House of Representatives

File No. 821

General Assembly

January Session, 2017

(Reprint of File No. 186)

Substitute House Bill No. 7052
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
June 1, 2017

AN ACT PREVENTING PRESCRIPTION OPIOID DIVERSION AND ABUSE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (j) of section 21a-254 of the general statutes is amended by adding subdivision (11) as follows (*Effective from passage*):

(NEW) (11) The commissioner may provide controlled substance prescription information obtained in accordance with subdivisions (3) and (4) of this subsection to other state agencies, pursuant to an agreement between the commissioner and the head of such agency, provided the information is obtained for a study of disease prevention and control related to opioid abuse or the study of morbidity and mortality caused by overdoses of controlled substances. The provision of such information shall be in accordance with all applicable state and federal confidentiality requirements.

Sec. 2. Section 21a-262 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Consumer Protection may receive, take into custody or destroy excess or undesired controlled substances and may in his or her discretion deliver, upon application, to any hospital, laboratory, incorporated college, scientific institution or any state or municipal agency or institution not operated for private gain, any controlled substances that have come into his or her custody by authority of this section. In the case of a care-giving or correctional or juvenile training institution having an institutional pharmacy, the Commissioner of Consumer Protection shall deliver such controlled substances only to the licensed pharmacist in charge of such pharmacy. The Commissioner of Consumer Protection may receive and take into custody excess or undesired controlled substances from pharmacists, manufacturers and wholesalers or any other registrant. Said commissioner shall keep a full and complete record of all substances received and of all substances disposed of, showing the exact kinds, quantities and forms of such substances, the persons from whom received and to whom delivered, by whose authority received, delivered and destroyed, and the dates of the receipt, disposal or destruction. Controlled substances and preparations shall at all times be properly safeguarded and securely kept. Minimum security and safeguard standards for the storage, manufacture, sale or distribution of all controlled substances shall be established by regulations adopted hereunder. Controlled substances seized or held as contraband or controlled substances, the title to which cannot be resolved, which controlled substances are not held by law enforcement agencies or court officials as evidence in criminal proceedings, shall be, upon the order of the court, destroyed by the seizing authority or delivered to the Commissioner of Consumer Protection as soon as possible upon resolution of the case or upon ascertaining the status of the unclaimed substance. The agent of the Commissioner of Consumer Protection shall issue a receipt for all such substance obtained. Any loss, destruction or theft of controlled substances shall be reported by a registrant within seventy-two hours to the Commissioner of Consumer Protection as follows: (1) Where, through breakage of the container or other accident, otherwise than in transit, controlled substances are lost

or destroyed, the person having title thereto shall make a signed statement as to the kinds and quantities of controlled substances lost or destroyed and the circumstances involved, and immediately forward the statement to the Commissioner of Consumer Protection. A copy of such statement shall be retained by the registrant; (2) where controlled substances are lost by theft, or otherwise lost or destroyed in transit, the consignee shall, immediately upon ascertainment of the occurrence, file with the Commissioner of Consumer Protection a signed statement of the facts, including a list of the controlled substances stolen, lost or destroyed and documentary evidence that the local authorities were notified. A copy of the statement shall be retained by the registrant. As used in this section, "care-giving institution", "correctional or juvenile training institution", "institutional pharmacy" and "pharmacist" have the same meanings as provided in section 20-571.

(b) For each long-term care facility, two or more of the following persons may jointly dispose of excess stock of controlled substances: A nursing home administrator, a pharmacist consultant, a director of nursing services or an assistant director of nursing services. Such facility shall maintain documentation of any such destruction and disposal for a period of three years and such documentation shall be maintained in a separate log and on a form prescribed by the department.

(c) For each outpatient surgical facility, as defined in section 19a-493b, two or more of the following persons may jointly dispose of excess stock of controlled substances: An administrator, a clinical director or chief of staff, or a nursing supervisor. Such facility shall maintain documentation of any such destruction and disposal for a period of three years and such documentation shall be maintained in a separate log and on a form prescribed by the department.

(d) A registered nurse licensed by the Department of Public Health and employed by a home health care agency, as defined in section 19a-490, may, with the permission of a designated representative of the

patient, oversee the destruction and disposal of the patient's controlled substances, using the recommendations for the proper disposal of prescription drugs on the Internet web site of the Department of Consumer Protection. Such registered nurse shall maintain written or electronic documentation for a period of three years of any such destruction and disposal on a form prescribed by the Commissioner of Consumer Protection. Such written or electronic documentation shall be maintained with the patient's medical record. Nothing in this subsection shall prevent the registered nurse and patient's designated representative from depositing the patient's controlled substances in a statutorily authorized prescription drug drop box.

Sec. 3. Section 21a-249 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) All prescriptions for controlled drugs shall include (1) the name and address of the patient, or the name and address of the owner of an animal and the species of the animal, (2) whether the patient is an adult or a child, or his specific age, (3) the compound or preparation prescribed and the amount thereof, (4) directions for use of the medication, (5) the name and address of the prescribing practitioner, (6) the date of issuance, and (7) the Federal Registry number of the practitioner. No prescription blank containing a prescription for a schedule II substance shall contain more than one prescription. No prescription or order for a controlled substance issued by a practitioner to an inanimate object or thing shall be considered a valid prescription within the meaning of this chapter.

(b) **[**Written prescriptions shall be written in ink or in indelible pencil or by typewriter. No duplicate, carbon or photographic copies and no printed or rubber-stamped orders shall be considered valid prescriptions within the meaning of this chapter. No prescription or order for any controlled substance issued by a practitioner to an inanimate object or thing shall be considered a valid prescription within the meaning of this chapter.**]** Each prescribing practitioner, as defined in section 20-14c, who the Department of Consumer Protection

authorizes to prescribe controlled substances, within the scope of practice of his or her license, shall electronically transmit the controlled substance prescription to a pharmacy. Electronically transmitted prescriptions shall be promptly printed out in hardcopy or created as an electronic record and filed by the prescriber. Electronically transmitted prescriptions shall be consistent with the requirements of the federal Controlled Substances Act, 21 USC 801, as amended from time to time. All records shall be kept on file for three years at the premises of the licensed practitioner and maintained in such form as to be readily available for inspection by the commissioner, his or her authorized agent or other persons, as authorized in section 21a-265, at reasonable times. For purposes of this subsection and subsections (c), (d) and (e) of this section, the term "electronically transmit" means to transmit by computer modem or other similar electronic device.

(c) A licensed practitioner shall not be required to electronically transmit a prescription when:

(1) Electronic transmission is not available due to a temporary technological or electrical failure. In the event of a temporary technological or electrical failure, the practitioner shall, without undue delay, reasonably attempt to correct any cause for the failure that is within his or her control. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record as soon as practicable, but in no instance more than seventy-two hours following the end of the temporary technological or electrical failure that prevented the electronic transmittal of the prescription. For purposes of this subdivision, "temporary technological or electrical failure" means failure of a computer system, application or device or the loss of electrical power to such system, application or device, or any other service interruption to such system, application or device that reasonably prevents the practitioner from utilizing his or her certified application to electronically transmit the prescription in accordance with subsection (b) of this section;

(2) The practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by an electronically transmitted prescription in a timely manner and that such delay would adversely impact the patient's medical condition, provided if such prescription is for a controlled substance, the quantity of such controlled substance does not exceed a five-day supply for the patient, if the controlled substance was used in accordance with the directions for use. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;

(3) The prescription is to be dispensed by a pharmacy located outside this state. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;

(4) Use of an electronically transmitted prescription may negatively impact patient care, such as a prescription containing two or more products to be compounded by a pharmacist, a prescription for direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion, a prescription that contains long or complicated directions, a prescription that requires certain elements to be included by the federal Food and Drug and Administration, or an oral prescription communicated to a pharmacist by a health care practitioner for a patient in a chronic and convalescent nursing home, licensed pursuant to chapter 368v; or

(5) The practitioner demonstrates, in a form and manner prescribed by the commissioner, that such practitioner does not have the technological capacity to issue electronically transmitted prescriptions. For the purposes of this subsection, "technological capacity" means possession of a computer system, hardware or device that can be used to electronically transmit controlled substance prescriptions consistent with the requirements of the federal Controlled Substances Act, 21

USC 801, as amended from time to time.

(d) Any prescription issued in a form other than an electronically transmitted prescription pursuant to subsection (c) of this section may be issued as a written order or, to the extent permitted by the federal Controlled Substance Act, 21 USC 801, as from time to time amended, as an oral order or transmitted by facsimile machine. Such oral order or order transmitted by facsimile machine shall be promptly reduced to writing on a prescription blank or a hardcopy printout or created as an electronic record and filed by the pharmacist filling it. No duplicate, carbon or photographic copies and no printed or rubber-stamped orders shall be considered valid prescriptions within the meaning of this chapter.

[(c)**]** (e) Prescriptions for schedule II substances **[**, if in writing,**]** shall be **[**signed**]** electronically transmitted by the prescribing practitioner at the time of issuance and previously signed orders for such schedule II substances shall not be considered valid prescriptions within the meaning of this chapter. No practitioner shall prescribe, dispense or administer schedule II sympathomimetic amines as anorectics, except as may be authorized by regulations adopted by the Departments of Public Health and Consumer Protection acting jointly. To the extent permitted by the federal Controlled Substances Act, 21 USC 801, as from time to time amended, in an emergency, the dispensing of schedule II substances may be made upon the oral order of a prescribing registrant known to or confirmed by the filling pharmacist. The filling pharmacist shall promptly reduce such oral order to writing on a prescription blank, provided such oral order shall be confirmed by the proper completion and mailing or delivery of a prescription prepared by the prescribing registrant to the pharmacist filling such oral order within seventy-two hours after the oral order has been given. Such prescription of the registrant shall be affixed to the temporary prescription prepared by the pharmacist and both prescriptions shall be maintained on file as required in this chapter. The Department of Public Health and the Department of Consumer Protection, acting jointly, may adopt regulations, in accordance with

chapter 54, allowing practitioners to prescribe, dispense or administer schedule II sympathomimetic amines as anorectics under certain specific circumstances. Nothing in this subsection shall be construed to require a licensed pharmacist to determine the diagnosis of a patient prior to dispensing a prescription for such substances to a patient.

[(d) To the extent permitted by the federal Controlled Substances Act, 21 USC 801, as from time to time amended, a prescribing practitioner may issue an oral order or an electronically transmitted prescription order and, except as otherwise provided by regulations adopted pursuant to sections 21a-243, 21a-244 and 21a-244a, such oral order or electronically transmitted prescription order shall be promptly reduced to writing on a prescription blank or a hardcopy printout or created as an electronic record and filed by the pharmacist filling it. For the purposes of subsections (d) and (h) of this section the term "electronically transmitted" means transmitted by facsimile machine, computer modem or other similar electronic device.

(e) To the extent permitted by the federal Controlled Substances Act, in an emergency the dispensing of schedule II substances may be made upon the oral order of a prescribing registrant known to or confirmed by the filling pharmacist who shall promptly reduce the oral order to writing on a prescription blank, provided, in such cases such oral order shall be confirmed by the proper completion and mailing or delivery of a prescription prepared by the prescribing registrant to the pharmacist filling such oral order within seventy-two hours after the oral order has been given. Such prescription of the registrant shall be affixed to the temporary prescription prepared by the pharmacist and both prescriptions shall be maintained on file as required in this chapter.**]**

(f) All prescriptions for controlled substances shall comply fully with any additional requirements of the federal food and drug laws, the federal Controlled Substances Act, and state laws and regulations adopted under this chapter.

(g) Repealed by P.A. 82-419, S. 46, 47.

(h) Except when dispensed directly by a practitioner, other than a pharmacy, to an ultimate user, a controlled substance included in schedule III or IV, which is a prescription drug as determined under federal food and drug laws, shall not be dispensed without a written, electronically transmitted or oral prescription of a practitioner. The prescription shall not be filled or refilled more than six months after the date thereof or be refilled more than five times, unless renewed by the practitioner.

(i) A controlled substance included in schedule V shall not be distributed or dispensed other than for a medical purpose.

(j) A pharmacy may sell and dispense controlled substances upon the prescription of a prescribing practitioner, as defined in subdivision (22) of section 20-571.

(k) Pharmacies shall file filled prescriptions for controlled substances separately from other prescriptions. All schedule II prescriptions shall be filed in a separate file or in an electronic file. All schedule III, IV and V prescriptions shall be filed in another separate file or in an electronic file, except as otherwise provided for in regulations adopted pursuant to section 21a-243, 21a-244 or 21a-244a. All written controlled substance prescriptions shall, immediately upon filling, be filed chronologically and consecutively.

(l) Any pharmacy may transfer prescriptions for controlled substances included in schedules III, IV and V to any other pharmacy in accordance with the requirements set forth in the federal Controlled Substances Act 21 USC 801 et seq. and the regulations promulgated thereunder, as from time to time amended.

(m) A practitioner authorized to prescribe controlled substances shall not prescribe anabolic steroids for the sole purpose of enhancing a patient's athletic ability or performance.

(n) Each pharmacy, as defined in section 20-571, shall accept an electronically transmitted prescription for a controlled substance from a practitioner, as defined in section 21a-316. All records shall be kept on file for three years at the premises of the pharmacy and maintained current and separate from other business records in such form as to be readily available at the pharmacy for inspection by the Commissioner of Consumer Protection, his or her authorized agent or other persons, as authorized in section 21a-265, at reasonable times. Prescription records received from the practitioner electronically may be stored electronically, provided the files are maintained in the pharmacy computer system for not less than three years. If the electronically transmitted prescription is printed, it shall be filed as required in subsection (k) of this section.

Sec. 4. (NEW) (*Effective October 1, 2017*) (a) As used in this section:

(1) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time;

(2) "Prescribing practitioner" has the same meaning as provided in section 20-14c of the general statutes; and

(3) "Voluntary nonopioid directive form" means a form that is voluntarily filed by a patient with a prescribing practitioner that indicates such patient's request to not be issued a prescription or medication order for an opioid drug.

(b) The Department of Public Health, in consultation with the Departments of Consumer Protection and Mental Health and Addiction Services, shall establish a voluntary nonopioid directive form and publish such form on its Internet web site for public use. Any person who does not wish to be issued a prescription or medication order for an opioid drug may file such form with a prescribing practitioner. Upon receipt of a voluntary nonopioid directive form, a prescribing practitioner shall document such receipt in the patient's medical record.

(c) The voluntary nonopioid directive form established by the Department of Public Health shall allow a patient to appoint a duly authorized guardian or health care proxy to override a previously recorded voluntary nonopioid directive form. Such patient, duly authorized guardian or health care proxy may revoke the directive, orally or in writing, for any reason, at any time.

(d) An electronically transmitted prescription to a pharmacy shall be presumed to be valid for the purposes of this section and a pharmacist shall not be held in violation of this section for dispensing a controlled substance in contradiction to a voluntary nonopioid directive form.

(e) No prescribing practitioner acting with reasonable care shall be liable for damages in a civil action, subject to criminal prosecution or deemed to have violated the standard of care for such prescribing practitioner for refusing to issue a prescription or medication order for an opioid pursuant to a voluntary nonopioid directive form.

(f) No person acting in good faith as a duly authorized guardian or health care proxy shall be liable for damages in a civil action or subject to criminal prosecution for revoking or overriding a voluntary nonopioid directive form.

(g) A prescribing practitioner who wilfully fails to comply with a patient's voluntary nonopioid directive form may be subject to disciplinary action pursuant to section 19a-17 of the general statutes.

(h) No emergency department prescribing practitioner, acting either as the patient's practitioner or as the medical control officer for emergency medical services personnel, and acting with reasonable care shall be liable for damages in a civil action, subject to criminal prosecution or deemed to have violated the standard of care for a prescribing practitioner for issuing a prescription for or administering a controlled substance containing an opioid to a person who has a voluntary nonopioid directive form, when, in such prescribing practitioner's professional medical judgment, a controlled substance containing an opioid is necessary and such prescribing practitioner

had no knowledge of the patient's voluntary nonopioid directive form at the time of issuance or administration.

Sec. 5. Section 20-14o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) As used in this section:

(1) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time;

(2) "Adult" means a person who is at least eighteen years of age;

(3) "Prescribing practitioner" has the same meaning as provided in section 20-14c;

(4) "Minor" means a person who is under eighteen years of age;

(5) "Opioid agonist" means a medication that binds to the opiate receptors and provides relief to individuals in treatment for abuse of or dependence on an opioid drug;

(6) "Opiate receptor" means a specific site on a cell surface that interacts in a highly selective fashion with an opioid drug;

(7) "Palliative care" means specialized medical care to improve the quality of life of patients and their families facing the problems associated with a life-threatening illness; and

(8) "Opioid antagonist" has the same meaning as provided in section 17a-714a, as amended by this act.

(b) When issuing a prescription for an opioid drug to an adult patient for the first time for outpatient use, a prescribing practitioner who is authorized to prescribe an opioid drug shall not issue a prescription for more than a seven-day supply of such drug, as recommended in the National Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain.

(c) A prescribing practitioner shall not issue a prescription for an opioid drug to a minor for more than a **[**seven-day**]** five-day supply of such drug. **[**at any time. When issuing a prescription for an opioid drug to a minor for less than a seven-day supply of such drug, the prescribing practitioner shall discuss the risks associated with use of an opioid drug, including, but not limited to, the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants, and the reasons why the prescription is necessary with (1) the minor, and (2) the custodial parent, guardian or other person having legal custody of the minor if such parent, guardian or other person is present at the time of issuance.**]**

(d) Notwithstanding the provisions of subsections (b) and (c) of this section, if, in the professional medical judgment of a prescribing practitioner, more than a seven-day supply of an opioid drug is required to treat an adult patient's acute medical condition, or more than a five-day supply of an opioid drug is required to treat a minor patient's acute medical condition, as determined by the prescribing practitioner, or is necessary for the treatment of chronic pain, pain associated with a cancer diagnoses or for palliative care, then the prescribing practitioner may issue a prescription for the quantity needed to treat the acute medical condition, chronic pain, pain associated with a cancer diagnosis or pain experienced while the patient is in palliative care. The condition triggering the prescription of an opioid drug for more than a seven-day supply for an adult patient or more than a five-day supply for a minor patient shall be documented in the patient's medical record and the practitioner shall indicate that an alternative to the opioid drug was not appropriate to address the medical condition.

(e) The provisions of subsections (b), (c) and (d) of this section shall not apply to medications designed for the treatment of abuse of or dependence on an opioid drug, including, but not limited to, opioid agonists and opioid antagonists.

(f) When issuing a prescription for an opioid drug to an adult or minor patient, the prescribing practitioner shall discuss with the patient the risks associated with the use of such opioid drug, including, but not limited to, the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants, and the reasons the prescription is necessary, and, if applicable, with the custodial parent, guardian or other person having legal custody of the minor if such parent, guardian or other person is present at the time of issuance of the prescription.

Sec. 6. (*Effective July 1, 2017*) On or before October 1, 2017, the Department of Public Health shall post information on its Internet web site concerning the ability of a prescribing practitioner, as defined in section 20-14c of the general statutes, to obtain certification to prescribe medicine indicated for treatment of opioid use disorder that a patient may take at home. Such information shall include, but need not be limited to, a list of educational requirements, available courses and information regarding waivers from such requirements.

Sec. 7. (NEW) (*Effective July 1, 2017*) (a) As used in this section:

(1) "Health care provider" means any person or organization that furnishes health care services and is licensed or certified to furnish such services pursuant to chapters 370, 372, 373, 375, 376, 376a, 376b, 377, 378, 379, 380, 383, 383a, 383b and 383c of the general statutes, or is licensed or certified pursuant to chapter 368d of the general statutes;

(2) "Pharmacist" means a pharmacist licensed pursuant to chapter 400j of the general statutes;

(3) "Opioid drug" has the same meaning as provided in section 20-14o of the general statutes, as amended by this act; and

(4) "Opioid antagonist" has the same meaning as provided in section 17a-714a of the general statutes, as amended by this act.

(b) On or before October 1, 2017, the Alcohol and Drug Policy Council, established under section 17a-667 of the general statutes, shall develop (1) a one-page fact sheet that includes, in clear and readily understandable language in at least twelve-point font size, the risks of taking an opioid drug, the symptoms of opioid use disorder and services available in the state for persons who experience symptoms of or are otherwise affected by opioid use disorder, and (2) strategies to encourage health care providers and pharmacists to disseminate the one-page fact sheet. Such one-page fact sheet shall be made available on the Internet web site of the Department of Mental Health and Addiction Services for use by health care providers and pharmacists to disseminate to any person (A) whom such provider treats for symptoms of opioid use disorder, (B) to whom such provider issues a prescription for or administers an opioid drug or opioid antagonist, or (C) to whom such pharmacist dispenses an opioid drug or opioid antagonist or issues a prescription for an opioid antagonist.

(c) (1) The Alcohol and Drug Policy Council shall examine the feasibility of the following:

(A) Developing a marketing campaign and making monthly public service announcements on the Internet web sites and social media accounts of the appropriate state agencies, as designated by the council, and any radio station and television station broadcasting to persons in the state, regarding (i) the risks of taking opioid drugs, (ii) symptoms of opioid use disorder, (iii) the availability of opioid antagonists in the state, and (iv) services in the state for persons with or affected by opioid use disorder; and

(B) Establishing a publicly accessible electronic information portal, in the form of an Internet web site or application, as a single point of entry for information regarding the availability of (i) beds at a facility in the state for persons in need of medical treatment for (I) detoxification for potentially life-threatening symptoms of withdrawal from alcohol or drugs, and (II) rehabilitation or treatment for alcohol dependency, drug dependency or intoxication, and (ii) slots for

outpatient treatment using opioid medication that is used to treat opioid use disorder, including methadone and buprenorphine. Such examination shall include the ability of the portal to (I) provide real-time data on the availability of beds and slots, including, but not limited to, the types of beds and slots available, the location of such beds and slots and the wait times, if available, for such beds and slots, and (II) be accessible to the public.

(2) Not later than January 1, 2019, the council shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health on the outcome of such examination.

(d) The Alcohol and Drug Policy Council shall convene a working group to advise the council of any recommendations for statutory or policy changes that would enable first responders or health care providers to safely dispose of a person's opioid drugs upon their death. Not later than February 1, 2018, the council shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the recommendations of the working group.

(e) The Alcohol and Drug Policy Council shall convene a working group to study substance abuse treatment referral programs that have been established by municipal police departments to refer persons with an opioid use disorder or seeking recovery from drug addiction to substance abuse treatment facilities. The working group shall (1) examine such referral programs, (2) identify any barriers faced by such referral programs, and (3) determine the feasibility of implementing such programs on a state-wide basis. Not later than February 1, 2018, the council shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and public safety and security regarding the findings of the

working group.

Sec. 8. (NEW) (*Effective January 1, 2018*) Each insurance company, hospital service corporation, medical service corporation, health care center, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state an individual health insurance policy providing coverage of the type specified in subdivision (1), (2), (4), (11) or (12) of section 38a-469 of the general statutes that provides coverage to an insured or enrollee who has been diagnosed with a substance use disorder, as described in section 17a-458 of the general statutes, shall cover medically necessary, medically monitored inpatient detoxification services and medically necessary, medically managed intensive inpatient detoxification services provided to the insured or enrollee. For purposes of this section, "medically monitored inpatient detoxification" and "medically managed intensive inpatient detoxification" have the same meanings as described in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions.

Sec. 9. (NEW) (*Effective January 1, 2018*) Each insurance company, hospital service corporation, medical service corporation, health care center, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state a group health insurance policy providing coverage of the type specified in subdivision (1), (2), (4), (11) or (12) of section 38a-469 of the general statutes that provides coverage to an insured or enrollee who has been diagnosed with a substance use disorder, as described in section 17a-458 of the general statutes, shall cover medically necessary, medically monitored inpatient detoxification services and medically necessary, medically managed intensive inpatient detoxification services provided to the insured or enrollee. For purposes of this section, "medically monitored inpatient detoxification" and "medically managed intensive inpatient detoxification" have the same meanings as described in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-

Related and Co-Occurring Conditions.

Sec. 10. (NEW) (*Effective July 1, 2017*) An alcohol or drug treatment facility, as defined in section 19a-490 of the general statutes, shall use the criteria for admission developed by the American Society of Addiction Medicine for purposes of assessing a person for admission to such facility in consideration of (1) the services for which the facility is licensed, and (2) the appropriate services required for treatment of such person.

Sec. 11. Subsection (e) of section 17a-714a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(e) Not later than October 1, **[**2016**]** 2017, each municipality shall amend its local emergency medical services plan, as described in section 19a-181b, to ensure that **[**the emergency responder**]** at least one emergency medical services provider, as defined in the regulations of Connecticut state agencies pertaining to emergency medical services, who is likely to be the first person to arrive on the scene of a medical emergency in the municipality, including, but not limited to, emergency medical services personnel, as defined in section 20-206jj, or a resident state trooper, **[**who is likely to be the first person to arrive on the scene of a medical emergency in the municipality**]** is equipped with an opioid antagonist and such person has received training, approved by the Commissioner of Public Health, in the administration of an opioid **[**antagonists**]** antagonist.

Sec. 12. (NEW) (*Effective October 1, 2017*) (a) A prescribing practitioner, as defined in section 20-14c of the general statutes, who is authorized to prescribe an opioid antagonist, as defined in section 17a-714a of the general statutes, as amended by this act, and a pharmacy may enter into an agreement for a medical protocol standing order at such pharmacy allowing a pharmacist licensed under part II of chapter 400j of the general statutes to dispense an opioid antagonist that is (1) administered by an intranasal application delivery system or an auto-

injection delivery system, (2) approved by the federal Food and Drug Administration, and (3) dispensed to any person at risk of experiencing an overdose of an opioid drug, as defined in 42 CFR 8.2, or to a family member, friend or other person in a position to assist a person at risk of experiencing an overdose of an opioid drug.

(b) Any such medical protocol standing order shall be deemed issued for a legitimate medical purpose in the usual course of the prescribing practitioner's professional practice. The pharmacy shall provide the Department of Consumer Protection with a copy of every medical protocol standing order agreement entered into with a prescribing practitioner under this section.

(c) A pharmacist may only dispense an opioid antagonist pursuant to a medical protocol standing order if the pharmacist has been trained and certified as part of a program approved by the Commissioner of Consumer Protection.

(d) A pharmacist who dispenses an opioid antagonist pursuant to a medical protocol standing order shall (1) provide appropriate training regarding the administration of such opioid antagonist to the person to whom the opioid antagonist is dispensed, (2) maintain a record of such dispensing and the training required pursuant to chapter 400j of the general statutes, and (3) send a copy of the record of such dispensing to the prescribing practitioner who entered into an agreement for a medical protocol standing order with the pharmacy.

(e) A pharmacist who dispenses an opioid antagonist in accordance with the provisions of this section shall be deemed not to have violated any standard of care for a pharmacist.

(f) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	21a-254(j)
Sec. 2	*from passage*	21a-262
Sec. 3	*January 1, 2018*	21a-249
Sec. 4	*October 1, 2017*	New section
Sec. 5	*July 1, 2017*	20-14o
Sec. 6	*July 1, 2017*	New section
Sec. 7	*July 1, 2017*	New section
Sec. 8	*January 1, 2018*	New section
Sec. 9	*January 1, 2018*	New section
Sec. 10	*July 1, 2017*	New section
Sec. 11	*July 1, 2017*	17a-714a(e)
Sec. 12	*October 1, 2017*	New section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 18 $	FY 19 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF - See Below	See Below	See Below

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 18 $	FY 19 $
Various Municipalities	See Below	See Below	See Below

Explanation

The bill results in the fiscal impact described below:

Section 5 of the bill may result in a savings to the state employee and retiree health plan and fully insured municipal plans from limiting opioid prescriptions to five days for a minor. Current law limits the prescription to seven days. The savings will depend on the reduction in the number of pills dispensed to covered members in the state employee and retiree health plan. The savings for fully-insured municipalities will be reflected in future premiums.

Since the seven day limit was enacted in 2016, the average day supply for a first prescription in the state plan went from 12 days to approximately 7. The average day supply was the highest in 2012 at approximately 86 days. The average per member per month cost of certain opioids prescribed in a 1-30 supply ranged from $3.70 to $41.20 (for an average of $13.34) for approximately 22,500 members.

Section 9 of the bill is not anticipated to result in a cost to the state and retiree health plan as the state plan currently provides coverage for medically necessary inpatient detoxification as subject to prior authorization which is not in conflict with the coverage requirements of the bill.[1] The bill may increase costs to certain fully insured, municipal plans that do not currently comply with the coverage requirements required by the bill for certain inpatient detoxification services. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2018. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.[2] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

Section 11 of the bill is expected to have no fiscal impact. This section clarifies the minimum number of emergency responders from each municipality that must be equipped and trained to administer opioid antagonists. Municipalities are already required to train and equip a medical responder to administer opioid antagonists. There is expected to be no change, to the extent that towns choose not to exceed the mandated minimum.

The bill specifies other administrative and process provisions that are not expected to result in a fiscal impact to the state or municipalities.

House "A" struck the underlying bill and its associated fiscal impact and results in the fiscal impact described herein.

The Out Years

The fiscal impact identified above will continue into the out years

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state plan has traditionally adopted all state health mandates.

[2] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

and be reflected in state health plan expenditures or for fully insured municipal plans, in future premiums.

OLR Bill Analysis

sHB 7052 (as amended by House "A")*

AN ACT PREVENTING PRESCRIPTION OPIOID DIVERSION AND ABUSE.

SUMMARY

This bill makes various changes to prevent and treat opioid drug abuse. Principally, it:

1. allows the Department of Consumer Protection (DCP) commissioner to share certain prescription drug monitoring program information with other state agencies for certain drug abuse studies (§ 1);

2. generally requires prescriptions for controlled substances to be transmitted electronically to a pharmacy, which must have the technology to accept such prescriptions (§ 3);

3. limits access to controlled substances by (a) allowing certain registered nurses employed by home health care agencies to destroy or dispose of them, (b) creating a process for patients to request to not be prescribed opioids, and (c) generally reducing the amount of opioid drugs a minor may be prescribed (§§ 2, 4, & 5);

4. requires practitioners, when prescribing opioids, to discuss with all patients, rather than only minors, the risks associated with opioid drug use (§ 5);

5. requires the Alcohol and Drug Policy Council (ADPC) to take certain actions to address opioid drug abuse (§ 7);

6. requires certain individual and group health insurers to cover

specified medically necessary, inpatient detoxification services for an insured or enrollee diagnosed with a substance use disorder (§§ 8 & 9);

7. requires alcohol or drug treatment facilities to use admissions criteria developed by the American Society of Addiction Medicine (§ 10);

8. extends the date by which municipalities must amend their local emergency medical services (EMS) plans to require at least one EMS provider likely to arrive first on the scene of a medical emergency to carry an opioid antagonist and complete a training on how to administer it (§ 11); and

9. allows a prescribing practitioner authorized to prescribe an opioid antagonist to issue a standing order (i.e., non-patient specific prescription) to a licensed pharmacist for an opioid antagonist under certain conditions (§ 12).

The bill also makes technical and conforming changes.

A section-by-section analysis follows.

*House Amendment "A" replaces the original bill (File 186). It adds the provisions on (1) practitioners obtaining certification to prescribe take-home medications, (2) the ADPC, (3) health insurance coverage for certain inpatient detoxification services, (4) substance use treatment facilities' admissions criteria, (5) local EMS plans, and (6) standing orders for opioid antagonists.

It also (1) allows practitioners to apply for a waiver from the electronic prescription requirements indefinitely instead of until July 1, 2019, as under the original bill, (2) provides immunity to certain prescribing practitioners who prescribe opioids without knowledge of a patient's voluntary non-opioid directive form, (3) generally reduces the amount of opioid drugs a minor may be prescribed, and (4) makes minor and technical changes.

EFFECTIVE DATE: July 1 2017, except that the provisions on (1) health insurance coverage for substance use disorder and electronic prescription requirements take effect January 1, 2018; (2) standing orders for opioid antagonists and opioid prescription drug provisions take effect October 1, 2017; and (3) drug monitoring information sharing and drug disposal take effect upon passage.

§ 1 — PRESCRIPTION DRUG MONITORING PROGRAM INFORMATION SHARING

The bill allows the DCP commissioner to provide certain controlled substance prescription information obtained as part of the prescription drug monitoring program (e.g., pharmacy and vendor records) to other state agencies. The sharing must be through an agreement between the DCP commissioner and the other agency head, provided that the information is obtained for a study of (1) disease prevention and control related to opioid abuse or (2) morbidity and mortality caused by controlled substance overdose. The information transfer must be done in accordance with all applicable state and federal confidentiality requirements (e.g., the 1996 Health Insurance Portability and Accountability Act).

By law, under the prescription drug monitoring program, DCP collects information on controlled substance prescriptions to prevent improper or illegal drug use or improper prescribing.

§ 2 — CONTROLLED SUBSTANCE DISPOSAL BY CERTAIN NURSES

The bill allows a registered nurse employed by a home health care agency, with a patient's designated representative's permission, to oversee the destruction and disposal of the patient's controlled substances. The nurse must use the recommendations for proper disposal of prescription drugs on DCP's website (e.g., add undesirable substances such as salt, sawdust, or used coffee grounds).

The nurse must maintain written or electronic documentation of such destruction or disposal on a DCP-prescribed form for three years.

This documentation must be kept with the patient's medical record.

Nothing in the bill prevents the nurse and patient's designated representative from depositing the patient's controlled substances in a statutorily authorized prescription drop box.

§ 3 — ELECTRONIC PRESCRIPTION FOR CONTROLLED SUBSTANCES

The bill, with exceptions, requires prescriptions for controlled substances to be electronically transmitted. "Electronically transmit" means to transmit by computer modem or other similar electronic device. Current law allows prescribers to issue prescriptions for controlled substances in writing, orally, or by electronic transmission. Written prescriptions must, among other things, be in ink, indelible pencil, or by typewriter and only original prescriptions are considered valid. Oral prescriptions must, among other things, be promptly reduced to writing.

Under the bill, prescribing practitioners of controlled substances, within the scope of their license, must electronically transmit controlled substance prescriptions to a pharmacy. The prescriber must promptly print a hard copy of the prescription or create it in an electronic record. Electronically transmitted prescriptions must be consistent with the requirements of the federal Controlled Substances Act (21 U.S.C. § 801). All records must be kept on the prescriber's premises for three years and maintained in a form that is readily available for inspection, at reasonable times, by the DCP commissioner, his authorized agent, or other authorized personnel.

Exceptions

Under the bill, prescribing practitioners are not required to electronically transmit a prescription when:

1. there are temporary technological or electrical failures;

2. the prescriber reasonably determines that it is impractical for the patient to obtain substances prescribed by an electronically

transmitted prescription in a timely manner and the delay would adversely impact the patient's medical condition;

3. the prescription is to be dispensed by an out-of-state pharmacy;

4. the prescription needs special attention and electronic transmission could negatively impact the patient care (e.g., compounding); and

5. the prescriber demonstrates that he or she does not have the technological capacity.

The bill allows any prescription under any of these exceptions to be issued as a written order or, to the extent allowed by federal law, as an oral order or transmitted by fax. Any oral order or order transmitted by fax must be promptly written on a prescription blank or hardcopy printout, or created as an electronic record and filed by the pharmacist filling the order. Under the bill, duplicates, carbon or photographic copies, and printed or rubber-stamped orders are not valid controlled substance prescriptions.

Temporary Technological or Electrical Failure. Under the bill, a prescribing practitioner is not required to electronically transmit a prescription when electronic transmission is not available because of temporary technological or electrical failures.

In the event of a temporary technological or electrical failure, the prescriber must, without undue delay, reasonably attempt to correct any cause for the failure that is within his or her control. A prescriber who issues a prescription under this exception must document the reason for failing to electronically transmit the prescription in the patient's medical record as soon as practicable, but must do so within 72 hours after the end of the temporary technological or electrical failure.

"Temporary technological or electrical failure" means a computer system, application, or device failure or the loss of electrical power or

any other service interruption to such system, application, or device, that reasonably prevents the prescriber from using his or her certified application to electronically transmit the prescription.

Delay that Adversely Impacts Patient's Health. The bill does not require electronic prescriptions when the prescriber reasonably determines that it would be impractical for the patient to obtain the prescribed substances by an electronically transmitted prescription in a timely manner and that such delay would adversely impact the patient's medical condition. The quantity must not exceed a five-day supply. A prescriber who issues a prescription under this exception must document the reason and place it in the patient's medical record.

Out-of-state Pharmacy. The bill allows a prescribing practitioner to issue a prescription that is not electronically transmitted if the prescription will be dispensed by an out-of-state pharmacy. The prescriber who issues a prescription under this exception must document the reason in the patient's medical record.

Certain Prescriptions that Need Special Attention. Under the bill, a practitioner is not required to electronically transmit a prescription when doing so may negatively impact patient care, such as a prescription:

1. containing two or more products that a pharmacist compounds;

2. for direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous, or intraspinal infusion;

3. that contains long or complicated directions;

4. that requires certain elements to be included by the federal Food and Drug and Administration; or

5. that must be orally communicated to a pharmacist for a patient in a chronic and convalescent nursing home.

Lack of Technological Capacity. Under the bill, prescribing

practitioners are not required to electronically transmit prescriptions when they demonstrate in a DCP-prescribed form and manner, that they do not have the technological capacity.

"Technological capacity" means possessing a computer system, hardware, or device that can be used to electronically transmit controlled substance prescriptions consistent with the federal Controlled Substances Act (21 U.S.C. § 801).

Pharmacy Technology

The bill requires pharmacies to accept a prescribing practitioner's electronically transmitted controlled substances prescription. All records must be kept on the pharmacy's premises and maintained in a form readily available for inspection, at reasonable times, by the DCP commissioner, his authorized agent, or other authorized personnel. The records must be kept on file for three years and such records may be stored electronically, provided the files are maintained in the pharmacy's computer system for at least three years. If the electronically transmitted prescription is printed, it must be filed in the same way as pharmacies file filled controlled substance prescriptions, which is separate from other prescriptions.

§ 4 — VOLUNTARY NON-OPIOID DIRECTIVE FORM

The bill requires the Department of Public Health (DPH), in consultation with DCP and the Department of Mental Health and Addiction Services (DMHAS), to establish a voluntary non-opioid directive form and publish it on the DPH website for public use.

A "voluntary non-opioid directive form" means a form voluntarily filed by a patient with a prescribing practitioner that indicates the patient requests not to be issued a prescription or medication order for an opioid drug.

Anyone who does not wish to be issued a prescription or medication order for an opioid drug may file such a form with a prescribing practitioner. Upon receiving the form, the prescribing

practitioner must document it in the patient's medical record.

Revocation

The form must allow a patient to appoint a duly authorized guardian or health care proxy to override a previously recorded voluntary non-opioid directive form. The patient, duly authorized guardian, or health care proxy may revoke the directive orally or in writing at any time and for any reason.

Presumption of Valid Prescription

An electronically transmitted prescription to a pharmacy is presumed to be valid for the purposes of complying with this form and a pharmacist must not be held in violation for dispensing a controlled substance in contradiction to a voluntary non-opioid directive form.

Liability

The bill immunizes prescribing practitioners acting with reasonable care from damages in a civil action for refusing to issue a prescription or medication order for an opioid pursuant to a voluntary non-opioid directive form. They also cannot be subject to criminal prosecution or be deemed to have violated their professional standard of care on the basis of such refusal.

Under the bill, no one acting in good faith as a duly authorized guardian or health care proxy may be held liable for damages in a civil action or subject to criminal prosecution for revoking or overriding a voluntary non-opioid directive form.

The bill also immunizes emergency departments' prescribing practitioners acting with reasonable care as either a patient's practitioner or the medical control officer for emergency medical services personnel. They are immunized from liability for civil damages, criminal prosecution, or standard of care violations for issuing a prescription or administering a controlled substance with an opioid to a person who has a voluntary non-opioid directive form if in

the professional's judgment an opioid was necessary and he or she had no knowledge of the form at the time of issuance or administration.

Disciplinary Action

Under the bill, a prescribing practitioner who willfully fails to comply with a patient's voluntary non-opioid directive form may be subject to certain DPH disciplinary actions.

By law, DPH can take the following actions, among others:

1. suspend or revoke the person's DPH license or permit,
2. issue a letter of reprimand to or censure the person,
3. place him or her on probation, or
4. take summary action against the person's DPH license or permit if he or she has been found guilty of a state or federal felony or is subject to disciplinary action in another jurisdiction (CGS § 19a-17).

§ 5 — OPIOID DRUG PRESCRIPTIONS

Prescription Supply for Minors

The bill generally reduces, from a seven-day supply to a five-day supply, the maximum amount of an opioid drug a practitioner may prescribe to a minor.

As under existing law, practitioners may prescribe more opioid drugs to a minor if, in their professional judgment, the drug is required (1) for palliative care or (2) to treat the person's acute medical condition, chronic pain, or cancer-associated pain.

Discussion of Opioid Addiction Risk

Current law requires a prescribing practitioner to discuss with minor patients (i.e., under age 18) along with their custodial parent, guardian, or legal custodian, if present, the risks associated with opioid drug use. The bill additionally requires prescribers to have such

discussions with adult patients. As under current law, the bill requires the practitioner to discuss:

1. the associated risks of addiction and overdose;
2. the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants; and
3. why the prescription is necessary.

§ 6 — CERTIFICATION TO PRESCRIBE AT-HOME OPIOID USE DISORDER TREATMENTS

By October 1, 2017, the bill requires DPH to post information on its website about the ability of a prescribing practitioner to obtain certification to prescribe at-home medication to treat opioid use disorder (e.g., Suboxone). (The bill does not specify the type of certification or the certifying organization.) This information must include a list of educational requirements, available courses, and any waivers from these requirements.

Under existing law, the following Connecticut-licensed health providers may prescribe medication within the scope of their practice: physicians, dentists, podiatrists, optometrists, physician assistants, advanced practice registered nurses, nurse-midwives, and veterinarians (CGS § 20-14c).

§ 7 — ALCOHOL AND DRUG POLICY COUNCIL (ADPC)

By law, the ADPC is charged with (1) reviewing state policies on substance abuse treatment programs and criminal sanctions and programs and (2) developing and coordinating a statewide plan for these matters.

Fact Sheet

By October 1, 2017, the bill requires the ADPC to develop a one-page fact sheet on opioid drugs that must:

1. be written in clear and readily understandable language and in at least 12-point font,

2. include the risks of taking an opioid drug and the symptoms of opioid use disorders, and

3. include services available in Connecticut for people experiencing these symptoms or who are otherwise affected by an opioid use disorder.

The council must make the fact sheet available on the DMHAS website for health care providers and pharmacists to use and encourage them to disseminate it to anyone the (1) provider treats for opioid use disorder symptoms, (2) provider issues a prescription for or administers an opioid drug or opioid antagonist, or (3) pharmacist dispenses an opioid drug or issues a prescription for or dispenses an opioid antagonist.

Feasibility Study

The bill requires the ADPC to examine the feasibility of (1) developing a marketing campaign and making monthly public services announcements (PSA) on opioid drugs and (2) establishing an electronic portal on the availability of substance use disorder treatment beds in Connecticut facilities. The council must report the results of the study to the Public Health Committee by January 1, 2019.

Marketing Campaign and PSA. The council must examine the feasibility of developing a marketing campaign and making monthly PSAs on appropriate state agencies' websites and social media accounts and any radio and televisions stations broadcasting to Connecticut residents on:

1. the risks of taking opioid drugs and symptoms of opioid use disorder,

2. the availability of opioid antagonists in the state, and

3. services in Connecticut for people with or affected by opioid use disorder.

Electronic Information Portal. The council must also examine the feasibility of establishing an electronic information portal (i.e., internet website or application) to serve as a single point of entry for information on the availability of:

1. beds at a Connecticut facility for people needing medical treatment for (a) detoxification for potentially life-threatening symptoms of alcohol or drug withdrawal and (b) rehabilitation or treatment for alcohol or drug dependency or intoxication and

2. slots for outpatient treatment using opioid medication to treat opioid use disorder, including methadone and buprenorphine.

The examination must also include the portal's ability to be publicly accessible and provide real-time data on the availability of these beds and slots, including their types and location and wait times, if available.

Working Group On Safe Disposal of Opioid Drugs

The bill requires the ADPC to convene a working group to advise the council on any legislative or policy changes to enable first responders or health care providers to safely dispose of a person's opioid drugs upon the person's death. The council must report on the working group's recommendations to the Public Health Committee by February 1, 2018.

Working Group on Substance Abuse Treatment Referral Programs

The bill requires the ADPC to convene a working group to study municipal police departments' substance abuse treatment referral programs. These programs refer people with an opioid use disorder or who are seeking recovery from drug addiction to treatment facilities. The study must identify any barriers these programs face as well as the feasibility of implementing them statewide. The council must report

the working group's findings to the Public Health and Public Safety and Security Committees by February 1, 2018.

§§ 8 & 9 — INSURANCE COVERAGE FOR SUBSTANCE USE DISORDER

The bill requires certain individual and group health insurance policies to cover medically necessary (1) medically monitored inpatient detoxification services and (2) medically managed intensive inpatient detoxification services for insureds or enrollees who have been diagnosed with a substance use disorder.

Under the bill, "medical monitored inpatient detoxification" and "medically managed intensive inpatient detoxification" are defined in the same way as in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

§ 10 — SUBSTANCE ABUSE TREATMENT FACILITY ADMISSIONS

The bill requires an alcohol or drug treatment facility to use admissions criteria developed by the American Society of Addiction Medicine to assess whether to admit a person to the facility based on the services the facility is licensed to provide and the appropriate services required to treat the person.

§ 11 — LOCAL EMS PLANS

Current law requires that EMS providers carry an opioid antagonist and complete a DPH-approved training on how to administer it if they are likely to arrive first on the scene of a medical emergency. The bill

clarifies that at least one EMS provider who is likely to arrive first on the scene must carry an opioid antagonist and complete the training, not all such providers.

Under the bill, "EMS provider" means a person, association, or organization who provides immediate or life-saving transportation and medical care away from a hospital to a victim of sudden illness or injury, and who may also provide invalid coach services. Providers include EMS personnel (e.g., paramedics, emergency medical technicians, and advanced emergency medical technicians) and resident state troopers.

Current law requires each municipality to amend its local EMS plan to include this requirement by October 1, 2016. The bill extends the deadline to October 1, 2017.

§ 12 — STANDING ORDERS FOR OPIOID ANTAGONISTS

The bill allows a prescribing practitioner authorized to prescribe an opioid antagonist (such as Narcan) to issue a standing order (i.e., non-patient specific prescription) to a licensed pharmacist for an opioid antagonist that is:

1. administered nasally or by auto-injection;

2. approved by the federal Food and Drug Administration (FDA); and

3. dispensed by the pharmacist to a (a) person at risk of an opioid drug overdose or (b) family member, friend, or other person who may assist a person at risk of such an overdose.

When dispensing an opioid antagonist under a standing order, the pharmacist must train the person to administer it and keep a record of the dispensing and training under the law's recordkeeping requirements. (Existing law already requires this for pharmacists trained by DCP to dispense opioid antagonists; see BACKGROUND.) The pharmacist must also send a copy of the dispensing record to the

prescribing practitioner who entered into a standing order agreement with the pharmacy.

Additionally, the bill requires the pharmacy to provide DCP with a copy of each standing order it enters into with a prescribing practitioner.

Under the bill, a prescribing practitioner who issues a standing order for an opioid antagonist is considered to have done so for a legitimate medical purpose in the usual course of his or her professional practice. Additionally, a pharmacist who accepts the standing order and dispenses the opioid antagonist is deemed not to have violated his or her professional standard of care.

The bill also authorizes the DCP commissioner to adopt regulations to implement the bill's standing order provisions.

BACKGROUND

Controlled Substances

Controlled substances are drugs whose use and distribution are monitored because of their abuse potential or risk. Controlled substances are categorized in order of their abuse risk and placed into schedules. Drugs with the highest abuse potential, no medical use and not prescribable are placed in Schedule I and those with the lowest abuse potential are placed in Schedule V.

Opioid Antagonist

By law, an opioid antagonist is Narcan or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration to treat an opioid drug overdose.

Prescriptive Authority for Pharmacists

By law, pharmacists may prescribe opioid antagonists if they do the following:

1. complete a DCP-approved training and certification program,

2. act in good faith,

3. train the recipient of the opioid antagonist to administer it,

4. maintain a record of the dispensing and training under the law's recordkeeping requirements, and

5. refrain from delegating or directing another person to prescribe the medication or provide the training to the recipient (CGS § 20-633c).

COMMITTEE ACTION

General Law Committee

Joint Favorable
Yea 17 Nay 0 (03/07/2017)

Public Health Committee

Joint Favorable
Yea 26 Nay 0 (04/10/2017)