OKLAHOMA SENATE BILL 1446 – BEST PRACTICE FOR AN ACT REGULATING OF OPIOID DRUGS

Effective November 1, 2018

Continuing Medical Education: Physicians are required to complete one (1) hour of CME in pain management per year.

OBNDD: May provide licensing boards with unsolicited referrals of physicians if a patient receives one (1) or more prescriptions in quantities or frequency inconsistent with accepted standards of safe practice. 63 O.S. §2-309D(M)

Prescription Monitoring Program – PMP: Failure to check PMP is grounds for disciplinary action by licensing board. PMP must be checked at the initial prescription and then at least every 180 days. 63 O.S. §2-309D(G)(2)(a), 63 O.S. §2-309D(G)(4)

Acute Pain Prescription Limits: For acute pain, practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding seven (7) day supply. Prescription shall be for the lowest effective dose of immediate-release opioid drug. 63 O.S. §2-309I (A). Following the initial seven (7) days, a second subsequent 7-day prescription may be issued, for an immediate-release opioid drug in Schedule II in a quantity not to exceed seven (7) days if: (i) The subsequent prescription is due to a major surgical procedure and/or "confined to home" status as defined in 42 U.S.C. 1395n(a); (ii) The practitioner provides the subsequent prescription on the same day as the initial prescription; (iii) The practitioner provides written instruction on the subsequent prescription indicating the earliest date on which the prescription may be filled (i.e. "do not fill until" date); and (iv) The subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription. 475:30-1-4 If the if the aforementioned conditions are NOT met, a second 7-day prescription may be issued, after consultation* (in person or by telephone), if practitioner determines prescription is necessary and appropriate, documents the rationale for the prescription and determines and documents it does not present undue risk of abuse, addiction or diversion. * For best practice, the 7-day consultation should be performed by the physician; however, it does not appear to be required. If a medication needs to be changed due to allergy, ineffective dose or other medical condition, document thoroughly in the record the need and rationale for change.

Chronic Pain Prescriptions: If continuing treatment for three months or more, practitioner shall: (1) review every three months the course of treatment, any new information regarding etiology of pain and progress toward treatment objectives; (2) assess patient prior to every renewal to determine if patient is experiencing dependency and document assessment; (3) periodically make reasonable efforts, unless clinically contraindicated to stop, decrease dosage or try other treatment modalities; (4) review PMP; (5) monitor compliance with pain management agreement. 63 O.S. §2-309I(F). *Assessment may be performed by a mid-level PA/APRN. Face-to-face assessment is recommended but not required.

Morphine Milligram Equivalent - MME: the law references 100 MME as a safe patient threshold. If you choose to prescribe greater than 100 MME, document the rationale thoroughly.

Prior to Initial Prescription for Pain a Prescription for a Schedule II or any Opioid: Practitioner shall: (1) take and document a thorough medical history; (2) conduct and document a physical exam; (3) develop a treatment plan; (4) access the PMP; (5) limit supply to no more than seven days; (6) if under 18, enter into a Patient-Provider Agreement [Pain Agreement] with patient. 63 O.S. §2-309I(B)

Informed Consent & Risk Discussions: Prior to initial prescription and again prior to third prescription, practitioner must discuss risks including: (1) risks of addiction and overdose, dangers of taking opioids with alcohol, benzodiazepines and other CNS depressants; (2) reason the prescription is necessary; (3) alternative treatment available; (4) risks can include fatal respiratory depression. Practitioner shall document the discussion in the medical record. 63 O.S. §2-309I(D)

Patient-Provider Agreement [Pain Management Agreement]: Practitioner shall enter into a Patient-Provider Agreement [Pain Management Agreement] with a patient: (1) at the time of the third prescription for opioid or Schedule II drug; (2) If patient requires more than three months of pain management; (3) if patient is prescribed benzodiazepines and opioids together; (4) if patient requires more than 100 mg morphine milligram equivalents (MME); (5) If patient is pregnant; or (6) with the parent or guardian if the patient is a minor. 63 O.S. §2-309I(I); 63 O.S. §2-309I(B)(6),(7)

Excluded: The requirements of SB 1446 do not apply to patients receiving active treatment of cancer, hospice, palliative care, or residents of a long-term care facility. 63 O.S. §2-309I(G)

Written Policy: Any provider authorized to prescribe opioids shall adopt and maintain a written policy regarding the same. 63 O.S. §2-309I (I)

Disclaimer: This Best Practices document is subject to change without notice and is made available to facilitate understanding of SB1446. This is not intended to be an official interpretation or commentary on the intent of the law. Revision 10/25/2018

Oklahoma State Board of Osteopathic Examiners

OSMA Oklahoma State Medical Association

OHA Oklahoma Hospital Association

Oklahoma Academy of Family Physicians — Strong Medicine for Oklahoma

Pain Management of Tulsa

OkPMA Oklahoma Podiatric Medical Association