Opioid FAQs

1. What is the education requirement?
    a. Prescribers are required to complete CME in pain management or opioid use or addiction each year.
        i. 1 hour: MDs, DOs, PAs, Optometrists, Veterinarians
        ii. 2 hours: Podiatrists, APRNs
        iii. 3 hours: Dentists
    b. The annual education requirement is tied to a licensee's renewal date. For example, if you renew in July 2020, the August 2019 event will count towards your renewal. After July 2020, the requirement would start again—and if an educational opportunity came along in November 2020, then that would count towards the 2020 renewal.

2. What was the purpose of SB 848?
    a. SB 848 went into effect May 21, 2019 and was intended to clarify some of the SB 1446 requirements. It supersedes SB 1446.
    b. Updates to the "initial prescription"
        i. Upon issuing initial prescription, a practitioner may issue one (1) subsequent prescription for an immediate-release opioid drug in a quantity not to exceed seven (7) days if:
            1. The subsequent prescription is due to a *major surgical procedure* and/or *confined to home* status
            2. The practitioner prescribes the subsequent prescription on the same day as the initial prescription
            3. The practitioner issues written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled (i.e. "do not fill until" date) and
            4. The subsequent prescription is dispensed no more than five (5) days after the *do not fill until* date indicated on the prescription.

3. Are opioid cough medications included in SB 848 requirements?
    a. Cough medications not being prescribed to treat acute pain would not be subject to SB 848 requirements. However, it is recommended the PMP still be reviewed.

4. Can INTEGRIS providers not on Epic in the ambulatory setting have access to the developed smart phrases?
    a. Yes, please take time to review the available resources on the INTEGRIS Source page at https://insideintegris.corp.integris-health.com/Resources/epcs/Pages/default.aspx (must be accessed from the INTEGRIS network).

5. How does marijuana fit into chronic pain management?
    a. Marijuana, a schedule I drug, is not specifically addressed in SB 848.
    b. INTEGRIS has a SYSTEM Policy (SYS PCS 819) to address medical marijuana use.

6. How does SB 848 impact patients being sent to inpatient hospice and potentially receiving sublingual morphine every hour?
    a. SB 848 requirements do not apply to patients receiving active treatment of cancer, hospice, palliative care, residents of long-term care facilities, or patients receiving medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

7. Is there specific criteria for a new diagnosis of “acute pain” when a patient has already had a script within the last year but is being discharged from the hospital?
    a. "Acute pain" is defined as “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.”
    b. If the patient has already received an initial 7-day prescription to treat an existing medical problem and is subsequently hospitalized for a related diagnosis, there would need to be either a 2nd 7-day prescription or patient-provider agreement for a 30-day prescription (if a 2nd 7-day had also been done for the same diagnosis in the past year) at time of discharge with an opioid.

   c. If the patient requires the prescription for the drug due to a surgical procedure or new acute event, it would be considered an initial prescription, even if the patient had a prescription for the drug or its pharmaceutical equivalent within the past year.

8. Is an agreement needed, for example, for 10 Percocet tablets every three months as needed for breakthrough pain to reduce the patient's ER visits?
   a. A patient-provider agreement is required in this example. Ten Percocet tablets refilled every 3 months would be considered part of a long-term treatment plan. The provider would need to assess the patient prior to each renewal.

9. As far as treating cancer pain, are providers exempt from the documentation requirements and quantity restrictions?
   a. SB 848 requirements do not apply to patients receiving active treatment of cancer, hospice, palliative care, residents of long-term care facilities, or patients receiving medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

10. Are benzodiazepines included in the SB 848 requirements?
    a. A patient who is prescribed benzodiazepines and opioids together for more than one 24-hour period is considered a "qualifying opioid therapy patient," and a patient-provider agreement would be required.

11. How often does the pain contract have to be redone?
    a. SB 848 does not specify; however, best practice would be to renew the patient-provider agreement annually.

12. How does the law impact the management of an acute or chronic pain patient at time of hospital discharge when the appropriate dose exceeds 100 MME/day?
    The law does not technically limit the total MME. It does, however, require that the initial prescription "be for the lowest effective dose of immediate-release opioid drug. Additionally, the law does require a "patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses" to enter into a written agreement with the provider as part of the informed consent process; the patient-provider agreement we drafted will suffice. If you

choose to prescribe greater than 100 MME, you should document the rationale thoroughly.

13. How would SB 848 apply to a Butrans patch?
    a. Lexi-comp says the Butrans patch should be changed every 7 days. The initial 7-day prescription would be for one patch if written to be changed every 7 days.

14. If a patient enters into a patient-provider agreement with a primary care physician and then is referred to a pain management specialist and a second agreement is executed, what happens to the first signed agreement?
    a. The agreement entered with the primary care provider would no longer be applicable. Both the primary care provider and pain management specialist should document the details of the care transition in the medical record.

15. For a patient who receives #45 tramadol every 6-12 months, is a patient-provider agreement needed, and how often does the patient have to be seen?
    a. Patient-provider agreements are executed between physician and patient at the time of the 3rd Rx for an opioid. The agreement is intended to document the pain-management plan for that patient and is part of an ongoing relationship. Patients receiving prescriptions beyond the initial and second 7-day prescriptions should have a patient-provider agreement in place. The provider would need to assess the patient prior to each renewal.

16. Does INTEGRIS have an easy way to take referrals for PT, biofeedback, medical massage, chiropractic care, etc.?
    a. Providers can use the referral system and send to Jim Thorpe for select therapy options.

17. Does SB 848 separately address patients who have had cancer in the past and are receiving pain medications for other issues?
    a. The law only excludes patients receiving active treatment of cancer. Patients with a previous history of cancer and not currently receiving active cancer treatment would need a patient-provider agreement as required by the law.

18. Nurse Practitioners can only write for 30 days. Do we now have to do face-to-face every 30 days?
    a. An assessment is required prior to every renewal to determine whether the patient is experiencing dependency, and the results of the assessment should be documented. Face-to-face assessment is recommended but not specifically required by the law.

19. What about prescriptions for patients being discharged from the hospital to a SNF?
    a. You could infer that a Skilled Nursing Facility is a long-term care facility, making the patient exempt from SB 848 requirements.

20. What happens when the PMP System goes down?
    a. Appropriately document your attempt to access the PMP system in the electronic health record.

21. What effective prescription medication alternatives are available and not affected by SB 848?
    a. NSAIDs, non-benzodiazepine muscle relaxers, corticosteroids, anticonvulsants (gabapentin), lidocaine topical patches, anti-depressants (venlafaxine, duloxetine nortriptyline), and alpha-2 delta ligands (pregabalin) are available prescription alternatives.

22. What happens when a patient takes an initial 7-day prescription in less than 7 days?
    a. The patient should be appropriately educated/counseled on medication usage. A second 7-day prescription could be issued, if appropriate, at the end of the original 7-day prescription. Determine the 2nd prescription does not present undue risk of abuse, addiction, or diversion, and document your thoughts and rationale.

23. How do I submit additional questions related to SB 848?
    a. Email opioid.law@integrisok.com (responses may take 24-48 hours)

24. For a subsequent 7-day prescription issued no less than 7-days after the initial prescription, can "consultation with the patient" be done via a phone call or secure patient portal? Can the "consultation" be completed by a physician's representative (nurse, medical assistant, office staff member, etc.)?
    a. The law does not specify the method of conducting the consultation with the patient. Some patients may require a face to face consultation, but many may be consulted by phone. While the consultation with the treating physician is preferred, the bill does not stipulate "who" shall make the consultation with the patient. Because of the seriousness of opioid prescribing, it is recommended that the consultation be done at least by either a physician assistant or nurse practitioner with prescribing authority. There are questionnaires available to be used via the portal, SOAPP-R and PEG score, which can be sent to the patient's INTEGRIS & Me account, completed and returned, and the Rx may be sent via EPCS. See Tip sheets for specifics.

25. Are pharmacists going to be involved with/responsible for enforcing SB 848?
    a. No, the pharmacy industry and profession is not addressed in the law as being involved in the enforcement of the new law. If the pharmacist sees something that seems concerning about the script elements, he/she currently may call the physician's office to alert them of a concern which could involve denying the prescription; however, pharmacists do not see the patient for a medical exam, diagnosis or treatment plan. The pharmacy board has no authority over the physician, PA or NP.
    b. A pharmacist shall fill the prescription to the specified dose, and shall not be permitted to fill a different dosage than what is prescribed. However, the pharmacist maintains the right not to fill the valid opioid prescription.

26. Will a physician be able to prescribe a new opioid within the first 7-days for uncontrolled pain? Example: Patient complains of severe acute exacerbation of chronic shoulder pain – normally takes nothing – PMP empty. Physician prescribed a 7-day quantity of Tramadol and scheduled the patient for a MRI. Patient continues to have shoulder pain while awaiting the MRI and the Tramadol is not helping.

a. The physician should evaluate the number of days/Rx dosage until the MRI and prescribe the least number of pills and dosage of another CDS until the MRI is completed, and then decide on the next 7-day prescription.

   Clarification: If the Tramadol was for 7-days and the patient calls after 5 days and explains that it is not working, the physician should evaluate the situation and give a 2-day prescription or a different CDS or non-CDS by e-prescribing directly to the pharmacy or write out the script to be picked up by the patient or if CDS is III – V it can be called into the pharmacy. With an initial 7-day script not working for the pain that close to the deadline and the MRI appointment still a ways off, the physician should consider the new CDS drug as the second 7-day prescription.

27. How does a physician handle a patient who develops allergies/intolerances to multiple opioid prescriptions? Example: A post-operative patient's chart shows allergies/intolerances to multiple narcotics. The allergies/intolerances were not documented at the time the prescriptions were written and the patient received multiple opioid prescriptions in a 7-day time frame.
    a. If the patient calls with an allergy unknown in advance by the physician's office, the physician, PA or NP should tell the patient to make arrangements to destroy the initial prescription [*OBN Takeback Program*] and then prescribe the new CDS by e-prescribing directly to the pharmacy or write out the script to be picked up by the patient or if CDS is III – V it can be called into the pharmacy. Do Not have the patient bring the old prescription to the physician's office for destruction. This process should always include a query to the PMP to make sure there is minimal chance of abuse of diversion. Document thoroughly.

28. How much of the new law applies to the acute care setting / hospitals while the patient is admitted or in the emergency department?
    a. The bill does not directly impact acute care settings such as hospitals while the patient is in the facility. The new law impacts outpatient prescriptions for opioids.

29. Who is responsible for "policing" SB 848?
    a. The respective licensing board:
        i. In most cases, "unprofessional conduct" includes "prescribing, dispensing, or administering opioid drugs in excess of the maximum limits authorized in Section 2-309I of Title 63 of the Oklahoma Statutes."
            1. 63 O.S. 2-309I: "Any opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug."
        ii. "The failure of a registrant to access and check the central repository as required under state or federal law or regulation may, after investigation, be grounds for the licensing board of the registrant to take disciplinary action against the registrant."
    b. If there are criminal allegations, the OBN, DEA and DA can file charges, just as they could prior to implementation of this law.

30. Can you clarify the intent of the law regarding opioid prescriptions after surgery for patients currently in pain management? For example, a patient undergoing joint replacement by an orthopedic surgeon but also currently seeing a pain management specialist (and prescribed an opioid) …who is responsible for the patient's post-operative pain control?
    a. The law would allow the orthopedic surgeon to write an "initial prescription" for acute pain due to a surgical procedure or new acute event (even if the patient has previously had a prescription for the drug or its pharmaceutical equivalent within the past year). The orthopedic surgeon could also prescribe a second 7-day prescription for the acute post-operative pain.