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Indicates New Matter

AMENDED

April 24, 2018

**S. 918**

Introduced by Senators Peeler, Malloy, Hembree and M.B. Matthews

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Read the first time April 5, 2018.

**A** **BILL**

TO AMEND SECTION 44‑53‑110, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO TERMS DEFINED IN THE “NARCOTICS AND CONTROLLED SUBSTANCES ACT”, SO AS TO ADD A DEFINITION FOR “TARGETED CONTROLLED SUBSTANCE”; TO AMEND SECTION 44‑53‑360, RELATING TO PRESCRIPTIONS, SO AS TO REQUIRE THE USE OF ELECTRONIC PRESCRIPTIONS WHEN PRESCRIBING NARCOTIC DRUGS, WITH EXCEPTIONS, AND TO ESTABLISH CERTAIN PRESCRIBING LIMITATIONS; BY ADDING SECTION 44‑53‑1655 SO AS TO REQUIRE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL TO PROVIDE PRESCRIPTION REPORTS TO PRACTITIONERS AND TO CONDUCT AUDITS OF THE PRESCRIPTION MONITORING PROGRAM, AND SECTION 44‑53‑1665 SO AS TO ESTABLISH REPORTING REQUIREMENTS OF THE DEPARTMENT; TO AMEND SECTIONS 44‑53‑1630, AS AMENDED, 44-53-1640, AS AMENDED, 44-53-1645, 44-53-1650, AND 44-53-1680, AS AMENDED, ALL RELATING TO THE PRESCRIPTION MONITORING PROGRAM, SO AS TO ADD A DEFINITION FOR “TARGETED CONTROLLED SUBSTANCE”, TO REQUIRE DISPENSERS TO SUBMIT ADDITIONAL INFORMATION TO THE PROGRAM AND TO REVIEW PROGRAM DATA BEFORE DISPENSING IN CERTAIN CIRCUMSTANCES, TO CHANGE THE REQUIREMENTS FOR PRACTITIONERS TO REVIEW PRESCRIPTION HISTORY BEFORE PRESCRIBING SELECT CONTROLLED SUBSTANCES, TO ALLOW PRACTITIONERS TO OBTAIN PRESCRIPTION REPORTS, AND TO MAKE CONFORMING CHANGES, RESPECTIVELY; AND TO AMEND SECTIONS 40‑47‑965 AND 40‑33‑34, BOTH AS AMENDED, RELATING TO PRESCRIPTIVE AUTHORITY OF PHYSICIANS ASSISTANTS AND NURSES, RESPECTIVELY, SO AS TO ADDRESS THE AUTHORITY TO PRESCRIBE NARCOTICS TO CERTAIN PATIENTS.

Amend Title To Conform

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 44‑53‑360 of the 1976 Code is amended by adding an appropriately lettered subsection at the end to read:

“( )(1) Initial opioid prescriptions for acute pain management or postoperative pain management must not exceed a seven‑day supply, except when clinically indicated for cancer pain, chronic pain, hospice care, palliative care, major trauma, major surgery, treatment of sickle cell disease, treatment of neonatal abstinence syndrome, or medication‑assisted treatment for substance use disorder. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new opioid prescription.

(2) This subsection does not apply to opioid prescriptions issued by a practitioner who orders an opioid prescription to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.

(3) A practitioner who acts in accordance with the limitation on prescriptions as set forth in this subsection is immune from any civil liability or disciplinary action from the practitioner’s professional licensing board.

(4) As used in this subsection:

(A) ‘Acute pain’ means pain that a practitioner reasonably expects to last for three months or less, whether resulting from disease, accident, intentional trauma, or other cause. The term does not include ‘chronic pain’ or pain being treated as part of cancer care, chronic care, hospice care, palliative care, major trauma, major surgery, treatment of sickle cell disease, treatment of neonatal abstinence syndrome, or medication‑assisted treatment for substance use disorder.

(B) ‘Chronic pain’ means pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(C) ‘Postoperative pain’ means acute pain experienced immediately after a surgical procedure.

(D) ‘Surgical procedure’ means a procedure performed for the purpose of altering the human body by incision or destruction of tissues as part of the practice of medicine such as diagnostic or therapeutic treatment of conditions or disease processes by use of instruments and includes lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light‑based, electromagnetic, or chemical means.”

SECTION 2. Article 15, Chapter 53, Title 44 of the 1976 Code is amended by adding:

“Section 44‑53‑1655. (A) The department shall develop and maintain as part of the prescription monitoring program a system to provide prescription report cards to practitioners to inform the practitioner about certain prescribing trends. The report card must provide, at a minimum:

(1) a comparison of the practitioner’s number of prescriptions issued per month by therapeutic class code or by specific substances to peer averages by specialty throughout the State;

(2) a comparison of the practitioner’s number of milligrams prescribed per month by therapeutic class code over by specific substances to peer averages by specialty throughout the State;

(3) the total number of patients receiving ninety morphine milligram equivalents (MMEs) or more a day;

(4) the total number of patients receiving opioid medications for thirty days or more;

(5) the total number of patients receiving opioids and benzodiazepines medications at the same time;

(6) the total number of patients issued prescriptions from three or more practitioners;

(7) the total number of patients filling prescriptions at three or more pharmacies;

(8) the total number of patients with controlled substance prescriptions whose dispensing dates overlap;

(9) the total number of patients obtaining refills on their prescriptions more than one week early; and

(10) the total number of prescription drug monitoring program queries made by the practitioner and a ratio of the queries to the number of patients or prescriptions issued.

The report card also must provide data on the number of practitioners registered against which the comparisons of items (1) and (2) are being made and any other demographic data relating to the pool of practitioners and may include regional or nationwide prescribing comparison data that would be useful to the practitioner. Prescription report cards, data, documents, records, and any other information accessed or compiled in preparing prescription report cards, are confidential and not subject to discovery, subpoena, or introduction into evidence in any civil action, unless confidentiality is waived by the practitioner.

(B) The department shall coordinate with the Board of Medical Examiners and any other appropriate professional boards as part of the development and implementation of a prescription report card program. The department may contract with another agency of the State or with a private vendor, as necessary, to ensure effective operation of the report card program, as provided in Section 44‑53‑1660, and may apply for public or private grants or other funding to develop, implement, and maintain the program.”

SECTION 3. Section 44‑53‑1650(D) of the 1976 Code is amended by an appropriately numbered item at the end to read:

“( ) a practitioner in a prescription report card provided to practitioners in accordance with Section 44‑53‑1655.”

SECTION 4. Section 44‑53‑1640 of the 1976 Code is amended to read:

“Section 44‑53‑1640. (A) The Department of Health and Environmental Control, Bureau of Drug Control shall establish and maintain a program to monitor the prescribing and dispensing of all Schedule II, III, and IV controlled substances by professionals licensed to prescribe or dispense these substances in this State and the administering of opioid antidotes by first responders in accordance with Section 44‑130‑60 and in hospital emergency departments or other health care facilities when a supervising physician diagnoses a patient as having experienced an opioid overdose.

(B)(1) A dispenser shall submit to drug control, by electronic means, information regarding each prescription dispensed for a controlled substance. The following information must be submitted for each prescription:

(a) dispenser DEA registration number;

(b) date drug was dispensed;

(c) prescription number;

(d) whether prescription is new or a refill;

(e) NDC code for drug dispensed;

(f) quantity dispensed;

(g) approximate number of days supplied;

(h) patient name;

(i) patient address;

(j) patient date of birth;

(k) prescriber DEA registration number;

(l) date prescription issued by prescriber.

(2) A dispenser shall submit daily to the department the information required pursuant to subsection (B)(1) in accordance with transmission methods and protocols provided in the latest edition of the ‘ASAP Telecommunications Format for Controlled Substances’, developed by the American Society for Automation in Pharmacy.

(3) Drug control may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means if all information required pursuant to subsection (B)(1) is submitted in this alternative format.

(C)(1) If a person is administered an opioid antidote in a hospital emergency department or other health care facility and the supervising physician diagnoses the patient as having experienced an opioid overdose, the supervising physician, the supervising physician’s authorized delegate, or the institutional pharmacy’s pharmacist‑in‑charge shall report to the department’s Bureau of Drug Control, within three business days after a discharge diagnosis of an opioid overdose and administration of an opioid antidote, information regarding the opioid antidote administered for inclusion in the prescription monitoring program. The information submitted must include:

(a) date the opioid antidote was administered;

(b) dosage of opioid antidote administered and route of administration; and

(c) name, address, and date of birth of the person to whom the opioid antidote was administered, if available.

(2)(a) After a supervising physician, the supervising physician’s authorized delegate, or the institutional pharmacy’s pharmacist‑in‑charge submits the name, address, and date of birth of a person to whom an opioid antidote was administered as required by subsection (A), Drug Control shall verify whether any prescription history of the person appears in the prescription monitoring program and, if prescription history exists, shall document for review by a practitioner or an authorized delegate the date on which the opioid antidote was administered to the person.

(b) Drug Control also shall maintain data on the administering of opioid antidotes as required by this section including, but not limited to, the frequency with which opioid antidotes are administered in hospital emergency departments as required pursuant to subsection (A) and other health care facilities by geographic location.

(D)(1) A first responder who administers an opioid antidote in accordance with Section 44‑130‑60 shall report to the department’s Bureau of Drug Control information regarding the opioid antidote administered for inclusion in the prescription monitoring program. The information submitted must include:

(a) date the opioid antidote was administered;

(b) dosage of opioid antidote administered and route of administration;

(c) name, address, and date of birth of the person to whom the opioid antidote was administered, if available; and

(d) dispenser from which the opioid antidote was obtained.

(2) A first responder shall submit the information required pursuant to item (1) electronically to Drug Control within seventy‑two hours of administration.

(3)(a) If a first responder submits the name, address, and date of birth of a person to whom an opioid antidote was administered, Drug Control shall verify whether any prescription history of the person appears in the prescription monitoring program and, if prescription history exists, shall document for review by a practitioner or an authorized delegate the date on which the opioid antidote was administered to the person.

(b) Drug Control also shall maintain data on the administering of opioid antidotes by first responders including, but not limited to, the frequency with which first responders administer opioid antidotes by geographic location, first responder, and dispenser.”

SECTION 5. Section 44‑53‑1645(A) of the 1976 Code is amended to read:

“(A) A practitioner, or the practitioner’s authorized delegate, shall review a patient’s controlled substance prescription history and history of the administering of an opioid antidote to the patient pursuant to Section 44‑53‑1640(C) or (D), as maintained in the prescription monitoring program, before the practitioner issues a prescription for a Schedule II controlled substance. If an authorized delegate reviews a patient’s controlled substance prescription history and history of the administering of an opioid antidote to the patient as provided in this subsection, the practitioner must consult with the authorized delegate regarding the prescription and opioid antidote administering history before issuing a prescription for a Schedule II controlled substance. The consultation must be documented in the patient’s medical record.”

SECTION 6. SECTION 2 is effective six months after the effective date of this act. SECTIONS 4 and 5 are effective one year after the effective date of this act. All other SECTIONS are effective upon approval by the Governor.

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