

1 **SENATE FLOOR VERSION**

2 April 11, 2022

3 **AS AMENDED**

4 ENGROSSED HOUSE
5 BILL NO. 3073

6 By: Talley, Randleman, Bush,
7 Miller, Echols, Pittman,
8 Stinson, and Goodwin of the
9 House

10 and

11 Rader and Dugger of the
12 Senate

13
14 An Act relating to **controlled dangerous substances**;
15 amending 63 O.S. 2021, Section 2-309I, which relates
16 to **prescription of opioid drugs**; adding an exception;
17 and declaring an emergency.

18 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

19 SECTION 1. AMENDATORY 63 O.S. 2021, Section 2-309I, is
20 amended to read as follows:

21 Section 2-309I. A. A practitioner shall not issue an initial
22 prescription for an opioid drug in a quantity exceeding a seven-day
23 supply for treatment of acute pain. Any opioid prescription for
24 acute pain shall be for the lowest effective dose of an immediate-
release drug.

B. Prior to issuing an initial prescription for an opioid drug
in a course of treatment for acute or chronic pain, a practitioner
shall:

1 1. Take and document the results of a thorough medical history,
2 including the experience of the patient with nonopioid medication
3 and nonpharmacological pain-management approaches and substance
4 abuse history;

5 2. Conduct, as appropriate, and document the results of a
6 physical examination;

7 3. Develop a treatment plan with particular attention focused
8 on determining the cause of pain of the patient;

9 4. Access relevant prescription monitoring information from the
10 central repository pursuant to Section 2-309D of this title;

11 5. Limit the supply of any opioid drug prescribed for acute
12 pain to a duration of no more than seven (7) days as determined by
13 the directed dosage and frequency of dosage; provided, however, upon
14 issuing an initial prescription for acute pain pursuant to this
15 section, the practitioner may issue one (1) subsequent prescription
16 for an opioid drug in a quantity not to exceed seven (7) days if:

17 a. the subsequent prescription is due to a major surgical
18 procedure or "confined to home" status as defined in
19 42 U.S.C., Section 1395n(a),

20 b. the practitioner provides the subsequent prescription
21 on the same day as the initial prescription,

22 c. the practitioner provides written instructions on the
23 subsequent prescription indicating the earliest date
24

1 on which the prescription may be filled, otherwise
2 known as a "do not fill until" date, and

3 d. the subsequent prescription is dispensed no more than
4 five (5) days after the "do not fill until" date
5 indicated on the prescription;

6 6. In the case of a patient under the age of eighteen (18)
7 years, enter into a patient-provider agreement with a parent or
8 guardian of the patient; and

9 7. In the case of a patient who is a pregnant woman, enter into
10 a patient-provider agreement with the patient.

11 C. No less than seven (7) days after issuing the initial
12 prescription pursuant to subsection A of this section, the
13 practitioner, after consultation with the patient, may issue a
14 subsequent prescription for the drug to the patient in a quantity
15 not to exceed seven (7) days, provided that:

16 1. The subsequent prescription would not be deemed an initial
17 prescription under this section;

18 2. The practitioner determines the prescription is necessary
19 and appropriate to the treatment needs of the patient and documents
20 the rationale for the issuance of the subsequent prescription; and

21 3. The practitioner determines that issuance of the subsequent
22 prescription does not present an undue risk of abuse, addiction or
23 diversion and documents that determination.

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1 D. Prior to issuing the initial prescription of an opioid drug
2 in a course of treatment for acute or chronic pain and again prior
3 to issuing the third prescription of the course of treatment, a
4 practitioner shall discuss with the patient or the parent or
5 guardian of the patient if the patient is under eighteen (18) years
6 of age and is not an emancipated minor, the risks associated with
7 the drugs being prescribed, including but not limited to:

8 1. The risks of addiction and overdose associated with opioid
9 drugs and the dangers of taking opioid drugs with alcohol,
10 benzodiazepines and other central nervous system depressants;

11 2. The reasons why the prescription is necessary;

12 3. Alternative treatments that may be available; and

13 4. Risks associated with the use of the drugs being prescribed,
14 specifically that opioids are highly addictive, even when taken as
15 prescribed, that there is a risk of developing a physical or
16 psychological dependence on the controlled dangerous substance, and
17 that the risks of taking more opioids than prescribed or mixing
18 sedatives, benzodiazepines or alcohol with opioids can result in
19 fatal respiratory depression.

20 The practitioner shall include a note in the medical record of
21 the patient that the patient or the parent or guardian of the
22 patient, as applicable, has discussed with the practitioner the
23 risks of developing a physical or psychological dependence on the
24 controlled dangerous substance and alternative treatments that may

1 be available. The applicable state licensing board of the
2 practitioner shall develop and make available to practitioners
3 guidelines for the discussion required pursuant to this subsection.

4 E. At the time of the issuance of the third prescription for an
5 opioid drug, the practitioner shall enter into a patient-provider
6 agreement with the patient.

7 F. When an opioid drug is continuously prescribed for three (3)
8 months or more for chronic pain, the practitioner shall:

9 1. Review, at a minimum of every three (3) months, the course
10 of treatment, any new information about the etiology of the pain,
11 and the progress of the patient toward treatment objectives and
12 document the results of that review;

13 2. In the first year of the patient-provider agreement, assess
14 the patient prior to every renewal to determine whether the patient
15 is experiencing problems associated with an opioid use disorder as
16 defined by the American Psychiatric Association and document the
17 results of that assessment. Following one (1) year of compliance
18 with the patient-provider agreement, the practitioner shall assess
19 the patient at a minimum of every six (6) months;

20 3. Periodically make reasonable efforts, unless clinically
21 contraindicated, to either stop the use of the controlled substance,
22 decrease the dosage, try other drugs or treatment modalities in an
23 effort to reduce the potential for abuse or the development of an
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1 opioid use disorder as defined by the American Psychiatric
2 Association and document with specificity the efforts undertaken;
3 4. Review the central repository information in accordance with
4 Section 2-309D of this title; and

5 5. Monitor compliance with the patient-provider agreement and
6 any recommendations that the patient seek a referral.

7 G. 1. Any prescription for acute pain pursuant to this section
8 shall have the words "acute pain" notated on the face of the
9 prescription by the practitioner.

10 2. Any prescription for chronic pain pursuant to this section
11 shall have the words "chronic pain" notated on the face of the
12 prescription by the practitioner.

13 H. This section shall not apply to a prescription for a patient
14 ~~who:~~

15 1. Who has sickle cell disease;

16 2. Who is in treatment for cancer or receiving aftercare cancer
17 treatment, ~~receiving;~~

18 3. Who is receiving hospice care from a licensed hospice, ~~or;~~

19 4. Who is receiving palliative care in conjunction with a
20 serious illness, ~~or;~~

21 5. Who is a resident of a long-term care facility, ~~or to;~~ or

22 6. For any medications that are being prescribed for use in the
23 treatment of substance abuse or opioid dependence.

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1 I. Every policy, contract or plan delivered, issued, executed
2 or renewed in this state, or approved for issuance or renewal in
3 this state by the Insurance Commissioner, and every contract
4 purchased by the Employees Group Insurance Division of the Office of
5 Management and Enterprise Services, on or after November 1, 2018,
6 that provides coverage for prescription drugs subject to a
7 copayment, coinsurance or deductible shall charge a copayment,
8 coinsurance or deductible for an initial prescription of an opioid
9 drug prescribed pursuant to this section that is either:

10 1. Proportional between the cost sharing for a thirty-day
11 supply and the amount of drugs the patient was prescribed; or

12 2. Equivalent to the cost sharing for a full thirty-day supply
13 of the drug, provided that no additional cost sharing may be charged
14 for any additional prescriptions for the remainder of the thirty-day
15 supply.

16 J. Any practitioner authorized to prescribe an opioid drug
17 shall adopt and maintain a written policy or policies that include
18 execution of a written agreement to engage in an informed consent
19 process between the prescribing practitioner and qualifying opioid
20 therapy patient. For the purposes of this section, "qualifying
21 opioid therapy patient" means:

22 1. A patient requiring opioid treatment for more than three (3)
23 months;

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1 2. A patient who is prescribed benzodiazepines and opioids
2 together for more than one twenty-four-hour period; or

3 3. A patient who is prescribed a dose of opioids that exceeds
4 one hundred (100) morphine equivalent doses.

5 K. Nothing in the Anti-Drug Diversion Act shall be construed to
6 require a practitioner to limit or forcibly taper a patient on
7 opioid therapy. The standard of care requires effective and
8 individualized treatment for each patient as deemed appropriate by
9 the prescribing practitioner without an administrative or codified
10 limit on dose or quantity that is more restrictive than approved by
11 the Food and Drug Administration (FDA).

12 SECTION 2. It being immediately necessary for the preservation
13 of the public peace, health or safety, an emergency is hereby
14 declared to exist, by reason whereof this act shall take effect and
15 be in full force from and after its passage and approval.

16 COMMITTEE REPORT BY: COMMITTEE ON HEALTH AND HUMAN SERVICES
17 April 11, 2022 - DO PASS AS AMENDED

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