24:21-15.2
LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2021 **CHAPTER:** 54

NJSA: 24:21-15.2 (Requires opioid antidote prescriptions for certain patients.)

BILL NO: S2323 (Substituted for A3869 (1R))

SPONSOR(S) Gopal, Vin and others

DATE INTRODUCED: 4/9/2020

COMMITTEE: **ASSEMBLY:** ---

SENATE: Health, Human Services & Senior Citizens

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 3/1/2021

SENATE: 1/28/2021

DATE OF APPROVAL: 4/19/2021

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Second Reprint enacted) Yes

S2323

INTRODUCED BILL (INCLUDES SPONSOR'S STATEMENT): Yes

COMMITTEE STATEMENT: **ASSEMBLY:** No

SENATE: Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: Yes

LEGISLATIVE FISCAL ESTIMATE: No

A3869 (1R)

INTRODUCED BILL (INCLUDES SPONSOR'S STATEMENT): Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: No

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: Yes

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org

REPORTS:	No
HEARINGS:	No
NEWSPAPER ARTICLES:	Yes

Livio, Susan K.. "Prescriptions for high-risk patients now must include an overdose antidote." Hunterdon County Democrat (Flemington, NJ), April 22, 2021: 011.

Livio, Susan K.. "Opioid OD risk patients to get antidote as RX New law requires Narcan with addictive drug prescriptions.." South Jersey Times (NJ), April 21, 2021: 017.

RH/CL

P.L. 2021, CHAPTER 54, ***approved April 19, 2021***
Senate, No. 2323 ***(Second Reprint)***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SHH committee amendments adopted July 22, 2020.
[2]Senate floor amendments adopted November 16, 2020.

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

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

(1) 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;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

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

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

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

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

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

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

(3) periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance,

decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken;

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

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

[1][g. A practitioner who prescribes an opioid drug which is a controlled dangerous substance to a patient who has a history of substance use disorder, whose daily opioid prescription is greater than 50 morphine milligram equivalents, or who has a prescription for a benzodiazepine that is concurrent to the patient's opioid prescription shall, at the time the practitioner issues the prescription for the opioid drug, additionally issue the patient an annual prescription for a product approved by the federal Food and Drug Administration for the reversal of an opioid overdose.]**[1]**

[g.**]** **[1]**[h.**]** g.**[1]** As used in this section:

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

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

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

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

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

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

[1]"Opioid antidote" means any drug, regardless of dosage amount or method of administration, which has been approved by the United States Food and Drug Administration (FDA) for the treatment of an opioid overdose. "Opioid antidote includes, but is not limited to, naloxone hydrochloride, in any dosage amount, which is administered through nasal spray or any other FDA-approved means or methods.**[1]**

"Pain management agreement" means a written contract or agreement that is executed between a practitioner and a patient, prior

to the commencement of treatment for chronic pain using a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41), as a means to:

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

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

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

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

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

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

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

[h.**]** ¹**[**i.**]** h.¹ This section shall not apply to a prescription for a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long term care facility, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

[i.**]** ¹**[**j.**]** i.¹ Every policy, contract or plan delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, and every contract purchased by the School Employees' Health Benefits Commission or State Health Benefits Commission, on or after the effective date of this act, that provides coverage for prescription drugs subject to a co-payment, coinsurance or deductible shall charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

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

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

[1]j. (1) Subject to paragraph (2) of this subsection, if a health care practitioner issues a prescription for an opioid drug which is a controlled dangerous substance to a patient, the prescriber shall additionally issue the patient a prescription for an opioid antidote if any of the following conditions is present:

(a) the patient has a history of substance use disorder;

(b) the prescription for the opioid drug is for a daily dose of more than 90 morphine milligram equivalents; or

(c) the patient holds a current, valid prescription for a benzodiazepine drug that is a Schedule III or Schedule IV controlled dangerous substance [2][or the patient was dispensed a benzodiazepine drug that is a Schedule III or Schedule IV controlled dangerous substance within the preceding 45 days]2.

(2) A practitioner shall not be required to issue more than one prescription for an opioid antidote to a patient under paragraph (1) of this subsection per year.

(3) Nothing in paragraph (2) of this subsection shall be construed to prohibit a practitioner from issuing additional prescriptions for an opioid antidote to a patient upon the patient's request or when the practitioner determines there is a clinical or practical need for the additional prescription.[1]

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

2. This act shall take effect immediately.

Requires opioid antidote prescriptions for certain patients.

SENATE, No. 2323

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED APRIL 9, 2020

Sponsored by:
Senator VIN GOPAL
District 11 (Monmouth)
Senator ANTHONY M. BUCCO
District 25 (Morris and Somerset)

Co-Sponsored by:
Senator Vitale

SYNOPSIS

Requires opioid antidote prescriptions for certain patients.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 7/22/2020)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Matter underlined <u>thus</u> is new matter.

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

(1) 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;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. This act shall take effect immediately.

STATEMENT

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

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

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

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 2323

with committee amendments

STATE OF NEW JERSEY

DATED: JULY 20, 2020

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 2323.

As amended by the committee, this bill establishes requirements for an opioid antidote to be prescribed to a patient at the same time as the patient is issued a prescription for an opioid drug when certain risk factors are present.

Specifically, the amended bill requires an opioid antidote to be prescribed along with an opioid prescription in situations in which: (1) the patient has a history of substance use disorder; (2) the daily dose of the opioid being prescribed is more than 90 morphine milligram equivalents; or the patient holds a current, valid prescription for a benzodiazepine drug that is a Schedule III or IV controlled dangerous substance or the patient was dispensed a benzodiazepine drug that is a Schedule III or IV controlled dangerous substance within the preceding 45 days.

A practitioner will not be required to issue more than one prescription for an opioid antidote under the requirements of the bill per year. However, nothing in the bill is to be construed to prohibit a practitioner from issuing additional prescriptions for an opioid antidote to a patient upon the patient's request or when the practitioner determines there is a clinical or practical need for the additional prescription.

COMMITTEE AMENDMENTS:

The committee amendments clarify that the co-prescribing requirement applies to benzodiazepine drugs that are a Schedule III or Schedule IV controlled dangerous substance, and that the requirement applies both when the patient holds a current, valid prescription for a benzodiazepine drug or when the patient was dispensed a benzodiazepine drug within the preceding 45 days.

The committee amendments revise the co-prescribing requirement for opioid prescriptions with a daily dose of more than 50 morphine milligram equivalents to apply to opioid prescriptions with a daily dose of more than 90 morphine milligram equivalents.

The committee amendments clarify that the bill only requires an opioid antidote to be prescribed to a patient once per year, but that nothing is to be construed to prohibit a practitioner from issuing additional prescriptions for an opioid antidote to the patient at the patient's request or when there appears to be a clinical need for the additional prescription.

The committee amendments add a definition for "opioid antidote" that tracks the definition used in the "Overdose Prevention Act," P.L.2013, c.46 (C.24:6J-1 et al.).

The committee amendments revise the provisions of the bill to provide additional clarity concerning the scope and effects of the opioid antidote co-prescribing requirement, and to make various technical corrections to conform the bill to current drafting conventions.

STATEMENT TO

[First Reprint]

SENATE, No. 2323

with Senate Floor Amendments
(Proposed by Senator GOPAL)

ADOPTED: NOVEMBER 16, 2020

These floor amendments remove language that requires a prescriber to issue a patient a prescription for an opioid antidote if the patient has been dispensed a benzodiazepine drug that is a Schedule III or Schedule IV controlled dangerous substance within the preceding 45 days.

ASSEMBLY, No. 3869

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED MARCH 23, 2020

Sponsored by:
Assemblyman JOHN ARMATO
District 2 (Atlantic)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)

SYNOPSIS

Requires opioid antidote prescriptions for certain patients.

CURRENT VERSION OF TEXT

As introduced.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Matter underlined <u>thus</u> is new matter.

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(1) 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;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. This act shall take effect immediately.

STATEMENT

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

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

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

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3869

with committee amendments

STATE OF NEW JERSEY

DATED: OCTOBER 21, 2020

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 3869.

As amended by the committee, this bill establishes requirements for an opioid antidote to be prescribed to a patient at the same time as the patient is issued a prescription for an opioid drug when certain risk factors are present.

Specifically, the amended bill requires an opioid antidote to be prescribed along with an opioid prescription in situations in which: (1) the patient has a history of substance use disorder; (2) the daily dose of the opioid being prescribed is more than 90 morphine milligram equivalents; or the patient holds a current, valid prescription for a benzodiazepine drug that is a Schedule III or IV controlled dangerous substance or the patient was dispensed a benzodiazepine drug that is a Schedule III or IV controlled dangerous substance within the preceding 45 days.

A practitioner will not be required to issue more than one prescription for an opioid antidote under the requirements of the bill per year. However, nothing in the bill is to be construed to prohibit a practitioner from issuing additional prescriptions for an opioid antidote to a patient upon the patient's request or when the practitioner determines there is a clinical or practical need for the additional prescription.

As reported by the committee, Assembly Bill No. 3869 is identical to Senate Bill No. 2323 (1R) which was reported by the committee on this date.

COMMITTEE AMENDMENTS:

The committee amendments clarify that the co-prescribing requirement applies to benzodiazepine drugs that are a Schedule III or Schedule IV controlled dangerous substance, and that the requirement applies both when the patient holds a current, valid prescription for a benzodiazepine drug or when the patient was dispensed a benzodiazepine drug within the preceding 45 days.

The committee amendments revise the co-prescribing requirement for opioid prescriptions with a daily dose of more than 50 morphine

milligram equivalents to apply to opioid prescriptions with a daily dose of more than 90 morphine milligram equivalents.

The committee amendments clarify that the bill only requires an opioid antidote to be prescribed to a patient once per year, but that nothing is to be construed to prohibit a practitioner from issuing additional prescriptions for an opioid antidote to the patient at the patient's request or when there appears to be a clinical need for the additional prescription.

The committee amendments add a definition for "opioid antidote" that tracks the definition used in the "Overdose Prevention Act," P.L.2013, c.46 (C.24:6J-1 et al.).

The committee amendments revise the provisions of the bill to provide additional clarity concerning the scope and effects of the opioid antidote co-prescribing requirement, and to make various technical corrections to conform the bill to current drafting conventions.

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 3869

with Assembly Floor Amendments
(Proposed by Assemblyman CONAWAY, JR.)

ADOPTED: NOVEMBER 16, 2020

These floor amendments remove language that requires a prescriber to issue a patient a prescription for an opioid antidote if the patient has been dispensed a benzodiazepine drug that is a Schedule III or Schedule IV controlled dangerous substance within the preceding 45 days.

Governor Murphy Takes Action on Legislation

04/19/2021

TRENTON - Today, Governor Phil Murphy signed the following bills and resolutions into law:
SJR-93/AJR-180 (Lagana, Cunningham, Pou/Wimberly, Reynolds-Jackson, Quijano) Designates February 14 of each year as Frederick Douglass Day in NJ.

S-275/A-2142 (Kean, Cruz-Perez/Tully, Swain, Dancer) Provides resident tuition rate to certain non-resident dependent children of United States military personnel attending public institutions of higher education.

S-551/A-1057 (Codey, Bucco/Jasey, McKeon, Dunn) Permits appointment of nonresident municipal emergency management coordinators in municipalities with populations under 5,000 persons in certain circumstances.

S-699/A-5245 (Ruiz, Singleton/Sumter, Reynolds-Jackson, Stanley) Requires training for DOE arbitrators to include issues related to cultural diversity and bias.

S-1017/A-2562 (Gopal, Lagana/DeAngelo, Dancer, Chaparro) Provides retirement allowance after 20 years of service regardless of age for current members of PFRS who retire within two years.

S-1851/A-4407 (Ruiz, Cryan/Jasey, Moriarty) Eliminates eligibility of postsecondary students and other individuals for State student assistance, training, and employment services if school or training provider requires student to consent to arbitration agreement or proceeding or to waive certain rights.

S-2323/A-3869 (Gopal, Bucco/Armato, Vainieri Huttle, Verrelli) Requires opioid antidote prescriptions for certain patients.

S-2476/A-3998 (Singleton, Addiego/Murphy, Giblin, Verrelli) Concerns certain workers' compensation supplemental benefits for surviving dependents of essential employees who die in course of employment.

Copy of Statement

S-2831/A-4783 (Ruiz, Beach/Quijano, Lampitt, Jasey) Requires DOE to establish Alternate Route Interstate Reciprocity Pilot Program

S-2973/A-4895 (Beach/Armato) Creates office of deputy superintendent of elections in counties of fifth class.

S-3004/A-4947 (Sarlo, Pou/Johnson, Wirths, Reynolds-Jackson) Establishes retroactive date for provisions of P.L.2018, c.165, which clarifies provisions of "Predatory Towing Prevention Act."

Governor Murphy vetoed the following bills:

S-347/A-1992 (Smith, Vitale/Stanley, Conaway, Houghtaling) - CONDITIONAL - Establishes "NJ One Health Task Force."

Copy of Statement

S-619/A-1635 (O'Scanlon/Lampitt, Downey) - CONDITIONAL - Permits use of telemedicine and telehealth to authorize patients for medical cannabis and to issue written instructions for dispensing medical cannabis.

Copy of Statement

S-2725/A-4473 (Gopal/Houghtaling, Downey) - CONDITIONAL - Concerns assessment of real property in counties operating under "Real Property Assessment Demonstration Program."

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