

ASSEMBLY, No. 3869

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED MARCH 23, 2020

Sponsored by:

Assemblyman JOHN ARMATO

District 2 (Atlantic)

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District 37 (Bergen)

SYNOPSIS

Requires opioid antidote prescriptions for certain patients.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 4/9/2020)

1 AN ACT concerning opioids and amending P.L.2017, c.28.

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3 **BE IT ENACTED** by the Senate and General Assembly of the State
4 of New Jersey:

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6 1. Section 11 of P.L.2017, c.28 (C.24:21-15.2) is amended to
7 read as follows:

8 11. a. A practitioner shall not issue an initial prescription for an
9 opioid drug which is a prescription drug as defined in section 2 of
10 P.L.2003, c.280 (C.45:14-41) in a quantity exceeding a five-day
11 supply for treatment of acute pain. Any prescription for acute pain
12 pursuant to this subsection shall be for the lowest effective dose of
13 immediate-release opioid drug.

14 b. Prior to issuing an initial prescription of a Schedule II
15 controlled dangerous substance or any other opioid drug which is a
16 prescription drug as defined in section 2 of P.L.2003, c.280
17 (C.45:14-41) in a course of treatment for acute or chronic pain, a
18 practitioner shall:

19 (1) take and document the results of a thorough medical history,
20 including the patient's experience with non-opioid medication and
21 non-pharmacological pain management approaches and substance
22 abuse history;

23 (2) conduct, as appropriate, and document the results of a
24 physical examination;

25 (3) develop a treatment plan, with particular attention focused
26 on determining the cause of the patient's pain;

27 (4) access relevant prescription monitoring information under
28 the Prescription Monitoring Program pursuant to section 8 of
29 P.L.2015, c.74 (C.45:1-46.1); and

30 (5) limit the supply of any opioid drug prescribed for acute pain
31 to a duration of no more than five days as determined by the
32 directed dosage and frequency of dosage.

33 c. No less than four days after issuing the initial prescription
34 pursuant to subsection a. of this subsection, the practitioner, after
35 consultation with the patient, may issue a subsequent prescription
36 for the drug to the patient in any quantity that complies with
37 applicable State and federal laws, provided that:

38 (1) the subsequent prescription would not be deemed an initial
39 prescription under this section;

40 (2) the practitioner determines the prescription is necessary and
41 appropriate to the patient's treatment needs and documents the
42 rationale for the issuance of the subsequent prescription; and

43 (3) the practitioner determines that issuance of the subsequent
44 prescription does not present an undue risk of abuse, addiction, or
45 diversion and documents that determination.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 d. Prior to issuing the initial prescription of a Schedule II
2 controlled dangerous substance or any other opioid drug which is a
3 prescription drug as defined in section 2 of P.L.2003, c.280
4 (C.45:14-41) in a course of treatment for acute pain and prior to
5 issuing a prescription at the outset of a course of treatment for
6 chronic pain, a practitioner shall discuss with the patient, or the
7 patient's parent or guardian if the patient is under 18 years of age
8 and is not an emancipated minor, the risks associated with the drugs
9 being prescribed, including but not limited to:

10 (1) the risks of addiction and overdose associated with opioid
11 drugs and the dangers of taking opioid drugs with alcohol,
12 benzodiazepines and other central nervous system depressants;

13 (2) the reasons why the prescription is necessary;

14 (3) alternative treatments that may be available; and

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

22 The practitioner shall include a note in the patient's medical
23 record that the patient or the patient's parent or guardian, as
24 applicable, has discussed with the practitioner the risks of
25 developing a physical or psychological dependence on the
26 controlled dangerous substance and alternative treatments that may
27 be available. The Division of Consumer Affairs shall develop and
28 make available to practitioners guidelines for the discussion
29 required pursuant to this subsection.

30 e. Prior to the commencement of an ongoing course of
31 treatment for chronic pain with a Schedule II controlled dangerous
32 substance or any opioid, the practitioner shall enter into a pain
33 management agreement with the patient.

34 f. When a Schedule II controlled dangerous substance or any
35 other prescription opioid drug is continuously prescribed for three
36 months or more for chronic pain, the practitioner shall:

37 (1) review, at a minimum of every three months, the course of
38 treatment, any new information about the etiology of the pain, and
39 the patient's progress toward treatment objectives and document the
40 results of that review;

41 (2) assess the patient prior to every renewal to determine
42 whether the patient is experiencing problems associated with
43 physical and psychological dependence and document the results of
44 that assessment;

45 (3) periodically make reasonable efforts, unless clinically
46 contraindicated, to either stop the use of the controlled substance,
47 decrease the dosage, try other drugs or treatment modalities in an
48 effort to reduce the potential for abuse or the development of

1 physical or psychological dependence and document with
2 specificity the efforts undertaken;

3 (4) review the Prescription Drug Monitoring information in
4 accordance with section 8 of P.L.2015, c.74 (C.45:1-46.1); and

5 (5) monitor compliance with the pain management agreement
6 and any recommendations that the patient seek a referral.

7 g. A practitioner who prescribes an opioid drug which is a
8 controlled dangerous substance to a patient who has a history of
9 substance use disorder, whose daily opioid prescription is greater
10 than 50 morphine milligram equivalents, or who has a prescription
11 for a benzodiazepine that is concurrent to the patient's opioid
12 prescription shall, at the time the practitioner issues the prescription
13 for the opioid drug, additionally issue the patient an annual
14 prescription for a product approved by the federal Food and Drug
15 Administration for the reversal of an opioid overdose.

16 **[g.] h.** As used in this section:

17 "Acute pain" means pain, whether resulting from disease,
18 accidental or intentional trauma, or other cause, that the practitioner
19 reasonably expects to last only a short period of time. "Acute pain"
20 does not include chronic pain, pain being treated as part of cancer
21 care, hospice or other end of life care, or pain being treated as part
22 of palliative care.

23 "Chronic pain" means pain that persists or recurs for more than
24 three months.

25 "Initial prescription" means a prescription issued to a patient
26 who:

27 (1) has never previously been issued a prescription for the drug
28 or its pharmaceutical equivalent; or

29 (2) was previously issued a prescription for, or used or was
30 administered the drug or its pharmaceutical equivalent, but the date
31 on which the current prescription is being issued is more than one
32 year after the date the patient last used or was administered the drug
33 or its equivalent.

34 When determining whether a patient was previously issued a
35 prescription for, or used or was administered a drug or its
36 pharmaceutical equivalent, the practitioner shall consult with the
37 patient and review the patient's medical record and prescription
38 monitoring information.

39 "Pain management agreement" means a written contract or
40 agreement that is executed between a practitioner and a patient,
41 prior to the commencement of treatment for chronic pain using a
42 Schedule II controlled dangerous substance or any other opioid drug
43 which is a prescription drug as defined in section 2 of P.L.2003,
44 c.280 (C.45:14-41), as a means to:

45 (1) prevent the possible development of physical or
46 psychological dependence in the patient;

47 (2) document the understanding of both the practitioner and the
48 patient regarding the patient's pain management plan;

1 (3) establish the patient's rights in association with treatment,
2 and the patient's obligations in relation to the responsible use,
3 discontinuation of use, and storage of Schedule II controlled
4 dangerous substances, including any restrictions on the refill of
5 prescriptions or the acceptance of Schedule II prescriptions from
6 practitioners;

7 (4) identify the specific medications and other modes of
8 treatment, including physical therapy or exercise, relaxation, or
9 psychological counseling, that are included as a part of the pain
10 management plan;

11 (5) specify the measures the practitioner may employ to monitor
12 the patient's compliance, including but not limited to random
13 specimen screens and pill counts; and

14 (6) delineate the process for terminating the agreement,
15 including the consequences if the practitioner has reason to believe
16 that the patient is not complying with the terms of the agreement.

17 "Practitioner" means a medical doctor, doctor of osteopathy,
18 dentist, optometrist, podiatrist, physician assistant, certified nurse
19 midwife, or advanced practice nurse, acting within the scope of
20 practice of their professional license pursuant to Title 45 of the
21 Revised Statutes.

22 **[h.] i.** This section shall not apply to a prescription for a patient
23 who is currently in active treatment for cancer, receiving hospice
24 care from a licensed hospice or palliative care, or is a resident of a
25 long term care facility, or to any medications that are being
26 prescribed for use in the treatment of substance abuse or opioid
27 dependence.

28 **[i.] j.** Every policy, contract or plan delivered, issued, executed
29 or renewed in this State, or approved for issuance or renewal in this
30 State by the Commissioner of Banking and Insurance, and every
31 contract purchased by the School Employees' Health Benefits
32 Commission or State Health Benefits Commission, on or after the
33 effective date of this act, that provides coverage for prescription
34 drugs subject to a co-payment, coinsurance or deductible shall
35 charge a co-payment, coinsurance or deductible for an initial
36 prescription of an opioid drug prescribed pursuant to this section
37 that is either:

38 (1) proportional between the cost sharing for a 30-day supply
39 and the amount of drugs the patient was prescribed; or

40 (2) equivalent to the cost sharing for a full 30-day supply of the
41 opioid drug, provided that no additional cost sharing may be
42 charged for any additional prescriptions for the remainder of the 30-
43 day supply.

44 (cf: P.L.2017, c.341, s.1)

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46 2. This act shall take effect immediately.

STATEMENT

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This bill requires a prescription for an opioid reversal agent for certain high risk patients.

Under the bill, a practitioner who prescribes an opioid drug which is a controlled dangerous substance to a patient who has a history of substance use disorder, whose daily opioid prescription is greater than 50 morphine milligram equivalents, or who has a prescription for a benzodiazepine that is concurrent to the patient's opioid prescription is to, at the time the practitioner issues the prescription for the opioid drug, additionally issue the patient an annual prescription for a product approved by the federal Food and Drug Administration for the reversal of an opioid overdose.

Drug overdose is the leading cause of accidental death in the United States, with opioids being the most common drug. Co-prescription legislation is a public health measure that coincides with existing New Jersey law that requires providers to educate patients on the risks of opioids and additionally offers a co-prescription of an opioid reversal agent, such as naloxone, that combats the effects of an overdose.