

Readopt with amendment Med 502, effective 5-3-16 (Document #11090), to read as follows:

PART Med 502 OPIOID PRESCRIBING

Med 502.01 Applicability. This part shall apply to the prescribing of opioids for the management or treatment of non-cancer and non-terminal pain, and shall not apply to the supervised administration of opioids in a health care setting.

Med 502.02 Noncompliance with Standards as Unprofessional Conduct. Noncompliance with the standards set forth in this part may constitute unprofessional conduct as used in NH RSA 329:17, VI(d).

Med 502.03 Definitions. Except where the context makes another meaning manifest, the following words have the meanings indicated when used in this chapter:

- (a) “Acute pain” means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It can be time-limited, often less than 3 months in duration;
- (b) “Administer” means an act whereby a single dose of a drug is instilled into the body of, applied to the body of, or otherwise given to a person for immediate consumption or use;
- (c) “Addiction” means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include impaired control over drug use, craving, compulsive use, or continued use despite harm. The term does not include physical dependence and tolerance, which are normal physiological consequences of extended opioid therapy for pain;
- (d) “Chronic pain” means a state in which non-cancer pain persists beyond the usual course of an acute disease or healing of an injury, or that might or might not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. It also includes intermittent episodic pain that might require periodic treatment. For the purposes of these rules, chronic pain does not include pain from cancer or terminal disease;
- (e) “Clinical coverage” means specified and prearranged coverage that is available 24 hours a day, 7 days a week, to assist in the management of patients with chronic pain;
- (f) “Dose unit” means one pill, one capsule, one patch or one liquid dose;
- (g) “Medication-assisted treatment” means any treatment of opioid addiction that includes a medication, such as methadone, buprenorphine, or naltrexone, that is approved by the FDA for opioid detoxification or maintenance treatment;
- (h) “Morphine equivalent dose (MED)” means a conversion of various opioids to a morphine equivalent dose by the use of board-approved conversion tables;
- (i) “Prescription” means a verbal, or written, or facsimile, or electronically transmitted order for medications for self-administration by an individual patient.
- (j) “Risk assessment” means a process for predicting a patient’s likelihood of misusing or abusing opioids in order to develop and document a level of monitoring for that patient;

- (k) “Treatment agreement” means a written agreement that outlines the joint responsibilities of licensee and patient; and
- (l) “Treatment plan” means a written plan that reflects the particular benefits and risks of opioid use for each individual patient and establishes goals, expectations, methods and time course for treatment.

Med 502.04 Acute Pain. If opioids are indicated and clinically appropriate for prescription for acute pain, prescribing licensees shall:

- (a) Conduct and document a physical examination and history;
- (b) Consider the patient’s risk for opioid misuse, abuse, or diversion and prescribe for the lowest effective dose for a limited duration;
- (c) Document the prescription and rationale for all opioids according to Med 501.02(d) and (e);
- (d) Ensure that the patient has been provided information that contains the following:
 - (1) Risk of side effects, including addiction and overdose resulting in death;
 - (2) Risks of keeping unused medication;
 - (3) Options for safely securing and disposing of unused medication; and
 - (4) Danger in operating motor vehicle or heavy machinery;
- (e) Comply with all federal and state controlled substances laws, rules, and regulations;
- (f) Complete a board-approved risk assessment tool, such as the evidence based screening tool Screener and Opioid Assessment for Patients with Pain (SOAPP);
- (g) Document an appropriate pain treatment plan and consideration of non-pharmacological modalities and non-opioid therapy;
- (h) Utilize a written informed consent that explains the following risks associated with opioids:
 - (1) Addiction;
 - (2) Overdose and death;
 - (3) Physical dependence;
 - (4) Physical side effects;
 - (5) Hyperalgesia;
 - (6) Tolerance; and

- (7) Crime victimization;
- (i) In an emergency department, urgent care setting, or walk-in clinic:
 - (1) Not prescribe more than the minimum amount of opioids medically necessary to treat the patient's medical condition. In most cases, an opioid prescription of 3 or fewer days is sufficient, but a licensee shall not prescribe for more than 7 days; and
 - (2) If prescribing an opioid for acute pain that exceeds a board-approved limit, document the medical condition and appropriate clinical rationale in the patient's medical record.
- (j) ~~Prescriptions for Persistent and Unresolved Acute Pain Where Continuity of Care is Anticipated.~~ Prescribers shall not be ~~[obligation]~~ **obligated** to prescribe opioids for more than 30 days, but if opioids are indicated and appropriate for persistent, unresolved acute pain that extends beyond a period of 30 days, the licensee shall conduct an in-office follow-up with the patient prior to issuing a new opioid prescription.

Med 502.05 Chronic Pain. If opioids are indicated and prescribed for chronic pain, prescribing licensees shall:

- (a) Conduct and document a history and physical examination;
- (b) Conduct and document a risk assessment, including, but not be limited to, the use of an evidence-based screening tool such as the Screener and Opioid Assessment for Patients with Pain (SOAPP);
- (c) Document the prescription and rationale for all opioids according to Med 501.02(d) and (e);
- (d) Prescribe for the lowest effective dose for a limited duration;
- (e) Comply with all federal and state controlled substances laws, rules, and regulations;
- (f) Utilize a written informed consent that explains the following risks associated with opioids:
 - (3) Addiction;
 - (4) Overdose and death;
 - (5) Physical dependence;
 - (6) Physical side effects;
 - (7) Hyperalgesia;
 - (8) Tolerance; and
 - (9) Crime victimization;

- (g) Create and discuss a treatment plan with the patient. This shall include, but not be limited to the goals of treatment, in terms of pain management, restoration of function, safety, time course for treatment, and consideration of non-pharmacological modalities and non-opioid therapy. Informed consent documents and treatment agreements may be part of one document for the sake of convenience;
- (h) Utilize a written treatment agreement that is included in the medical record, and specifies conduct that triggers the discontinuation or tapering of opioids;
- (i) The treatment agreement shall also address, at a minimum, the following:
 - (1) The requirement of safe medication use and storage;
 - (2) The requirement of obtaining opioids from only one prescriber or practice;
 - (3) The consent to periodic and random drug testing; and
 - (4) The prescriber's responsibility to be available or to have clinical coverage available;
- (j) Document the consideration of a consultation with an appropriate specialist in the following circumstances:
 - (1) When the patient receives a 100 mg morphine equivalent dose daily for longer than 90 days;
 - (2) When a patient is at high risk for abuse or addiction; or
 - (3) When a patient has a co-morbid psychiatric disorder;
- (k) Reevaluate treatment plan and use of opioids at least twice a year;
- (l) Require random and periodic urine drug testing at least annually for all patients using opioids for longer than 90 days. Unanticipated findings shall be addressed in a manner that supports the health of the patient;
- (m) Have clinical coverage available for 24 hours per day, 7 days per week, to assist in the management of patients; and
- (n) The prescriber may forego the requirements for a written treatment agreement and for periodic drug testing for patients:
 - (1) Who are residents in a long-term, non-rehabilitative nursing home facility where medications are administered by licensed staff; or
 - (2) Who are being treated for episodic intermittent pain and receiving no more than 50 dose units of opioids in a 3 month period.

Med 502.06 Prescription Drug Monitoring Program.

(a) Prescribers required to register with the program under RSA 318-B:31-40, or their delegate, shall query the prescription drug monitoring program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient's pain and then periodically and at least twice per year, except when:

- (1) Controlled medications are to be administered to patients in a health care setting;
- (2) The program is inaccessible or not functioning properly, due to an internal or external electronic issue; or
- (3) An emergency department is experiencing a higher than normal patient volume such that querying the program database would materially delay care.

(b) A licensee shall document the exceptions described in (a)(2) and (3) above in the patient's medical record.

Med 502.07 Medication Assisted Treatment.

- (a) Licensees who prescribe medication assisted treatment shall adhere to the principles outlined in the American Society of Addiction Medicine's National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015) found at <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline> as cited in Appendix II.

Appendix I

Rule	Statute
Med 502	RSA 329:9, V and XV-a

Appendix II Incorporated References

Rule	Reference	Obtain at:
Med 502.07 (a)	The American Society of Addiction Medicine’s “National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use,” adopted on June 1, 2015.	No cost to download from: http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline