Oklahoma State Board of Osteopathic Examiners
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# POLICY AND PROCEDURE ON CME APPROVAL FOR PROPER PRESCRIBING INVOLVING SB 1446 & SB 848

4/15/2024

**POLICY:**

It shall be the policy of this Board that:

1. All presentations regarding pain management, opioid use, and addiction be attended in person or via live interactive media which enables attendees to ask live questions with immediate responsive answers and action. This hour cannot be obtained via previously recorded webinar, seminar, on demand or other such means that does not afford live and immediate question and answers.

2. An Osteopathic Physician must be present and sponsor the proper prescribing portion of the instruction in order to acquire the one hour necessary for approval by the Osteopathic Board.

("Sponsor" is defined as: Review, approve, and be physically present. However, the officially sponsoring D.O. is not required to instruct the material presented.)

3. This one hour of Proper Prescribing course needs to be approved by the Executive Director at the Oklahoma State Board of Osteopathic Examiners.

4. One hour of Proper Prescribing is required to be attended every year.

5. For the one (1) hour programs, no credit will be awarded without the above requirements being followed.

**PROCEDURE:**

1. All portions of CME materials involving SB 1446 and/or SB 848 shall be approved prior to presentation in order for CME Credit to be awarded. Requests for approval must be in writing and the applicable portions of the course materials need to be provided in advance directed to the Board's Executive Director at the Oklahoma

State Board of Osteopathic Examiners office at 4848 N. Lincoln, Suite 100, Oklahoma City, OK 73105.

2. In order to allow time for processing, requests should be submitted at least thirty (30) days prior to the presentation.

3. Approved presentations may advertise that, "This program meets the requirements for approval of one (1) hour of CME credit by the Oklahoma State Board of Osteopathic Examiners."

**EXECUTIVE DIRECTOR APPROVAL STANDARDS:**

1. No presentation shall be approved by the Executive Director unless it discusses the following minimum requirements:

    a. A Reference must be made to Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC *Clinical Practice Guideline for Prescribing Opioids for Pain* — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1
    At a minimum the following points from the Guideline must be discussed:
        1. Acute, subacute, and chronic pain needs to be appropriately assessed and treated independent of whether opioids are part of a treatment regimen.
        2. Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.
        3. Discontinuing opioids after extended periods of continuous opioid use can be challenging for clinicians and patients. Tapering or discontinuing opioids in patients who have taken them long term can be associated with clinically significant risks, particularly if opioids are tapered rapidly or patients do not receive effective support. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech),

opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.

b. A thorough discussion of each of the following must be included in the proposed presentation.
    1. Prescription Monitoring Program – PMP must be checked at the initial prescription and then at least every 180 days. 63 O.S. § 2-309D(G)
    2. Acute Pain Prescription Limits: For acute pain, prescriber shall not issue an initial prescription for an opioid drug in a quantity exceeding seven (7) day supply. Prescription shall be for the lowest effective dose of immediate-release opioid drug and must state "acute pain" on the face of the prescription. 63 O.S. § 2-309I(A) & (G). Following the initial seven (7) days, after consultation (in person or by telephone), a subsequent 7-day prescription may be issued if prescriber determines the prescription is necessary and appropriate, documents the rationale for prescribing, and determines and documents the prescription does not present undue risk of abuse, addiction or diversion. A second 7-day prescription of an immediate-release opioid drug in a quantity not to exceed seven (7) days may be issued on the same day as the initial prescription if: (i) The subsequent prescription is due to a major surgical procedure and/or "confined to home" status as defined in 42 U.S.C. 1395n(a); (ii) The practitioner provides the subsequent prescription on the same day as the initial prescription; (iii) The practitioner provides written instruction on the subsequent prescription indicating the earliest date on which the prescription may be filled (i.e. "do not fill until" date); and (iv) The subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription. 63 O.S. § 2-309(I)(B)(5)
    3. If a medication needs to be changed due to allergy, ineffective dose or other medical condition, document thoroughly in the record the need and rationale for change.

4. Chronic Pain Prescriptions: If continuing treatment for three months or more, practitioner shall: (1) review every three (3) months the course of treatment, any new information regarding etiology of pain and progress toward treatment objectives; (2) assess patient prior to every renewal to determine if patient is experiencing dependency, Opioid Use Disorder, or addiction and document assessment; if a Substance use disorder (SUD) is present a referral to a specialist should be considered 3) periodically make reasonable efforts, unless clinically contraindicated to stop, decrease dosage, or try other treatment modalities; (4) review PMP; (5) monitor compliance with patient provider agreement, and state "chronic pain" on the face of the prescription. After one year of compliance with the patient provider agreement, physician may review treatment plan and assess patient at six-month intervals. 63 O.S. § 2-309I(F)
5. Morphine Milligram Equivalent - MME: If you the prescriber chooses to prescribe greater than 100 MME, document the rationale should be documented thoroughly. 63 O.S § 2-309I(J)(3)
6. Prior to an Initial Prescription for any Opioid: Practitioner shall: (1) take and document a thorough medical history; (2) conduct and document a physical exam; (3) develop a treatment plan; (4) access the PMP; (5) limit supply to no more than seven (7) days for acute pain; (6) if the patient is under 18, enter into a Patient-Provider Agreement with the parent or legal guardian; (7) if the patient is a pregnant woman enter into a patient-provider agreement. 63 O.S. § 2-309I(A) & (B)
7. Informed Consent & Risk Discussions: Prior to initial prescription and again prior to third prescription, practitioner must discuss risks including: (1) risks of addiction and overdose, dangers of taking opioids with alcohol, benzodiazepines and other CNS central nervous system depressants; (2) reason the prescription is necessary; (3) alternative treatment available; (4) risks can include fatal respiratory depression. Practitioner shall document the discussion in the medical record. 63 O.S. § 2-309I(D)

8. Patient-Provider Agreement: Practitioner shall enter into a Patient-Provider Agreement with a patient: (1) at the time of the third prescription for opioid drug; (2) If patient requires more than three months of pain management; (3) if patient is prescribed benzodiazepines and opioids together; (4) if patient requires more than 100 mg morphine milligram equivalents (MME); (5) If patient is pregnant; or (6) with the parent or legal guardian if the patient is a minor. 63 O.S. § 2-309I(J); 63 O.S. § 2-309I(B)(6),(7); 63 O.S. § 2-101(45)
9. The requirements of SB 1446 and SB 848 do not apply to a patient who has sickle cell disease, receiving active is in treatment of cancer or receiving aftercare cancer treatment, hospice, palliative care, residents of a long-term care facility, or medications for treatment of substance abuse or opioid dependence. 63 O.S. § 2-309I(H)
10. Written Policy: Any provider authorized to prescribe opioids shall adopt and maintain a written policy including execution of written contract patient-provider agreement between practitioner and qualifying opioid therapy patient. 63 O.S. § 2-309I (I) (J)
11. Standard of Care: This law shall not be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner.

This Policy and Procedure is effective April 15, 2024.