AMCP Academy of Managed Care Pharmacy®
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OPIOID SUMMARY

OVERVIEW

One of AMCP's policy and advocacy focus areas for 2018 is Opioid Management. AMCP has been actively involved on the federal and state levels to increase awareness of the role of managed care pharmacy in support of patient-centered and clinically effective approaches to reduce overuse, diversion, and misuse of prescription opioids.

The Center for Disease Control (CDC) estimates that over 115 people die from an opioid overdose every day in the United States, amounting to over 63,000 fatalities every year and creating what is considered an opioid epidemic.[1,2] Although the opioid epidemic first began in the late 1990s, opioid diversion and misuse has increased exponentially since 2015, leading state and federal lawmakers to focus on enacting legislation to prevent both opioid abuse and opioid-related overdoses in recent years.[3] The CDC collects information on the number of drug overdose deaths by state and the 2016 data is available on the CDC website.

Last year, Congress increased its focus on the opioid epidemic. The U.S. House Energy and Commerce Committee took the lead on this issue by targeting efforts at "Combating the Opioid Crisis." During the month of June, the U.S. House of Representatives passed more than 70 opioid related bills and a summary prepared by AMCP is available on the AMCP website.

The Centers for Medicare and Medicaid Services (CMS) released a roadmap to address the opioid epidemic that includes an explanation of its three key focus areas: prevention, treatment, and data. The roadmap also provides important statistical information regarding opioid misuse in 2016, examples of successful prevention measures already taken by CMS, and an outline of future plans to build on those measures.

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[1] CDC/NCHS, National Vital Statistics System, Mortality. CDC Wonder, Atlanta, GA: US Department of Health and Human Services, CDC; 2017. https://wonder.cdc.gov.
[2] Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017.
[3] Rudd RA, AlesRudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. MMWR 2016, 64(50); 1378-82. hire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. MMWR 2016, 64(50); 1378-82.

STATE LEGISLATIVE ACTIVITY 2018

Since January of this year, state legislatures have enacted over 75 new opioid abuse prevention bills. More than 50 of those bills fall into six common categories trending in state opioid focused legislation.

Prescribing Guidelines & Limits- These measures set limits on when opioid treatments may be initiated and continued, dosage and duration of treatments, and who can prescribe opioids. The purpose of creating these guidelines is to ensure that patients have access to safe and effective treatments for acute and chronic pain while preventing the development of addiction, overdoses, and deaths.

Naloxone & Rescue Drug Accessibility- This type of legislation focuses on expanding access to rescue drugs such as Naloxone and training individuals on how to correctly administer rescue drugs to reverse potentially fatal overdoses and reduce opioid-related deaths. Key provisions include education and training, standing orders for rescue drugs, and good Samaritan provisions.

Prescription Drug Monitoring Program (PDMP)- PDMPs are electronic databases that track controlled substance prescriptions. PDMPs are used to improve prescribing behavior, inform clinical practice, and protect patients who are at risk for substance use disorders.

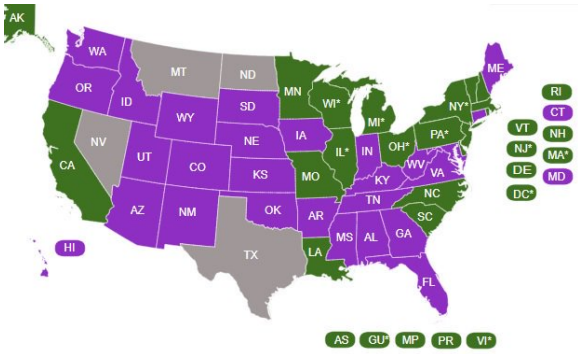
Continuing Education for Prescribers- State lawmakers have focused on taking steps to train health care professionals to identify the signs of substance use disorder and prescribe alternative pain management treatments when appropriate.

Safe Disposal of Controlled Substances- The purpose of this type of legislation is to encourage individuals to safely dispose of controlled substances following termination of treatment, expiration of prescriptions, and/ or upon death the of a patient. Key provisions include ensuring access to safe pharmaceutical disposal options, such as secure drop boxes, and education for patients and families on proper disposal of controlled substances.

Other Legislation Enacted – Some states addressed mandatory suspicious order reporting, e-prescribing, mandatory warning labels on prescription bottles, mandatory reporting of overdoses, and voluntary non-opioid advanced directives.

STATE MAP - JULY 2018

As of July, 10 states and the District of Columbia are still in session: Arkansas, California, Illinois, Ohio, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, and Wisconsin. A summary of legislative activity in the 39 states that have adjourned for 2018 follows.



OVERVIEW OF OPIOID RELATED STATE LEGISLATION ENACTED IN 2018
JULY 2018

State	Effective Date	Summary
ARIZONA **H.B. 2042**	1/01/2019	**Telemedicine: Coverage of Health Care Services** Requires coverage for urological services, pain management, and substance abuse via telehealth by including them under the definition of "health care services."
H.B. 2235	8/02/2018	**Limits on Dental Therapist Practice** Provides that a dental therapist is not permitted to prescribe, dispense, or administer narcotic drugs.
H.B. 2250	10/01/2018	**Prescribing Authority of Physician Assistants** Provides that the Board of Pharmacy must authorize physician assistants to prescribe Schedule II or III controlled substances that are not opioids or benzodiazepines for 90-day prescriptions rather than 30-day prescriptions.
H.B. 2549	8/2/2018	**Morphine Dosage Limits** • Provides that a prescriber is allowed to prescribe more than 90 morphine milligram equivalents per day if a board-certified consulting physician or an opioid assistance and referral call service designated by the Department of Health Services, such as the Arizona Poison Control System (APCS), agrees that a higher dose is necessary. **Dispensing of Natural Substances, Drugs, and Devices: Conditions** • Prohibits naturopathic physicians from dispensing opioids. • Provides that allopathic prescribers may dispense implantable devices that are opioids for medication-assisted therapy. **Pain Management Clinic Licensure Requirements** • Requires that a private office/ clinic must apply for licensure as a pain management clinic within 60-days after it meets the definition of a pain management clinic. **Poison and Drug Information Centers and APCS** • Provides that the APCS may provide opioid assistance and referral resources through a toll-free telephone service for all communities in Arizona.
H.B. 2633	8/2/2018	**Controlled Substances; Initial Prescriptions; Limits; Exceptions** • Provides that an initial prescription for an opioid that is written for more than a 5-day supply, or for more than 90 morphine milligram equivalents per day, is deemed to be exempt from the initial prescription limits if the prescription is presented to the dispenser. **Prescription Orders; Labels; Packaging; Definition** • Provides that the Board of Pharmacy may waive the "red cap requirement," requiring red caps on opioid containers, for Schedule II controlled substances if implementation is not feasible for the specific dosage form or packaging type.

Arizona Cont'd		**Electronic Prescription Order** • Provides that a pharmacist is not required to verify with a medical practitioner whether the practitioner has received a waiver from implementing electronic prescription orders.
S.B. 1001	4/26/2018	**Drug and Paraphernalia Drop-off Locations** • Provides that, on or before December 31, 2018, the Board of Supervisors from each county shall establish at least one location in the county where a person may (1) drop off any legal or illegal drug or substance and drug paraphernalia and (2) receive a referral to a substance abuse treatment facility. **Prior Authorization of Prescription Drugs for Chronic Pain Conditions** • Requires a health insurer, or its utilization review agent, to honor a prior authorization for chronic pain services through the earlier of: (1) six months of the date of approval or (2) the last day of the enrollee's coverage. • Provides that a health insurer, or its utilization review agent, may (1) require indication that the enrollee's chronic pain condition has not changed as a condition of prior authorization renewal and (2) deny a request if a provider does not respond to this request within five business days. • Provides that these provisions do not apply to (1) prescription drugs for which the FDA recommends less than six months of use or (2) any opioid, benzodiazepine, or Schedule I or II controlled substance. **Veterinarian Duty to Report** • Requires that a veterinarian who reasonably suspects or believes that a client or person is trying to obtain controlled substances with an intent other than to treat the patient animal (1) report that suspicion or (2) cause a report to be made to local law enforcement within forty-eight hours after the treatment of examination. • Provides that the report should include the name and address of the client or person who sought the examination or treatment. **Opioid Prescribing Guidelines** •Requires a veterinarian dispensing a Schedule II controlled substance or benzodiazepine to: (1) limit the initial amount of a Schedule II controlled substance dispensed to a five-day supply at a dosage clinically appropriate for the animal being treated, unless dispensed at a pharmacy; (2) limit the initial amount of a benzodiazepine dispensed to a 14-day supply at a dosage clinically appropriate for the animal being treated, unless dispensed at a pharmacy; and (3) for treatment of an animal with a chronic condition that requires long-term use of a Schedule II controlled substance or benzodiazepine, after the initial five-day or fourteen-day period, dispense not more than a 30-day supply at one time at a dosage clinically appropriate for the animal being treated, unless dispensed at a

Arizona Cont'd		pharmacy. • Limits the initial prescription for an opioid to a five-day supply generally or a 14-day supply following surgery. • Limits the initial prescription for an opioid to no more than 90 morphine milligram equivalents (MME) per day, unless the patient is hospitalized. • Requires the prescription of an opioid antagonist for any patient who is prescribed more than 90 MME per day. • Exempts a patient from initial prescription limits if the patient: (1) has an active oncology diagnosis; (2) has a traumatic injury, not including a surgical procedure; (3) is receiving hospice care; (4) is receiving end-of-life care; (5) is receiving palliative care; (6) is receiving skilled nursing facility care; (7) is receiving treatment for burns; (8) is receiving medication-assisted treatment for a substance use disorder; or (9) is an infant who is being weaned off opioids at the time of hospital discharge. • Provides an exemption for continuations of prior prescriptions for opioids issued within the previous 60 days from the 90 MME per day limit. • Provides that a prescriber may prescribe more than 90 MME per day, if the prescriber consults with a physician who is board-certified in pain. The measure allows this consultation to be done via telephone or telemedicine and specifies that if the physician is not available within 48 hours, the prescriber may prescribe more than 90 MME per day. **Continuing Education for Prescribers** • Requires prescribers authorized to prescribe Schedule II controlled substances to complete at least three hours of opioid-related, substance use disorder-related, or addiction-related continuing medical education as a condition of licensure renewal. **Mandatory Reporting** • Provides that quarterly, starting on or before September 1, 2018, each hospital or health care facility in this state that provides substance abuse treatment shall submit electronically to the Department of Health (the "Department"), on a form prescribed by the Department, a report that includes (1) the name and address of the facility, (2) the number of available substance abuse treatment beds, (3) the number of days in the quarter that the facility was at capacity, and (4) a signature from the facility representative. • Provides that quarterly, starting on or before December 31, 2018, a copy of the report must be submitted to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of State.

OVERVIEW OF OPIOID RELATED STATE LEGISLATION ENACTED IN 2018
JULY 2018

Arizona Cont'd		**Opioid Abuse Prevention Campaign** • Requires the Department to develop opioid abuse prevention campaign strategies that target youth and at-risk populations using a variety of communication platforms to maximize outreach. **Naloxone Kits** • Requires the Department to continue to distribute naloxone kits as necessary and may provide to a person who is at risk of experiencing or who is experiencing an opioid-related overdose a kit that contains naloxone or any other opioid antagonist that is approved by the United States Food and Drug Administration for the treatment of a drug overdose. **Electronic Prescribing** • Requires, beginning on January 1, 2019, that a patient must have an electronic prescription in order to be dispensed an opioid. **PDMP** • Requires the Board of Pharmacy to notify each pharmacist of the pharmacist's duty to register and obtain access to the PDMP. • Requires a dispenser to check the PDMP for the previous 12 months before dispensing a Schedule II controlled substance. • Requires that a practitioner check the PDMP if they are prescribing no more than a 10-day prescription for an invasive medical or dental procedure or an acute injury.
COLORADO **H.B. 1003**	5/21/2018	**Continuing Medical Education** • Requires the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery (the "Center") to develop and implement a series of continuing education activities designed to help a prescriber of pain medication to safely and effectively manage patients and prescribe opioids or medication assisted treatment. • Requires that the educational activities apply to physicians, physician assistant nurses, and dentists. • Requires the Center to develop education and training for law enforcement officers and first responders concerning the use of opioid antagonists for opioid overdose and community-based training for persons at risk of opioid overdose.
H.B. 1007	1/01/2019	**Concerning Payment Issues Related to Substance Use Disorders (SUDs)** **Mandatory Coverage** • Requires that individual and group health benefit plans provide coverage for at least one of the FDA approved drugs to treat opioid dependence without prior authorization for a first request within a 12-month period. **Carrier and Provider Contracts** • Prohibits carriers from taking adverse action against a provider, or from providing

Colorado Cont'd		financial incentives or disincentives to a provider, based solely on a patient satisfaction survey relating to patients' satisfaction with pain treatment. **Pharmacy Reimbursement for SUDs** • Permits a pharmacist participating in a collaborative pharmacy practice agreement to administer injectable antagonist medication-assisted treatment for SUDs and receive an enhanced dispensing fee for the treatment. **Medicaid Community Medtal Health Services- Administration Rules** • Requires the State Department of Health Care Policy and the Office of Behavioral Health to establish rules that standardize utilization management authority timelines for the non-pharmaceutical components of medication-assisted treatment for SUDs.
H.B. 1307	8/07/2018	**Sale of Dextromethorphan (DXM)** • Provides that it is unlawful to knowingly or willfully dispense, sell, or distribute a finished drug product containing any quantity of DXM to a person less than 18 years of age. • Provides that a seller, retailer, or vendor making a retail sale of a finished drug product containing any quantity of DXM must require and obtain proof of age from the purchaser before completing the sale unless the seller, retailer, or vendor reasonably presumes from the purchaser's outward appearance that the purchaser is at least 25 years of age. • Provides that the prohibition does not apply to a medication containing DXM that is sold pursuant to a valid prescription.
S.B. 22	5/21/2018	**Safer Opioid Prescribing** • Restricts the number of opioid pills that health care practitioners may prescribe for an initial prescription to a 7-day supply and one refill for a 7-day supply to a patient who has not had an opioid prescription in the last 12 months. • Provides that the limits on initial prescribing do not apply if, in the judgment of the practitioner, the patient: (1) Has chronic pain that typically lasts longer than 90 days or past the time of normal healing, as determined by the practitioner, or following transfer of care from another practitioner of the same type who prescribed an opioid to the patient; (2) Has been diagnosed with cancer and are experiencing cancer-related pain; or (3) Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days. • Provides that practitioners may prescribe opioids electronically. • Requires that practitioners refer to the PDMP before prescribing the first refill prescription for an opioid except under specified circumstances, and requires the practitioner to indicate his or her specialty or practice area upon the initial query. • Requires that each practitioner query the PDMP before prescribing the second fill for an opioid unless the person receiving the prescription: (1) Is receiving the opioid in a hospital, skilled nursing facility, residential facility, or correctional facility;

Colorado Cont'd		(2) Has been diagnosed with cancer and is experiencing cancer-related pain; (3) Is undergoing palliative care or hospice care; (4) Is experiencing post-surgical pain that is expected to last more than 14 days; (5) Is receiving treatment during a natural disaster or incident where mass casualties have taken place; or (6) Has received only a single dose to relieve pain for a single test or procedure.
Connecticut **S.B. 195**	1/01/2019	**Suspicious Order Reporting** • Requires each manufacturer or wholesaler of drugs to operate a system to identify suspicious orders or controlled substances and immediately inform the Director of the Drug Control Division (DCD) of suspicious orders such as orders of unusual size, orders deviating substantially from a normal pattern and orders of unusual frequency. • Provides that each registered manufacturer or wholesaler of drugs shall also send the DCD a copy of any suspicious activity submitted to the DEA. **General Reporting** • Requires that manufacturers and wholesalers prepare a complete and accurate record of all stocks of controlled substances on hand annually, rather than biennially. • Requires that this report be made available to the Commissioner of Consumer Protection (CCP). **Pharmacy Inventory** • Requires each pharmacy and institutional pharmacy to maintain a perpetual inventory of each Schedule II controlled substance. • Requires (1) that the inventory be reconciled on a monthly basis and (2) that any loss, theft or unauthorized destruction of a controlled substance must be reported within 72 hours after discovery to the CCP.

Florida		**Continuing Education for Prescribers** •Requires that individuals registered with the DEA and authorized to prescribe controlled substances must complete a specified board-approved two-hour continuing education course on prescribing controlled substances, particularly opiates. •Requires that the board-approved continuing education course include information on the current standards for prescribing controlled substances, alternatives to those standards, non-pharmacological therapies, prescribing emergency opioid antagonists, and the risks of opioid addiction following all stages of treatment in the management of acute pain. •Prohibits the Department of Health (DOH) from renewing the license of a prescriber who fails to complete the course. **Standards for Prescribing Opioids for Acute Pain** •Requires the DOH to adopt guidelines for prescribing controlled substances for acute pain, including rules regarding the evaluation of the patient, treatment plans, consultations, medical record review, and compliance with controlled substance laws and regulations. • Requires that prescriptions for Schedule II controlled substances to treat acute pain may not exceed a 3-day supply unless the prescriber believes that more than a 3-day supply is necessary, in which case he or she may prescribe up to a 7-day supply if (1) the justification is documented in the patient's medical record, and (2) "ACUTE PAIN EXCEPTION" is indicated on the prescription. • Requires that a prescriber must indicate "NONACUTE PAIN" on a prescription for the treatment of pain other than acute pain. **Standard for Prescription of a Schedule II Opioid for Pain Related to a Traumatic Injury** •Requires a prescriber to concurrently prescribe an emergency opioid antagonist with a prescription for a Schedule II opioid for the treatment of pain related to a traumatic injury with an International Classification Injury Severity Score of 9 or higher. **Requirements for Dispensing Controlled Substances to Unknown Persons** • Requires that, before dispensing a controlled substance to a person not known to the pharmacist, he or she must require that person to present a valid government photo id or other verification of his or her identity. **PDMP** • Requires that the DOH maintain an electronic system to collect and store controlled substance dispensing information. • Provides that dispensers must report to the electronic system:
H.B. 21	7/01/2018	(1) Identifying information of the prescribing practitioner;

Florida Cont'd		(2) The date that the prescription was filled; (3) Payment information; (4) Patient information; (5) Prescription details; (6) Pharmacy information; (7) Refill information; and (8) The personal information of the individual who picked up the prescription. • Provides information regarding who has access to the electronic system and who may request access to the electronic system. • Requires a prescriber or dispenser to consult the system to review a patient's controlled substance history before prescribing or dispensing a controlled opioid substance for a patient age 16 or older. • Provides that the DOH conduct and/ or participate in studies to examine the feasibility of enhancing the PDMP to improve quality of services and safety, advance technology, reduce duplicative prescriptions and overprescribing, and reduce drug abuse. • Requires the DOH to disclose identifying patient information to practitioners, pharmacists, program managers, support staffs, regulatory boards, and medical examiners as needed to review the controlled drug prescription history of a patient. **Preventing the Manufacturing of Counterfeit Controlled Substances** • Provides that it is unlawful for a person to possess, purchase, deliver, sell, or possess with intent to sell, a tableting machine, encapsulating machine, or controlled substance counterfeiting machines except as part of a regulated transaction with a regular customer.
Idaho **H.B. 354**	7/01/2018	**Reporting of Opioid Antagonists** Requires the reporting of dispensed opioid antagonists to the PDMP.
Indiana **H.B. 1007**	7/01/2018	**Opioid Treatment Programs** • Provides that, beginning on July 1, 2018, the Division may approve the operation of not more than 9 additional opioid treatment programs if the Division determines that there is a need for a new opioid treatment program in the proposed location. • Provides that the legislative council should assign an interim study committee (the "Committee") the task of studying the impact that opioid treatment programs have on the neighborhoods and communities in the immediate area of the opioid treatment programs. • Provides that the Committee must consider the effect on the neighborhoods and communities in the immediate area that the opioid treatment programs have regarding criminal activity, emergency medical services, the local economy, the residents' quality of life, and any other direct impact. • Provides that the Committee must study other states' and localities' best practices to monitor and regulate opioid treatment programs to reduce negative impacts to

Indiana Cont'd		the neighborhoods and communities in the immediate area of the opioid treatment programs.
IOWA		**PDMP** • Provides that the program shall obtain from first responders information regarding administration of opioid antagonists. • Provides that the Department of Public Health shall provide information on the administration of opioid antagonists to the Board of Pharmacy (the "Board"). • Provides that the Board shall adopt rules requiring the following information to be provided regarding the administration of opioid antagonists: (1) Patient identification (2) Identification of the person administering opioid antagonists (3) The date of administration (4) The quantity of opioid antagonists administered • Provides that a prescribing practitioner shall register for the program at the same time the prescribing practitioner applies to the Board to register or renew registration to prescribe controlled substances as required by the Board. • Provides that each prescribing practitioner furnishing, dispensing, or supplying controlled substances to the prescribing practitioner's patient shall submit the following information to the program: (1) Pharmacy identification (2) Patient identification (3) Prescribing practitioner information (4) Issue date of prescription (5) Dispense date of prescription (6) An indication of whether the prescription dispensed is new or a refill (7) Identification of the drug dispensed (8) Quantity of the drug dispensed (9) The number of days' supply of the drug dispensed (10) Serial or prescription number assigned by the pharmacy (11) Type of payment for the prescription • Provides that information shall be timely submitted within one business day **Electronic Prescriptions** • Requires that all prescriptions for all drugs, including refills, be transmitted to a pharmacy electronically starting January 1, 2020. • Requires that prescriptions issued electronically comply with federal laws for the electronic transmittal of prescriptions for controlled substances. • Provides that a person subject to these requirements may petition the Board for exemption based on economic hardship, technical limitation, or other exceptional circumstances. **Prescriber Activity Reports**
H.F. 2377	7/01/2018	• Requires the Board and the Prescription Monitoring Program Advisory Council to

Iowa Cont'd		promulgate rules allowing the annual issuance of privileged and confidential activity reports to prescribing practitioners who prescribe any controlled substances in an electronic format and at as low a cost as possible. • Provides that the report include a summary of the prescribing practitioner's history of prescribing controlled substances, comparisons to other prescribing practitioners of the same profession and specialty, the prescribing practitioner's history of program use, general patient risk factors, educational updates, and other pertinent information. **Substance Abuse Prevention** • Provides that the Board and the Prescription Monitoring Program Advisory Council may establish criteria for the identification of patients who are potentially misusing or abusing prescription controlled substances. • Provides that the Board is authorized to proactively notify the pharmacists and prescribing practitioner involved in the care of the patient. **Opioid Prescribing Guidelines** • Requires the Board of Medicine, Board of Dentistry, Board of Physician Assistants, Board of Podiatry, and Board of Nursing to establish rules requiring licensees who have prescribed opioids to a patient during the previous licensure cycle to receive continuing education credits regarding the U.S. Centers for Disease Control and Prevention guideline for prescribing opioids for chronic pain, including recommendations on limitations on dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacologic therapy options, as a condition of license renewal. • Provides that each licensing board will have the authority to determine how often a licensee must receive continuing education credits. **Registration** • Requires that a person who manufactures, distributes, or dispenses any controlled substance in Iowa, or who proposes to engage in such activities, must obtain and maintain a registration issued by the Board of Pharmacy. • Requires a separate registration for each principal place of business of a registrant when the registrant is conducting research with controlled substances. **Controlled Substances- Precursor Substances** • Provides that the Iowa Schedule I and Schedule II substances must conform with scheduling actions taken by the DEA. **Good Samaritan Immunity** • Provides that a person seeking treatment for a drug-related overdose, or a person seeking medical treatment for a person experiencing a drug-related overdose, cannot be arrested or prosecuted for possession of a controlled substance and

Iowa Cont'd		delivery of a controlled substance without profit on the basis of information collected or derived from a person's actions in seeking medical assistance if the person has not previously received such immunity.
S.F. 2322	7/16/2018	**Administration of Naloxone** • Provides that a pharmacist may order and administer Naloxone to a person 18 years of age or older. **Pharmacist Requirements For Administration of a Prescription Drug, Product, Test, or Treatment** • Provides that a pharmacist ordering or administering a prescription drug, product, test, or treatment must: (1) Maintain a record of all prescription drugs, products, and treatments administered to a patient; (2) Notify the patient's primary health care provider or provide a written record to the patient; (3) Consult the statewide immunization registry or health information network; and (4) Complete annual continuing pharmacy education related to the protocols adopted by the Board of Pharmacy.
KENTUCKY **H.B. 124**	4/02/2018	**Enhanced Standards and Criteria for Substance Use Disorder (SUD) Treatment and Recovery Services** • Provides that the Cabinet for Health and Family Services (the "Cabinet") shall conduct a comprehensive review of all current state licensure and quality standards that apply to substance use disorder treatment and recovery services and programs that operate within Kentucky. • Provides that, based on the results of the review, the Cabinet shall develop license and quality standards for SUD treatment and recovery. • Requires that the standards include: (1) comprehensive quality standards and criteria for SUD treatment and recovery services and programs that are based on nationally recognized and evidence-based standards, (2) standardized, nationally recognized outcome measures for SUD treatment programs, and (3) conditions necessary for reimbursement with state funds for the provision of SUD treatment and recovery services and programs. • Requires that the Cabinet promulgate administrative regulations necessary for implementing the enhanced licensure and quality standards by January 1, 2019.
H.B. 246	7/12/2018	**Pilot Program** • Provides for the establishment of a pilot program to analyze the outcomes and effectiveness of a community pharmacy care delivery model for non-controlled medication assisted therapy for the treatment of substance abuse. • Provides that requiring prior authorization is prohibited for non-controlled medication assisted therapies for community pharmacies as part of the pilot

Kentucky Cont'd		project. • Requires the Cabinet to report findings and any recommendations by December 31, 2019.
S.B. 6	7/12/2018	**Safe Disposal of Controlled Substances** • Requires that a pharmacist or practitioner inform persons who receive a prescription for a controlled substance that contains any salt, compound, derivative, or preparation of an opioid, benzodiazepine, barbiturate, codeine, or an amphetamine, about the importance of proper and safe disposal of unused, unwanted, or expired prescription drugs verbally, in writing, or by posted signage. • Provides that, upon dispensing of any prescription that contains any salt, compound, derivative, or preparation of an opioid, benzodiazepine, a barbiturate, codeine, or an amphetamine, a pharmacist or physician may: (1) make available for purchase or distribute at no charge, a non-toxic composition for the sequestration, deactivation, destruction, and disposal of any unused, unwanted, or expired prescription or (2) provide an on-site safe and secure receptacle or kiosk for the safe disposal of any unused, unwanted, or expired prescription. • Provides that Medicaid is not required to pay for when a practitioner or pharmacist sells or offers to sell the required nontoxic composition but encourages manufacturers and distributors of nontoxic compositions for the sequestration or deactivation of controlled substances to enter into a consignment-reimbursement contract with a pharmacy in order to expand the nontoxic composition inventory.
LOUISIANA **H.B. 755**	8/01/2018	**Naloxone Administration in Elementary and Secondary Schools** • Provides that the governing authority of each public and non-public elementary and secondary school may adopt a policy that authorizes a school to maintain a supply of naloxone or other opioid antagonists. • Authorizes a school nurse or other school employee to administer naloxone or another opioid antagonist to any student or other person on school grounds in the event of an actual or perceived opioid emergency. • Provides that the policy must require school employees other than school nurses to receive at least six hours of general training, including training on emergency administration, from a registered nurse or a licensed medical physician prior to being authorized to perform such administration. • Provides that a school governing authority that does not adopt such a policy will not be subject to civil liability for failing to authorize such supply or administration.
S.B. 90	8/01/2018	**Non-Opioid Directive Form** • Requires the Louisiana Department of Health to develop a voluntary nonopioid directive form and allows a patient to execute and file the voluntary nonopioid directive form with a prescribing practitioner when the patient does not wish to be issued a prescription or medication order for an opioid. • Provides that, upon receipt of a voluntary nonopioid directive form, the measure requires a prescribing practitioner to:

Louisiana Cont'd		(1) date and affix his signature to the form in the presence of the patient as evidence of acceptance, (2) document the receipt in the patient's medical record, and (3) provide a signed copy of the form to the patient. • Requires that the form allow a patient to appoint a duly authorized guardian or health care representative to override a previously recorded voluntary nonopioid directive form, orally or in writing, for any reason, at any time.
S.B. 285	8/01/2018	**Coverage of Prescriptions for Chronic Pain** • Provides that a health insurance issuer is prohibited from denying coverage of a non-opioid prescription drug in favor of an opioid prescription drug. • Provides that when opioids are deemed medically necessary by a licensed physician, it is unlawful for an insurer to deny a physician prescribed medication and recommend an alternative prescription which requires any of the following: (1) An increased number of pills per prescription; (2) A higher DEA schedule medication than the one prescribed; or (3) The substitution of an extended release medication that does not have defined abuse-deterrent properties for a prescription of a medication that does have defined abuse-deterrent properties.
MAINE **L.D. 565**	7/17/2018	**Prescribing and Dispensing of Naloxone Hydrochloride by Pharmacists** Provides that a pharmacist may prescribe and dispense naloxone hydrochloride to an individual at risk of experiencing an opioid overdose and requires the Board of Pharmacy to establish standards and protocols including training requirements and protocols for prescribing and dispensing.
L.D. 1892	5/02/2018	**Allows Prescribing and Dispensing of Naloxone Hydrochloride by Pharmacists for Patients of Any Age** Provides that a pharmacist may prescribe and dispense naloxone hydrochloride to an individual of any age at risk of experiencing an opioid overdose.
MARYLAND **H.B. 653**	10/01/2018	**Opioid and Benzodiazepine Prescriptions- Discussion of Benefits and Risks** • Requires that, when a patient is prescribed an opioid, the patient must be advised of the benefits and risks associated with that opioid. • Requires that, when a patient is co-prescribed a benzodiazepine with an opioid, the patient must be advised of the benefits and risks associated with the benzodiazepine and the co-prescription of the benzodiazepine.

Maryland Cont'd		**The "Pill Mill" Tip Line** • Requires that, on or before December 1, 2018, the Maryland Department of Health (the "Department") identify a method for establishing a tip line through which a person may report a licensed individual who the reporting person suspects is prescribing medication or overprescribing medication in violation of the law. • Requires that the Department ensure that reports to the tip line are forwarded to the appropriate licensing board. **The Overdose Report** • Provides that, on or before July 1st each year, the Secretary of Health (the "Secretary") examine the prescription and treatment history of individuals in Maryland who suffered fatal overdoses involving opiates and other controlled substances in the immediately preceding 4 calendar years. • Provides that the Secretary collaborate with any State and local agency that the Secretary considers necessary in conducting the examination. • Provides that, beginning July 1, 2019, and each year thereafter, the Secretary provide a report on the findings of the examination to the Governor of Maryland and the General Assembly of Maryland. • Provides that the report: (1) Include an assessment of the factors associated with fatal and non-fatal opioid overdose risk and an assessment of the programs targeted at opioid use and misuse; (2) Identify and assess methods of intervening with populations found to be at risk of overdose or a substance abuse disorder; and (3) Include recommendations for improving and providing statewide prevention, response, and data collection efforts related to substance use disorder. • Provides that the assessments provided in the report should include accessing, and if possible, providing links to, data sets of: (only pharmacy related data sets listed below) (2) substance use treatment, (3) PDMP, (4) emergency medical services database, (8) hospital case mix, emergency department and inpatient records associated with substance use disorder and non-fatal controlled dangerous substance-related poisonings, (9) all payer claims database, (11) needle exchange program, (18) Maryland medical assistance program pharmacy claims. • Provides that, on or before September 1, 2018, each entity shall provide data to the Department and enter into a data sharing agreement with the Department. • Provides that any records and information provided to the Department that could identify any individual are not public records and are not subject to discovery, subpoena, or other means of legal compulsion in civil or criminal litigation.
H.B. 922	7/01/2018	

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Maryland Cont'd **H.B. 1452 (identical to S.B. 1223)**	10/01/2018	**Continuing Education Program for Physicians** • Provides that an authorized provider applying for registration to dispense a controlled dangerous substance, and who will prescribe or dispense controlled dangerous substances under that registration, shall attest on the registration form to the Department of Health that he has completed two hours of continuing education.
H.B. 1480 (identical to S.B. 982)	10/01/2018	**Controlled Dangerous Substances - Distributors - Reporting Suspicious Orders** • Requires a registrant distributor to report to the Department of Health and the Office of the Attorney General any suspicious order of controlled dangerous substances, including an order of unusual size, unusual frequency, or that deviates substantially from a normal pattern.
S.B. 522	10/01/2018	**Opioid and Benzodiazepine Prescriptions- Discussion of Benefits and Risks** • Requires that patients be advised of the benefits and risks associated with a prescription opioid when he or she is prescribed an opioid. • Requires that, when a patient is co-prescribed a benzodiazepine with an opioid, the patient must be advised of the benefits and risks associated with the benzodiazepine and the co-prescription of the benzodiazepine.
Mississippi **S.B. 2836**	7/01/2018	**Administration of Mental Health Benefits** • Provides that mental health benefits may be administered by managed care plans. **Reimbursement for Treatment of Opioid Dependency** • Provides that the Division of Medicaid (the "Division") is authorized to reimburse eligible providers for treatment of opioid dependency and other highly addictive substance use disorders (SUDs) as determined by the Division. • Provides that treatment related to these conditions shall not count against any physician visit limit imposed by the Division. **Commission on Expanding Medicaid Managed Care** • Provides for the establishment of the Commission on Expanding Medicaid Managed Care (the "Commission") to develop a recommendation to the Legislature and the Division in regards to authorizing the Division to expand Medicaid managed care contracts to include all Medicaid-eligible beneficiaries. • Provides that the Commission must submit its recommendations by December 1, 2018.

NEBRASKA L.B. 731	7/18/2018	**Continuing Education Requirements** • Requires nurse midwives, dentists, physicians, physician assistants, nurse practitioners, podiatrists, and veterinarians who prescribe controlled substances to undergo at least three hours of continuing education biennially on opioid prescribing. • Requires that one-half hour of these three hours must cover the PDMP. **Remote Dispensing Pharmacies** • Requires that, for remote dispensing pharmacies which employ certified pharmacy technicians to dispense prescription drugs, remote dispensing must occur under remote supervision via a real-time audiovisual communication system by a licensed pharmacist employed by the supervising pharmacy, who must be licensed and located in Nebraska. • Provides that this supervision may be delegated to another pharmacist at the supervising pharmacy. • Provides that remote dispensing is prohibited if the real-time audiovisual communication system is not functional. • Requires the remote dispensing pharmacies to have the same pharmacist in charge as the supervising pharmacy. • Requires the pharmacist in charge to ensure that a pharmacist is on site at the remote dispensing pharmacy at least once a month. • Requires the supervising pharmacist to attempt to counsel on all new prescriptions dispensed from the remote dispensing pharmacy. • Requires electronic transmissions of authorized refills to be sent directly to a pharmacist, pharmacist intern, or pharmacy technician.
L.B. 931	7/18/2018	**Limits on Prescriptions for Controlled Substances** • Provides that, when prescribing a Schedule II controlled substance or an opiate, prior to a practitioner's initial prescription for a course of treatment for acute or chronic pain, and again prior to the practitioner's initial prescription for such course of treatment, a practitioner shall discuss with the patient, or the patient's parent or guardian: (1) the risks of addiction and overdose associated with the prescribed medication, (2) the reasons why the medication is necessary, and (3) alternative treatments that may be available. • Provides that initial opioid prescriptions for patients under 19 years of age must be limited to no more than a 7-day supply. • Provides that, if an opiate prescription exceeds three days, the prescriber should re-evaluate the patient prior to issuing another prescription for opiates. • Provides that chronic pain management, pain associated with cancer, and pain associated with palliative care are exempt from the prescription limit. • Provides that the above provisions sunset on January 1, 2029. • Requires an individual to display photo identification as proof of identification before being dispensed an opioid, unless they are personally and positively known to the pharmacist or are in a health care facility.

New Hampshire **S.B. 376**	1/01/2019	**Possession and Sale of Ephedrine and Pseudoephedrine** • Requires that no person shall knowingly and unlawfully possess a drug product containing ephedrine, pseudoephedrine, or phenylpropanolamine with the intent to use the product as a precursor to manufacture methamphetamine or another controlled substance. • Provides that a drug product containing ephedrine, pseudoephedrine, or phenylpropanolamine shall not be distributed at retail to the general public unless it is maintained in a locked display case or behind the counter out of the public's reach. • Requires that a retail establishment shall not knowingly complete a sale to a person if the drug product or combination of drug products purchased would surpass a total of more than 3.6 grams within a 24-hour period or 9 grams within a 30-day period of ephedrine base, pseudoephedrine base, or phenylpropanolamine base or their isomers. The "base" form means the fraction of ephedrine, pseudoephedrine, or phenylpropanolamine present within a formulation containing a salt form of those respective drugs. **Electronic Registry System** • Requires retail establishments to use an electronic registry system to record the sale of non-prescription drug products containing ephedrine base, pseudoephedrine base, or phenylpropanolamine bases. • Provides that the registry system would have the capacity to block a sale that would result in a purchaser exceeding the lawful daily or monthly amount, as well as an override system if the dispenser has a reasonable fear of imminent bodily harm if the transaction is not completed. • Provides that the electronic registry system will be available free of charge, will operate in real time communication, and will be hosted by the National Precursor Log Exchange (NPLEx) online portal or its equivalent. • Requires that, prior to completing a sale, a retail establishment must require the person purchasing the drug to present a current, valid government-issued identification document. • Requires that a retail establishment shall record in the electronic registry system: (1) The name and address of the purchaser; (2) The name of the drug product and quantity of ephedrine, pseudoephedrine, and phenylpropanolamine sold in grams; (3) The date and time of purchase; (4) The form of identification presented, the issuing government entity, and the corresponding identification number; and (5) The name of the person selling or furnishing the drug product.

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OKLAHOMA **H.B. 2795**	11/01/2018	**Medical Facility Registration** • Requires every person who owns, in whole or in part, a public or private medical facility for which a majority of patients are issued on a reoccurring monthly basis a prescription for opioids, benzodiazepines, barbiturates or carisoprodol, but not including suboxone or buprenorphine, to obtain a registration issued by the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control.
S.B. 956	11/01/2018	**Dispensing of Non-Controlled and Controlled Prescription Drugs** • Provides that pharmacists may dispense prescriptions for non-controlled prescription drugs authorized by an advanced practice nurse or physician assistant, not located in Oklahoma, provided that they are licensed in the state in which they are actively prescribing. • Provides that pharmacists may only dispense prescriptions for controlled dangerous substances prescribed by an advanced practice nurse or physician assistant licensed in the State of Oklahoma and supervised by an Oklahoma-licensed practitioner. **Good Samaritan Act** • Provides that any provider prescribing or administering an opiate antagonist in a manner consistent with addressing opiate overdose shall be covered under the Good Samaritan Act.
S.B. 1446	11/01/2018	**Opioid Prescribing Guidelines** • Provides for the creation of opioid prescribing guidelines but exempts (1) patients receiving active treatment for cancer, (2) patients in hospice or palliative care, and (3) residents of long-term care facilities. • Requires limits on initial opioid prescriptions to a seven-day supply for treatment of acute pain for both adults and children. Under this bill, any prescription for acute pain must be for the lowest effective dose of the immediate-release opioid drug. • Requires that, before issuing an initial prescription for a Schedule II opioid for either acute or chronic pain, the practitioner is required to: (1) Take a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management, as well as substance abuse history; (2) Conduct a physical exam; (3) Develop a treatment plan; (4) Access relevant prescription monitoring information; (5) Limit the supply of any prescribed opioid to seven days; and (6) If the patient is under 18, enter into a pain management agreement with a parent. • Provides that, after the first prescription, a practitioner may issue a prescription in any quantity, provided that the practitioner determines the prescription does not present an undue risk of abuse or addiction. • Provides that, prior to issuing the initial prescription of a Schedule II controlled dangerous substance or any opioid drug which is a prescription drug in a course of

Oklahoma Cont'd		treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner must discuss with the patient the risks associated with the drugs being prescribed, including: (1) The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants; (2) The reasons why the prescription is necessary; (3) Alternative treatments that may be available; and (4) Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression. • Provides that a practitioner must review, at least every three months, the course of treatment, and must make periodic efforts to try other drugs or treatment modalities. • Requires that a licensee receive not less than one hour of education in pain management and opioid use and addiction each year preceding an application for renewal of a license. • Provides that the Insurance Commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this subsection.
OREGON **H.B 4137**	3/27/2018	**Development of an Addiction, Prevention, Treatment, and Recovery Plan** • Requires that the Alcohol and Drug Policy Commission develop preliminary recommendations for the scope and framework of the state comprehensive addiction, prevention, treatment, and recovery plan by September 15, 2018. • Requires the Commission to incorporate the recommendations for the plan into a request for proposals issued by November 1, 2018. • Requires the Commission to report to the interim committees of the Legislative Assembly related to health no later than December 31, 2018. • Requires that the addiction, prevention, treatment, and recovery plan be completed by July 1, 2020.
H.B. 4143	3/27/2018	**Report on Barriers to Treatment for Substance-Use Disorders** • Requires that the Director of the Department of Consumer and Business Services study and report on existing barriers to effective treatment for and recovery from substance use disorders (SUDs), including addictions to opioids and opiates, that are due to current structures of payment for treatment and recovery services in both publicly and privately funded health systems in Oregon. • Provides that the Report should include findings on the impact of reimbursement systems, access to treatment, recovery resources, the classification of SUD as an acute rather than chronic illness, access to medication-assisted treatment for SUD in rural and underserved communities in Oregon, and SUD treatment options other

Oregon Cont'd		than medication-assisted treatment. **Pilot Project to Increase Access to Treatment** Requires the Oregon Health Authority to establish a pilot project to determine the effectiveness of establishing immediate access to appropriate evidence-based treatment for individuals who suffer from opioid and opiate overdoses by creating a direct link between emergency departments and appropriate treatments and resources in Coos, Jackson, Marion, and Multnomah Counties. **PDMP** • Requires practitioners to register. • Provides that, once registered, practitioners may apply for access to the electronic system. • Requires that the Oregon Health Authority establish rules for registering practitioners with the electronic system.
SOUTH CAROLINA **H.B. 3819**	11/17/2018	**Opioid Prescription Requirements** • Requires a prescriber, before issuing an initial prescription for an opioid analgesic to a minor, to: (1) Assess whether the minor has ever suffered from or is currently suffering from a mental health or substance abuse disorder and whether the minor has taken or is currently taking prescription drugs for treatment of a mental health or substance abuse disorder; (2) Discuss with the minor and the minor's parent, guardian, or another adult authorized to consent to the minor's medical treatment the risk of addiction and overdose, the dangers of taking opioid analgesics with benzodiazepines, alcohol, or other central nervous system depressants, any other information in the patient counseling information section of the labeling for the opioid analgesic; and (3) Obtain written consent for the prescription from the minor's parent, guardian, or other adult authorized to consent. • Provides that the prescriber will record the consent required on a 'Start Talking!' consent form developed by the State Board of Medical Examiners, which must contain the following: (1) The name and quantity of the opioid analgesic being prescribed and the amount of the initial dose; (2) A statement indicating that a controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse; (3) A statement certifying that the prescriber discussed with the minor and the minor's parent, guardian, or another adult authorized to consent to the minor's medical treatment the matters; (4) The number of refills, if any, authorized by the prescription; and (5) The signature of the minor's parent, guardian, or another adult authorized to consent to the minor's medical treatment and the date of signing.

South Carolina Cont'd		• Provides that this measure does not apply if: (1) The prescription is associated with or incident to a medical emergency; (2) The prescription is associated with or incident to surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis; (3) Is associated with pain management treatment for palliative care, cancer care, or hematological disorders including, but not limited to, sickle cell disease (4) Is associated with the treatment of neonatal abstinence syndrome; the prescription is associated with pain management treatment for cancer or hematological disorders including, but not limited to, sickle cell disease; (5) The prescription is associated with the treatment of neonatal abstinence syndrome; (6) In the prescriber's professional judgment, complying with the measure would be a detriment to the minor's health or safety; (7) The treatment is rendered in a hospital, emergency facility, ambulatory surgical facility, nursing home, pediatric respite care program, residential care facility, freestanding rehabilitation facility, or similar institutional facility, including a prescription rendered at discharge at these facilities; (8) Is ordered by a practitioner issuing a prescription for a Schedule II controlled substance to treat a hospice-certified patient; (9) Is ordered by a practitioner issuing a prescription for a Schedule II controlled substance that does not exceed a five-day supply for a patient; or (10) Is ordered by a practitioner prescribing a Schedule II controlled substance for a patient with whom the practitioner has an established relationship for the treatment of a chronic condition; however, the practitioner must review the patient's controlled substance history maintained in the PDMP at least every three months.
H.B. 3826	5/17/2018	**Tamper-resistant Prescription Pads** • Requires all prescriptions for Schedule II through V controlled substances to be written on tamper-resistant prescription pads, unless transmitted by fax, orally, or electronically. • Provides that the tamper-resistant prescription pad requirements do not apply to refill prescriptions of an original written prescription that was presented to a pharmacy before the effective date of this act. • Provides that, if a written prescription is not submitted on a tamper-resistant prescription form meeting the requirements of this section, a pharmacy may fill the prescription in full as written on an emergency basis as long as the pharmacy receives a verbal, facsimile, electronic, or compliant written prescription from the prescriber within seventy-two hours after the date on which the prescription was filled.

South Carolina Cont'd **H.B. 4600**	5/03/2018	**Distribution of Opioid Antidotes** • Provides that a community distributor acting in good faith may distribute an opioid antidote pursuant to a written prescription, standing order by a prescriber, and written joint protocol issued by the Board of Medical Examiners and the Board of Pharmacy. • Provides that the Board of Medical Examiners and the Board of Pharmacy must appoint an advisory committee to advise and assist in the development of the joint protocol for their consideration. The membership of the committee must include, but not be limited to, a representative of the Department of Health and Environmental Control, a representative of the Department of Alcohol and Other Drug Abuse Services, and health care professionals licensed in the State.
S.B. 345	7/01/2018	**Authorizations to Prescribe Schedule II Controlled Substances** •Provides that nurse practitioners, certified nurse midwives, and clinical nurse specialists may prescribe Schedule II controlled substances if the substance is authorized in the practice agreement, electronically submitted. • Provides that, for narcotic substances prescribed to hospice or palliative care patients, the prescription must be for no more than 30 days, and that, for narcotic substances prescribed to other patients, the prescription must be for no more than five days.
S.B. 918	1/01/2019	**Initial Opioid Prescriptions for Acute and Postoperative Pain** • Prohibits initial opioid prescriptions for acute pain management or postoperative pain management from exceeding a seven-day supply unless prescribed for: (1) cancer pain, (2) chronic pain, (3) hospice care, (4) palliative care, (5) major trauma, (6) major surgery, (7) the treatment of sickle cell disease, (8) treatment of neonatal abstinence syndrome, or (9) medication-assisted treatment for substance use disorder. • Provides that the measure does not regulate subsequent prescriptions. • Provides exemptions for prescriptions issued by practitioners who administer opioid prescriptions in a hospital, nursing home, hospice facility, or residential care facility. **Practitioner Prescription Report Cards** • Provides that the Department of Health and Environmental Control shall develop and maintain as part of the PDMP a system to provide prescription report cards to practitioners to inform the practitioner about certain prescribing trends. The report card must provide, at a minimum: (1) A comparison of the practitioner's number of prescriptions issued per month by therapeutic class code or by specific substances to peer averages by specialty

South Carolina Cont'd		throughout the State; (2) A comparison of the practitioner's number of milligrams prescribed per month by therapeutic class code or by specific substances to peer averages by specialty throughout the State; (3) The total number of patients receiving ninety morphine milligram equivalents (MMEs) or more a day; (4) The total number of patients receiving opioid medications for thirty days or more; (5) The total number of patients receiving opioids and benzodiazepines medications at the same time; (6) The total number of patients issued prescriptions from three or more practitioners; (7) The total number of patients filling prescriptions at three or more pharmacies; (8) The total number of patients with controlled substance prescriptions whose dispensing dates overlap; (9) The total number of patients obtaining refills on their prescriptions more than one week early; and (10) The total number of PDMP queries made by the practitioner and a ratio of the queries to the number of patients or prescriptions issued. • Provides that the report card also must provide data on the number of practitioners registered against which the comparisons of items (1) and (2) are being made and any other demographic data relating to the pool of practitioners and may include regional or nationwide prescribing comparison data that would be useful to the practitioner. Prescription report cards, data, documents, records, and any other information accessed or compiled in preparing prescription report cards, are confidential and not subject to discovery, subpoena, or introduction into evidence in any civil action, unless confidentiality is waived by the practitioner. • Provides that department shall coordinate with the Board of Medical Examiners and any other appropriate professional boards as part of the development and implementation of a prescription report card program. **PDMP Confidentiality Exceptions** • Requires prescribers to check the PDMP regarding the administration of opioid antagonists to a patient before prescribing a Schedule II controlled substance.

TENNESSEE **H.B. 901**	5/03/2018	**Opioid Prescriptions in the TennCare Program** • Requires the bureau of TennCare to promulgate rules to promote the safe and responsible coverage of opioids for TennCare members who have the TennCare pharmacy benefit. • Provides that the rules must, at a minimum, address prior authorization requirements for opioid prescriptions, as determined by the bureau, to reduce the development of opioid dependency and addiction. • Provides that, on or before January 1, 2019, the bureau shall report to both the health and welfare committee of the Senate and the health committee of the House of Representatives regarding the status of the rules.
H.B. 1831	7/01/2018	**Section 1- Commissioner Authority to Establish a Controlled Substance Database (the "Database)** Provides that the Commissioner of Health shall have the authority to promulgate rules as necessary to: (1) establish, maintain, and operate the database, (2) determine access to the database and how access is obtained, (3) control and disseminate data and information in the database, (4) control, share, and disseminate data and information in the database, and (5) establish the morphine milligram equivalent calculation for an opioid drug contained in Schedules ll-V. **Section 2- Submission of Information to the Database** Provides that each dispenser or dispenser's agent shall, regarding each controlled substance dispensed, submit to the database information (1) the ICD-10 code for any prescription that contains an ICD-10 code; provided, that this shall not be mandatory prior to January 1, 2019, for a dispenser who has not updated the dispenser's software system to enable submission of ICD-10 codes; and (2) that a value signifying opioid treatment is occurring pursuant to a medical necessity for any prescription containing the words "medical necessity." **Section 3- Mandatory Checking of the Database** • Provides that, when prescribing a controlled substance, all healthcare practitioners, unless otherwise exempted, must check the controlled substance database: (1) prior to prescribing a controlled substance to a human patient at the beginning of a new episode of treatment, (2) before the issuance of each new prescription for the controlled substance for the first ninety days of a new episode of treatment, and (3) every six months when a prescribed controlled substance remains part of the treatment thereafter. • Provides that, when dispensing a controlled substance, all healthcare practitioners, unless otherwise exempted, shall check the controlled substance database:

Tennessee Cont'd		(1) prior to dispensing a controlled substance to a human patient at that practice site, and (2) at least once every six months after the initial dispensing for the duration of the time the controlled substance is dispensed to a patient. **Section 6- Prescription Requirements** • Provides that a healthcare practitioner is prohibited from treating an opioid naive patient with more than a 3-day supply on an opioid and treating a patient with an opioid dosage that exceeds a total of a one 180 morphine milligram equivalent dose, aside from specified exemptions when a second prescription is deemed necessary. • Provides that a patient is prohibited from being treated with an opioid more frequently than every 10 days; provided, however, that if the patient has an adverse reaction to an opioid, a healthcare practitioner may treat a patient with a different opioid within a ten-day period under specified circumstances. Where the treatment provided by a healthcare practitioner is dispensing an opioid, the healthcare practitioner may treat a patient more than once within 10 days; provided, that the healthcare practitioner cannot dispense an opioid in an amount that exceeds the greater of a 5-day supply per encounter or half of the total prescribed amount. • Provides that a practitioner may treat a patient with more than a 3-day supply of an opioid if the healthcare practitioner treats the patient with no more than one prescription for an opioid per encounter and: (1) Personally conducts a thorough evaluation of the patient; (2) Documents consideration of non-opioid and nonpharmacologic pain management strategies and why the strategies failed or were not attempted; and (3) Obtains informed consent and documents the reason for treating with an opioid in the chart. • Provides that, if a healthcare practitioner treats a patient with more than a three-day supply of an opioid, the healthcare practitioner may treat the patient with no more than a 10-day supply and with a dosage that does not exceed a total of a 500 morphine milligram equivalent dose. • Provides that, in rare cases where the patient has a condition that will be treated by a procedure that is more than minimally invasive and sound medical judgment would determine the risk of adverse effects from the pain exceeds the risk of the development of a substance use disorder or overdose event, a healthcare practitioner may treat a patient with up to a 20-day supply of an opioid and with a dosage that does not exceed a total of an 850 morphine milligram equivalent dose. • Provides that, in rare cases after trial and failure of reasonable, appropriate, and available non-opioid treatments for the pain condition or documenting the contraindication, inefficacy, or intolerance of nonopioid treatments, where medical necessity and sound medical judgment would determine the risk of adverse effects from the pain exceeds the risk of the development of a substance use disorder or

Tennessee Cont'd		overdose event, a healthcare practitioner may treat a patient with up to a 30-day supply of an opioid and with a dosage that does not exceed a total of a 1,200 morphine milligram equivalent dose. The healthcare practitioner must include the phrase "medical necessity" on the prescription for any prescription issued. **Section 7- Sharing of Information with Patients** Provides that any agreement purporting to limit the ability of a pharmacist to discuss any issue related to the dispensing of a controlled substance with a patient is void and unenforceable. This includes information about the risks, effects, and characteristics of the controlled substance, what to expect when taking the controlled substance, and how the controlled substance should be used, reasonable alternatives to the prescribed controlled substance, and any applicable cost sharing for a controlled substance or any amount an individual would pay for a controlled substance if that individual were paying cash. **Section 9** Provides that Sections 1 and 6 of the Act shall terminate on July 1, 2023 and the law in effect prior to this act's effective date shall be restored.
H.B. 2002	4/02/2018	**Buprenorphine** Provides for the direct administration of buprenorphine mono or buprenorphine without the use of naloxone as a treatment for substance use disorder (SUD) pursuant to a medical order or prescription order from a physician, provided that the buprenorphine mono or buprenorphine without use of naloxone is not dispensed in a manner that would permit it to be administered away from the premises on which it is dispensed.
H.B. 2004	1/01/2019	**Reporting Opioid Abuse and Diversion** • Requires the Department of Health to accept allegations of opioid abuse or diversion and to publicize a means of reporting allegations of opioid abuse or diversion. • Requires an entity that that prescribes, dispenses, or handles opioids to provide information to employees about reporting suspected opioid abuse or diversion. The information may be provided to each employee individually in writing, documented by the employing entity, or by posting, in a conspicuous location in a non-public area regularly used by employees, a sign at least eleven inches in height and seventeen inches in width stating: "NOTICE: Please report any suspected abuse or diversion of opioids, or any other improper behavior with respect to opioids, to the Department of Health's toll-free hotline [NUMBER OF HOTLINE]."
H.B. 2348	4/19/2018	**Physician Counseling of Women of Childbearing Age** Requires a prescriber, before prescribing more than a 3-day supply of an opioid or an opioid dosage that exceeds a total of 180 morphine milligram equivalent dose to a woman of childbearing age, to: (1) advise the patient about the risks associated with opioid use during pregnancy, (2) counsel the patient on appropriate and effective forms of birth control, and

Tennessee Cont'd		(3) offer information about the availability of free or reduced cost birth control to the patient.
H.B. 2510	7/01/2018	**Working Group Formation** • Requires the Commissioner of Mental Health and Substance Abuse Services to convene a working group to examine the potential impact of authorizing advance practice nurses and physician assistants in Tennessee to prescribe buprenorphine containing products for the treatment of opioid use disorder and any potentially appropriate clinical settings for any such prescribing authority. • Provides that the working group must submit a report by February 1, 2019.
S.B. 777	5/21/2018	**Opioid Prescribing Guidelines** • Requires the Commissioner of Mental Health and Substance Abuse Services (the "Commissioner") to revise rules for non-residential office-based opiate treatment facilities to be consistent with federal law and to establish: (1) Standards for determining what constitutes a high dose of the opioid employed in treatment at a nonresidential office-based opiate treatment facility; (2) Protocols for initiating or switching a patient at a nonresidential office-based treatment facility to a high dose of the opioids employed in treatment; and (3) Protocols for initiating periodic prescriber-initiated and led discussions with patients regarding patient readiness to taper down or taper off the opioids employed in treatment. • Requires periodic review of these rules. **Non-Residential Buprenorphine Treatment Guidelines** • Requires the Commissioner to revise the nonresidential buprenorphine treatment guidelines to be consistent with state and federal law and establish protocols for initiating periodic prescriber initiated and led discussions with patients regarding patient readiness to taper down or taper off opioids employed in treatment. • Prohibits the dispensing of buprenorphine products by any person or entity unless the dispensing is done by a non-residential office-based opiate treatment facility, a non-residential substitution-based treatment center, a pharmacy, or a hospital. • Requires the Department of Health to identify the top 20 prescribers who have unique Drug Enforcement Administration numbers of buprenorphine products in the previous calendar year and require these prescribers to submit an explanation demonstrating these prescriptions were medically necessary. **PDMP** • Requires that practitioners submit the dispensing of buprenorphine products to the PDMP, except when reporting the dispensing of buprenorphine products would conflict with 42 CFR Part 2. • Requires the Department of Mental Health and Substance Abuse Services to promulgate rules to establish requirements for approval of dispensing of buprenorphine products at a nonresidential office-based opiate treatment facility. These rules must include a requirement that a provider who dispenses

Tennessee Cont'd		buprenorphine products at a nonresidential office-based opiate treatment facility must report the fact that the provider dispenses buprenorphine products to the provider's licensing board, check the controlled substance database prior to dispensing, and enter the amounts dispensed into the controlled substance database, to the extent permitted by 42 CFR Part 2. **Reporting Requirement** • Requires pharmacies and distributors to report to the Department of Health the quantities of buprenorphine that the pharmacy or distributor delivers to nonresidential office-based opiate treatment facilities in this state.
S.B. 2025	5/21/2018	**Section 1- Partially Filled Prescriptions** • **Subsection B(1)-** Provides that a prescription for a controlled substance may be partially filled if the partial fill is requested by the patient or the practitioner who wrote the prescription and the total quantity dispensed through partial fills does not exceed the total quantity prescribed for the original prescription. • **Subsection B(2)-** Provides that, if a partial fill is made, the measure requires the pharmacist to retain the original prescription at the pharmacy where the prescription was first presented and the partial fill dispensed. • **Subsection D-** Requires that a person who presents a prescription for a partial fill for an opioid must be required to pay the prorated portion of cost sharing and copayments and authorizes a pharmacist or pharmacy to charge a dispensing fee to cover the actual supply and labor costs associated with the dispensing of the original prescription of an opioid or other controlled substance and each partial fill associated with the original prescription. • **Subsection E(1)(2)-** Requires that a person who presents a prescription for a partial fill for a non-opioid controlled substance must be required to pay the prorated portion of cost sharing and copayments and authorizes a pharmacist or pharmacy to charge a dispensing fee to cover the actual supply and labor costs associated with the dispensing of the original prescription of an opioid or other controlled substance and each partial fill associated with the original prescription. • **Subsection E(3)(4)-** Provides that any cost sharing, copayment, dispensing fee, or any portion thereof, made to a pharmacist or pharmacy for the dispensing of a partial fill will not be considered an overpayment and that a health insurance issuer or pharmacy benefits manager is prohibited from utilizing partial fills to reduce payments to a pharmacist or pharmacy for dispensing multiple partial fills. **Section 1- Effectives Dates** • Provides that Subsection (d) in Section 1 shall take effect January 1, 2019, the public welfare requiring it. Subsection (e) in Section 1 shall take effect July 1,2019, the public welfare requiring it. • Provides that all other provisions of the act shall take effect upon becoming law, the public welfare requiring it.

Utah **H.B. 399**	5/07/2018	**Opiate Abuse Prevention Pamphlet** • Requires the Department of Health (DOH) to develop a pamphlet with information about opiates regarding risks of dependency and addiction, methods for storage and disposal, alternative options for pain management, benefits of and ways to obtain naloxone, and resources if the patient believes that he or she has a substance abuse disorder. The pamphlet must be evaluated and revised periodically, written in plain language, and available in English and other languages. **Opiate Warning Label** • Requires a pharmacist who is dispensing or selling a Schedule II or Schedule III controlled substance that is an opiate to affix a warning label to the substance container or lid that states "Caution: Risk of overdose or addiction," and, if available, display at the point of sale the information pamphlet developed by the DOH.
Vermont **S.B. 225**	7/01/2018	**Access to the Vermont Prescription Monitoring System** • Requires the Commissioner of Vermont Health Access (the "Commissioner") to develop pilot programs in which one or more health insurers contribute funding to providers who are not affiliated with an authorized treatment program, but who meet the federal requirements for use of controlled substances in the treatment of opioid addiction, in order to support the costs of funding licensed alcohol and drug counselors and other medical professionals who support this work. • Requires that the Commissioner collaborate with one or more health insurers in developing the pilot program. • Requires that the pilot program: (1) Aligns with current Blueprint funding or other payment models developed in consultation with stakeholders for opioid treatment programs and other providers who are not affiliated with an authorized treatment program but who meet federal requirements; (2) Aligns with potential integration of Medicare funding into opioid treatment programs and other providers who are not affiliated with an authorized treatment program but who meet federal requirements; and (3) Is designed to allow integration into accountable care organization funding. • Requires the Commissioner to complete a report by January 15, 2019.
VIRGINIA **H.B. 322**	7/01/2018	**Possession and Administration of Naloxone** Provides that probation officers, parole officers, and corrections officers may possess and administer naloxone pursuant to a standing order by a prescriber or the Commissioner of Health.
  H.B. 842	3/02/2018	**Possession or Distribution of Controlled Paraphernalia; Hypodermic Needles and Syringes; Naloxone.** Provides that the laws prohibiting the possession of drug paraphernalia do not apply to: (1) a person who dispenses naloxone and who, in conjunction with such dispensing of naloxone, dispenses or distributes hypodermic needles and syringes

Virginia Cont'd		for injecting such naloxone or (2) a person who possesses naloxone, hypodermic needles, and syringes for injecting such naloxone.
H.B. 1532	7/01/2018	**Public School Health Education and Prescription Drugs** Provides that health curriculum in public schools may include an age-appropriate program of instruction on the safe use of prescription drugs and the risks of abuse of prescription drugs that is consistent with curriculum guidelines developed and approved by the State Board of Health.
H.B. 1556 (Identical to S.B. 832)	7/01/2018	**PDMP** Provides that Schedule V controlled substances that require a prescription and naloxone must both be reported to the PDMP.
S.B. 632	7/01/2018	**Controlled Substances and Limits on Prescriptions Containing Opioids** Eliminates the surgical or invasive procedure treatment exception to the requirement that a prescriber request certain information from the PDMP when initiating a new course of treatment for a patient to last more than seven days.
Washington **S.B. 6399**	6/06/2018	**Telemedicine Payment Parity** •Requires the Collaborative for the Advancement of Telemedicine to review the concept of telemedicine payment parity and develop recommendations on reimbursing for telemedicine at the same rate as if the service were provided in person by the provider for 5 conditions, including opioid dependence and chronic pain. • Provides that the Collaborative should develop recommendations and parameters for a telemedicine payment parity pilot program to evaluate the benefits of telemedicine using a recommended reimbursement methodology for reimbursing services. • Provides that the Collaborative should design a training program to teach health care professionals about telemedicine and proper billing methodologies.
WEST VIRGINIA **H.B. 4079**	3/09/2018	**Authorizations for Boards to Promulgate Rules Related to PDMP, Opioid Antagonists, and Continuing Education on Drug Diversion.** Authorizes the Board of Pharmacy to approve a legislative rule related to registration and control of the dispensing of controlled substances within the state by licensed practitioners.
S.B. 165	2/28/2018	**Authorization to Promulgate Rules Related to Substance Abuse Disorder Treatment Facilities and Opioid Overdose Research** • Authorizes the Department of Health and Human Services to promulgate a legislative rule relating to the development of methodologies to examine the needs for substance abuse disorder treatment facilities within the state. • Authorizes the Department of Health and Human Resources to promulgate a legislative rule relating to collection and exchange of data related to overdoses
S.B. 272	5/05/2018	**Required Reporting** • Requiring pharmacies, health care providers, medical examiners, law-enforcement agencies, emergency response providers, and hospital emergency

West Virginia Cont'd		rooms and departments operating in the state to report to the Office of Drug Control Policy: (1) An emergency medical or law-enforcement response to a suspected, reported, or confirmed overdose; (2) Medical treatment for an overdose; (3) The dispension or provision of an opioid antagonist; and (4) Death attributed to overdose or "drug poisoning." **Community Pilot Project** • Requiring that the Director of the Office of Drug Control Policy establish a "Community Overdose Response Demonstration Pilot Project" to develop model government programs and to promote public health and general welfare through a comprehensive community-based response to drug overdoses in West Virginia Communities that experience a high frequency of drug overdoses compared to national averages. • Provides that the Pilot Project must create outreach programs to educate concerned family and community members on how to: (1) recognize and immediately respond to an opioid overdose with life-saving measures such as the administration of Naloxone, (2) create quick response teams to conduct in-home visits within one week of an overdose, and (3) provide linkage to treatment and services for rehabilitation. **Access to Opioid Antagonists** • Requires that state and local governments that employ initial responders must: (1) Provide opioid antagonist rescue kits to their initial responders; (2) Require initial responders to successfully complete opioid antagonist kit training; and (3) Require initial responders to carry the opioid antagonist rescue kits in accordance with agency procedures. • Provides that a state health officer may prescribe on a statewide basis an opioid antagonist to eligible recipients by one or more standing orders. • Provides that a standing order must specify at a minimum: (1) The opioid antagonist formulations and means of administration approved for dispensing; (2) The eligible recipients for dispensing the opioid antagonist; (3) Any training required for an eligible recipient to whom the opioid antagonist is dispensed; (4) The circumstances under which an eligible recipient may distribute or administer the opioid antagonist; and (5) The timeline for renewing and updating the standing order.

West Virginia Cont'd		**Voluntary Non-Opioid Advanced Directive** • Requiring that the Office of Drug Control Policy create a voluntary non-opioid advance directive form that will indicate to a health care practitioner that an individual may not be administered or offered a prescription or medication order for an opioid. • Requires that the form be available on the Office of Drug Control Policy's website. • Provides that this form, once completed, be filed in the individual's medical record in either a healthcare facility or a private office of a practitioner, or both. • Provides that an individual may revoke the non-opioid advanced directive form for any reason by written or oral means. **Opioid Prescription Notifications** • Requires a practitioner to consult with the patient regarding (1) the quantity of an opioid, (2) the patient's option to fill the prescription in a lesser quantity, and (3) the risks associated with opioid use before issuing a prescription for an opioid. **Opioid Prescription Limitations** • Requires that a health care practitioner may not issue an initial prescription for an opioid to an adult patient seeking treatment in an emergency room or an outpatient facility setting for outpatient use for more than a four-day supply. • Requires that a health care practitioner may not issue an initial prescription for an opioid to a minor for more than a three-day supply and must discuss both the risks associated with opioid use and the reasons why the prescription is necessary to the parent or guardian of the minor before prescribing the opioid. • Provides that dentists and optometrists may not prescribe more than a 3-day supply of opioids under any circumstances. • Requires, in all other circumstances that (1) a practitioner may not issue an initial opioid prescription for more than a seven-day supply and (2) the prescription must be for the lowest effective dose which the practitioner believes would be the best course of treatment for the patient. • Provides that, before issuing an initial opioid prescription, a practitioner must: (1) Take a thorough medical history of the patient, including medication history; (2) Conduct a physical examination of the patient; (3) Develop a treatment plan with attention to the cause of the patient's pain; and (4) Access relevant prescription monitoring information under the Controlled Substances Monitoring Program Database. **Standards for Schedule II Controlled Substance Prescriptions** • Provides that no Schedule II controlled substance may be prescribed by a practitioner for greater than a 30-day supply. However, two additional prescriptions, each for a 30-day period, may be prescribed if the practitioner accesses the Controlled Substance Monitoring Program Database.
S.B. 273	5/07/2018	

West Virginia Cont'd		• Provides an exception for cancer patients, hospice patients, palliative care patients, long-term care facility patients, or patients receiving medications prescribed for the treatment of substance abuse or opioid dependence. • Requires that a patient and prescribing provider enter into a narcotics contract whenever the patient requires a Schedule II controlled substance for greater than a seven-day period. This contract shall outline how and where the patient will get his or her prescriptions and when the prescribing practitioner may terminate the patient's Schedule II drug prescriptions and/ or the provider-patient relationship. **Standards for Opioid Prescription Renewals and Ongoing Treatment** • Provides that a provider may only renew a prescription if: (1) The subsequent prescription is more than 6 days after the initial prescription; (2) The provider determines that the prescription is necessary; (3) The practitioner documents the patient's need for the renewal; and (4) The patient does not present an undue risk of abuse, addiction, or diversion. • Requires that a provider, after issuing a third prescription for a prescription opioid, must consider treatment alternatives, refer the patient to a pain clinic or specialist, and discuss risks of continued opioid treatment with patient before providing additional opioid treatments. • Requires that the provider also document risks, rationales, and alternative treatments in the patient's medical record before providing an opioid prescription renewal. • Requires that, at the issuance of the third prescription for an opiate, the provider refer the patient to a chronic pain clinic. • Provides that, if the patient continues to require opiate treatment after the referral, the provider must: (1) Review the patient's condition every 90 days; (2) Assess the patient prior to every renewal for signs of dependence; (3) Periodically make reasonable efforts to either stop or reduce opioid use; and (4) Review the Controlled Substance Monitoring Database. • Provides that these standards do not apply to an existing provider-patient relationship established before January 1, 2018 where there is an established and current opioid treatment plan. • Provides that a provider may prescribe an initial 7-day supply of an opioid to a post-surgery patient immediately following a surgery procedure. **PDMP** • Requires a provider who acquires a patient after January 1, 2018, who is currently being prescribed an opioid to access the PDMP. • Requires a provider to access the PDMP before prescribing an opioid. • Requires state licensing boards to identify abnormal prescribers of controlled substances and notify providers if they are identified as a potentially abnormal prescriber.

West Virginia Cont'd		• Provides that, on a second consecutive quarterly identification as an abnormal prescriber, the measure requires the boards to investigate the prescriber's prescribing practices. • Requires the following prescribers to report to the PDMP: (1) A medical services provider dispensing a Schedule II, III, IV, or V controlled substance or opioid antagonist; (2) A pharmacist or pharmacy located in the state, hospital or other health care facility for outpatient use, or a pharmacy or pharmacist located outside the state for delivery to a person in the state filling a prescription for a Schedule II, III, IV, or V controlled substance or opioid antagonist; and (3) A pharmacist or pharmacy selling an opioid antagonist. • Requires any individual with prescriptive or dispensing authority, upon initially prescribing or dispensing any Schedule II controlled substance, opioid, or benzodiazepine to a patient who does not have a terminal illness and least annually after, to access the PDMP.
Wyoming **S.F. 78**	3/16/2018	**Creation of an Opioid Task Force** •Provides for the creation of an opioid addiction task force of fourteen members to consider: (1) PDMPs and electronic prescribing systems; (2) Grants relating to substance abuse education, prevention, treatment, and recovery made available by federal and state government; (3) The availability and use of naloxone and other prescription drugs to counteract opioid overdoses; (4) The quality and availability of treatment for addiction and overdoses in Wyoming; (5) Strategies to reduce the administration of opioids including the promotion of alternative treatments, methods, and possible limitations on the quantity of opioids that a healthcare provider is authorized to prescribe; (6) Authorized uses of opioids and any needed exceptions for authorized uses; (7) Strategies for community engagement; (8) Strategies for the state of Wyoming to approach to undertake a unified approach to opioid education, prevent, and treatment; (9) Prescriber and dispenser education relating to opioids; (10) Necessary law enforcement strategies; (11) Relevant findings developed by the advisory council on palliative care; (12) Any other matter relating to opioids determined to be relevant by the task force. • Provides that the task force will include: (1) Two members of the Senate; (2) Two members of the House of Representatives; (3) One member who is the Director of the Department of Health or his designee; (4) One member who is a mental health care provider that specializes in mental health and substance abuse;

Wyoming Cont'd		(5) One member who is a law enforcement officer specializing in drug enforcement; (6) Two members of the public; (7) One of whom shall by a practicing physician in the state of Wyoming; (8) One member from the Attorney General's office; (9) One member who is a practicing pharmacist; (10) One member who is a Board of Pharmacy member that is familiar with the prescription drug monitoring program; (11) One member who is Chairman of the Advisory Council on Palliative Care or his designee; and (12) One member who is engaged in the treatment of chronic pain.