~~Indicates Matter Stricken~~

Indicates New Matter

COMMITTEE REPORT

April 18, 2018

**S. 918**

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

S. Printed 4/18/18--H.

Read the first time April 5, 2018.

**THE COMMITTEE ON JUDICIARY**

To whom was referred a Bill (S. 918) to amend Section 44‑53‑110, Code of Laws of South Carolina, 1976, relating to terms defined in the “Narcotics and Controlled Substances Act”, etc., respectfully

**REPORT:**

That they have duly and carefully considered the same and recommend that the same do pass with amendment:

Amend the bill, as and if amended, by striking all after the enacting words and inserting:

/ 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. /

Renumber sections to conform.

Amend title to conform.

F. GREGORY DELLENEY, JR. for Committee.

**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.

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

SECTION 1. Section 44‑53‑110(38) of the 1976 Code is amended to read:

“(38) ‘Targeted controlled substance’ means any Schedule II or Schedule III controlled substance.

(39) ‘Ultimate user’ means a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for administration to an animal owned by him or a member of his household.”

SECTION 2. Section 44‑53‑360 of the 1976 Code is amended by adding subsections (j) and (k) at the end to read:

“(j)(1) Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe any targeted controlled substance. This subsection does not apply to prescriptions for a targeted controlled substance issued by any of the following:

(A) a practitioner, other than a pharmacist, who dispenses directly to an ultimate user;

(B) a practitioner who orders a targeted controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis facility, or residential care facility;

(C) a practitioner who experiences temporary technological or electrical failure or other extenuating circumstances that prevent the prescription from being transmitted electronically; however, the practitioner must document the reason for this exception in the patient’s medical record;

(D) a practitioner who writes a prescription for a targeted controlled substance to be dispensed by a pharmacy located on federal property; however, the practitioner must document the reason for this exception in the patient’s medical record; or

(E) a person licensed to practice veterinary medicine pursuant to Chapter 69, Title 40.

(2) A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in item (1) before dispensing a targeted controlled substance. A dispenser may continue to dispense a targeted controlled substance from valid written, oral, faxed, or electronic prescriptions that are otherwise consistent with applicable laws.

(k)(1) A practitioner may not prescribe more than a five‑day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain. Initial opiod prescriptions for post-surgical procedure pain management must not exceed a seven-day supply, except when clinically indicated for chronic pain, cancer pain, hospice care, palliative care, or medication-assisted treatment for substance abuse. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This item does not apply to prescriptions for targeted controlled substances issued by a practitioner who orders a targeted controlled substance to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility. A practitioner who acts in accordance with the limitation on prescriptions as set forth in this item is immune from any civil liability or disciplinary action from the practitioner’s professional licensing board.

(2) 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 pain being treated as part of cancer care, hospice care, palliative care, or medication‑assisted treatment for substance use disorder.

(B) ‘Surgical procedure’ means a procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as 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.

(3) A dispenser is immune from any civil or criminal liability or disciplinary action from the State Board of Pharmacy for dispensing a prescription written by a prescriber in violation of subsection (j).”

SECTION 3.A. Article 15, Chapter 53, Title 44 of the 1976 Code is amended by adding:

“Section 44‑53‑1655. (A)(1) The department shall develop and maintain as part of the prescription monitoring program a system to provide prescription reports to practitioners to inform the practitioner about certain prescribing trends.

(2) The department shall coordinate with the Board of Medical Examiners for South Carolina 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 prescription report 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.

(B) Beginning in 2020, the department shall conduct periodic audits of the review of the prescription monitoring program by practitioner. The audit must include a process for selecting a subset of the prescriptions to examine during each review period. The department shall report to the appropriate board any practitioner found to be in violation of Section 44‑53‑1645. A violation may constitute cause for the licensing board to suspend or revoke a practitioner’s license.

Section 44‑53‑1665. (A) Annually on May first, beginning May 1, 2019, the department shall report to the Medical Affairs Committee of the Senate, the Medical, Military, Public and Municipal Affairs Committee of the House of Representatives, the South Carolina Law Enforcement Division, the State Board of Dentistry, the State Board of Medical Examiners for South Carolina, the State Board of Nursing for South Carolina, the South Carolina Board of Examiners in Optometry, the State Board of Pharmacy, the State Board of Podiatry Examiners, and the State Board of Veterinary Medical Examiners on data reported to the prescription monitoring program. The report must include at least all of the following information reported to the program during the preceding calendar year:

(1) the total number of prescriptions for targeted controlled substances dispensed, broken down by schedule;

(2) demographics about the ultimate users to whom prescriptions for targeted controlled substances were dispensed;

(3) statistics regarding the number of pills dispensed for each prescription for a targeted controlled substance;

(4) the number of ultimate users who were prescribed a targeted controlled substance by two or more practitioners; and

(5) any other data deemed appropriate and requested by the entities identified in this subsection.

(B) The Department of Health and Environmental Control, State Department of Health and Human Services, State Department of Mental Health, Department of Disabilities and Special Needs, the Department of Alcohol and Other Drug Abuse Services, and the Department of Labor, Licensing and Regulation shall continue to work together to address and find solutions to the opioid abuse and overdose crisis.”

B. Section 44‑53‑1630 of the 1976 Code, as last amended by Act 91 of 2017, is further amended by adding an appropriately numbered item at the end to read:

“( ) ‘Targeted controlled substance’ means any Schedule II or Schedule III controlled substance.”

C. Section 44‑53‑1640 of the 1976 Code, as last amended by Act 91 of 2017, is further 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.

(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 phone number;

(k) patient date of birth;

(l) method of payment of the prescription;

~~(k)~~(m) prescriber DEA registration number; and

~~(l)~~(n) 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) Before dispensing a targeted controlled substance, a dispenser shall review the information in the prescription monitoring program pertaining to the patient for at least the preceding twelve‑month period and document this review electronically under any of the following circumstances:

(a) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user’s medical condition.

(b) The practitioner is located outside the usual geographic area served by the dispenser.

(c) The ultimate user resides outside the usual geographic area served by the dispenser.

(d) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser.

(e) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following:

(i) overutilization of the controlled substance;

(ii) requests for early refills;

(iii) utilization of multiple practitioners;

(iv) an appearance of being overly sedated or intoxicated upon presenting a prescription; or

(v) a request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks.

(2) If a dispenser has reason to believe that a prescription for a targeted controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the practitioner and verify that the prescription is medically appropriate.

(3) A dispenser is immune from any civil or criminal liability for actions authorized in this subsection. Failure to review the prescription monitoring program in accordance with this subsection does not constitute negligence.”

D. Section 44‑53‑1645(A) and (B) of the 1976 Code, as added by Act 91 of 2017, is amended to read:

“(A) A practitioner, or the practitioner’s authorized delegate, shall review a patient’s controlled substance prescription history, as maintained in the prescription monitoring program~~, before~~ for at least the twelve‑month period preceding the date on which the practitioner issues ~~a~~ an initial prescription for a ~~Schedule II~~ targeted controlled substance. If an authorized delegate reviews a patient’s controlled substance prescription history, the practitioner must consult with the authorized delegate regarding the prescription history before issuing a prescription for a ~~Schedule II~~ targeted controlled substance. The consultation must be documented in the patient’s medical record.

(B) The requirements of this section do not apply to:

(1) a practitioner issuing a prescription for a ~~Schedule II~~ targeted controlled substance to treat a hospice‑certified patient;

(2) a practitioner issuing a prescription for a ~~Schedule II~~ targeted controlled substance that does not exceed a five‑day supply for a patient;

(3) a practitioner prescribing a ~~Schedule II~~ targeted controlled substance for a patient with whom the practitioner has an established relationship for the treatment of a chronic condition; however, the practitioner must review the patient’s controlled substance history maintained in the prescription monitoring program at least every three months;

(4) a practitioner approving the administration of a ~~Schedule II~~ targeted controlled substance by a health care provider licensed in South Carolina;

(5) a practitioner prescribing a ~~Schedule II~~ targeted controlled substance for a patient in a skilled nursing facility, nursing home, community residential care facility, or an assisted living facility and the patient’s medications are stored, given, and monitored by staff; or

(6) a practitioner who is temporarily unable to access the prescription monitoring program due to exigent circumstances; however, the exigent circumstances and the potential adverse impact to the patient if the prescription is not issued timely must be documented in the patient’s medical record.”

E. Section 44‑53‑1650(D) of the 1976 Code is amended by adding an appropriately numbered item to read:

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

F. Section 44‑53‑1680(E) of the 1976 Code, as last amended by Act 91 of 2017, is further amended to read:

“(E) Except as provided in Section 44‑53‑1640(C)(1), nothing in this chapter requires a pharmacist to obtain information about a patient from the prescription monitoring program. A practitioner or authorized delegate of a practitioner who knowingly fails to review a patient’s controlled substance prescription history, as maintained in the prescription monitoring program, or a practitioner who knowingly fails to consult with his authorized delegate regarding a patient’s controlled substance prescription history before issuing a prescription for a ~~Schedule II~~ targeted controlled substance, as required by this article, must be reported to his respective board for disciplinary action.”

SECTION 4. Section 40‑47‑965(A), as last amended by Act 28 of 2013, is further amended by adding an appropriately numbered item at the end to read:

“( ) notwithstanding item (6), if a patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications and advertises in any medium for any type of pain management services, and the therapeutic use of a targeted controlled substance will or is expected to exceed a period of thirty days, the physician assistant must personally consult with the supervising physician prior to prescribing a targeted controlled substance. When a targeted controlled substance prescribed in accordance with this item is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every ninety days to verify that the prescription remains medically appropriate for the patient. For purposes of this item, a ‘targeted controlled substance’ means a Schedule II or Schedule III controlled substance.”

SECTION 5. Section 40‑33‑34(F)(1)(c) of the 1976 Code is amended to read:

“(c) do not include prescriptions for Schedule II controlled substances; however, Schedules III through V controlled substances may be prescribed if listed in the approved written protocol and as authorized by Section 44‑53‑300. If the patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications and advertises in any medium for any type of pain management services, and the therapeutic use of a Schedule III controlled substance will or is expected to exceed a period of thirty days, the NP, CNM, or CNS must personally consult with the supervising physician prior to prescribing a Schedule III controlled substance. When a controlled substance prescribed in accordance with this subitem is continuously prescribed to the same patient, the NP, CNM, or CNS shall consult with the supervising physician at least once every ninety days to verify that the prescription remains medically appropriate for the patient;”

SECTION 6. Except as otherwise provided, this act takes effect January 1, 2019.

‑‑‑‑XX‑‑‑‑