescribed if a Schedule II Opioid is prescribed for pain related to a traumatic injury with a severity score of 9 or greater

    1) is correct, but the PDMP must be checked prior to prescribing
    2) the PDMP must be checked as above; "ACUTE PAIN EXCEPTION" must be indicated on the prescription; and the prescriber must adequately document in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply limit established.
    3) while subsection a. is correct, any pain that is not acute (according to the law's definition) requires "NONACUTE PAIN" be indicated on the prescription. This designation is not just for the 4 categories indicated above, but also chronic, nonmalignant pain.

76. One of our providers attended a conference you led on the new Opioid law. He indicated you stated that providers and not legally able to discuss the EFORCE history with the patient. Where in the legislation is this addressed? What is the purpose of not being able to discuss the report with the patient? Allow me to clarify. The inclusion of the PDMP query into the patient's medical record, and the distribution of such to the patient are not allowed. The prescriber may, and should, in fact, discuss the information contained therein, especially if there is concern of doctor-shopping. However, he/she should take care not to include specifics in the medical record, within which such would be discoverable. The PDMP section of the law begins on the bottom of page 89 of 205, s. 893.055.

77. How does the new law apply to chronic use amphetamines and similar drugs (e.g. Adderall)? Does eForsce/PDMP need to be checked at all or every time those are prescribed? The law did not change the duration of a prescription to treat diagnoses other than acute pain, however, the PDMP must be queried before prescribing a controlled substance, each and every time, except for C-V nonopioids and for patients under 16. In your example above, you may continue to prescribe stimulants as you deem clinically warranted, but the PDMP must be checked before each prescription.

78. 2) At around minute 10:50 in your presentation, pretty sure you said Tramadol was a benzo, but it is an opioid agonist. Is prescription of benzodiazepines affected by the new law? Again, does the PDMP need to be checked with benzos? (incidentally, several of my previous office staff were caught self prescribing xanax and tramadol using my credentials. I now run any potential or current employee through eForsce) I believe that I said tramadol was a C-IV, like the benzodiazepines. I apologize if there was any confusion from that statement. As above, the PDMP must be checked

before prescribing a controlled substance for any patient age 16 years or older, except a C-V nonopioid. Since benzodiazepines are controlled substances, the PDMP must be checked.

3) Why does a class II rx expire in a year, but a class III rx expire in 6 months? I would think it would be the other way around. According to the DEA, "There is no federal time limit within which a schedule II prescription must be filled after being signed by the practitioner. However, the pharmacist must determine that the prescription is still needed by the patient. While some states and many insurance carriers limit the quantity of controlled substances dispensed to a 30-day supply, there are no express federal limits with respect to the quantities of drugs dispensed via a prescription. However, the amount dispensed must be consistent with the requirement that a prescription for a controlled substance be issued only for a legitimate medical purpose by a practitioner acting in the usual course of professional practice."

According to Florida Statute 893.04(1)(g), "A prescription for a controlled substance listed in Schedule III, Schedule IV, or Schedule V may not be filled or refilled more than five times within a period of 6 months after the date on which the prescription was written unless the prescription is renewed by a practitioner."

Finally, according to Florida Administrative Code
64B16-27.211, Prescription Refills, "No prescription may be filled or refilled in excess of one (1) year from the date of the original prescription was written. No prescription for a controlled substance listed in Schedule II may be refilled. No prescription for a controlled substance listed in Schedules III, IV, or V may be filled or refilled more than five (5) times within a period of six (6) months after the date on which the prescription was written."

Therefore, because the State of Florida has a more restrictive law than the Federal Government, it applies. Since there is no explicit time frame for a C-II, it defaults to the one year limit, and the C-III - C-Vs are limited to six months. But, the pharmacist has a corresponding responsibility to ensure that the prescription is legitimate for its intended use. Thus, if a patient presents with a prescription for oxycodone 9 months after it was written, concern will naturally be voiced by the dispensing pharmacist who may wish to have the patient obtain a more current prescription before filling it, even though the prescription presented is technically still valid.

4) I don't have a lot of patients on chronic pain meds (I have a concierge practice with a patient load of about 430), but help me with the following examples.

5) I have a 94 y/o male in a wheelchair due to disabling knee and back arthritis (clearly surgery is not an option), I finally managed to control his pain with fentanyl patches (100 mcg is what it took), on top of meloxicam and gabapentin. He has no confusion, constipation, etc. So what happens with this law? Do I need to send him to a pain specialist to continue the fentanyl? Does he need an rx for naloxone to keep on hand? The only two stipulations provided in this law as it relates to the treatment of chronic, nonmalignant pain, are (1) you must indicate "nonacute pain" on the prescription for a C-II opioid (like Fentanyl in the example above); and (2) the PDMP must be checked before prescribing a controlled substance for this patient (as he is over the age of 16 and this is not a C-V nonopioid). He does not need to be referred to a pain specialist if you both believe he is receiving adequate pain control. It is up to you whether or not naloxone should be prescribed, but there is no requirement to do so according to this law.

6) I have a 53 y/o male with severe DJD of the neck, has seen neurosurg, refusing surgery, he takes oxycontin everyday as well as ibuprofen, gabapentin and prn soma. Clearly he is habituated to the oxy, so what happens to my treating him going forward? Incidentally, these two cases are stable, they don't ask for higher doses or early refills. I have maybe 2 or 3 more similar patients. Same as above since it is clear that you are treating him for chronic, nonmalignant pain. The guidance above related to the law's stipulations are applicable in this example as well.

7) I am not clear when I need to rx naloxone. To everybody on chronic narcotic use? The law requires that an emergency opioid antagonist be prescribed concurrently with any C-II when it is prescribed for the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater. If you believe that other patients of yours would benefit from such a prescription, you are free to do so according to your professional judgment.

78. Do I need to check PDMP in the hospital if phenobarb is prescribed for abortive treatment for status migranosus as inpt? From your material, it appears I do, even if patient has never had the drug. Checking the PDMP is indeed mandatory prior to prescribing or dispensing a controlled substance. Within a hospital, medications are ordered and administered, rather than prescribed and dispensed. This is an important semantic, and legal, distinction. Hence, based on the scenario below, you would **not** be required to check the PDMP prior to ordering phenobarb for an inpatient.

79. Do I need to check PDMP in the hospital if phenobarb is prescribed for abortive treatment for status migranosus as inpt? From your material, it appears I do, even if patient has never had the drug? Checking the PDMP is indeed mandatory prior to prescribing or dispensing a controlled substance. Within a hospital, medications are ordered and administered, rather than prescribed and dispensed. This is an important semantic, and legal, distinction. Hence, based on the scenario below, you would **not** be required to check the PDMP prior to ordering phenobarb for an inpatient.

80. What is the requirement for General Surgeons that perform cases in the hospitals or surgery centers for registration of PDMP? Prescriptions are given to patients following surgery in these settings. Do the surgeons still have to register since the medication is given outside of the office setting? With respect to the PDMP aspect of the law, the location of the surgery is but part of the equation. The other variable is the venue within which the medication is provided. In a facility, prescribers order medications that are administered. In outpatient settings, medications are prescribed and dispensed. Not only a semantic difference, but a legal one as well since the law affects prescribing and dispensing, not ordering and administering. So, if a controlled substance prescription is considered for a patient 16 years or older, the PDMP must be consulted before prescribing (except for C-V nonopioids). That is, if a prescription is written for a post-op patient who will be filling it for outpatient use, the prescriber needs to register with E-FORCSE and he/she or his/her designee must consult the database. This registration is quick, easy, and free (see the following link: https://flpdm-ph.hidinc.com/flmoved.html. The 3rd sentence directs you to create an account). If a designee is to be used, the prescriber must register first, and then assign a designee who will register independently. Also note that the duration limitation of 3-7 days will apply to C-II opioids being prescribed for the treatment of acute pain.

81. I am the pain provider for a subacute rehab facility proving pain management while the patients are admitted and undergoing therapy. What are the rules regarding prescriptions for opioid prescribing during their admission? Can they be given more then a 7-Day Supply while they are admitted at the sub-acute facility? The law essentially affects the prescription of C-II opioids in the treatment of acute pain. Within a facility such as yours, in which a prescriber orders a medication for administration, the law does not materially impact your current practice. That is, there are no duration limitation, except those that may be imposed by your individual facility, and there is no requirement to check the PDMP. After the patient's stay in your facility, if an opioid is to be prescribed for outpatient dispensing, the law's stipulations would apply. If the patient is age 16 years or older, and a controlled substance other than a C-V nonopioid is prescribed, the PDMP must be consulted. Further, if the patient is to be treated for acute pain with a C-II opioid, the duration is limited to 3 days (7 days as an exception adhering to the law's requirements).

82.. I do have only two patients on Opiates, one on Lortab for chronic back pain and one on Stadol Nasal Spray for Migraine; both have been on these for years now, monitored ; they have been unresponsive to other therapies .

The one on Lortab will be referred to Pain Management You describe what appears to be chronic, nonmalignant pain. You may continue to see and treat the patient, but must indicate "NONACUTE PAIN" on the prescription, and check the PDMP before prescribing the medication. Other than those two stipulations, your current practice need not change. Of course, it is your prerogative to refer the patient to a pain management specialist. but I do not know want to do with the one on Stadol ; she has been on every preventive therapy and abortive medications . How do I write her script if she is on it monthly and uses one bottle every 12 days. Should I refer her to Detox , to a Pain Clinic ? Butorphanol is a C-IV agent. So long as you wish to continue prescribing it for a legitimate purpose, there are no changes to your current practice, except that you must check the PDMP before prescribing it. I assume the patient is 16 years of age or older. I do not have any more patients on opiates since I stopped several years ago, referring these patients out little by little.

I do prescribe Tramadol prn and Benzodiazepines prn, which are in Schedule IV. You correctly note that these are C-IV agents. As such, prescriptions are only valid for up to six months or up to five refills, whichever comes first. The law does not impose any other duration or amount limitations. Also have like 5 patients on Amphetamines for AD, Schedule II N - these can be given the scripts for 30 day supply with no refills. Correct, as a C-II agent, there are no refills allowable.

However, you can prescribe up to a total of 90 days by issuing 3 separate prescriptions. Each of them must have the date written appropriately indicated, but prescriptions for future dispensing should include 'do not fill before' a future date. You cannot post-date a prescription.

83. I have a question about the prescribing of Amphetamines for ADHD. Until now we could prescribed quantities of up to 90 day supply through the electronic prescribing, has this changed? Depends on the type of amphetamine being prescribed as some are C-II agents. To that end, a prescription can only be written for a 30 day supply, but you may provide the patient with a total of 3 prescriptions for a 90 day supply. Each prescription must have the date written, but should also include a 'do not fill before' date so the patient can receive the medication in the future. You cannot post-date a prescription. Can the amphetamines be refilled? As above, if the amphetamine to which you are referring is a C-II, no. There are no refills on C-II medications. Also benzodiazepines for sleep and anxiety could be prescribed for a 90 day supply. Is there a time or quantity restriction on these and can these be refilled? Since most benzodiazepines are C-IV agents, there is no quantity restriction per se. The pharmacist has a corresponding responsibility to ensure the prescription is written for a legitimate reason and the amount is apropos. For example, if you write a prescription for short-term anxiety, prescribing hundreds of tablets would appropriately raise a red flag. With respect to refills, a C-III or C-IV is only valid for up to six months from the date it is written, and can only be refilled for a maximum of five times, whichever comes first. Is there a quantity restriction on Tramadol? As a C-IV agent, the same rules above apply to tramadol. That is, there is no quantity limit so long as the amount is relevant and appropriate for the condition being treated. Can it be prescribed for 90 days? While a 90 day supply of medications in C-III or C-IV is permissible, note that the prescription is only valid for six months from the date it is written or up to five refills, whichever comes first.

84.