



July 2017

Connecticut Enacts Legislation Intended to Curb Opioid Drug Abuse

On June 30, 2017, Connecticut Governor Dannel P. Malloy signed into law An Act Preventing Prescription Opioid Diversion and Abuse (Public Act No. 17-131). This legislation addresses opioid drug abuse in Connecticut by revising current laws related to controlled substance prescribing and disposal and enacting new laws regarding opioid abuse prevention and treatment.

ELECTRONIC TRANSMISSION OF PRESCRIPTIONS — EFFECTIVE JANUARY 1, 2018

This legislation significantly revises the procedure for issuing controlled substance prescriptions in Connecticut. Currently, Connecticut law generally requires controlled substance prescriptions to be written in ink, in indelible pencil, or by typewriter. As of January 1, 2018, prescribing practitioners will be required to “electronically transmit” controlled substance prescriptions to pharmacies, except in narrow excepted circumstances. Electronically transmit refers to transmission “by computer modem or other similar electronic device.”

PA 17-131 sets forth five circumstances in which a licensed practitioner is not required to electronically transmit a prescription:

1. Where electronic transmission is not available due to a temporary technological or electronic failure, provided that the practitioner is required to reasonably attempt to remedy the issue, and the practitioner must document the reason for not electronically transmitting any prescriptions issued in the respective patients’ medical records as soon as practicable (but no later than 72 hours following the end of the reason that prevented the electronic transmittal).
2. If the practitioner reasonably determines it is impractical for the patient to obtain a substance via an electronically transmitted prescription in a timely manner, and any such delay would adversely affect the patient’s condition. In this circumstance, the practitioner must document the reason for not electronically transmitting the prescription in the patient’s medical record. Note that, in the event a prescriber seeks to issue a prescription for a controlled substance under this timeliness exception, the quantity of the controlled substance cannot exceed a five-day supply for the patient if used in accordance with the directions for use.
3. If the prescription is to be dispensed by an out-of-state pharmacy, in which case the prescribing practitioner must document this basis for not electronically transmitting the prescription in the patient’s medical record.
4. If electronically transmitting a prescription may negatively affect patient care, including without limitation where (i) a prescription is for a compounded medicine, (ii) a prescription contemplates direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous, or intraspinal infusion, (iii) the prescription contains long or complicated

directions, (iv) the prescription must incorporate certain elements required by the federal Food and Drug Administration (FDA), or (v) the prescription is communicated orally to a pharmacist by a health care practitioner for a patient in a chronic and convalescent nursing home.

5. If the prescribing practitioner demonstrates, via a form and manner to be established by the Department of Consumer Protection (DCP), that the practitioner does not have the technological capacity to electronically transmit prescriptions (that is, the practitioner does not possess a computer system or other hardware or device that can be used to electronically transmit controlled substance prescriptions in accordance with the federal Controlled Substances Act (CSA)).

A prescription issued pursuant to one of the above exceptions may be issued as a written order or, where permitted by the CSA, as an oral order or transmitted via fax. Such a permissible oral or fax prescription order must promptly be reduced to writing on a prescription blank or hard copy printout or created as an electronic record and filed by the pharmacist filling it. As is the case currently, duplicate, carbon or photographic copies, as well as printed or rubber-stamped orders, will not constitute valid prescriptions under Connecticut law.

This legislation requires prescribing practitioners to promptly print out in hard copy, or store as an electronic record, an electronically transmitted prescription. This legislation further obligates prescribing practitioners and pharmacies to retain records of electronically transmitted prescriptions for at least three years in a readily available form for inspection by the DCP or other authorized federal or state officials at reasonable times. Relatedly, this legislation affirms that pharmacies are to accept electronically transmitted prescriptions for controlled substances from practitioners and that pharmacies may store electronically transmitted prescription records electronically in computer systems or may print electronically transmitted prescription records and retain them in accordance with current retention requirements applicable to written prescriptions (filed chronologically and consecutively but separating Schedule II prescriptions from prescriptions for Schedules III-V).

This legislation requires prescriptions for Schedule II controlled substances to be electronically transmitted except in certain emergency circumstances. In an emergency, this legislation permits dispensing of Schedule II controlled substances upon the oral order of a prescribing registrant known to or confirmed by the pharmacist as long as the order is also permissible under the CSA. This legislation requires the pharmacist to promptly reduce the oral order to writing on a prescription blank and obligates the prescribing registrant to confirm the oral order by completing and mailing or delivering a prescription to the filling pharmacist within 72 hours. Upon receipt of the written prescription, the pharmacist must affix the temporary prescription prepared by the pharmacist pursuant to the oral order to such written prescription.

REVISED LIMIT ON PRESCRIBING OPIOID DRUGS TO MINORS — EFFECTIVE JULY 1, 2017

Before this month, Conn. Gen. Stat. § 20-14o provided that a prescribing practitioner may not issue a prescription to a minor for more than a seven-day supply of an opioid drug at any time except in limited circumstances. PA 17-131 reduces that time frame to provide that an opioid drug prescription for a minor cannot exceed more than a five-day supply of such opioid drug as of July 1, 2017, except where, in the professional medical judgment of the prescribing practitioner, more than a five-day supply is required to treat a minor patient's acute medical condition or is necessary for treatment of the minor patient's chronic pain, pain associated with a cancer diagnosis, or pain related to palliative care. Where a prescription for more than a five-day supply of an opioid drug is issued to a minor patient in such an excepted circumstance, this legislation retains the current requirements that (1) the condition triggering the exception must be documented in the patient's medical record and (2) the practitioner indicate that an alternative to the opioid drug is not appropriate to address the patient's medical condition.

PA 17-131 also clarifies that whenever a prescribing practitioner issues an opioid drug prescription to

an adult or minor patient, the practitioner must discuss the risks associated with the use of such opioid drug with the patient and with the patient's custodial parent, guardian, or other person having legal custody if the patient is a minor and such parent, guardian, or other person is present at the time of issuance of the prescription. The risks of opioid drug use to be discussed include but are not limited to addiction and overdose; the dangers of combining opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants; and the reason(s) the prescription is necessary. Previously, the requirement to conduct this discussion applied only where a prescribing practitioner issued an opioid drug prescription to a minor patient for less than a seven-day supply of such drug.

VOLUNTARY NONOPIOID DIRECTIVE FORM — EFFECTIVE OCTOBER 1, 2017

This legislation permits patients to file a "voluntary nonopioid directive form" with a practitioner that indicates the patient's request to not be issued a prescription or medication order for an opioid drug. The Department of Public Health (DPH) is required to establish a voluntary nonopioid directive form and publish that form on its website for public use. The DPH form must allow a patient to appoint a duly authorized guardian or health care proxy to override a previously recorded voluntary nonopioid directive form, and a patient, duly authorized guardian, or proxy may revoke such a nonopioid directive for any reason at any time, orally or in writing.

This legislation obligates prescribing practitioners to document receipt of a voluntary nonopioid directive form in the particular patient's medical record. This legislation further states that a prescribing practitioner cannot face civil or criminal liability or be deemed to have violated the applicable standard of care for refusing to issue a prescription or medication order for an opioid pursuant to a voluntary nonopioid directive form as long as the practitioner acts with reasonable care. That said, a prescribing practitioner who willfully fails to comply with a patient's voluntary nonopioid directive form may be subject to disciplinary action. PA 17-131 also carves out certain permissible actions related to voluntary nonopioid directive forms, including the following:

Pharmacists may presume that electronically transmitted prescriptions are valid and may not be held in violation of this provision for dispensing a controlled substance in contradiction to a voluntary nonopioid directive form.

A person acting in good faith as a duly authorized guardian or health care proxy cannot be held civilly or criminally liable for revoking or overriding a voluntary nonopioid directive form. Emergency department prescribing practitioners, whether acting as the patient's practitioner or as a medical control officer for emergency medical services personnel, cannot face civil or criminal liability (or be deemed to have violated the applicable standard of care) when such a practitioner acting with reasonable care issues a prescription for, or administers, a controlled substance containing an opioid to a person with a voluntary nonopioid directive form as long as such controlled substance is necessary in the practitioner's medical judgment and the practitioner has no knowledge of the patient's voluntary nonopioid directive form at the time of such issuance or administration.

OPIOID ANTAGONIST STANDING ORDERS — EFFECTIVE OCTOBER 1, 2017

This legislation allows a prescribing practitioner authorized to prescribe opioid antagonists to enter into an agreement for a medical protocol standing order with a pharmacy allowing a licensed pharmacist to dispense an opioid antagonist that is (1) administered by an intranasal application delivery system or an auto-injection delivery system, (2) approved by the FDA, and (3) dispensed to any person at risk of overdosing on an opioid drug or a family member, friend, or other person in a position to assist a person at risk of an opioid drug overdose. Such a medical protocol standing order will be deemed to have been issued for a legitimate medical purpose in the usual course of the prescribing practitioner's professional practice. A pharmacy must provide DCP with copies of every medical protocol standing order agreement entered into under this provision.

This legislation allows only pharmacists who have been trained and certified by a DCP-approved program to dispense an opioid antagonist pursuant to a medical protocol standing order. Pharmacists that dispense an opioid antagonist pursuant to a medical protocol standing order in accordance with this law must (1) provide appropriate training regarding opioid antagonist administration to the recipient, (2) maintain a record of the dispensing and training furnished, and (3) send a copy of the record of such dispensing to the prescribing practitioner who entered into the medical protocol standing order agreement with the pharmacy. Pharmacists that dispense opioid antagonists pursuant to this legislation will not be deemed to violate the applicable standard of care for a pharmacist.

ALCOHOL OR DRUG TREATMENT FACILITY ADMISSIONS — EFFECTIVE JULY 1, 2017

This legislation directs alcohol or drug treatment facilities in Connecticut to use the admission criteria developed by the American Society of Addiction Medicine when making admission assessments, in consideration of the facility's licensed services and the services necessary for an individual's prospective treatment.

CONTROLLED SUBSTANCE DISPOSAL BY HOME HEALTH NURSES — EFFECTIVE FROM PASSAGE

PA 17-131 now permits a DPH-licensed registered nurse employed by a home health care agency in Connecticut to oversee the destruction and disposal of a patient's controlled substances upon receiving the permission of a designated representative of the patient. Disposal of controlled substances under this provision is to be done using DCP's recommendations for the proper disposal of prescription drugs, which will be posted on DCP's website. Registered nurses are required to retain written or electronic documentation of any such destruction and disposal on a form prescribed by DCP, and such written or electronic documentation must be maintained with the patient's medical record for at least three years.

Additionally, this legislation states that nothing in this provision prevents a registered nurse and a patient's designated representative from depositing a patient's controlled substances in an authorized prescription drug drop box.

INTERAGENCY SHARING OF CONTROLLED SUBSTANCE PRESCRIPTION INFORMATION — EFFECTIVE FROM PASSAGE

This legislation permits DCP to share certain controlled substance prescription information obtained via the state's Prescription Monitoring Program with other state agencies as long as the information is obtained for a study of disease prevention and control related to opioid abuse or the study of morbidity and mortality caused by controlled substance overdoses. Disclosure of such information must be done pursuant to an agreement between DCP and the applicable state agency and must comply with applicable state and federal confidentiality requirements.

MANDATORY INSURANCE COVERAGE OF INPATIENT DETOXIFICATION SERVICES — EFFECTIVE JANUARY 1, 2018

This legislation mandates coverage of medically necessary, medically monitored inpatient detoxification services and medically necessary, medically managed intensive inpatient detoxification services for an insured or enrollee diagnosed with a substance use disorder covered under a group or individual health insurance policy that includes the following type(s) of coverage: (1) basic hospital expense coverage, (2) basic medical-surgical expense coverage, (3) major medical expense coverage, (4) hospital or medical service plan contracts, or (5) hospital and medical coverage provided to subscribers of a health care center. The terms "medically monitored inpatient detoxification" and "medically managed intensive inpatient detoxification" are defined in accordance with the most recent edition of the American Society of Addiction Medicine Treatment Criteria for

Addictive, Substance-Related and Co-Occurring Conditions.

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