General Assembly

Amendment

January Session, 2017

LCO No. **8124**

* H B 0 7 0 5 2 0 8 1 2 4 H D O *

Offered by:

REP. STEINBERG, 136th Dist.
REP. RITTER M., 1st Dist.
SEN. SOMERS, 18th Dist.
SEN. GERRATANA, 6th Dist.
REP. KLARIDES, 114th Dist.
REP. SRINIVASAN, 31st Dist.
REP. CANDELORA, 86th Dist.
SEN. KENNEDY, 12th Dist.
SEN. LOGAN, 17th Dist.
REP. BARAM, 15th Dist.
REP. SCANLON, 98th Dist.
REP. STANESKI, 119th Dist.
REP. PETIT, 22nd Dist.
SEN. HWANG, 28th Dist.
REP. SMITH, 108th Dist.
REP. ARCONTI, 109th Dist.
REP. D'AGOSTINO, 91st Dist.
REP. RUTIGLIANO, 123rd Dist.
REP. ZIOBRON, 34th Dist.
REP. O'DEA, 125th Dist.
REP. HOYDICK, 120th Dist.
REP. BOCCHINO, 150th Dist.
REP. CUMMINGS, 74th Dist.
REP. SIEGRIST, 36th Dist.
REP. BUCKBEE, 67th Dist.
REP. DE LA CRUZ, 41st Dist.
REP. JOHNSON, 49th Dist.
REP. MCGEE, 5th Dist.
REP. ORANGE, 48th Dist.
REP. CARPINO, 32nd Dist.
REP. ROSARIO, 128th Dist.
REP. LEMAR, 96th Dist.
REP. SIMMONS, 144th Dist.
REP. GRESKO, 121st Dist.
REP. RILEY, 46th Dist.
REP. LOPES, 24th Dist.
REP. ABERCROMBIE, 83rd Dist.
REP. MCCARTHY VAHEY, 133rd Dist.
REP. RYAN, 139th Dist.
REP. HADDAD, 54th Dist.
REP. CURREY, 11th Dist.
REP. MACLACHLAN, 35th Dist.
REP. DAUPHINAIS, 44th Dist.
REP. PAVALOCK-D'AMATO, 77th Dist.
REP. POLLETTA, 68th Dist.
REP. CARNEY, 23rd Dist.
SEN. WITKOS, 8th Dist.
SEN. LEONE, 27th Dist.
REP. TWEEDIE, 13th Dist.

To: Subst. House Bill No. **7052** File No. 186 Cal. No. 155

"AN ACT PREVENTING PRESCRIPTION OPIOID DIVERSION AND ABUSE."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"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 Section 21a-262 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):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 <u>or her</u> 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 <u>or her</u> 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*) (a) 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