Summary of State Legislation and Regulations Addressing Prescription Drug and Opioid Abuse

October 6, 2017

Below is a compilation of state legislation, rules and regulations, and court cases that address prescription drug and opioid abuse in the United States. The information in the chart is organized state-by-state in alphabetical order. To stay updated as relevant opioid legislation, rules and regulations are considered in 2018, please visit the ADEA United States Interactive Legislative Tracking Map and the ADEA United States Interactive Regulatory Tracking Map, and select "Prescription Drug Monitoring" from the drop-down menus. Information on the ADEA interactive maps is updated daily. Note: The notation "NA" next to a state indicates that no information was available at the time of inquiry.

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Alabama	On Aug. 8, 2017, the governor issued Executive Order No. 708 adding additional members to the Alabama Opioid Overdose and Addiction Council. Council membership includes the Executive Director of the Alabama Dental Association and the Executive Director of the Alabama Board of Dental Examiners. The Council shall develop and submit a strategic action plan to the governor by December 31, 2017, that establishes recommendations for policy, regulatory and legislative actions to address the overdose crisis in Alabama. The plan shall include clear goals, objectives and metrics for measuring progress in combating the addiction and overdose crisis and reducing opioid-overdose deaths in the state. The plan may include recommendations for enhancing the Prescription Drug Monitoring Program and promoting evidence-based guidelines for pain management.
Alaska	On July 25, the governor signed HB 159 into law. The new law allows patients to execute a Voluntary Nonopioid Directive, making it clear that they do not desire to be administered an opioid. The confidential information would be provided to an individual's healthcare provider or hospital, and is revocable at any time. Alaskans will also be able to request partial fills of opioid prescriptions from pharmacists, without voiding the remainder of the prescription. Additionally, the new law limits first-time opioid prescriptions to no more than a 7-day supply with exceptions, strengthens reporting and education requirements for pharmacists and healthcare providers, and requires the controlled substance prescription database to be updated daily starting July 1, 2018, instead of weekly, to increase communication among providers and transparency.
Arizona	On March 24, the governor signed HB 2307 into law. The new law requires all medical practitioner regulatory boards in the state, upon application for initial licensure or for license renewal, to notify each licensee of his/her responsibility to register with the state board of pharmacy to be granted access to the state's prescription drug monitoring program.

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	On June 5, the governor declared a statewide health emergency with regard to the opioid epidemic. The declaration requires the Director of the Arizona Department of Health Services to: 1) initiate emergency rule making with the Arizona Office of the Attorney General in order to develop rules for opioid prescribing and treatment within health care institutions; 2) develop guidelines to educate healthcare providers on responsible prescribing practices; and 3) provide a report with policy and legislative recommendations to the governor by Sept. 5. The report recommends that all undergraduate and graduate medical, dental and veterinary education programs, as well as residency programs, incorporate evidence-based pain management and substance-use-disorder treatment into their curriculum.
Arkansas	On April 13, the governor signed SB 339 into law. Under the new law, a prescriber shall check the information in the Prescription Drug Monitoring Program (PDMP) when prescribing an opioid from Schedule II or Schedule III every time the medication is prescribed to a patient and a benzodiazepine medication the first time the medication is prescribed to a patient. The new law provides that a practitioner's licensing board will also require practitioners to check the PDMP before prescribing opioids or benzodiazepine (to first time patients).
California	On July 17, the Supreme Court of California ruled that a state medical board's review of patient records in the state's prescription drug monitoring database did not violate patients' privacy rights because it was justified by public interest in regulating potent prescription drugs and protecting patients from negligent doctors. Specifically, the Court unanimously determined that the Medical Board of California did not violate patients' privacy rights under the state constitution when it obtained data from the state's Controlled Substance Utilization Review and Evaluation System (CURES), which tracks prescriptions of Schedule II, III or IV controlled substances, in order to investigate Dr. Alwin Carl Lewis for allegedly over-prescribing drugs to patients, among other claims. The justices determined that the CURES data obtained by the board for hundreds of patients treated by Dr. Lewis, without their authorization, was justified due to public health and safety concerns regarding highly regulated drugs, and outweighed any invasion of privacy.
Colorado	On April 6, the governor signed SB 17-146 into law. The new law allows a health care provider who has authority to prescribe controlled substances, or the provider's designee, to query the program regarding a current patient, regardless of whether the provider is prescribing or considering prescribing a controlled substance to that patient.
Connecticut	On June 30, Gov. Dan Malloy (D-CT) signed SHB 7052 into law. The legislation is titled *An Act Preventing Prescription Opioid Diversion and Abuse*. Among its several provisions, the new law: • Reduces the maximum opioid drug prescription for minors from seven days to five days. • Requires certain scheduled drugs be electronically prescribed. • Increases data sharing between state agencies regarding opioid abuse and opioid overdose deaths. • Allows patients to file a voluntary nonopioid form in their medical records indicating that they do not want to be prescribed or administered opioid drugs.

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	• Expands requirements about information regarding provider communications about the risk and signs of addiction and the dangers of drug interactions to cover all opioid prescriptions (current law applies only to minors). • Requires the Department of Public Health to make information available online about how prescribers can obtain certification for suboxone and other medicines to treat opioid use disorder.
Delaware	On July 21, the governor signed SB 44 into law. The new law requires all prescribers who hold a controlled substance registration to be registered with the Prescription Monitoring Program (PMP). It also requires prescribers who receive a controlled substance registration to register with the PMP within 90 days.
District of Columbia	A bill to make naloxone available in D.C. pharmacies was passed by the Council of the District of Columbia, transmitted to Congress for a 30-day review and became effective Feb. 18. However, to date, the D.C. Department of Health has not released regulations allowing pharmacies to begin selling the drug without a prescription.
Florida	On May 3, the governor signed an executive order declaring a public health emergency in Florida. The declaration allowed the state to immediately draw down more than $27 million in federal funding from the U.S. Department of Health and Human Services State Targeted Response to the Opioid Crisis Grants program. On Sept. 26, the governor announced that during the upcoming legislative session, he will propose major legislation and more than $50 million as part of his 2018-2019 recommended budget to combat opioid abuse in Florida. The proposed legislation will include: • Placing a 3-day limit on prescribed opioids, unless strict conditions are met for a 7-day supply; • Requiring all healthcare professionals that prescribe or dispense medication to participate in the Florida Prescription Drug Monitoring Program, a statewide database that monitors controlled substance prescriptions; and • Additional reforms to fight unlicensed pain management clinics, require continuing education courses on responsibly prescribing opioids, and create new opportunities for federal grant funding.
Georgia	On May 4, the governor signed into law HB 249, which moves the Prescription Drug Monitoring Program (PDMP) from the Georgia Drugs and Narcotics Agency to the Department of Public Health. The new law also provides that each prescriber who has a Drug Enforcement Administration (DEA) registration number shall enroll to become a user of the PDMP as soon as possible, and no later than January 1, 2018; provided, however, that prescribers who attain a DEA registration number after such date shall enroll within 30 days of attaining such credentials. A prescriber who violates this subsection shall be held administratively accountable to the state regulatory board governing such prescriber for such violation.
Hawaii	On July 3, the governor signed into law SB 505. The new law requires prescribing health care providers to adopt and maintain policies for informed consent to opioid therapy in circumstances that carry elevated risk of dependency. The law also limits initial concurrent

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	prescriptions for opioids and benzodiazepines to a maximum of seven consecutive days, except for treatment of specified conditions. On July 12, the governor announced the convening of a multidepartment opioid abuse prevention initiative. The collaborative effort led by the state's Department of Health includes representatives of the Department of the Attorney General, Department of Human Services Med-QUEST Division, and Department of Public Safety Narcotics Enforcement Division. The two areas within the Department of Health facilitating this effort with the support of federal grant funds are the Alcohol and Drug Abuse Division and the Emergency Medical Services and Injury Prevention System Branch. The multidepartment initiative will build on policy initiatives that align with those recommended by the National Governor's Association to prepare proposals for the 2018 legislative session.
Idaho	HB 5 was signed into law Feb. 16 by the governor. The new law enhances the use and functionality of the state's Prescription Monitoring Program (PMP) database. Specifically, the law allows medical and pharmacy students to access the PMP as delegates of a supervising practitioner or pharmacist; limits the Board of Pharmacy's recordkeeping of PMP data to five (5) years; and requires one-time pharmacist registration for free PMP access in a manner similar to what is required for prescribers.
Illinois	As of Aug. 4, SB 2011 as amended was on third reading in the Senate. The bill provides that when issuing a prescription for an opiate to a patient who is 18 years of age or older for outpatient use for the first time, a practitioner may not issue a prescription for more than a 7-day supply. A practitioner may not issue an opiate prescription to a person under 18 years of age for more than a 7-day supply at any time and shall discuss with the parent or guardian of the person under 18 years of age the risks associated with opiate use and the reasons why the prescription is necessary. The bill provides that, notwithstanding this provision, if, in the professional medical judgment of a practitioner, more than a 7-day supply of an opiate is required to treat the patient's acute medical condition or is necessary for the treatment of chronic pain management, pain associated with a cancer diagnoses, or for palliative care, then the practitioner may issue a prescription for the quantity needed to treat that acute medical condition, chronic pain, pain associated with a cancer diagnosis, or pain experienced while the patient is in palliative care. The bill provides that the condition triggering the prescription of an opiate for more than a 7-day supply shall be documented in the patient's medical record, and the practitioner shall indicate that a nonopiate alternative was not appropriate to address the medical condition. The bill also provides that these provisions do not apply to medications designed for the treatment of substance abuse or opioid dependence. On Sept. 6, the governor signed Executive Order 17-05, creating the governor's Opioid Overdose Prevention and Intervention Task Force. The task force will be co-chaired by the lieutenant governor and the director of the Illinois Department of Public Health. The task force will look at strategies to prevent expansion of the opioid crisis, treat and promote the recovery of individuals with opioid-use disorder, and reduce the number of opioid-overdose deaths.
Indiana	On April 26, the governor signed into law SEA 226. The new law limits a prescriber's ability to issue a prescription for an adult being prescribed an opioid for the first time to a 7-day supply. If the prescription is for a child less than 18 years of age, the prescription may not

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	exceed a 7-day supply. The law outlines certain exceptions to the prescriber limits for treatments of cancer, palliative care and other specified medical conditions. Under the new law, upon the request of a patient or a guardian or legal representative of the patient, a prescriber must issue the opioid prescription for a lesser amount than the prescriber initially intended to prescribe and must indicate the request and who made the request in the patient's medical file. HB 1337, signed by the governor and effective July 1, 2017, will allow providers to prescribe controlled substances via telemedicine without an in-person examination, albeit with some notable limitations and restrictions. The law reverses Indiana's 2016 telehealth law that prevented providers from prescribing controlled substances via telehealth technologies. *Prescribing Drugs via Telemedicine* Under the new law an Indiana provider may prescribe noncontrolled substances via telemedicine, without an in-person exam, if the following conditions are met (this list is not exhaustive): • The provider has satisfied the applicable standard of care in the treatment of the patient. • The issuance of the prescription by the provider is within the provider's scope of practice and certification. • The prescription is not for a controlled substance. *Prescribing Controlled Substances via Telemedicine* Under the new law an Indiana provider may prescribe controlled substances via telemedicine, without an in-person exam, if the prescriber satisfies the conditions outlined above *and* the following conditions are met (this list is not exhaustive): • The prescription is not for an opioid, unless the opioid is a partial antagonist that is used to treat or manage opioid dependence. • The prescriber maintains a valid controlled substance registration. • The patient has been examined in person by a licensed Indiana health care provider, and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient. • The prescriber has reviewed and approved that treatment plan and is prescribing for the patient pursuant to that treatment plan. • The prescriber complies with Indiana's INSPECT prescription drug monitoring program.
Iowa	The Iowa Joint Opioid Epidemic Evaluation Study Committee is currently meeting. The Joint Committee is charged with comprehensively evaluating the state's response to the opioid epidemic in the state, including a review of the protocols and practices relating to the prescribing of opioid medications and the treatment options available including medication-assisted treatment. The committee must receive input from agencies and entities including but not limited to representatives of the professional licensing boards for professionals authorized to prescribe controlled substances, representatives of public safety and public health, representatives of the medical community and health insurance payers, and consumers and representatives of consumers. The committee must submit a report,

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	including findings and recommendations, to the governor and legislature by November 15, 2017. On Aug. 1, the University of Iowa Injury Prevention Research Center (UI IPRC), along with several stakeholders, released a report titled, *The Prescription Opioid Crisis: Policy and Program Recommendations to Reduce Opioid Overdose and Deaths in Iowa*. The report includes policy recommendations such as 1) educating physicians, nurses, pharmacists and other practitioners to ensure a strong knowledge base in recognizing patients at high risk for opioid abuse and addiction; 2) providing evidenced-based physician training in pain management and opioid prescribing at the point of medical education; and 3) for current licensed professionals, developing a presentation that will provide a historical perspective with up-to-date epidemiological data focusing on evidence-based solutions to alter the course of the opioid epidemic.
Kansas	On Apr. 7, the governor signed into law HB 2217 requiring the Board of Pharmacy to issue a statewide opioid antidote protocol with educational requirements for individuals who will be administering antidotes for opioid overdoses.
Kentucky	On April 10, the governor signed HB 333 into law. The new law prohibits a practitioner from issuing a prescription for more than a 3-day supply of a Schedule II controlled substance if the prescription is intended to treat pain as an acute medical condition. Several exceptions to the 3-day supply limit are outlined, such as pain associated with a valid cancer diagnosis or for end-of-life treatment.
Louisiana	HB 192, was signed into law by the governor on June 12 with an effective date of Aug. 1. The new law prohibits a medical practitioner from prescribing more than a 7-day supply when issuing a first-time opioid prescription for outpatient use to an adult patient with an acute condition. The new law prohibits a medical practitioner from issuing a prescription for more than a 7-day supply of an opioid to a minor at any time and requires the practitioner to discuss with the minor's parent, tutor or guardian the risks associated with opioid use and the reasons why the prescription is necessary. New law exempts prescriptions for more than a 7-day supply which, in the professional medical judgment of the medical practitioner, are necessary to treat the adult or minor patient's acute medical condition or are necessary for the treatment of chronic pain management, pain associated with a cancer diagnosis or for palliative care. Prior to issuing a prescription for an opioid, new law requires a medical practitioner to do both of the following: (1) consult with the patient regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity; and (2) inform the patient of the risks associated with the opioid prescribed. HB 490 was also signed by the governor. The new law provides that the Drug Policy Board shall establish an Advisory Council on Heroin and Opioid Prevention and Education to coordinate resources and expertise to assist in a statewide response. SB 55 was also signed into law on June 12. The new law establishes a process for automatic enrollment into the Prescription Monitoring Program upon initial licensure or upon annual renewal of a prescriber's controlled dangerous substance license. The new law expands the mandate to access the program prior to initially prescribing any opioid or if the patient's course of treatment continues for more than 90 days. It further provides for exceptions when a prescriber is not required to check the program. The new law requires all prescribers to obtain three continuing education credit hours as a prerequisite of license renewal in the

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	first annual renewal cycle after Jan. 1, 2018. The new law also requires the health profession licensing boards that regulate prescribing practitioners to promulgate rules and regulations to implement the continuing education requirements established by new law, requires the boards to collect and maintain data on compliance, and submit aggregate data to the Senate and House committees on health and welfare regarding compliance, and clarifies that these continuing education hours shall be considered among those already required on the effective date of new law and not be in addition to what is already required.
Maine	On June 2, the governor signed into law LD 273. The new law outlines specific exceptions to the Prescription Monitoring Program (PMP) requirements. On June 13, LD 479 was enacted into law. No later than January 1, 2018, a health care entity that includes a licensed individual whose scope of practice includes prescribing opioid medication must have in place an opioid medication prescribing policy that applies to all prescribers of opioid medications employed by the entity. The policy must include, but is not limited to, procedures and practices related to risk assessment, informed consent and counseling on the risk of opioid use. On June 16, the governor signed LD 1031 into law. The new law removes the requirement to submit to the Department of Health and Human Services information regarding a controlled substance that is dispensed by a hospital emergency department for use during a period of 48 hours or less. To the list of individuals who can access the controlled substances PMP information, the law adds the staff members of a group practice of prescribers who are authorized by a designated group practice leader, insofar as the information relates to a patient receiving care from that group practice. The new law removes the requirement for a dispenser to notify the controlled substances PMP if the dispenser has reason to believe that a prescription is fraudulent or duplicative, maintaining the requirement that the dispenser contact the prescriber. The new law clarifies that the requirement to check the controlled substances PMP does not apply for surgical procedures, rather than only inpatient surgery. The law clarifies that dispensing in connection with surgical procedures is exempt from the 100 morphine milligram equivalents limitation on opioids. The law clarifies that an opioid product that is labeled by the federal Food and Drug Administration to be dispensed only in a stock bottle that exceeds a 7-day supply may be prescribed as long as the amount dispensed does not exceed a 14-day supply. On Aug. 22, the Maine Department of Health and Human Services, Maine Office of Substance Abuse and Mental Health Services issued notice of the agency's adoption of major rule changes related to the *Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications* (Rule). The effective date of the changes is Sept. 17. The rule changes made necessary corrections and additions to be consistent with Maine law, specifically, legislation enacted into law during the 2017 legislative session.
Maryland	On Jan. 24, the governor announced his administration's 2017 Heroin and Opioid Prevention, Treatment and Enforcement Initiative, which includes the creation of a statewide Opioid Operational Command Center to assist in breaking down governmental silos and to aid in the coordination of federal, state and local resources.

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	On May 25, the governor signed into law several bills related to opioid abuse. HB 1432 requires a health care provider, on treatment for pain and based on the clinical judgment of the provider, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance (CDS). An exception is provided if the opioid is prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain. The dosage, quantity and duration of a prescribed opioid subject to the bill's requirements must be based on an evidence-based clinical guideline for prescribing a CDS that is appropriate for the health care delivery setting for the patient, the type of health care services required by the patient, and the age and health status of the patient. A violation of the bill's requirements is grounds for disciplinary action by the appropriate health occupations board. HB 1329 and SB 967, on an emergency basis, expresses the intent of the General Assembly that the $10 million for the opioid crisis in the FY 2018 operating budget be used to implement the bill's provisions. As of June 1, the new law does the following: (1) establishes that the Department of Health and Mental Hygiene (DHMH) may take certain actions relating to a CDS registration; (2) authorizes local fatality review teams to review nonfatal overdoses; and (3) requires DHMH to establish crisis treatment centers and a crisis hotline, and disseminate specified opioid use disorder information; and (4) requires DHMH to establish guidelines for co-prescribing opioid overdose reversal drugs.
Massachusetts	On March 29, President Donald Trump signed an executive order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. Gov. Charlie Baker (R-MA) is a commission member. On July 31, the Commission issued a draft interim report making several recommendations, including mandating prescriber education with the help of dental and medical schools.
Michigan	On Aug. 15, the governor issued an executive order to improve coordination of Michigan's efforts to combat the ongoing opioid epidemic. Specifically, the executive order establishes the Council on Opioid and Prescription Drug Enforcement (COPE). The council, which was recommended by the Michigan Prescription Drug and Opioid Abuse Task Force, will address, develop and maintain relationships among local, state and federal agencies charged with enforcing the laws and regulations.
Minnesota	At the Annual Summit of State and Tribal Leaders in July 2016, leaders of Minnesota's Tribal Nations highlighted for the governor the devastating impact of opioids on tribal communities throughout Minnesota. In response, the governor and Minnesota's Tribal Leaders agreed to partner on a summit focused on developing strategies and solutions to address the opioid crisis in Indian Country. The Tribal-State Opioid Summit took place on Oct. 18, 2016. As a result, a report summarizing potential policy and budget recommendations was released on March 9, 2017. The overall recommendation is to provide $20 million in state funds to specific strategies of prevention and to have the funds be on-going/noncompetitive for Tribes and Urban American Indian specific organizations. The strategies to be funded include such policy recommendations as working with the Indian Health Service to mandate that the PMP be utilized and checked; and enacting legislation on Schedule II Narcotics that places limits on the number of tablets prescribed per person (no more than 12 tablets per prescription).

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	Effective May 1, the Minnesota Board of Dentistry *Statement on Safe Prescribing and the Use of Opioids in Dental Settings*. The statement, according to the Board, is meant to offer guidance to dental providers in the management of pain and is not intended to set a standard of care or replace state and federal statutes. This year there was a change in opioid prescribing practices for dentists in the Health and Human Services Omnibus SF 2 (See pdf page 504). The new law limits the quantity of opiates prescribed for acute dental and ophthalmic pain to a 4-day supply. However, the new law also provides that if in the professional clinical judgment of a practitioner more than a 4-day supply of an opioid is needed, the practitioner may prescribe a larger quantity.
Mississippi	At its April 1, 2016, meeting, the Mississippi State Board of Dental Examiners (Board) amended Board Regulation Number 35 to require, effective July 1, 2017, that every dentist licensed by the Board who prescribes, administers or dispenses any controlled substance within the State of Mississippi, or who proposes to engage in the prescribing, administering or dispensing of any controlled substance within the State of Mississippi, must be registered with the Mississippi Prescription Monitoring Program (MPMP). Additionally, once registered with the PMP, Mississippi licensed dentists must adhere to all guidelines, protocols and restrictions adopted by the PMP, in as much as failure to do so shall subject the Mississippi-licensed dentist to disciplinary action. On Aug. 2, the Governor's Opioid and Heroin Study Task Force released its Strategic Plan to combat the opioid and heroin epidemic in the state. There are several recommendations in the Strategic Plan that should be of note: Recommendations to Address Health Care Provider Community • Providers should be discouraged from writing a prescription for more than a 3-day supply of opioids for acute noncancer pain, and shall not provide greater than a 7-day supply for acute noncancer pain. Providers may issue an additional 7-day supply if clinically necessary, and such need must be documented in the chart. • The Mississippi State Board of Dental Examiners should work with the task force in order to engage Mississippi dentists in an effort to decrease opioid prescribing, addiction and death. All dentists with a license should be required to register with the MPMP and all dentists should be required to receive at least five hours of continuing dental education every two years on prescribing opioids and/or benzodiazepines. • The MPMP should be run at each patient encounter in which a Schedule II opioid and/or benzodiazepine prescription is written. Benzodiazepines may be written in two refills, which would mean that the MPMP should be checked every 90 days for benzodiazepines. Recommendations for Enhanced Education, Prevention and Treatment • Create a comprehensive Mississippi Opioid Resource website with separate modules to provide information, such as a link to the MPMP, for medical, pharmacy, dental and veterinary professionals.
Missouri	On July 17, the governor signed an executive order directing the Missouri Department of Health and Senior Services (DHSS) to implement a multiphase prescription drug monitoring

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	program (PDMP). Missouri is the only state in the country that does not have a system to monitor prescription drug activity.
Montana	The Legislative Council assigned 20 interim studies to interim committees on June 6. As a result of HJ 6, the Law and Justice Interim Committee will study methamphetamine and opioid abuse while the legislature is not in regular session. The study resolution asks that the committee review: • The extent of methamphetamine use and illegal use of opioids in Montana. • The degree to which the substance abuse had affected services provided by law enforcement, the judiciary, state and local government agencies, and programs that work with the drug users or family members affected by the drug use. • The availability of substance abuse treatment and whether the type of treatment affects a person's ability to be reunified with children who have been removed from the home. • The efforts being undertaken by law enforcement, the judiciary, and state and local governments to reduce drug use and mitigate the impacts of drug abuse.
Nebraska	LR 186 failed to pass during the legislative session. The bill would have created an interim study to examine the Nebraska Prescription Drug Monitoring Program and how providers access prescription drug data.
Nevada	On May 30, the governor signed into law SB 59. The new law provides that a practitioner must, before initiating a prescription for a controlled substance listed in Schedule II, III or IV, or for an opioid that is a controlled substance listed in Schedule V, obtain a patient utilization report regarding the patient from the computerized program established by the Board and the Investigation Division of the Department of Public Safety. On June 16, the governor signed AB 474 into law. The new law authorizes certain occupational licensing boards to access the database to investigate the fraudulent, illegal, unauthorized or otherwise inappropriate prescribing, dispensing or use of a controlled substance. The new law also requires a practitioner, other than a veterinarian, to take certain actions before issuing a prescription for a controlled substance listed in Schedule II, III or IV to continue the treatment of pain of a patient who has used the controlled substance for 90 consecutive days or longer. The new law requires a practitioner, other than a veterinarian, who intends to prescribe a controlled substance listed in Schedule II, III or IV for more than 30 days for the treatment of pain to enter into a prescription medication agreement with the patient. The new law requires a practitioner, other than a veterinarian, to consider certain factors before prescribing a controlled substance listed in Schedule II, III or IV.
New Hampshire	On June 16, the governor signed HB 291 into law. The new law, effective Aug. 15, removes the requirement that the board of veterinary medicine adopt rules regarding prescribing opioids and that veterinarians' query the controlled drug Prescription Monitoring Program when prescribing such drugs. On Aug. 11, the governor sent a letter to Pres. Trump asking that when the Trump Administration "considers criteria for state assistance, any resources delivered to New Hampshire be proportionate to the size of [the problem in the state] and not based on [the state's population]."

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New Jersey	On Jan. 17, the governor signed Executive Order 219 declaring the state's opioid epidemic a public health crisis. A roundtable discussion on drug addiction and recovery followed the signing of the executive order. On Feb 6, the governor signed legislation, S 2156, requiring medical professionals to educate children and teenagers about addiction risks before issuing prescription drugs. On Feb. 15, the governor signed into law S 3. The law places certain restrictions on how opioids and other Schedule II controlled substances may be prescribed. In cases of acute pain, the bill provides that a practitioner cannot issue an initial prescription for an opioid drug in a quantity exceeding a 5-day supply. Any prescription for acute pain must be for the lowest effective dose of immediate-release opioid drug. In cases of acute or chronic pain, prior to issuing an initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug, a practitioner must document the patient's medical history, develop a treatment plan, conform with a monitoring requirement, limit the supply of opioid drug prescriptions, and comply with state and federal laws. The law also would require certain health care professionals to receive training on topics related to prescription opioid drugs. On March 29, President Donald Trump signed the Presidential Executive Order Establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. Gov. Chris Christie (R-NJ), is Chair of the commission. On July 31, the Commission issued a draft interim report making several recommendations, including mandating prescriber education with the help of dental and medical schools.
New Mexico	NA
New York	On April 19, the governor signed the FY 2018 Budget, which invests $213 million—a 100% increase in comparison with FY 2011—to address the heroin and opioid crisis in New York. The investments include: • $145 million for community-based providers. • $65 million for 8,000 residential treatment beds. • $9 million for housing units. • $41 million for opioid treatment programs. • $21 million for outpatient services. • $9 million for crisis/detox programs. • $27 million for state-operated addiction treatment centers. • $6 million for naloxone kits and training. • $25 million for expanded programs, including family support navigators, peer engagement and 24/7 urgent access centers.
North Carolina	On March 29, President Donald Trump signed the Presidential Executive Order Establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. Gov. Roy Cooper (D-NC) is a commission member. On July 31, the Commission issued a draft interim report making several recommendations, including mandating prescriber education with the help of dental and medical schools.

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	On June 29, the governor signed HB 243, the STOP Act, into law. The STOP Act, which stands for the Strengthen Opioid Misuse Prevention Act, seeks to help curb epidemic levels of opioid drug addiction and overdose in North Carolina through several key provisions, including: • Strengthening oversight and tightening supervision on opioid prescriptions. • Requiring prescribers and pharmacies to check the prescription database before prescribing opioids to patients. • Instituting a 5-day limit on initial prescriptions for acute pain, with exemptions for chronic pain, cancer care, palliative care, hospice care or medication-assisted treatment for substance use disorders. • Saving lives through increased access to naloxone, which can reverse opioid overdose. • Allowing local governments to support needle exchange programs.
North Dakota	Effective July 1, the North Dakota Administrative Code (NDAC) 20-02-01-12 was amended to read the following: prior to the initial prescribing of any controlled substance, including samples, a dentist authorized by the drug enforcement administration to prescribe, administer, sign for, dispense, or procure pharmaceuticals shall authorize an employee to review or personally request and review the prescription drug monitoring program report for all available prescription drug monitoring program data on the patient within the previous twelve months. Certain exceptions to the review requirement are outlined in NDAC 20-02-01-13.
Ohio	On Jan. 4, the governor signed SB 319. The new law specifies that not more than a 90-day opioid analgesic supply may be dispensed or sold and that a prescription cannot be filled if more than 14 days have elapsed since it was issued or, if the prescription specifies the earliest date on which it may be filled and other conditions are satisfied, 14 days since that date. HB 167 and SB 119, companion bills, were introduced for consideration, but to date have not moved through the legislative process. The bills would (1) prohibit a primary care physician or general dentist from prescribing or furnishing an opioid analgesic in an amount indicated for a period greater than three days or with a morphine equivalent daily dose (MED) in excess of 50 milligrams; (2) permit a primary care physician or general dentist to exceed the 3-day limit and prescribe or furnish an opioid analgesic for a period of not more than seven days if the physician or dentist satisfies specified conditions, including completing training in opioid addiction; and (3) authorize the State Medical and Dental Boards to establish limits on the amount or MED of an opioid analgesic that may be prescribed or furnished by a physician or dentist practicing in a specialty other than primary care or general dentistry. On Aug. 21, the Ohio Mayors Alliance sent a letter to the governor asking him to, among other things (1) immediately activate the State of Ohio's Emergency Operations Center and Joint Dispatch Facility and (2) have every cabinet agency review all possible funding opportunities through the federal government and the philanthropic sector. The Ohio State Dental Board issued notice that new rules establishing guidelines on the prescribing of opioid analgesics for acute pain became final on Aug. 31. The rules provide that before prescribing an opioid analgesic, the dentist must first consider nonopioid

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	treatment options. If opioid analgesics are required as determined by a patient history and clinical examination, the dentist must prescribe the minimum quantity and potency needed to treat the expected duration of pain, with a presumption that a 3-day supply or less is frequently sufficient and that limiting the duration of opioid use to the necessary period will decrease the likelihood of subsequent chronic use or dependence. In all circumstances where opioid analgesics are prescribed for acute pain, the first opioid analgesic prescription for the treatment of an episode of acute pain shall be (1) for adults, not more than a 7-day supply with no refills; (2) for minors, not more than a 5-day supply with no refills.
Oklahoma	SCR 12 was adopted by both chambers and filed with the secretary of state's office. The resolution creates until July 1, 2018, the Oklahoma Commission on Opioid Abuse. The commission shall be chaired by the attorney general and be composed of nine (9) members representing the health community, state and local law enforcement, and the legislature. The commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services, or a designee, and the director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control, or a designee, shall serve as ex officio members.
Oregon	On June 26, the governor signed into law HB 2114. The new law provides that not later than January 1, 2018, the Oregon Medical Board, the Oregon State Board of Nursing, the Oregon Board of Naturopathic Medicine and the Oregon Board of Dentistry shall provide notice to the practitioners regulated by each board who are authorized under the laws of this state to prescribe opioids or opiates of the *Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications*, as endorsed by the Oregon Medical Board in January 2017.
Pennsylvania	On June 29, the governor announced that the Pennsylvania Prescription Drug Monitoring Program is sharing data with drug monitoring programs in 10 states and Washington D.C.
Puerto Rico	NA
Rhode Island	On July 19, the governor signed into law, H 5975a and S 0546aa. The new law requires electronic prescribing for drugs in schedules II, II, IV and V by January 1, 2020; and adds opioid antagonists (including naloxone) to be transmitted to the Department of Health's Prescription Drug Monitoring Program (PDMP). Also, the governor signed H 6307 and S 0493a into law. The new law requires health professionals to discuss addiction potential with their patients or their patients' guardian before prescribing opiates. The director of the Rhode Island Department of Health shall develop and make available to prescribers guidelines for the discussions with patients or their guardians.
South Carolina	In April the Speaker of the House created the House Opioid Abuse Prevention Study Committee, which will look into how to curb the growing use of opioids in South Carolina. On May 19, the governor signed into law H 3824. The new law requires practitioners authorized to prescribe controlled substances, or their delegates, to review a patient's controlled substance prescription history, maintained in the Prescription Monitoring Program, before issuing a prescription for a Schedule II controlled substance. Exceptions to this review requirement exist when treating hospice-certified patients, patients in a skilled nursing facility, patients undergoing chronic pain treatment under certain circumstances, and patients with prescriptions that do not exceed a 5-day supply. The new law also requires dentists, optometrists, physician assistants, podiatrists and pharmacists to complete at least

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	two hours of continuing education every two years related to the approved procedures for prescribing and monitoring controlled substances listed in schedules II, III and IV.
South Dakota	On Feb. 9 the governors signed into law SB 4. The new law requires the Board of Pharmacy to report annually to the legislature regarding monitoring and use of opioids in the state. On March 8, the governor signed SB 1 into law. The new law requires persons authorized to prescribe or dispense a controlled drug or substance to register with the state's prescription monitoring program.
Tennessee	On June 15, the Tennessee attorney general announced he will be leading a bipartisan coalition of a majority of attorneys general from across the country as part of an effort to combat the opioid epidemic. The attorneys general are conducting comprehensive investigations into the widespread prescribing and use of opioids, as well as the role parties involved in the manufacture and distribution of opioids may have played in creating or prolonging this problem.
Texas	On June 1, the governor signed SB 584 into law. The new law, effective Sept. 1, amends the Texas Occupations Code to require the Texas Medical Board to adopt guidelines for the prescription of opioid antagonists. The bill exempts from liability a physician whose act or omission with respect to prescribing an opioid antagonist is made in good faith and reasonable care.
Utah	On March 22, the governor signed HB 50 into law. The new law limits the number of days an opiate may be prescribed for certain individuals. Specifically, the new law provides that a prescription for a Schedule II or Schedule III controlled substance that is an opiate and that is issued for an acute condition shall be completely or partially filled in a quantity not to exceed a 7-day supply as directed on the daily dosage rate of the prescription. The requirement does not apply to a prescription issued for a surgery when the practitioner determined that a quantity exceeding seven days is needed, in which case the practitioner may prescribe up to a 30-day supply, with a partial fill at the discretion of the practitioner. The requirement does not apply to prescriptions issued for complex or chronic conditions which are documented as being complex or chronic in the medical record. Also, under the new law a prescriber must check the database for information about a patient before the first time the prescriber gives a prescription to a patient for a Schedule II opioid or a Schedule III opioid. Certain exceptions exist. Also, if a prescriber is repeatedly prescribing a Schedule II opioid or Schedule III opioid to a patient, the prescriber shall periodically review information about the patient in: (i) the database; or (ii) other similar records of controlled substances the patient has filled.
Vermont	On May 8, the governor issued an executive order creating the Governor's Opioid Coordination Council to lead and strengthen Vermont's response to the opioid crisis by ensuring full interagency and intra-agency coordination between state and local governments in the areas of prevention, treatment, recovery and law enforcement activities.
Virginia	In late Feb., the governor signed into law H 2161 and S 1179, which require Virginia's Secretary of Health and Human Resources (HHR) to convene a work group to develop educational standards and curricula for training health care providers, including dentists, in the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse. The new law requires that the work group include representatives

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	from each of the Commonwealth's dental schools, medical schools, schools of pharmacy, physician assistant education programs and nursing education programs, as well as representatives of the State Council of Higher Education for Virginia. In addition, the work group must include representatives of HHR's departments of Behavioral Health and Developmental Services, Health and Health Professions. The work group must report its progress and the outcomes of its activities to the governor and the general assembly by Dec. 1. On Feb. 24, H 1885 and S 1232 were enacted into law. The new law requires a prescriber registered with the Prescription Monitoring Program (the Program) to request information about a patient from the Program upon initiating a new course of treatment that includes the prescribing of opioids anticipated, at the onset of treatment, to last more than seven consecutive days and exempts the prescriber from this requirement if the opioid is prescribed as part of treatment for a surgical or invasive procedure and such prescription is for no more than 14 consecutive days. The new law extends the sunset for this requirement from July 1, 2019, to July 1, 2022. In late Feb. and mid-March, the governor signed H 2165 and S 1230 into law. The new law requires a prescription for any controlled substance containing an opiate to be issued as an electronic prescription and prohibits a pharmacist from dispensing a controlled substance that contains an opiate unless the prescription is issued as an electronic prescription, beginning July 1, 2020. The law requires the secretary of Health and Human Resources to convene a work group of interested stakeholders to review actions necessary for the implementation of the law's provisions, to evaluate hardships on prescribers and the inability of prescribers to comply with the deadline for electronic prescribing, and to make recommendations for any extension or exemption processes relative to compliance or disruptions due to natural or manmade disasters or technology gaps, failures or interruptions of services. The work group must report on their progress to the chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2017, and a final report to such chairmen by November 1, 2018. In March, the governor signed into law H 2167 and S 1180. The new law directs the boards of Dentistry and Medicine to adopt regulations for the prescribing of opioids and products containing buprenorphine. The law requires the Program at the Department of Health Professions to annually provide a report to the Joint Commission on Health Care and the chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health on the prescribing of opioids and benzodiazepines in the commonwealth that includes data on reporting of unusual patterns of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or on potential misuse of a covered substance by a recipient. The law became effective immediately. The Virginia Board of Dentistry approved an emergency regulation related to prescribing opioids for pain management, including updates to continuing education requirements. The emergency regulation became effective July 21.
Washington	On May 16, the governor signed HB 1427 into law. The new law provides that by January 1, 2019, the following disciplining authorities must adopt rules establishing requirements for prescribing opioid drugs: the Dental Quality Assurance Commission, the Medical Quality

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	Assurance Commission, the Board of Osteopathic Medicine and Surgery, the Nursing Care Quality Assurance Commission, and the Podiatric Medical Board. The rules may contain exemptions based on education, training, amount of opioids prescribed, patient panel and practice environment. In developing the rules, the disciplining authorities must consider the Agency Medical Directors' Group and Centers for Disease Control guidelines and may consult with the Department of Health, the University of Washington and professional associations. As part of the implementation of HB 1427, there will be a series of seven workshops, open to the public, held around the state to implement the new law between September 2017 and March 2018. Members of the public may provide comment during the workshops. For the boards and commissions, representatives from the five boards and commissions will form a work group to create prescribing rules. The deadline for the boards and commissions to adopt their rules is January 1, 2019. The Prescription Monitoring Program (PMP) plans to complete its work during this same time. To learn more about the key aims of the work group click here. Additionally, on July 17, the Department of Health filed a notification of intent to amend a rule with the Office of the Code Reviser. The notice indicates forthcoming rule changes related to the PMP and implementation of HB 1427.
West Virginia	On Apr. 26, the governor signed HB 2620 into law. The new law establishes the Office of Drug Control Policy, created within the Department of Health and Human Resources under the direction of the Secretary and the supervision of the State Health Officer. The Office of Drug Control Policy must create a state drug control policy in coordination with the bureaus of the department and other state agencies. This policy shall include all programs that are related to the prevention, treatment and reduction of substance abuse use disorder. The Office of Drug Control Policy shall (1) develop a strategic plan to reduce the prevalence of drug and alcohol abuse and smoking by at least 10% by July 1, 2018; (2) monitor, coordinate and oversee the collection of data and issues related to drug, alcohol and tobacco access, substance use disorder policies and smoking cessation and prevention and their impact on state and local programs; (3) make policy recommendations to executive branch agencies that work with alcohol and substance use disorder issues, and smoking cessation and prevention to ensure the greatest efficiency and consistency in practices will be applied to all efforts undertaken by the administration; (4) identify existing resources and prevention activities in each community that advocate or implement emerging best practices and evidence-based programs for the full substance use disorder continuum of drug and alcohol abuse education and prevention, including smoking cessation or prevention, early intervention, treatment and recovery; and (5) encourage coordination among public and private, state and local agencies, organizations and service providers and monitor related programs.
Wisconsin	On Jan. 5, the governor issued an executive order directing multiple agencies to take specific actions as outlined in a report by the Governor's Task Force on Opioid Abuse. On that day, the governor also signed an executive order calling for a special session of the state legislature to consider 11 bills implementing the recommendations of the task force related to legislation and funding.

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	On July 17, the governor signed a total of 11 opioid abuse bills into law. A few are spotlighted here. AB 7 appropriates additional funds of $63,000 for fiscal year 2017–18, and the same amount for FY 2018–19, to support graduate fellowships in addiction medicine or addiction psychiatry. As a requirement of receiving a grant of funds appropriated under the Act, a hospital must expand fellowship positions in addiction medicine or addiction psychiatry for physicians practicing family medicine, general internal medicine, general surgery, pediatrics or psychiatry. AB 4 generally prohibits the dispensing of a Schedule V controlled substance that is categorized as a "narcotic drug containing nonnarcotic active medicinal ingredients" without a prescription. The Schedule V controlled substances currently included in this category are those containing codeine, dihydrocodeine, ethyl morphine, diphenoxylate, opium, or difenoxin in the amounts and in certain compounds, as applicable, that are specified in the statutes. However, the prescription requirement created under the Act does not apply to a substance dispensed directly by a practitioner, other than a pharmacy, to an ultimate user. AB 9 requires the Department of Health Services to create and administer an addiction medicine consultation program. The purposes of the consultation program must include assisting clinicians in providing enhanced care to patients with substance addiction and providing referral support for patients with a substance abuse disorder. The Act appropriates $500,000 for fiscal year 2017–18, and the same amount for fiscal year 2018–19, to create and operate the program.
Wyoming	On March 6, the governor signed SF 42 into law. The new law authorizes pharmacists, physicians, physician assistants and advanced practice registered nurses to prescribe an opiate antagonist to a person at risk of experiencing an overdose, a person in a position to assist another person or a person who, in the course of the person's official duties or business, may encounter another person experiencing an overdose. The law took effect July 1.