STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

HOUSE BILL 1013 By: Talley

AS INTRODUCED

An Act relating to public health; amending Section 5, Chapter 175, O.S.L. 2018, as last amended by Section 19, Chapter 428, O.S.L. 2019 (63 O.S. Supp. 2020, Section 2-309I), which relates to prescription limits and rules for opioid drugs; clarifying construction of the Anti-Drug Diversion Act; defining the standard of care; protecting practitioners who prescribe in good faith; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY Section 5, Chapter 175, O.S.L. 2018, as last amended by Section 19, Chapter 428, O.S.L. 2019 (63 O.S. Supp. 2020, Section 2-309I), is amended to read as follows:

Section 2-309I. A. A practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a seven-day supply for treatment of acute pain. Any opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.

B. Prior to issuing an initial prescription for an opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

1. Take and document the results of a thorough medical history, including the experience of the patient with nonopioid medication and nonpharmacological pain-management approaches and substance abuse history;

2. Conduct, as appropriate, and document the results of a physical examination;

3. Develop a treatment plan with particular attention focused on determining the cause of pain of the patient;

4. Access relevant prescription monitoring information from the central repository pursuant to Section 2-309D of this title;

5. Limit the supply of any opioid drug prescribed for acute pain to a duration of no more than seven (7) days as determined by the directed dosage and frequency of dosage; provided, however, upon issuing an initial prescription for acute pain pursuant to this section, the practitioner may issue one (1) subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:

a. the subsequent prescription is due to a major surgical procedure or "confined to home" status as defined in 42 U.S.C., Section 1395n(a),

b. the practitioner provides the subsequent prescription on the same day as the initial prescription,

c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and

d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription;

6. In the case of a patient under the age of eighteen (18) years old, enter into a patient-provider agreement with a parent or guardian of the patient; and

7. In the case of a patient who is a pregnant woman, enter into a patient-provider agreement with the patient.

C. No less than seven (7) days after issuing the initial prescription pursuant to subsection A of this section, the practitioner, after consultation with the patient, may issue a subsequent prescription for the drug to the patient in a quantity not to exceed seven (7) days, provided that:

1. The subsequent prescription would not be deemed an initial prescription under this section;

2. The practitioner determines the prescription is necessary and appropriate to the treatment needs of the patient and documents the rationale for the issuance of the subsequent prescription; and

3. The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

D. Prior to issuing the initial prescription of an opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient or the parent or guardian of the patient if the patient is under eighteen (18) years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, 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.

The practitioner shall include a note in the medical record of the patient that the patient or the parent or guardian of the

patient, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The applicable state licensing board of the practitioner shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

E. At the time of the issuance of the third prescription for an opioid drug, the practitioner shall enter into a patient-provider agreement with the patient.

F. When an opioid drug is continuously prescribed for three (3) months or more for chronic pain, the practitioner shall:

1. Review, at a minimum of every three (3) months, the course of treatment, any new information about the etiology of the pain, and the progress of the patient toward treatment objectives and document the results of that review;

2. In the first year of the patient-provider agreement, assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with an opioid use disorder and document the results of that assessment. Following one (1) year of compliance with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months;

3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an

effort to reduce the potential for abuse or the development of an opioid use disorder as defined by the American Psychiatric Association and document with specificity the efforts undertaken;

4. Review the central repository information in accordance with Section 2-309D of this title; and

5. Monitor compliance with the patient-provider agreement and any recommendations that the patient seek a referral.

G. 1. Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner.

2. Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner.

H. This section shall not apply to a prescription for a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long-term care facility, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

I. Every policy, contract or plan delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the Insurance Commissioner, and every contract purchased by the Employees Group Insurance Division of the Office of Management and Enterprise Services, on or after November 1, 2018,

that provides coverage for prescription drugs subject to a copayment, coinsurance or deductible shall charge a copayment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

1. Proportional between the cost sharing for a thirty-day supply and the amount of drugs the patient was prescribed; or

2. Equivalent to the cost sharing for a full thirty-day supply of the drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the thirty-day supply.

J. Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing practitioner and qualifying opioid therapy patient. For the purposes of this section, "qualifying opioid therapy patient" means:

1. A patient requiring opioid treatment for more than three (3) months;

2. A patient who is prescribed benzodiazepines and opioids together for more than one twenty-four-hour period; or

3. A patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses.

K. Nothing in the Anti-Drug Diversion Act shall be construed to require a practitioner to limit or forcibly taper a stable long-term

opioid therapy patient. The standard of care requires effective and individualized treatment for each patient without limits or thresholds on dose or quantity.

L. When a practitioner thoroughly assesses and documents his or her findings as required by this section and prescribes in good faith using his or her clinical expertise, neither an individual patient's nor practitioner's practice's average prescribed doses or quantities alone shall be used as the basis to initiate an investigation or disciplinary action, or to pursue civil liability or criminal penalties.

SECTION 2. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

58-1-6540 AB 12/11/20