Summary of State Legislation and Regulations Addressing Prescription Drugs and Opioids

November 2018

This document is a compilation of recently enacted state legislation, rules and regulations that address prescription drug and opioid policies. The policies highlighted in this document are limited to those relevant to academic dentistry, generally covering policy changes to prescribing practices, prescription drug monitoring programs, or continuing education requirements. Changes to treatment or law enforcement policies are not covered. To stay updated as relevant opioid legislation, rules and regulations are considered in 2019, please visit the ADEA U.S. Interactive Legislative Tracking Map and the ADEA U.S. 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" indicates that no information was available at the time of inquiry or that the state has not recently made changes to opioid policies. For further assistance, please contact Tim Leeth, ADEA Chief Advocacy Officer, at leetht@adea.org or Phillip Mauller, ADEA Senior Manager of Government Relations, at maullerp@adea.org.

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United States	In October 2018, President Trump signed the Support for Patients and Communities Act. This legislation addressed numerous aspects of the opioid crisis, including treatment, education, and prescribing practices. This summary highlights the provisions that affected prescribing practices, but does not include those specific to Medicare populations as Medicare does not provide coverage for dental services. A complete summary of the bill can be found using the above link. This bill made the following changes: • Allows the Centers for Disease Control and Prevention (CDC) to provide technical assistance and award grants to improve Prescription Drug Monitoring Programs (PDMPs), promote new approaches for responding to emerging public health crises, and improve overdose data reporting. • Alters requirements relating to PDMPs. Among other changes, the bill authorizes federal support for specific PDMP improvements regarding use, data reporting, and intrastate and interstate interoperability. • Requires the U.S. Department of Health and Human Services (HHS) to establish a demonstration program through which hospitals and emergency departments receive grants to support alternative pain-management protocols and treatments that limit the use and prescription of opioids in emergency departments. • Requires the Food and Drug Administration (FDA) to develop guidance regarding alternative methods for collecting data on opioid sparing (i.e., the use of drugs that reduce pain while also allowing reduced use or avoidance of oral opioids) and using such information in product labels.

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	• Requires HHS to develop best practices for health care providers and state agencies regarding the display of a patient's history of opioid addiction in the patient's medical records. • Requires the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) to annually notify health care providers about health information that may be disclosed under federal privacy laws to families, caregivers, and health care providers during emergencies, including overdoses.
Alabama	SB 200 created the Information Release Review Committee to review statistical, research, or educational requests for information under the PDMP. In June, the Board of Dental Examiners adopted a new administrative rule that requires licensed dentists and dentists who are issued a special teaching permit to register with the PDMP before renewing a state controlled substance license. In September, the Board adopted another administrative rule that requires dentists to utilize the state's PDMP and use risk and mitigation strategies. A violation of the rule is subject to discipline, and dentists are required to document the use of risk and mitigation strategies under the following circumstances: • The continuation of controlled substance therapy greater than seven days for any patient. • Prior to prescribing any controlled substance of more than 50 MME/day. • For any patient that is prescribed three or more acute pain medicine prescriptions by the dentist in any 90-day period. • For any patient who gives a history of chronic pain medicines and/or benzodiazepines, so that the dentist may coordinate therapy with the patient's other prescribing medical providers and verify the specifics of the chronic medications. Due to the heightened risk of adverse events associated with the concurrent use of opioids and benzodiazepines, dentists should consider alternative forms of treatment.
Alaska	In September 2018, the Board of Dental Examiners adopted a new rule that requires dentists who hold an active Drug Enforcement Agency (DEA) registration number to register with the state's PDMP and complete at least two hours of continuing education in pain management and opioid use and addiction.
Arizona	SB 1001 was signed by the Governor in January 2018. The bill made numerous changes to opioid laws, including the following provisions that are relevant to academic dentistry: • Prohibits dentist, podiatrists, allopathic physicians, physician assistants, osteopathic physicians, optometrists and homeopathic physicians from dispensing Schedule II controlled substances that are opioids and establishes violations as an act of unprofessional conduct. • Limits an initial prescription, with exceptions for specified conditions, for a Schedule II controlled substance that is an opioid to a five-day supply and permits a 14-day supply for initial prescriptions following a surgical procedure. • Prohibits a prescriber from issuing a new prescription order for a Schedule II controlled opioid that exceeds 90 morphine milligram equivalents (MMEs), unless the prescription is a continuation of a prior prescription order issued within the previous 60 days, an opioid with a maximum approved total daily dose in the

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	labeling as approved by the FDA, or for a patient who is hospitalized or has another specified medical condition. • Directs a health professional who believes a patient requires more than 90 MMEs per day to consult with a licensed physician who is a board-certified pain specialist. • Permits a health professional to prescribe in excess of the 90 MME limitation if the consulting physician is not available for consult within 48 hours. • Requires that a health professional additionally prescribe Naloxone, or another opioid antagonist, to a patient who is prescribed more than 90 MMEs per day. • Requires an electronic prescription to a pharmacy for a Schedule II drug that is an opioid in Maricopa, Pima, Pinal, Yavapai, Mohave and Yuma counties beginning Jan. 1, 2019. • Requires an electronic prescription to a pharmacy for a Schedule II drug that is an opioid in Greenlee, La Paz, Graham, Santa Cruz, Gila, Apache, Navajo, Cochise and Coconino counties beginning July 1, 2019. • Requires the Board of Pharmacy to adopt rules to establish a waiver process for electronic prescription requirements for medical practitioners who lack adequate access to broadband or face other hardships that prevent compliance. • Directs the Director of the Board of Pharmacy to provide a report to the Governor and the presiding officer in each legislative chamber by Sept. 1, 2018, regarding the ability of health care providers to access and use electronic prescribing tools and comply with electronic prescribing requirements. • Allows health regulatory boards to receive information from the PDMP regardless of if there is an open investigation or complaint. • Eliminates the exemption from requirements to query the PDMP if prescribing no more than a five-day supply and the PDMP has been reviewed in the last 30 days. • Directs each county Board of Supervisors to establish, by Dec. 31, 2018, at least one location in the county where a person is permitted to drop off drugs, substances and drug paraphernalia, and receive a referral to a substance abuse treatment facility. • Requires medical students who are enrolled in a public or private medical school in this state, and whose intended degree may render the student eligible for a DEA registration, to complete at least three hours of opioid-related clinical education. HB 2549 became law in April 2018. The bill made numerous changes to opioid laws, including the following provisions that are relevant to academic dentistry: • Exempts prescriptions capped at a 14-day supply (established by SB 1001) that are issued following a surgical procedure from the 90 MME per day limitation. • Clarifies that the 90 MME limit applies to prescriptions that are filled or dispensed outside of a health care institution. • Allows a health professional to issue a prescription that exceeds 90 MMEs if the consulting physician who is board-certified in pain or an opioid call service agrees with the higher dose. SB 1111 became law in March 2018. This bill amends unemployment law to require before prescribing an opioid analgesic or benzodiazepine controlled substance listed in Schedule II–IV for an employee, and at least quarterly while that prescription remains a part of the treatment, a physician to query the PDMP and report the results of that inquiry to the

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	carrier, self-insured employer, or commission as soon as reasonably practicable but not later than 30 days after the date of injury. In October, the Department of Health Services adopted a new rule (page 3020 in the linked document) that will be effective July 1, 2019. The rule requires an administrator of a health care institution where opioids are prescribed or ordered as part of treatment shall establish, document, and implement policies and procedures for prescribing or ordering an opioid as part of treatment that includes how, when, and by whom a patient's profile in the PDMP is reviewed and, if applicable, include documenting a dispensed opioid in the PDMP
Arkansas	The Arkansas Board of Dental Examiners adopted a rule that: • Requires dentists who prescribe to register with the PDMP and access patient information before writing a prescription for an opioid. Provides that failure to access the PDMP is subject to disciplinary action. • Limits prescriptions for Schedule II or III opiates to the total maximum manufacturer's recommended daily dose for a total of 7 days administration • Obtain a minimum of three hours of prescribing education approved by the board that includes specified topics by Dec. 31, 2019, within the first two years of being granted a license in the state. • Document patient records for any need of re-dosing.
California	AB 1751 was signed by the Governor in September 2018. The bill authorizes the state Department of Justice (DOJ) to share prescription records between the state's PDMP, with a requirement that other states meet California's patient privacy and data security standards. Require the DOJ to, no later than July 1, 2020, memorialize its policies regarding the access and use of the information within the PDMP through the public rulemaking process, which must among other things include regulations dictating when a warrant is required for searches of the system as part of a criminal investigation. AB 2086 became law in September 2018, and requires the state DOJ to allow prescribers to access the PDMP database for a list of patients for whom that prescriber is listed as a prescriber in the PDMP. SB 1109 became law in September 2018. This bill made several changes, including: • Requires the mandatory continuing education course for dentists and other healthcare professions to include the subject of the risks of addiction associated with the use of Schedule II drugs. • Requires the Medical Board of California to give its highest priority to considering a course in the risks of addiction associated with use of Schedule II drugs among its continuing education. Provides that a violation of these requirements is not a criminal offense. • Provides that a dispenser must prominently display on the label or container, by means of a flag or other notification mechanism attached to the container, a notice that states "Caution: Opioid. Risk of overdose and addiction," whenever a prescription drug containing an opioid is dispensed for outpatient use. • Requires a prescriber to discuss the risks of addiction and overdose with a minor, or the minor's parent or guardian, or another adult authorized to consent to the minor's medical treatment before directly dispensing or issuing the first

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	prescription in a single course of treatment for a controlled substance containing an opioid.
Colorado	SB 22 was signed into law on May 21, 2018. This legislation: • Restricts the amount of opioid medication that a health care practitioner, including dentists, may prescribe for an initial prescription to a seven-day supply and allows each health care practitioner to exercise discretion to include a second fill for a seven-day supply. • Allows for exceptions to the limitation if, in the judgment of the practitioner, the patient: has chronic pain that typically lasts longer than 90 days or past the time of normal healing; has been diagnosed with cancer and is experiencing cancer-related pain; or is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days. • Allows a dentist to prescribe opioid electronically. • Requires the department of public health and environment to report to the general assembly its findings from studies regarding the prescription drug monitoring program conducted pursuant to a federal grant program. HB 1003 was signed into law on May 21, 2018 and made the following changes: • Directed the center for research into substance use disorder prevention, treatment, and recovery to develop and implement continuing medical education activities to help prescribers to safely and effectively manage patients with chronic pain, and when appropriate, prescribe opioids. • Established the opioid and other substance use disorders study committee, consisting of general assembly members, to study specified topics and solutions regarding the scope of the substance use disorder problem in Colorado. Authorizes the committee is authorized to meet six times in a calendar year and report up to six legislative measures to the legislative council. • Directed the department of health care policy and financing, starting July 1, 2018, to award grants to organizations to operate a substance abuse screening, brief intervention, and referral program. • Made several changes to policies related to treatment and education. • Required the legislature to appropriate a specified amount of funds to implement each policy.
Connecticut	HB 5241 was signed into law on June 7 and requires the public health and consumer protection commissioners to review pharmacists' and prescribing practitioners' compliance rate with the electronic Prescription Drug Monitoring Program's requirements. By January 1, 2019, the commissioners must submit a joint report to the General Law and Public Health committees with their shared recommendations, if any, to achieve a 100% compliance rate.
Delaware	SB 206 became law on Sept. 10, 2018. The bill allows the State Epidemiologist to use PDMP data for the purpose of public health surveillance. "Public health surveillance" is defined as "the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice." The legislation allows public health surveillance to be used for any of the following purposes: an early warning system for impending public health emergencies; to document the impact of an intervention; track progress towards specified goals; monitor and clarify the epidemiology of health problems; establish public health priorities; and inform public health policy and strategies. The bill also requires the Office of Controlled

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	Substances to provide data in the PDMP in the form of a report to the Office of the State Epidemiologist in the Division of Public Health, for the purpose of reviewing and analyzing public health surveillance data related to drug overdoses. SB 225 was signed by the Governor on Sept. 10, 2018. This legislation adds continuing education requirements for prescribers relating to risks of opioids and alternatives to opioids. The bill also requires mandatory coverage for services provided by physical therapists, and prohibits insurers from placing numerical limits on physical therapy and chiropractic care.
District of Columbia	N/A
Florida	HB 21 was signed by Governor Scott in March 2018. This legislation took effect on July 1 and established numerous changes to the state's opioid prescribing and dispensing policies. Those changes included: • All medical prescribers are now required to complete a board-approved two-hour continuing education course on prescribing controlled substances. The course must be completed no later than Jan. 31, 2019, and before each subsequent licensure renewal, as a condition for licensure. • Prescriptions for Schedule II opioids prescribed for acute pain are limited to no more than a three-day supply (with exceptions for specified conditions), or up to a seven-day supply may be issued if it is determined to be medically necessary the prescriber records the acute medical condition and lack of alternative treatment options that justify deviation from the three-day supply limit, and indicates "acute pain exception" on the prescription. • Dispensing practitioners are limited from dispensing a supply of a Schedule II opioid to three days, or up to a seven-day supply if the practitioner determines it is medically necessary, and follows the same specified procedures listed for prescribing Schedule II opioids for acute pain. • All regulatory boards within the Department of Health are required to adopt rules establishing guidelines for the prescribing of controlled substances to treat acute pain. Practitioners who fail who fail to follow the guidelines to are subject to disciplinary action by respective boards. • All prescribers and dispensers, or an authorized designee, are required to consult the PDMP to review a patient's dispensing history prior to prescribing or dispensing a controlled substance for patients age 16 and older. • Increases penalties for medically unnecessary or fraudulent prescriptions. • Allows the Department of Health to enter into agreements or contracts to establish secure connections between the system and a prescribing or dispensing health care practitioner's electronic health recordkeeping system. • Allows the state PDMP to share data with compatible systems from other states pursuant to agreements entered into by the Department of Health. • Requires all Schedule V opioids dispensed to be reported to the PDMP by the dispenser • Aligns the state's Controlled Substance Act with the federal Schedules of controlled substances. • Purges PDMP records after four years.

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	In August, rule amendments adopted by the Board of Dentistry implemented a rule to provide that failure to report controlled substance dispensing information to the PDMP results in a $250 fine and failure to consult the PDMP as required shall result in a $100 fine. Also in August, the board adopted a rule required by HB 21 to compel all licensees who are registered with the DEA and authorized to prescribe controlled substances to complete a board-approved 2-hour course on prescribing controlled substances by Jan. 31, 2019 and at each subsequent biennium renewal or for reactivation of a license. Newly adopted board standards for the prescribing of controlled substances for the treatment of acute pain go into effect December 2018. These were adopted to comply with HB 21.
Georgia	SB 407 became law on July 1, 2018. This bill deletes requirements that delegates be licensed to access the PDMP, allows PDMP data to be shared with other state programs or an electronic medical records system operated by a prescriber or health care facility, and amends provisions related to law enforcement access to PDMP data. The Department of Public Health adopted rule changes in July to provide that PDMP information may be accessed by a PDMP operated by a government entity in another state, or an electronic medical records system operated by a prescriber or health care facility, provided that the program or system has been determined by DPH to contain legal, administrative, technical, and physical safeguards that meet or exceed the security measures employed by DPH in the operation of the PDMP. The rule also grants PDMP access to federal law enforcement or prosecutorial officials may obtain PDMP information with an administrative subpoena or civil investigation demand.
Hawaii	The following measures were signed into law on July 11, 2018. HB 1602 requires a health care professional or pharmacist who dispenses any opioid drug to include a specific warning label on the drug's package advising the patient of the risks of addiction and overdose, and also requires the warning to be included in an acknowledgement signed by the patient or person receiving the medication for the patient, and by the dispensing practitioner or pharmacist. SB 2247 authorizes pharmacists to prescribe, dispense, and provide related education on opioid antagonists to individuals at risk of opioid overdose and to family members and caregivers of individuals at risk of opioid overdose without the need for a written, approved collaborative agreement; subject to certain conditions. SB 2646 requires prescribers to consult the state's PDMP before issuing a prescription for a Schedule II–IV controlled substance, under certain circumstances. Exempt from this requirement: any prescription for a supply of three days or less that is made in an emergency situation, by an emergency medical provider, and any prescription written while the PDMP is nonfunctional. Provides that a violation by a prescriber shall not be subject to criminal penalty provisions but that a violation may be grounds for professional discipline.
Idaho	HB 354 became law in February 2018 and requires the dispensing of opioid antagonists to be reported to the PDMP.

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Illinois	HB 4707 became law in August 2018 and creates the Prescription Drug Task Force to study prescription opioid abuse in this State; study the over-prescription of opioids such as Hydrocodone and Oxycodone; and recommend any legislation, including amendments to the Illinois Controlled Substances Act, which would have the effect of reducing opioid addiction and abuse. HB 4907 was signed by the Governor in August 2018. This bill requires a designee authorized to access the PDMP on behalf of the prescriber or dispenser to receive training in the federal Health Insurance Portability and Accountability Act (HIPPAA), and to be employed in the office of the prescriber or dispenser. SB 336 became law in August 2018. This bill establishes a pilot program allowing an individual with a medical condition for which an opioid has been or could be prescribed to instead use medical marijuana for a period of no more than 90 days. Participation in the program requires the written certification from a physician, and dentists are not currently permitted to write the certification. SB 2777 was signed by the Governor on August 2018 and requires every prescriber who is licensed to prescribe controlled substances, during the pre-renewal period, to complete three hours of continuing education on safe opioid prescribing practices offered or accredited by a professional association, State government agency, or federal government agency. SB 2952 became law in August 2018. This bill: • Provides that the PDMP administrator must receive, store, and maintain a prescription record users database which shall be the Prescription Information Library. • Provides that to ensure the federal HIPPAA privacy of an individual's prescription data reported to the PDMP received from a retail dispenser under this Act, and in order to execute the duties and responsibilities under this Act and rules for disclosure under this Act, the Clinical Director of the PDMP or his or her designee must maintain direct access to all PDMP data. • Requires any request for PDMP data from any other department or agency must be approved in writing by the Clinical Director of the Prescription Monitoring Program or his or her designee unless otherwise permitted by law. • Alters composition of the PDMP advisory committee.
Indiana	SB 139 was signed by the Governor on March 22, 2018. This law requires the county coroner to do the following if the cause of a person's death is reasonably suspected to be accidental or intentional overdose of a controlled substance: (1) obtain any relevant information about the decedent maintained by the PDMP, (2) extract and test certain bodily fluids of the decedent, (3) report test results to the state department of health (department), and (4) provide the department notice of the decedent's death, including any information related to the controlled substances involved, if any. SB 221 became law on March 22, 2018. This bill makes the following changes: • Requires the following practitioners to obtain information about a patient from the PDMP before prescribing an opioid or benzodiazepine to the patient: (1) a practitioner who has had the information from the PDMP integrated into

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	the patient's electronic health records; (2) beginning Jan. 1, 2019, a practitioner who provides services to the patient in the emergency department of a hospital or a pain management clinic; (3) beginning Jan. 1, 2020, a practitioner who provides services to the patient in a hospital; (4) beginning Jan. 1, 2021, all practitioners. • Provides that a practitioner is not required to obtain information about a patient who is subject to a pain management contract from the PDMP more than once every 90 days. • Requires, beginning Jan. 1, 2019, a practitioner who is permitted to distribute, dispense, prescribe, conduct research with respect to a controlled substance must be certified to receive information from the PDMP. • Allows a practitioner to request a waiver from the requirement of checking the PDMP before prescribing an opioid or benzodiazepine if the practitioner does not have access to the Internet at the practitioner's place of business. SB 225 was signed by the Governor on March 13, 2018. This bill requires licensed health care practitioners who apply for a controlled substances registration to complete two hours of continuing education during the previous two years addressing the topics of opioid prescribing and opioid abuse. The law also requires all courses to be approved by the licensing board that regulates the practitioner and to be offered by an approved organization. The continuing education requirements expire July 1, 2025.
Iowa	HF 2377 was signed into law on May 11, 2018. The bill makes the following changes: • Requires all prescribing practitioners to register for the PDMP. • Requires the Boards of Medicine, Nursing, and Dentistry to adopt rules requiring licensees to receive continuing education credits regarding the Centers for Disease Control and Prevention guidelines for prescribing opioids. • Requires pharmacies or prescribing practitioners that dispense a controlled substance to report the dispensing of the controlled substance to the Program within one business day. • Removes the four-year retention limit of PDMP information. • Requires all prescriptions to be electronically transmitted to a pharmacy effective Jan. 1, 2020, and includes provisions for exemptions and administrative penalties. • Requires the Board of Pharmacy to annually issue a prescribing practitioner activity report of PDMP activity to each practitioner registered with the Program. • Requires the Board to include information on general patient risk factors and educational updates in the PMP. • Requires the Board of Pharmacy to establish criteria for the identification of patients who are potentially misusing or abusing prescription opioids, and authorizes the Board to proactively notify the pharmacist and prescribing practitioner involved in the patient's care of the Board's concern. • Requires licensing boards that have prescribing practitioners to establish penalties for those who prescribe in dosage amounts exceeding what would be prescribed by a reasonably prudent prescribing practitioner. • Adds opioid antagonists (including the administration of) to the list of drugs reportable to the PDMP. • Removes "biennial" from the Controlled Substance Act registration requirements, which will permit registration frequency to be established by the Board of Pharmacy.

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	• Expands the disciplinary action available for the Board to take against CSA registrants beyond suspension, revocation, or restriction. • Changes the scheduling of specified opioid substances.
Kansas	SB 282 adds several synthetic opioid fentanyl compounds and an opioid analgesic drug to Schedule I. This bill was signed by the Governor on May 4, 2018.
Kentucky	HB 213 expands interstate PDMP data sharing allowed under state law to allow the Secretary of the Cabinet for Health and Family Services to enter into PDMP data sharing agreements with any jurisdiction, county, or political subdivision, in addition to state and U.S. government entities already allowed by law. This legislation was signed into law on March 28, 2018.
Louisiana	SB 75 was signed into law on May 23, 2018. This bill requires a health profession licensing board to provide notice to a prescriber and provide an opportunity to come into compliance with the statutory requirements to consult PDMP upon the prescriber's first failure to comply. Provides that licensing boards must consider second and subsequent failures to comply as a complaint against the licensee (previous law required this to be done after the first failure). SB 285 prohibits a health insurance issuer from denying coverage of a non-opioid prescription drug in favor of an opioid prescription drug. Provides that when opioids are deemed medically necessary by a licensed physician, it is unlawful for an insurer to deny a physician prescribed medication and recommend an alternative prescription which requires any of the following: (1) An increased number of pills per prescription, (2) A higher Drug Enforcement Administration schedule medication than the one prescribed; (3) The substitution of an extended release medication that does not have defined abuse deterrent properties for a prescription of a medication that does have defined abuse deterrent properties. This bill was signed into law on May 20, 2018.
Maine	HP 1325 allows a pharmacist to prescribe and dispense naloxone hydrochloride to an individual of any age who is at risk of experiencing an opioid-related drug overdose, or to an immediate family member or a friend of an individual at risk of experiencing an opioid-related drug overdose. This bill became law on May 2, 2018. In November 2018, the Board of Dental Practice adopted new rules that required dentists to complete at least 40 credit hours of CE, including three hours that cover the prescription of opioid medication.
Maryland	HB 115 and SB 13 are identical companion bills that were signed into law on May 8, 2018. These bills require the Maryland Health Care Commission to assess the benefits and feasibility of developing an electronic system to allow health care providers to access a patient's prescription medication history. This would allow for integration of the state's PDMP data with e-health records. This type of integration reduces workflow disruptions for providers and increases compliance with state laws that require prescribers to consult the PDMP before prescribing an opioid medication. HB 517 became law on May 15, 2018 and provides that a prescriber is not required to request PDMP data when prescribing an opioid or benzodiazepine to treat or prevent acute pain for a period of not more than 14 days following a surgical procedure. Previous law only provided this exemption following a surgical procedure in which general anesthesia was used.

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	HB 653 and SB 522 are identical companion bills that became law on April 24, 2018 and require prescribers to discuss the benefits and risks associated with opioids when prescribing an opioid medication or co-prescribing a benzodiazepine with an opioid. SB 896 was signed into law on May 8, 2018. This bill establishes a Maryland Health Record and Payment Integration Program Advisory Committee to study the feasibility of creating a health record and payment integration program, including the feasibility of incorporating PDMP data into the state designated health information exchange so that prescription drug data can be entered and retrieved. HB 922 was passed on April 24, 2018 and requires the Maryland Department of Health to identify a method for establishing a tip line through which a person may report an individual suspected of prescribing medication or overprescribing medication in violation of the law. The bill also requires the Secretary of Health to examine the prescription and treatment history of individuals who suffered fatal overdoses involving opiates and other controlled substances and report the findings beginning July 1, 2019.
Massachusetts	HB 4742 became law on Aug. 9, 2018. This bill: • Requires the Department of Public Health to promulgate rules and regulations that require prescribers to utilize the prescription monitoring program each time a prescription for a narcotic drug that is contained in Schedule II or III, or a prescription for a benzodiazepine, prior to issuance. • Allows the department to require prescribers to utilize the prescription monitoring program prior to the issuance of any Schedule IV or V prescription drug, which is commonly misused and may lead to physical or psychological dependence or which causes patients with a history of substance dependence to experience significant addictive symptoms. • Creates a commission to review, make recommendations and report on non-opioid and non-pharmacological pain management strategies. Requires the commission to: (1) develop a plan for insurers to provide adequate coverage and access to non-pharmacological pain management treatment administered by health care providers licensed by the commonwealth, and (2) develop reasonable standards by which to assess provider networks and patient utilization of evidence-based treatment for pain management.
Michigan	N/A
Minnesota	N/A
Mississippi	N/A
Missouri	These bills became law on July 9, 2018: SB 718 specifies that patient scoring of pain control is not required when defining data standards for quality of care and patient satisfaction, and requires the Director of the Department of Insurance, Financial Institutions and Professional Registration to discontinue the use of patient satisfaction scores. SB 826 • Limits initial prescriptions for opioids to no more than a 7-day supply for the treatment of acute pain. • Allows more than a seven-day supply, if, in the practitioner's medical judgment, more than a seven-day supply is required to treat the patient, and the practitioner

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	notes in the patient's medical record, the condition triggering the necessity for a greater quantity and that a nonopioid was not appropriate. • Prior to prescribing the opioid, a practitioner must consult with the patient regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity, as well as inform the patient of the risks associated with the prescribed opioid. • Exempts prescriptions for a patient who is: currently undergoing treatment for cancer, receiving hospice care or palliative care, a resident of a long-term care facility, or receiving treatment for substance abuse or opioid dependence. • Allows a Drug Enforcement Agency-authorized collector, in accordance with federal regulations, to accept unused controlled substances from ultimate consumers, even if the authorized collector did not originally dispense the drug.
Montana	N/A
Nebraska	LB 731 was enacted in April 2018. This bill requires several categories of prescribers, including dentists, to complete three hours of continuing education biennially regarding prescribing opiates, and requires that at least a half hour of the CE to include information regarding the state's PDMP. LB 931 was enacted in April 2018. This legislation: • Prohibits a practitioner who is prescribing an opiate for a patient younger than eighteen years of age for outpatient use for an acute condition from prescribing more than a seven–day supply and, if the practitioner has not previously prescribed an opiate for such patient, discuss with a parent or guardian of such patient, the risks associated with use of opiates and the reasons why the prescription is necessary. o Allows more than a seven-day supply if it is necessary in the professional medical judgment of the practitioner to treat a medical condition or is necessary for the treatment of pain associated with a cancer diagnosis or for palliative care. Requires the practitioner to document the medical condition triggering the prescription of more than a seven-day supply, and indicate that a non-opiate alternative was not appropriate to address the medical condition. • Requires a prescriber, prior to issuing an initial prescription or third prescription for an opiate or Schedule II controlled substance, for a course of treatment for acute or chronic pain, to discuss with the patient: the risks of addiction and overdose associated with the controlled substance or opiate being prescribed, that addresses specific topics required by the legislation; the reasons the prescription is necessary; and alternative treatments that may be available. • Requires individuals to display identification when receiving opiate medication, unless the individual taking receipt of dispensed opiates listed in Schedule II, III, or IV is personally and positively known to the pharmacist or dispensing practitioner. LB 1034 became law in April 2018, and creates a clarifying technical change to the definition of dispensed prescription for purposes of reporting to the PDMP.

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Nevada	In January, the Board of Pharmacy adopted a regulation requiring the dispensing of Schedule V controlled substances to be reported to the PDMP. In June, the Board of Pharmacy adopted another regulation that • Requires a practitioner or other person who is required to register with the Board to dispense controlled substances to enroll with the Board for Internet access to the PDMP. • Authorizes a practitioner and a hospital, respectively, to designate certain persons as delegates for the purpose of accessing the PDMP. Delegates must complete training, and practitioners are held liable actions of the delegate. • Authorizes the Executive Secretary of the Board on behalf of the Board to suspend or terminate, before a hearing, the Internet access of a practitioner or other person to the database of the computerized program if the practitioner or other person accesses the database in violation of certain provisions, and establishes hearing requirements if a violation occurs. In June, the Board of Pharmacy adopted a regulation clarifying rules for the treatment of pain, that included: • Defining "acute pain" as pain that has an abrupt onset and is caused by injury or another cause that is not ongoing. The term does not include chronic pain or pain that is being treated as part of care for cancer, palliative care, hospice care or other end-of-life care. • Defining "course of treatment" means all treatment of a patient for a particular disease or symptom of a disease, including, without limitation, a new treatment initiated by any practitioner for a disease or symptom for which the patient was previously receiving treatment. • Specifying the conditions under which a practitioner has obtained informed written consent from a patient for the use of a controlled substance. • Specifying the conditions under which a practitioner will be deemed to have made a good faith effort to obtain the medical records of the patient.
New Hampshire	N/A
New Jersey	S 3604 passed the legislatures in December 2017 and was signed by the Governor on Jan. 16, 2018. This bill: • Requires practitioners to access the PDMP on or after the date that the division first makes information available on an electronic system that collects and displays health information, any time the practitioner prescribes a Schedule II controlled dangerous substance for acute or chronic pain to a patient receiving care or treatment in the emergency department of a general hospital. • Prohibits a pharmacist from dispensing any opioid medication that is a Schedule II-IV controlled substance prior to consulting the PDMP. • Grants medical scribes, and athletic trainers authorized by a practitioner, access to the PDMP. • Allows PDMP information to be made available on electronic systems that collect and display health information.

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	In July, The Division of Consumer Affairs adopted a regulation that required the director of the division to review PDMP information to identify whether: (1) any person is obtaining a prescription in a manner that may be indicative of misuse, abuse, or diversion of a controlled dangerous substance; when an evaluation of the information indicates that a person may be obtaining a prescription for the same or similar controlled dangerous substance from multiple practitioners or pharmacies during the same period, the Division may provide PDMP information about the person to practitioners and pharmacies; and (2) a violation of law or regulation or breach of the applicable standards of practice by any person may have occurred, including, but not limited to, diversion of a controlled dangerous substance; if the Division determines that such a violation or breach may have occurred, the Division shall notify the appropriate law enforcement agency or professional licensing board and provide the PDMP information required for an investigation.
New Mexico	N/A
New York	SB 7507 was signed by the Governor in April 2018. This bill prohibits, with exceptions for cancer treatment and end of life care, opioids from being prescribed to a patient for pain lasting more than three months or past the time of normal tissue healing, unless the medical record contains a written treatment plan that follows generally accepted national professional or governmental guidelines. SB 9100 became law in July 2018, and enacts the drug take back act requiring certain manufacturers to operate a drug take back program to accept and dispose of covered drugs. The act requires the commissioner of health to establish a distribution plan that ensures that on-site collection receptacle or drop-box placement shall be reasonably accessible to all residents, for any city with a population of 125,000 or more as of the last decennial census.
North Carolina	SB 616 became law in June 2018, and makes several changes to the state's PDMP laws, including: • Requiring dispensers to report a prescriber's national provider identification number, and relieving a pharmacy or pharmacist from liability for failure to report a prescriber's national identification number when it is not received by the pharmacy. • Authorizing access to the Attorney General of North Carolina, and the Tactical Diversion Squad in North Carolina. • Creating the following criminal offenses: class I felony for accessing unauthorized prescription information in the CSRS; class I felony for disclosing prescription information for an unauthorized purpose; and class H felony for maliciously obtaining, disclosing, or disseminating prescription information for personal gain or to cause harm. • Expands the SBI's Diversion & Environmental Crimes Unit's jurisdiction to include suspected criminal use of the CSRS, and establishes conditions for the use and release of that information.
Ohio	N/A
Oklahoma	SB 937 became law in April 2018 and grants tribal law enforcement access to the state's PDMP.

	SB 1446 was signed by the Governor on May 2, 2018. This law: • Provides that failure to consult the PDMP, by a person registered to dispense, prescribe, or administer controlled substances, is grounds for a licensing board to take disciplinary action • Prohibits a practitioner from issuing an initial prescription for an opioid intended to treat acute pain for more than a seven-day supply, and requires all prescriptions for acute pain to be for the lowest effective dose of immediate-release opioid drug. o Allows for a second seven-day supply to be prescribed after no less than seven days from issuing the initial prescription provided that practitioner determines it is necessary and documents the rationale for the second prescription, and the practitioner determines the prescription does not present undue risk of abuse, addiction, or diversion and documents that determination. • Requires a practitioner to discuss with the patient or the parent or guardian if the patient is under 18, prior to issuing an initial prescription for an opioid or any Schedule II controlled substance for the treatment of acute pain, the risks of addiction and overdose, why the prescription is necessary, alternative treatments, and the risks associated with the use the drugs being prescribed. • Requires practitioners, prior to issuing an initial prescription for an opioid, to conduct an examination of a patient pursuant to procedures prescribed by the bill, develop a treatment plan with attention focused on determining the cause of the pain, and enter into a patient-provider agreement if the patient is pregnant, or in the case of a patient under 18, enter into an agreement with the patient's parent or guardian. • Requires practitioners, when continuously prescribing Schedule II or any opioid for more than three months (subject to exemptions for patients with specified conditions) to review the course of treatment at least every three months, ass the patient prior to every renewal, periodically make reasonable efforts to stop the use of the controlled substance or decrease dosage, review the PDMP, and monitor compliance with the pain management agreement. • Requires practitioners to enter into a pain management agreement with the patient with any patient at the time of the issuance of the third prescription for an opioid drug. • Provides that individuals licensed by the Board of Medical Licensure must at least one hour of education in pain management or opioid use and addiction each year preceding an application for renewal of a license. • Modifies the definition of "unprofessional conduct" for individuals licensed by the Board of Medical Licensure by including the prescribing, dispensing or administering opioid drugs in excess of the authorized maximum dosages. • Permits the Oklahoma State Bureau of Narcotics and Dangerous Drugs to provide unsolicited notification to the licensing board of a pharmacist or practitioner if a patient has received one or more prescriptions for controlled substances in quantities or a frequency inconsistent with generally recognized standards of safe practice or if a practitioner or prescriber has exhibited prescriptive behavior consistent with generally recognized standards indicating potentially problematic prescribing patterns. • Provides that insurers must implement a cost sharing requirement for an initial prescription of an opioid medication.

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	• Requires the Insurance Department to evaluate the effect of the limits on prescriptions of opioid medication on claims paid by health insurance carriers.
Oregon	HB 4143 was signed by the Governor on April 11 and requires practitioners to register with the PDMP. The Oregon Health Authority, Public Health Division adopted a rule to implement HB 4143 and requires all practitioners with an active DEA registration number to register with the PDMP.
Pennsylvania	N/A
Puerto Rico	N/A
Rhode Island	HB 7416 and SB 2541 are identical companion bills that became law in July 2018 and allow a pharmacist to dispense a partial fill of a Schedule II controlled substance at the request of the patient or the prescriber. Provides that subsequent fills must occur at the pharmacy where the original prescription was partially filled, until the original prescription is completely dispensed, and that the prescription expires 31 days after the date on which the prescription was written. HB 7496 and SB 2539 are identical companion bills that became law in July 2018, and establishes a procedure for individuals to file a revocable voluntary non-opiate directive form with the person's licensed health care practitioner. Requires the state Department of Health to establish a voluntary non-opiate directive form, and requires the department to establish specified regulations to implement the protocol. The state Department of Health adopted a rule in June 2018 that requires: • ICD-10 codes to be entered and transmitted with a prescription for controlled substances • Co-prescribing of Naloxone when: o Prescribing an opioid which individually or in aggregate with other medications is more than or equal to 50 morphine milligram equivalents (MMEs) per day, or document in the medical record why this is not appropriate for the patient. o Prescribing any dose of an opioid when a benzodiazepine has been prescribed in the past 30 days, or will be prescribed at the visit. Prescribers must note medical necessity of the co-prescription of the opioid and the benzodiazepine and explain why the benefit outweighs the risk given the FDA black box warning. o Prescribing any dose of an opioid to a patient with a prior history of opioid use disorder or overdose. Prescribers must note medical necessity of prescribing of the opioid and explain why the benefit outweighs the risk given the patient's previous history. The state Department of Health adopted another rule in May 2018 that adds Schedule V controlled substances and opioid antagonists to the list of substances required to be reported to the PDMP. The new rule also changes PDMP reporting requirements for pharmacists.

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South Carolina	HB 3819 became law in May 2018. This bill requires a prescriber, before issuing an initial opioid prescription to a minor to: • Assess whether the minor has ever suffered from or is currently suffering from a mental health or substance abuse disorder and whether the minor has taken or is currently taking prescription drugs for treatment of a mental health or substance abuse disorder. • Discuss the risks of addiction and dangers associated with taking an opioid including risks associated with the use of other substances. • Obtain written consent from the patient's parent or guardian, or authorized adult. • Prohibits the issuance of more than a 72-hour supply of an opioid if an authorized adult other than a parent or guardian signs the consent form. • Record the consent on a form developed by the Board of Medical Examiners. SB 918 became law in May 2018. This bill: • Prohibits an initial opioid prescription for acute pain management or postoperative pain management from exceeding a seven-day supply, except when clinically indicated for cancer pain, chronic pain, hospice care, palliative care, major trauma, major surgery, treatment of sickle cell disease, treatment of neonatal abstinence syndrome, or medication-assisted treatment for substance use disorder. • Requires the department to develop and maintain as part of the PDMP a system to provide prescription report cards to practitioners to inform the practitioner about certain prescribing trends. Requires the report card to contain specified information about the prescribers prescribing habits and patients receiving specified types of prescriptions. In December 2017, Governor McMaster established the South Carolina Opioid Emergency Response Team. The response team was tasked with reviewing state resources and developing methods to address specified elements of the opioid crisis in the state. The team and other collaborators issued the South Carolina Opioid Emergency Response Plan in June 2018. Included among the plan's policy recommendations, were recommendations for mandated prescriber education, implementing opioid prescribing guidelines, and integrating PDMP's into clinical settings.
South Dakota	N/A
Tennessee	HB 1831 was signed by the Governor in July 2018 and made numerous changes, including: • Prohibits a practitioner from treating an opioid naïve patient with more than a five-day supply of an opioid or a daily morphine milligram equivalent (MME) of 40 MME o Allows for a second prescription to be issued in exceptional cases where a health care practitioner determines that an additional supply of the opioid may be warranted and that circumstances would make it difficult for the patient to acquire a second prescription. • Prohibits treatment of an acute care patient with more than a 30-day supply of opioids, and requires a practitioner to personally assess and obtain informed consent from an acute care patient. • Provides that if the patient is a woman of childbearing age, the information provided as part of the informed consent process must include information regarding Neonatal Abstinence Syndrome and specific information regarding how to access contraceptive services in the community.

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	• Prohibits an acute care patient from being treated with opioids until after trial and failure of reasonable, appropriate, and available non-opioid treatments for the pain condition or documenting the contraindication or intolerance of non-opioid treatments. • Requires prescribing practitioners to check the PDMP prior to an initial prescription which has not been prescribed during the previous six months, and at least every six months thereafter; and prior to prescribing to an opioid naïve patient or an acute care patient and before the third prescription issued to such a patent. • Specifies that a practitioner has the professional responsibility to use heightened attention when prescribing to a patient who has recently been prescribed to by other practitioners. • Requires a dispensing practitioner to check the database at least once every six months after the initial dispensing, and also requires practitioners to check the database prior to dispensing pursuant to any prescription with written instructions indicating the earliest date on which the prescription can be filled. • Deletes present law exceptions to checking the database regarding low potential for abuse and small quantities. • Requires the commissioner, in consultation with regulatory boards that license healthcare practitioners, to study, analyze, and report on the impact and effects of the restrictions and limitations in the above provisions regarding opioid naive and acute care patients. HB 2348 became law in May 2018. This bill requires a prescriber who prescribes more than a five-day supply of opioids to a non-pregnant fertile woman to inform the woman of the risk of neonatal abstinence syndrome. Encourages prescribers to provide specified information regarding contraceptives, and minimize fetal exposure if pregnancy does occur. SB 777 was signed by the Governor in May 2018. This bill requires the Commissioner of Health to make appropriate recommendations for any needed additional legislation to address issues raised by opioid abuse, and report to the health committee of the house of representatives and the health and welfare committee of the senate on the impact of recent legislation regulating and licensing pain management clinics. SB 2025 became law in May 2018 and authorizes a partial fill of a prescription of a controlled substance. Requires any subsequent fill to occur at the pharmacy that initially dispensed the partial fill, and requires any subsequent fill shall be filled within 30 days from issuance of the original prescription.
Texas	In May the state Board of Dental Examiners adopted a rule increasing fees for registration with PDMP.
Utah	HB 37 became law in March 2018 and deletes PDMP requirement that each individual who is registered to use the PDMP must participate in the online tutorial and pass the online test, and also deletes provision that completing the online tutorial and passing the test counts as a half hour of continuing professional education. HB 127 became law in May 2018. This bill: • Eliminates the following exemptions to the requirement to check the PDMP for Schedule II and III opioids: prescriptions for less than a three-day supply; the

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	prescriber has prior knowledge of the patient's prescription history based on review of the patient's health record; or) the prescription is post-surgical for less than a 30 day supply. • Provides that a prescriber complies with the requirement to check the PDMP for Schedule II and III opioids by checking an electronic health record system if the electronic health record system that is connected to the PDMP, and is approved by the designated state agency. • Provides that a prescriber is not in violation for failure to consult the PDMP if the failure is: necessary due to an emergency; caused by a suspension or disruption in the operation of the database; or caused by a failure in the operation or availability of the Internet. • Prohibits the division from acting against the license of a prescriber for failure to consult the PDMP unless the failure occurs after the earlier of December 31, 2018, or the date that the division has the capability to establish a connection that meets the requirements established by law between the database and an electronic health record system. • Requires the division to review the database to identify any prescriber who has a pattern of prescribing opioids not in accordance with the recommendations of: (i) the CDC Guideline for Prescribing Opioids for Chronic Pain; (ii) the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, (iii) other publications describing best practices related to prescribing opioids as identified by division rule and in consultation with the Physicians Licensing Board. o Requires the division to offer voluntary education to a prescriber identified regarding best practices in the prescribing of opioids. HB 158 became law in March 2018 and grants Utah's Opioid Fatality Review Committee access to PDMP for the purpose of reviewing a specific fatality due to opioid use and recommending policies to reduce the frequency of opioid use fatalities. The bill also requires the division to make rules to establish submission requirements under this section, including electronic format, submission procedures, and required information and data fields, and changes requirements for the submission of data by pharmacists.
Vermont	N/A
Virginia	HB 313 and SB 728 are identical companion bills that became law in March 2018. These bills require the Director of the Department of Health Professions, in consultation with an advisory panel consisting of representatives from the relevant health regulatory boards, to annually review controlled substance prescribing and dispensing patterns. The bills also require the Director to make any necessary changes to the criteria for unusual patterns of prescribing and dispensing and report any findings and recommendations for best practices to the Joint Commission on Health Care by Nov. 1 of each year. HB 1173 and SB 632 are identical companion bills that became law in March 2018. These bills eliminate the surgical or invasive procedure treatment exception to the requirement that a prescriber request information from the PDMP when initiating a new course of treatment that includes prescribing opioids for a human patient to last more than seven days.

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	HB 1556 and SB 832 are identical companion bills that were signed by the Governor in March 2018. These bills add naloxone and Schedule V controlled substances for which a prescription to the list of covered substances that must be reported to the PDMP. HB 5002 is the state's budget bill that was signed by the Governor in June 2018. The bill provides that out of the appropriations for the Department of Health Professions, $250,000 to implement a demonstration program with the Medical Society of Virginia and the PDMP to enhance the use of the PDMP by prescribers through the use of real time access to the program via interoperability with electronic health records systems; the department shall design the demonstration program using $25,000 in PDMP funds and $225,000 in federal HITECH Act funds. SB 735 allows the Director of the Department of Health Professions to disclose PDMP information about a specific recipient of covered substances who is a recipient of medical assistance services to a physician or pharmacist licensed in the Commonwealth, or a designee who holds a multistate licensure privilege to practice nursing or a license issued by a health regulatory board within the Department of Health Professions and is employed by the Department of Medical Assistance Services, for the purpose of determining eligibility for and managing the care of the recipient in a Patient Utilization Management Safety or similar program. In October the Department of Professional and Occupational Licensing adopted a rule requiring the dispensing of Schedule V controlled substances for which a prescription is required, naloxone, and cannabidiol oil or THC-A oil dispensed by a pharmaceutical processor to be reported to the PDMP. The Board of Pharmacy adopted several rules during 2018 that temporarily classified specified synthetic opioids as Schedule I controlled substances. In September, Governor Northam issued an executive order creating the Advisory Commission on Opioids and Addiction to provide comments to the co-chairs of the Governor's Executive Leadership Team on Opioids and Addiction. The Commission is tasked with addressing specific prevention and treatment issues including limiting availability of prescription opioids for misuse.
Washington	HB 1047 became law in March 2018. The bill establishes a system for the safe and secure collection and disposal of unwanted medications, and requires covered manufacturers to establish and implement a drug take back program. SB 6032 is the state's budget bill that was signed by the Governor in March 2018. This bill appropriates $160,000 for additional staffing to coordinate the integration of the PDMP data into electronic health systems. The bill also appropriates $996,000 to establish a statewide electronic emergency medical services data system for licensed ambulances and aid services to report and furnish patient encounter data, for the distribution of health care supplies through the hub and spoke community-based public health programs, and for knowledge-based identity verification for the PDMP.
West Virginia	SB 273 became law in April 2018. This bill made many significant changes, including: • Prohibits a dentist or an optometrist from issuing an opioid prescription for more than a three-day supply at any time. Other professions are limited to a seven-day

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	supply, and prohibits a second prescription from being issued fewer than six days after issuing an initial prescription. Requires practitioners to follow a specified procedure before issuing a second prescription and requires the practitioner to consider referring a patient to a pain specialist prior to issuing a third prescription. • Requires practitioners, upon initially prescribing or dispensing a Schedule II controlled substance, or any opioid or benzodiazepine, to query the PDMP and query the PDMP again at least annually regarding the specific patient. Requires the PDMP information to be documented and included in the patient's medical record. • Prohibits a practitioner from issuing an opioid prescription to a minor for more than a three-day supply and requires discussion with the parent or guardian of the minor regarding the risks associated with opioid use and the why the prescription is necessary. • Prohibits a practitioner from issuing more than a four-day supply of opioids to an adult patient seeking treatment in an emergency room or an urgent care facility setting for outpatient use. • Prohibits, with specified exceptions, any practitioner from issuing a prescription for a Schedule II controlled substance for more than a 30-day supply, allowing for two additional prescriptions for a 30-day supply if the practitioner access the PDMP. • Requires the Office of Drug Control Policy to establish a voluntary nonopioid advanced directive form that is filed in an individual's medical records and indicates to a health care practitioner that an individual may not be administered or offered a prescription or medication order for an opioid. Provides that a practitioner without knowledge of the advanced directive who prescribes an opioid in a medical emergency is not civilly or criminally liable, except for cases of willful misconduct or gross negligence. • Requires practitioners to execute a narcotics contract with a patient when more than a seven-day supply of a Schedule II controlled substance is prescribed. • Requires a practitioner, prior to issuing a prescription for an opioid, to advise the patient regarding the quantity of the opioid and a patient's option to fill the prescription in a lesser quantity, and inform the patient of the risks associated with the opioid prescribed. • Requires practitioners to consider specified treatment alternatives before issuing a prescription for an opioid. • Requires insurers to cover at least 20 visits to a physical therapist, osteopathic manipulation, a chronic pain management program, and chiropractic care. • Requires a licensing board to notify a prescriber if they have been identified as a potentially unusual or abnormal prescriber, and allows the board to investigate or take disciplinary action. • Adds abnormal or unusual prescribing or dispensing patterns, or both as identified by the PDMP, as an act subject to discipline or prosecution. • Creates a civic penalty for any person who retaliates against a health care provider for refusal to dispense, administer, or prescribe narcotics. • Requires dispensing of and prescriptions for opioid antagonists to be prescribed to the PDMP.

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	The Board of Pharmacy adopted several changes to the PDMP to add the following as authorized to receive PDMP information: • A dean of a medical school located in this state or his or her designee to access prescriber level data to monitor prescribing practices of faculty members, prescribers and residents enrolled in a degree program at the school where he or she serves as dean. • Authorized agents of the WV Bureau for Medical Services. • Authorized agents of the WV Office of Health Facility Licensure and Certification for use in certification, licensure, and regulation of health facilities. • A physician reviewer designated by an employer of medical providers to monitor prescriber level information of prescribing practices of physicians, advance practice registered nurses, or physician assistants in their employ. • A chief medical officer of a hospital, or a physician designated by the chief executive officer of a hospital which does not have a medical officer, to monitor prescriber level information of prescribing practices of prescribers who have admitting privileges to the hospital.
Wisconsin	AB 907 became law in April 2018. The bill requires the dentistry examining board, medical examining board, the podiatry affiliated credentialing board, the Board of Nursing, and the Optometry Examining Board to submit a report that details proactive efforts taken by the board to address the issue of opioid abuse. The Boards must: specify if they have required, or otherwise encouraged, continuing education related to prescribing controlled substances; set goals for addressing the issue of opioid abuse, as that issue pertains to or implicates the practices of the professions regulated by the board; and describe the actions taken by the board so that the goals identified can be achieved, whether those goals have been achieved, and, if the goals have not been achieved, the reasons. The Controlled Substances Board adopted numerous rules changes to the PDMP program to implement legislation that passed the legislature in 2015. The changes relevant to dental education include: • An update to the authority and scope of the PDMP to provide that the purpose of creating the PDMP is to "collect and disclose" information related to the prescribing and dispensing of monitored prescription drugs, rather than "collect and maintain" such information. • Requires a practitioner or practitioner delegate to review the PDMP before prescribing unless the patient is receiving hospice care, the prescription is for three days or less, the drug is administered to the patient, the practitioner is unable to review the PDMP due to an emergency or because the PDMP is not operation or other technological failure that is reported to the board. o The board may refer a practitioner that fails to review the PDMP to the licensing board for discipline. • Updates the definition of practitioner to include a practitioner licensed by another state that engages in the practice of their credentialed profession within the contiguous borders of this state as a person authorized to prescribe and administer drugs. • Requires the submission of dispensing data to be done before the end of the next business day after a drug was dispensed. • Allows health care professionals to access audit trails about themselves and their delegates. A practitioner may access the audit trails accessible to health care

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	professionals and a prescribing metrics report about themselves. Medical coordinators may access prescribing metrics reports and audit trails about individuals they direct or supervise or if they are evaluating the job performance or performing quality assessment and improvement activities. o Amends the definition of "access" to the PDMP to mean to have the ability to view monitored prescription drug history reports, audit trails, and PDMP. o Defines "audit trail" as the log that contains information about each time the PDMP system discloses PDMP data, monitored prescription drug history reports, and prescribing metrics reports. o Defines a "medical coordinator" as the person responsible for the operating procedures for a healthcare professional. o Creates a definition of "prescribing metrics report," which includes PDMP data, audit trails, reports about a patient submitted to the program and information from the analytics platform.
Wyoming	SF 83 was signed by the Governor in March 2018. This bill requires the Board of Pharmacy to enroll any practitioner authorized to dispense controlled substances in Schedules II through V with the PDMP. This bill also adds Schedule V controlled substances dispensed to the list of substances required to be monitored by the PDMP. SF 78 became law in March 2018. This bill creates the opioid addiction task force which to consider the following issues: • PDMPs and electronic prescribing systems, including the PDMP and patient prescription history verification requirements. • Grants relating to substance abuse education, prevention, treatment and recovery made available by the federal government. • Strategies to reduce the administration of opioids including promotion of alternative treatments, methods and possible limits on the quantity of opioids that a health care provider is authorized to prescribe. • Strategies to reduce the administration of opioids including promotion of alternative treatments, methods and possible limits on the quantity of opioids that a health care provider is authorized to prescribe. • Authorized uses of opioids and any needed legal exceptions for authorized use. • Strategies for community engagement, including outreach to stakeholders and support for families of persons who have been impacted by opioids. • Strategies for the state of Wyoming to undertake a focused, unified and cross agency approach relating to opioid education, prevention and treatment. • Prescriber and dispenser education relating to opioids. • Other issues related to law enforcement and treatment.