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EMERGENCY ADOPTIONS
LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

Adopted Emergency Amendments and Concurrent Proposed Amendments: N.J.A.C. 13:35-2A.14, 2B.12, and 7.6

Limitations on Prescribing, Administering, or Dispensing of Controlled Dangerous Substances, and Special Requirements for Management of Acute and Chronic Pain: Physicians, Podiatrists, Physician Assistants, and Certified Nurse Midwives

Emergency Amendments Adopted and Concurrent Proposed Amendments Authorized: March 1, 2017, by Christopher S. Porrino, Attorney General, State of New Jersey and by George J. Scott, D.P.M., D.O., President, State Board of Medical Examiners.

Filed: March 1, 2017, as R.2017 d.051.

Gubernatorial Approval: March 1, 2017.

Authority: N.J.S.A. 45:1-17.b and 45:9-2.

Calendar Reference: See the notice introduction below for explanation of exception to calendar requirement.

Concurrent Proposal Number: PRN 2017-046.

Emergency Amendments Effective Date: March 1, 2017.

Emergency Amendments Expiration Date: April 30, 2017.

Submit comments by April 19, 2017, to:

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This is an emergency adoption and concurrent proposal of amendments to N.J.A.C. 13:35-2A.14, 2B.12, and 7.6 concerning limitations on prescribing, administering, or dispensing of controlled dangerous substances, with specific limitations for opioid drugs, and establishing special requirements for the management of acute and chronic pain. These limitations and requirements apply to physicians, podiatrists, physician assistants, and certified nurse midwives.

On January 18, 2017, the Attorney General advised the State Board of Medical Examiners (Board) of his intention to amend existing Board rules, pursuant to the Attorney General's rulemaking authority in N.J.S.A. 45:1-17.b, because of the imminent peril created by the

epidemic of prescription opioid and heroin abuse in New Jersey. In response to this advice, the Attorney General and the Board are adopting emergency amendments, and concurrently proposing the same, establishing limitations on prescribing of controlled dangerous substances, pursuant to their respective rulemaking authority in N.J.S.A. 45:1-17.b and 45:9-2.

On February 15, 2017, P.L. 2017, c. 28, was signed into law, imposing certain restrictions on how opioids and other Schedule II controlled dangerous substances may be prescribed, including, in cases of acute pain, prohibiting a practitioner from issuing an initial prescription for an opioid drug in a quantity exceeding a five-day supply, and requiring the prescription to be for the lowest effective dose of an immediate-releasing opioid drug. However, because P.L. 2017, c. 28, does not become effective until May 16, 2017, the Attorney General has determined that this rulemaking is necessary because the State of New Jersey is confronting a staggering public health crisis brought about by prescription opioid and heroin abuse. One reason for the public health emergency is the prevalence of opioid prescribing. The Attorney General believes that the adoption of these amendments on an emergency basis will substantially reduce the risk of addiction and the accumulation of opioids in the household medicine cabinets across the State. Failure to adhere to the standards set forth in this rulemaking will provide a basis to seek emergent action to suspend or limit licenses pending a plenary hearing, pursuant to N.J.S.A. 45:1-22, and/or for disciplinary sanctions pursuant to N.J.S.A. 45:1-21.

These amendments have been adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-6.5(b)). The provisions of this emergency adoption are proposed concurrently as permanent (non-emergency) pursuant to the rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The concurrently adopted amendments will be effective upon acceptance for filing by the Office of Administrative Law (N.J.A.C. 1:30-6.5(d)), if filed on or prior to the expiration date of the emergency amendments.

Because these are emergency amendments published in accordance with N.J.S.A. 52:14B-4(c), this rulemaking is excepted from the rulemaking calendar requirement under N.J.A.C. 1:30-3.3(a)3.

The agency emergency adoption and concurrent proposal follows:

Summary

The abuse of prescription drugs has reached epidemic proportions nationwide. Moreover, according to the National Institute on Drug Abuse (NIDA), research now suggests that abuse of prescription pain relievers may actually open the door to heroin use. Most alarmingly, the 2016 American Society of Addiction Medicine (ASAM) Facts and Figures notes that "four in five new heroin users started out misusing prescription painkillers."

New Jersey is not immune. Prescription opioid and heroin abuse is growing at an alarming rate among the citizens of New Jersey. A 2014 report from the Governor's Council on Alcoholism and Drug Abuse noted a startling rise in the rate of patient admissions to drug addiction treatment centers of more than 200 percent over the past five years, and nearly 700 percent over the past decade. Heroin and opioid admissions accounted for 49 percent of all substance abuse admissions in New Jersey in 2014, the highest in at least a decade, according to data from the State Division of Mental Health and Addiction Services. There were 781 heroin-related overdose deaths in New Jersey in 2014, according to data by the

State Division of Criminal Justice. That is more than twice as many as in 2010. And, as observed in the July 2013 report from the State of New Jersey Commission of Investigation, staggering amounts of legitimate medicines manufactured by major pharmaceutical companies and intended for those needing relief from the pain of disease and injury have been diverted into criminal enterprises founded on drug abuse and addiction. New Jersey's opioid and heroin epidemic, like those facing many states across the nation, shows no signs of abating. In 2014, there were 1,306 drug-related deaths; in 2015, that number increased to 1,587. Naloxone administrations in 2014 numbered 5,174. In 2015, that number rose to 7,222. With the expansion of programs for first responders, the Attorney General fully expects that number to be exceeded this year. According to the New Jersey Division of Mental Health and Addiction Services, in 2014, there were 28,653 patients in treatment for opioids; by 2015 that number had risen to 35,529.

One reason for the public health emergency we face today is the prevalence of opioid prescribing. The March 2016 Guideline for Prescribing Opioids for Chronic Pain, issued by the Centers for Disease Control and Prevention (CDC), noted these alarming findings: 1) nationally, an estimated 20 percent of patients presenting to physician offices with non-cancer pain symptoms, pain-related diagnoses, or acute and chronic pain reportedly receive an opioid prescription; 2) in 2013, an estimated 1.9 million persons abused or were dependent on opioid pain medication; 3) having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder; 4) in the past decade, death rates associated with opioid pain medication have increased markedly; 5) a long-term (13 years) study concluded that, of the patients receiving opioids for chronic non-cancer pain, one in 550 patients died from an opioid-related overdose at a median of 2.6 years from their first opioid prescription, and one in 32 patients who escalated to opioid dosages of more than 200 morphine milligram equivalents died from an opioid-related overdose; and 6) most fatal overdoses could be identified retrospectively on the basis of two pieces of information, multiple prescribers and high total daily dosages.

[page=553] Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from an overdose related to opioid pain medication in the United States. Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths. The Drug Abuse Warning Network estimated that more than 420,000 emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011, the most recent year for which data are available. In 2013, on the basis of DSM-IV diagnosis criteria, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication. Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder, highlighting the value of guidance on safer prescribing practices for clinicians.

The prevalence of opioid prescribing for pediatric populations is of particular concern, with a large number of adolescents commonly prescribed opioid pain medications for conditions such as headache and sports injuries. An estimated 20 percent of adolescents with currently prescribed opioid medications report using them intentionally to get high or increase the effects of alcohol or other drugs. Research suggests that misuse of opioid pain medications in adolescence strongly predicts later onset of heroin use.

As set forth in the CDC Guideline, "the clinical evidence review found that opioid use for acute pain is associated with long-term opioid use, and that a greater amount of early opioid exposure is associated with greater risk for long-term use." In addition, "experts noted that more than a few days of exposure to opioids significantly increases hazards, that each day of unnecessary opioid use increases likelihood of physical dependence without adding benefit, and that prescriptions with fewer days' supply will minimize the number of

pills available for unintentional or intentional diversion." As noted in the CDC Guideline, experts agree that when opioids are needed for acute pain, prescribers "should prescribe opioids at the lowest effective dose and for no longer than the expected duration of pain severe enough to require opioids to minimize unintentional initiation of long-term opioid use." "Some experts thought that because some types of acute pain might require more than 3 days of opioid treatment, it would be appropriate to recommend a range of three to five days or three to seven days when opioids are needed. Some experts thought that a range including 7 days was too long given the expected course of severe acute pain for most acute pain syndromes seen in primary care." The CDC recommends that prescribers "should not prescribe additional opioids to patients 'just in case' pain continues longer than expected," but rather "should re-evaluate the subset of patients who experience severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly."

The amendments set forth steps a practitioner must take when prescribing, dispensing, or administering a controlled dangerous substance. The amendments establish special requirements when prescribing a Schedule II controlled dangerous substance for pain or any opioid drug; for the treatment of chronic pain; and the prescribing of opioid drugs for the treatment of acute pain. The Attorney General believes that these amendments will substantially reduce the risk of addiction and the accumulation of opioids in household medicine cabinets across the State, stockpiles that are ripe for diversion.

Amendments to N.J.A.C. 13:35-2A.14 and 2B.12 will require certified nurse midwives and physician assistants, respectively, to comply with all of the requirements and limitations on prescribing controlled dangerous substances set forth in N.J.A.C. 13:35-7.6 and the controlled dangerous substance rules at N.J.A.C. 13:45H.

Existing N.J.A.C. 13:35-7.6 sets forth limitations on prescribing, administering, or dispensing of controlled substances, and special exceptions for the management of pain. Amendments to the heading of N.J.A.C. 13:35-7.6 delete "special exceptions" for management of pain and, instead, reflect that the rule will concern special requirements for the management of acute and chronic pain. Existing subsection (a) is proposed to be deleted and its provisions amended and relocated to proposed new subsection (b). Proposed new subsection (a) sets forth the definitions for the section. Definitions are provided for the terms "acute pain," "chronic pain," "initial prescription," "palliative care," and "practitioner." The term "chronic pain" is consistent with the definition as found in the prescription monitoring program (PMP) rules at N.J.A.C. 13:45A-35. The term "acute pain" differs from that found in the PMP rules by specifying that it is pain that the practitioner reasonably expects to last only a short period of time, and excludes chronic pain, pain being treated as part of cancer care, hospice or other end of life care, and pain being treated as part of palliative care. "Palliative care" is defined as care provided to an individual suffering from an incurable progressive illness that is expected to end in death, which is designed to decrease the severity of pain, suffering, and other distressing symptoms, and the expected outcome of which is to enable the individual to experience an improved quality of life. This definition is consistent with the definition of "palliative care" under Department of Human Services' rules concerning decision-making for the terminally ill, set forth at N.J.A.C. 10:48B-2.1. "Practitioner" is defined to include physicians, podiatrists, physician assistants, and certified nurse midwives who are currently licensed, registered, or otherwise authorized to prescribe drugs in the course of professional practice, acting within the scope of practice of their professional license or certification.

Proposed new subsection (b) specifies the actions a practitioner must perform when prescribing, dispensing, or administering any controlled dangerous substances. As is

currently required in existing subsection (a), a practitioner must take a thorough medical history of the patient, which reflects the nature, frequency, and severity of any pain and the patient's history of substance use or abuse, and must conduct a physical examination. The proposed amendments require that the medical history now include the patient's experience with non-opioid medication and non-pharmacological pain management approaches. The practitioner must conduct a physical examination, appropriate to the practitioner's specialty, which includes an assessment of physical and psychological function, and an evaluation of the underlying or coexisting diseases or conditions. The proposed amendments also require the practitioner to access and consider relevant PMP information in accordance with the PMP rules at N.J.A.C. 13:45A-35. In addition, the proposed amendments require a practitioner to develop a treatment plan, which identifies the objectives by which treatment success is to be evaluated, and any further diagnostic evaluations or other treatments planned, with particular attention focused on determining the cause of the patient's pain. In addition to the current medical record requirements of including the complete name of the controlled dangerous substance, the dosage, strength, and quantity of the controlled dangerous substance, and the instructions as to frequency of use, the proposed amendments specify that the medical record must reflect the medical history, the findings on examination, any relevant PMP data, and the treatment plan.

Recodified subsection (c) is proposed to be amended to refer to the prescribing limitations for opioids set forth in proposed subsection (g). In addition, the reference to a "120 dosage unit or a 30-day supply, whichever is less," is proposed to be replaced with "a quantity not to exceed a 30-day supply, which shall be at the lowest effective dose as determined by the directed dosage and frequency of dosage." The lead-in text of existing subsection (c) and paragraph (c)1 are proposed to be deleted. Existing paragraphs (c)2 and 3, concerning the prescribed use of an implantable infusion pump and the multiple prescriptions authorizing a patient to receive a total of up to a 90-day supply for a Schedule II controlled dangerous substance are proposed for recodification as paragraphs (c)1 and 2.

Proposed new subsection (d) provides that, prior to issuing the first prescription for a Schedule II controlled dangerous substance for pain or any opioid drug, and then again prior to issuing the third prescription, the practitioner must discuss with the patient the reasons why the medication is being prescribed, the possible alternative treatments, and the risks associated with the medication. With respect to opioid drugs, the discussion must also include the risks of addiction, physical or psychological dependence, and overdose associated with opioid drugs, the danger of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants, and the requirements for proper storage and disposal. The **Division of Consumer Affairs** will make guidance materials available on its website that may be used by practitioners to help facilitate the required discussion. The practitioner is required to include a note in the patient record that this discussion took place. The rule also provides that when the patient is under 18 years of [page=554] age and is not an emancipated minor, the discussion is with, and the written acknowledgement is from, the patient's parent or guardian. With respect to the treatment of minors, the rule provides, consistent with P.L. 2017, c. 8, which became effective on February 6, 2017, that, if the prescription is for an opioid drug that is a Schedule II controlled dangerous substance, the practitioner shall have the required discussion prior to the issuance of each prescription, and shall include a note in the patient record that the discussion took place.

Proposed new subsection (e) establishes the requirement for a practitioner to enter into a pain management agreement with a patient when issuing the third prescription for a Schedule II controlled dangerous substance for pain or any opioid drug. The Board's existing rule required a practitioner "to consider the use" of such agreements. Subsection (e) also

sets forth the requirements for the pain management agreement, which must be signed and dated by the practitioner and patient prior to the issuance of the third prescription for the ongoing treatment of pain using a Schedule II controlled dangerous substance or any opioid drug. The agreement must document the understanding of both the practitioner and the patient concerning the patient's pain management plan; establish the patient's rights in association with treatment, and the patient's obligations in relation to the responsible use, discontinuation of use, and storage and disposal of Schedule II controlled dangerous substances and any opioid drugs, including any restrictions on the refill of or the acceptance of such prescriptions from other practitioners or prescribers; identify the specific medications and other modes of treatment that are included as part of the treatment plan; specify the measures the practitioner may employ to monitor the patient's compliance, such as random specimen screens and pill counts; and delineate the process for terminating the agreement, including the consequences if the practitioner has reason to believe that the patient is not complying with the terms of the agreement. The **Division of Consumer Affairs** will provide sample pain management agreements on its website for use by practitioners.

Recodified subsection (f) sets forth the requirements for the management of pain for three or more months using controlled substances. Recodified subsection (f) is proposed to be amended to reference "chronic pain" instead of "pain for three months or more" consistent with the addition of the definition for "chronic pain" in proposed new subsection (a). The practitioner currently must review, at least every three months, the course of treatment, new information about the etiology of the pain, and the patient's progress toward treatment objectives. The proposed amendments to recodified paragraph (f)1 also require that the practitioner document the results of that review. Existing paragraph (d)2, containing the requirement for the practitioner to remain alert to problems associated with physical and psychological dependence is proposed for deletion and replacement with new paragraph (f)2, which contains an affirmative obligation to assess the patient prior to the issuance of each prescription for a controlled dangerous substance to determine whether the patient is experiencing problems associated with physical and psychological dependence, and to document the results of that assessment. Recodified paragraph (f)3, which requires the practitioner to make periodic reasonable efforts to either stop the use of the controlled dangerous substance, decrease the dosage, try other drugs or treatment modalities to reduce the potential for abuse or the development of physical or psychological dependence, is proposed for amendment to modify the rule language from "decrease" to "taper" the dosage, and add "utilize alternative" before "treatment modalities." In addition, the proposed amendments require that the practitioner document, with specificity, the efforts undertaken by the practitioner consistent with the paragraph. Under proposed new paragraphs (f)4 through 8, practitioners are also required to access relevant PMP information; monitor compliance with the pain management agreement, and any recommendation that the patient seek a referral, and discuss with the patient any breaches and document within the patient record the plan after that discussion; conduct random urine screens at least once every 12 months; refer the patient to a pain management or addiction specialist for independent evaluation or treatment to achieve treatment objectives, if those objectives are not being met; and for those patients who are being prescribed an opioid drug to treat chronic pain, advise the patient of the availability of an opioid antidote. Overall, the amendments to this subsection are designed to increase practitioner involvement and vigilance when prescribing for the treatment of chronic pain, and to ensure that the patient record reflects active pain management procedures.

Existing subsections (e), (f), and (g) are proposed for deletion. Existing subsection (e) concerns the actions a practitioner must take if treatment objectives are not met. The requirement to consider referring the patient for independent evaluation or treatment is

incorporated into recodified subsection (f) and requires the practitioner to make such a referral when treatment objectives are not being met. The requirement to assess the appropriateness of continued treatment with controlled dangerous substances is also part of recodified subsection (f) and applies whenever controlled dangerous substances are continuously prescribed for the management of chronic pain. Existing subsection (f) requires the practitioner to remain alert to the possibility that controlled substances may be misused or diverted and sets forth special requirements for a practitioner managing pain in a patient with a history of substance abuse. Recodified subsection (f) provides that, for all patients who are continuously prescribed controlled dangerous substances for the management of chronic pain, the practitioner must assess the patient to determine whether the patient is experiencing problems associated with physical and psychological dependence, make periodic reasonable efforts to reduce the potential for abuse or the development of such dependence, monitor compliance with pain management agreements, and refer the patient to a pain management or addiction specialist if treatment objectives are not being met. Existing subsection (g) sets forth recordkeeping requirements. Specific recordkeeping requirements are established in proposed new subsections (b), (d), and recodified (f).

Proposed new subsections (g), (h), and (j) are specific to the prescribing of opioid drugs for the treatment of acute pain. Proposed new subsection (g) sets forth the limitations on the quantities of opioid drugs for the treatment of acute pain issued in an initial prescription. The regulation is intended to infuse into the practitioner/patient relationship, a need for consultation after the expected course of recovery, and prior to issuing additional prescriptions. As noted above, the CDC recommends that prescribers "should not prescribe additional opioids to patients 'just in case' pain continues longer than expected" but rather "should re-evaluate the subset of patients who experience severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly." Moreover, as specifically set forth in subsection (j), subsection (g) is not to be construed to limit a practitioner's professional judgment to issue subsequent prescriptions for an opioid drug for the continued treatment of acute pain associated with the condition that necessitated the initial prescription.

Specifically, proposed new subsection (g) provides that the initial prescription for an opioid drug for treatment of acute pain shall not exceed a five-day supply, as determined by the directed dosage and frequency of dosage. An "initial prescription" is defined (in subsection (a)) as a prescription issued to a patient who has never previously been issued a prescription for the drug or its pharmaceutical equivalent, or who was previously issued a prescription for the drug or its pharmaceutical equivalent more than one year prior to the date the current prescription is being issued. When determining whether a patient was previously issued a prescription for a drug or its pharmaceutical equivalent, the practitioner must consult with the patient, review prescription monitoring information, and, to the extent it is available to the practitioner, review the patient's medical record. The initial prescription shall be for the lowest effective dose of an immediate-release opioid drug. The rule further provides that a practitioner shall not issue an initial prescription for an opioid drug that is for an extended-release or long-acting opioid. No less than four days after issuing the initial prescription, upon request of the patient, a practitioner may issue a subsequent prescription for an opioid drug for the continued treatment of acute pain associated with the condition that necessitated the initial prescription. Prior to issuing the subsequent prescription, the practitioner must consult with the patient. The consultation may be in person, via telephone, or via other means of direct communication. After the consultation, the practitioner, in the exercise of professional judgment, must determine that an additional days' supply of the prescribed opioid drug is necessary and appropriate to the patient's treatment needs and does not present an undue risk of abuse, [page=555] addiction, or diversion. The practitioner is required to document the rationale for the authorization in the

patient record. Paragraph (g)4 provides that subsequent prescriptions for an additional days' supply of the prescribed opioid drug must be tailored to the patient's expected need at the stage of recovery, and in no case may the quantity exceed a 30-day supply, unless otherwise authorized under subsection (c). The proposed amendments do not alter existing requirements under the controlled dangerous substances rules at N.J.A.C. 13:45H-7.8(d), which permit a pharmacist to dispense a controlled dangerous substance in an amount adequate to treat the patient during an emergency period not to exceed 72 hours. The requirements of subsection (f) concerning the treatment of chronic pain apply once the pain persists for three or more consecutive months.

Proposed new subsection (h) provides that when a practitioner issues an initial prescription for an opioid drug for the treatment of acute pain, the practitioner shall indicate on the prescription that it is an initial prescription for the treatment of acute pain. Proposed new subsection (i) specifies that the requirements for prescribing controlled dangerous substances set forth in subsections (d) through (h) do not apply to a prescription for a patient who is currently in active treatment for cancer, or receiving hospice care from a licensed hospice, is receiving 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.

Proposed new subsection (j) specifies that proposed new subsection (g) is not to be construed to limit a practitioner's professional judgment to issue subsequent prescriptions for an opioid drug in a quantity consistent with paragraph (g)4 for the continued treatment of acute pain associated with the condition that necessitated the initial prescription.

Social Impact

The proposed amendments will have a positive social impact by substantially reducing the risk of addiction and the accumulation of opioids in household medicine cabinets across the State, stockpiles that are ripe for diversion. In addition, the proposed amendments will provide clear standards for practitioners who prescribe, dispense, or administer controlled dangerous substances.

Economic Impact

The proposed amendments may have an economic impact upon prescribers and their patients to the extent there are costs associated with the requirement for a practitioner to consult with the patient to authorize an additional days' supply of opioid drugs for acute pain. In addition, the proposed amendments may have an economic impact upon patients and pharmacies to the extent that there are costs associated with co-payments, co-insurance, or deductibles for an initial prescription issued consistent with requirements imposed under the proposed amendments. Patients may also experience costs associated with the required urine screenings and referrals to a pain management or addiction specialist. The costs, if any, will vary based upon third-party payor benefit plans, and are outweighed by the interest in reducing the risk of opioid and heroin addiction, and protecting the public health and safety.

The CDC Guideline notes that yearly direct and indirect costs related to prescription opioids have been estimated (based on studies published since 2010) to be \$ 53.4 billion for nonmedical use of prescription opioids; \$ 55.7 billion for abuse, dependence (that is, opioid use disorder), and misuse of prescription opioids; and \$ 20.4 billion for direct and indirect costs related to opioid-related overdoses alone.

Federal Standards Statement

A Federal standards analysis is not required because the proposed amendments are governed by N.J.S.A. 45:9-1 et seq. To the extent that the CDC Guideline may be viewed as establishing and setting forth Federal standards and requirements for the prescribing and dispensing of opioid drugs, the proposed amendments are consistent with these standards.

Jobs Impact

The proposed amendments may result in the creation of jobs in the State to the extent that additional employment opportunities may be created for pain management specialists as a result of the requirement in the proposed amendments that a practitioner must refer a patient to such specialists when treatment objectives are not being met.

Agriculture Industry Impact

The proposed amendments will have no impact on the agriculture industry in the State.

Regulatory Flexibility Analysis

Currently, the Board licenses approximately 39,469 physicians, 1,203 podiatrists, 3,120 physician assistants, and 280 certified nurse midwives who have prescriptive authority. If these licensees are considered "small businesses" within the meaning of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., then the following analysis applies.

The proposed amendments will impose new recordkeeping and compliance requirements upon practitioners who issue prescriptions for controlled dangerous substances. These requirements are discussed in the Summary above. No additional professional services will be needed to comply with the proposed amendments. The costs of compliance with the proposed amendments are discussed in the Economic Impact statement above. The proposed amendments should be uniformly applied to all licensed practitioners who are authorized to prescribe drugs in order to ensure the health, safety, and welfare of the general public. Therefore, no differing compliance requirements for any licensed practitioner are provided based upon the size of the business.

Housing Affordability Impact Analysis

The proposed amendments will have an insignificant impact on the affordability of housing in New Jersey and there is an extreme unlikelihood that the amendments would evoke a change in the average costs associated with housing because the proposed amendments concern the prescribing, administering, or dispensing of controlled dangerous substances.

Smart Growth Development Impact Analysis

The proposed amendments will have an insignificant impact on smart growth and there is an extreme unlikelihood that the amendments would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey because the proposed amendments concern the prescribing, administering, or dispensing of controlled dangerous substances.

Full text of the emergency adoption and concurrent proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 2A. LIMITED LICENSES: MIDWIFERY

13:35-2A.14 Prescriptive authorization

(a)-(h) (No change.)

(i) When prescribing controlled dangerous substances, a CNM shall comply with all of the requirements and limitations as set forth in N.J.A.C. 13:35-7.6 and 13:45H.

SUBCHAPTER 2B. LIMITED LICENSES: PHYSICIAN ASSISTANTS

13:35-2B.12 Requirements for issuing prescriptions for medications; special requirements for issuance of CDS

(a)-(b) (No change.)

(c) A physician assistant may order or prescribe controlled dangerous substances (CDS) if:

1. A supervising physician has authorized a physician assistant to order or prescribe Schedule II, III, IV, or V controlled dangerous substances in order to:

i.-iii. (No change.)

iv. Initiate an order or prescription for a controlled dangerous substance as part of a treatment plan for a patient with a terminal illness, which for the purposes of this subparagraph means a medical condition that results in a patient's life expectancy being 12 months or less as determined by the supervising physician; [and]

2. The physician assistant has registered with and obtained authorization to order or prescribe controlled dangerous substances from the appropriate State and Federal agencies[.]; **and**

[page=556] **3. The physician assistant complies with all of the requirements and limitations as set forth in N.J.A.C. 13:35-7.6 and 13:45H.**

(d)-(e) (No change.)

SUBCHAPTER 7. PRESCRIPTION, ADMINISTRATION, AND DISPENSING OF DRUGS

13:35-7.6 Limitations on prescribing, administering, or dispensing of controlled **dangerous** substances; special [exceptions] **requirements** for management of **acute and chronic** pain

[(a) When prescribing, dispensing or administering controlled substances, a practitioner shall ensure that a patient's medical history has been taken and physical examination accomplished, including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of any pain. The medical record shall reflect:

1. A recognized medical indication for the use of the controlled substance;

2. The complete name of the controlled substance;

3. The dosage, strength and quantity of the controlled substance; and
4. The instructions as to frequency of use.]

(a) The following words and terms when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

"Acute pain" means the pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time. "Acute pain" does not include chronic pain, pain being treated as part of cancer care, hospice or other end of life care, or pain being treated as part of palliative care.

"Chronic pain" means pain that persists for three or more consecutive months and after reasonable medical efforts have been made to relieve the pain or its cause, it continues, either continuously or episodically.

"Initial prescription" means a prescription issued to a patient who:

- 1. Has never previously been issued a prescription for the drug or its pharmaceutical equivalent; or**
- 2. Was previously issued a prescription for the drug or its pharmaceutical equivalent, and the date on which the current prescription is being issued is more than one year after the date the patient last used or was administered the drug or its equivalent. When determining whether a patient was previously issued a prescription for a drug or its pharmaceutical equivalent, the practitioner shall consult with the patient, review prescription monitoring information, and, to the extent it is available to the practitioner, review the patient's medical record.**

"Palliative care" means care provided to an individual suffering from an incurable progressive illness that is expected to end in death, which is designed to decrease the severity of pain, suffering, and other distressing symptoms, and the expected outcome of which is to enable the individual to experience an improved quality of life.

"Practitioner" means an individual currently licensed, registered, or otherwise authorized to prescribe drugs in the course of professional practice, to include a physician, a podiatrist, a physician assistant, and a certified nurse midwife, acting within the scope of practice of his or her professional license or certification.

(b) When prescribing, dispensing, or administering controlled dangerous substances, a practitioner shall:

- 1. Take a thorough medical history of the patient, which reflects the nature, frequency, and severity of any pain, the patient's history of substance use or abuse, and the patient's experience with non-opioid medication and non-pharmacological pain management approaches;**
- 2. Conduct a physical examination appropriate to the practitioner's specialty, including an assessment of physical and psychological function, and an evaluation of underlying or coexisting diseases or conditions;**

3. Access relevant prescription monitoring information as maintained by the Prescription Monitoring Program (PMP) pursuant to section 8 of P.L. 2015, c. 74 (N.J.S.A. 45:1-46.1) and consider that information in accordance with N.J.A.C. 13:45A-35;

4. Develop a treatment plan, which identifies the objectives by which treatment success is to be evaluated, such as pain relief and improved physical and psychological function, and any further diagnostic evaluations or other treatments planned, with particular attention focused on determining the cause of the patient's pain; and

5. Prepare a medical record, which reflects the medical history, the findings on examination, any relevant PMP data, and the treatment plan, as well as:

i. The complete name of the controlled substance;

ii. The dosage, strength, and quantity of the controlled substance; and

iii. The instructions as to frequency of use.

[(b)] **(c)** With respect to Schedule II controlled **dangerous** substances, unless the requirements of [(c) below] **this subsection** are met **or the prescribing of opioids is subject to limitations as set forth in (g) below**, a practitioner [shall not] **may** authorize a quantity [calculated to], **not to exceed** [120 dosage units or] a 30-day supply, [whichever is less.] **which shall be at the lowest effective dose as determined by the directed dosage and frequency of dosage. The prescribing of opioids in any schedule is subject to limitations as set forth in (g) below.**

[(c) A practitioner may exceed the 120 dosage unit or 30-day supply limitations for Schedule II controlled substances in (b) above in the following circumstances:

1. For the 120 dosage unit limitation, the practitioner follows a treatment plan designed to achieve effective pain management, which has been tailored to the needs of a patient who is suffering pain from cancer, intractable pain or terminal illness. The treatment plan shall state objectives by which treatment success is to be evaluated, such as pain relief and improved physical and psychological function, and shall indicate if any further diagnostic evaluations or other treatments are planned. The practitioner shall discuss the risks and benefits of the use of controlled substances with the patient, guardian or authorized representative;]

[2.] **1.** [With regards to] **Notwithstanding** the 30-day supply limitation, a practitioner may prescribe the use of an implantable infusion pump [which] **that** is utilized to achieve pain management for patients suffering from cancer, intractable pain, or terminal illness. A prescription for such an implantable infusion pump may provide up to a 90-day supply, as long as the physician evaluates and documents the patient's continued need at least every 30 days; and

[3.] **2.** [With regards to] **Notwithstanding** the 30-day supply limitation, a practitioner may prescribe multiple prescriptions authorizing a patient to receive a total of up to a 90-day supply of a Schedule II controlled dangerous substance provided that:

i. -iv. (No change.)

(d) Prior to issuing the first prescription for a Schedule II controlled dangerous substance for pain or any opioid drug, a practitioner shall discuss with the patient, or the patient's parent or guardian if the patient is under 18 years of age and is not an emancipated minor, the reasons why the medication is being prescribed, the possible alternative treatments, and the risks associated with the medication. With respect to opioid drugs, the discussion shall include, but not be limited to, the risks of addiction, physical or psychological dependence, and overdose associated with opioid drugs and the danger of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants, and requirements for proper storage and disposal.

1. If the patient is under 18 years of age and is not an emancipated minor, the practitioner shall have the discussion required under (d) above prior to the issuance of each subsequent prescription for any opioid drug that is a Schedule II controlled dangerous substance.

2. In addition to the requirements of (i) below, the practitioner shall reiterate the discussion required in (d) above prior to issuing the third prescription of the course of treatment for a Schedule II controlled dangerous substance for pain or any opioid drug.

[page=557] **3. The practitioner shall include a note in the patient record that the required discussion(s) took place.**

(e) At the time of issuance of the third prescription for a Schedule II controlled dangerous substance for pain or any opioid drug, the practitioner shall enter into a pain management agreement with the patient. The pain management agreement shall be a written contract or agreement that is executed between a practitioner and a patient, that is signed and dated prior to the issuance of the third prescription for the ongoing treatment of pain using a Schedule II controlled dangerous substance or any opioid drug, and which shall:

1. Document the understanding of both the practitioner and the patient regarding the patient's pain management plan;

2. Establish the patient's rights in association with treatment, and the patient's obligations in relation to the responsible use, discontinuation of use, and storage and disposal of Schedule II controlled dangerous substances and any opioid drugs, including any restrictions on the refill or acceptance of such prescriptions from practitioners and other prescribers;

3. Identify the specific medications and other modes of treatment, including physical therapy or exercise, relaxation, or psychological counseling, that are included as part of the treatment plan;

4. Specify the measures the practitioner may employ to monitor the patient's compliance including, but not limited to, random specimen screens and pill counts; and

5. Delineate the process for terminating the agreement, including the consequences if the practitioner has reason to believe that the patient is not complying with the terms of the agreement.

[(d)] **(f)** When controlled **dangerous** substances are continuously prescribed for management of **chronic** pain [for three months or more], the practitioner **shall** :

1. [Shall review] **Review** , at a minimum of every three months, the course of treatment, any new information about the etiology of the pain and the patient's progress toward treatment objectives, **and document the results of that review**;

[2. Shall remain alert to problems associated with physical and psychological dependence; and]

2. Assess the patient prior to issuing each prescription to determine whether the patient is experiencing problems associated with physical and psychological dependence, and document the results of that assessment;

3. [Shall periodically make] **Make periodic** reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled **dangerous** substance, [decrease] **taper** the dosage, try other drugs, such as nonsteroidal anti-inflammatories, or **utilize alternative** treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence[.], **and document, with specificity, the efforts undertaken**;

4. Access relevant prescription monitoring information as maintained by the Prescription Monitoring Program (PMP) pursuant to section 8 of P.L. 2015, c. 74 (N.J.S.A. 45:1-46.1) and consider that information in accordance with N.J.A.C. 13:45A-35;

5. Monitor compliance with the pain management agreement and any recommendations that the patient seek a referral, and discuss with the patient any breaches that reflect that the patient is not taking the drugs prescribed or is taking drugs, illicit or prescribed by other practitioners or prescribers, and document within the patient record the plan after that discussion;

6. Conduct random urine screens at least once every 12 months;

7. For those patients being prescribed an opioid drug to treat chronic pain, advise the patient, or the patient's parent or guardian if the patient is under 18 years of age and is not an emancipated minor, of the availability of an opioid antidote; and

8. Refer the patient to a pain management or addiction specialist for independent evaluation or treatment in order to achieve treatment objectives, if those objectives are not being met.

[(e) If treatment objectives are not being met, the practitioner:

1. Shall assess the appropriateness of continued treatment with controlled substances or undertake a trial of other drugs or treatment modalities; and

2. Shall consider referring the patient for independent evaluation or treatment in order to achieve treatment objectives.

(f) A practitioner shall remain alert to the possibility that controlled substances may be misused or diverted. A practitioner managing pain in a patient with a history of substance abuse shall exercise extra care by way of monitoring, documentation and possible

consultation with addiction medicine specialists, and should consider the use of an agreement between the practitioner and the patient concerning controlled substance use and consequences for misuse.

(g) The practitioner shall keep accurate and complete records including that information required by (a) above as well as:

1. The medical history and physical examination of the patient;
2. Other evaluations and consultations;
3. Treatment plan objectives;
4. Evidence of informed consent;
5. Treatments and drugs prescribed or provided, as in (a) above;
6. Any agreements with the patient; and
7. Periodic reviews conducted.]

(g) A practitioner shall not issue an initial prescription for an opioid drug for treatment of acute pain in a quantity exceeding a five-day supply as determined by the directed dosage and frequency of dosage. The initial prescription shall be for the lowest effective dose of an immediate-release opioid drug. A practitioner shall not issue an initial prescription for an opioid drug that is for an extended-release or long-acting opioid. No less than four days after issuing the initial prescription, upon request of the patient, a practitioner may issue a subsequent prescription for an opioid drug for the continued treatment of acute pain associated with the condition that necessitated the initial prescription provided the following conditions are met:

- 1. The practitioner consults (in person, via telephone, or other means of direct communication) with the patient;**
- 2. After the consultation with the patient, the practitioner, in the exercise of his or her professional judgment, determines that an additional days' supply of the prescribed opioid drug is necessary and appropriate to the patient's treatment needs and does not present an undue risk of abuse, addiction, or diversion;**
- 3. The practitioner documents the rationale for the authorization in the patient record;**
- 4. The subsequent prescription for an additional days' supply of the prescribed opioid drug is tailored to the patient's expected need at the stage of recovery, as determined under (g)2 above and any subsequent prescription for an additional days' supply shall not exceed a 30-day supply, unless authorized pursuant to (c) above.**

(h) When a practitioner issues an initial prescription for an opioid drug for the treatment of acute pain, the practitioner shall so indicate it on the prescription.

(i) The requirements for prescribing controlled dangerous substances set forth in

(d) through (h) above shall not apply to a prescription for a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice, receiving 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.

(j) Nothing in (g) above shall be construed to limit a practitioner's professional judgment to authorize a subsequent prescription for an opioid drug in a quantity consistent with (g)4 above for the continued treatment of acute pain associated with the condition that necessitated the initial prescription.