

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF NURSING

Emergency Regulation

Title of Regulation: **18VAC90-40. Regulations for Prescriptive Authority for Nurse Practitioners (amending 18VAC90-40-150, 18VAC90-40-160, 18VAC90-40-180, 18VAC90-40-190, 18VAC90-40-200, 18VAC90-40-250 through 18VAC90-40-280).**

Statutory Authority: §§ 54.1-2400 and 54.1-2928.2 of the Code of Virginia.

Effective Dates: August 24, 2017, through November 7, 2018.

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Preamble:

Section 2.2-4011 of the Code of Virginia authorizes an agency to adopt emergency regulations upon consultation with the Attorney General, and the necessity for the action is at the sole discretion of the Governor. Emergency regulations for nurse practitioners prescribing medication containing opioids and products containing buprenorphine were published in [33:20 VA.R. 2265-2269 May 29, 2017](#), and became effective May 8, 2017.

The Boards of Nursing and Medicine adopted amendments to the emergency regulation that became effective May 8, 2017. The amendments (i) prohibit prescribing buprenorphine mono-product in tablet form for chronic pain; (ii) clarify the limitations on prescribing buprenorphine mono-product for patients with a demonstrated intolerance to naloxone; (iii) permit prescribing buprenorphine mono-product for a pregnant woman if medically indicated; and (iv) replace the term "abuse" with "misuse."

The purpose of the amendments is to provide patients who have a demonstrated intolerance to naloxone with access to buprenorphine in the treatment of substance misuse and provide prescribers with definitive rules to follow so that prescribers are more assured of their ability to treat pain in an appropriate manner to avoid under-prescribing or over-prescribing.

18VAC90-40-150. Evaluation of the patient for acute pain.

A. The requirements of this part shall not apply to:

1. The treatment of acute pain related to (i) cancer, (ii) a patient in hospice care, or (iii) a patient in palliative care;
2. The treatment of acute pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or
3. A patient enrolled in a clinical trial as authorized by state or federal law.

B. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.

C. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the prescriber shall perform a history and physical examination appropriate to the

complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance [~~abuse~~ misuse] as a part of the initial evaluation.

18VAC90-40-160. Treatment of acute pain with opioids.

- A. Initiation of opioid treatment for patients with acute pain shall be with short-acting opioids.
1. A prescriber providing treatment for a patient with acute pain shall not prescribe a controlled substance containing an opioid in a quantity that exceeds a seven-day supply as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the medical record. This shall also apply to prescriptions of a controlled substance containing an opioid upon discharge from an emergency department.
 2. An opioid prescribed as part of treatment for a surgical procedure shall be for no more than 14 consecutive days in accordance with manufacturer's direction and within the immediate perioperative period, unless extenuating circumstances are clearly documented in the medical record.
- B. Initiation of opioid treatment for all patients shall include the following:
1. The practitioner shall carefully consider and document in the medical record the reasons to exceed 50 MME/day.
 2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist.
 3. Naloxone shall be prescribed for any patient when risk factors of prior overdose, substance [~~abuse~~ misuse], doses in excess of 120 MME/day, or concomitant benzodiazepine are present.
- C. Due to a higher risk of fatal overdose when opioids are used with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.
- D. Buprenorphine is not indicated for acute pain in the outpatient setting, except when a prescriber who has obtained a SAMHSA waiver is treating pain in a patient whose primary diagnosis is the disease of addiction.

18VAC90-40-180. Evaluation of the chronic pain patient.

- A. The requirements of this part shall not apply to:
1. The treatment of chronic pain related to (i) cancer, (ii) a patient in hospice care, or (iii) a patient in palliative care;
 2. The treatment of chronic pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or
 3. A patient enrolled in a clinical trial as authorized by state or federal law.
- B. Prior to initiating management of chronic pain with a controlled substance containing an opioid, a medical history and physical examination, to include a mental status examination, shall be performed and documented in the medical record, including:
1. The nature and intensity of the pain;
 2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;
4. The effect of the pain on physical and psychological function, quality of life, and activities of daily living;
5. Psychiatric, addiction, and substance [~~abuse~~ misuse] histories of the patient and any family history of addiction or substance [~~abuse~~ misuse];
6. A urine drug screen or serum medication level;
7. A query of the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia;
8. An assessment of the patient's history and risk of substance [~~abuse~~ misuse]; and
9. A request for prior applicable records.

C. Prior to initiating opioid analgesia for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective.

18VAC90-40-190. Treatment of chronic pain with opioids.

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids.

B. In initiating opioid treatment for all patients, the practitioner shall:

1. Carefully consider and document in the medical record the reasons to exceed 50 MME/day;
2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist;
3. Prescribe naloxone for any patient when risk factors of prior overdose, substance [~~abuse~~ misuse], doses in excess of 120 MME/day, or concomitant benzodiazepine are present; and
4. Document the rationale to continue opioid therapy every three months.

C. Buprenorphine [~~may~~ mono-product in tablet form shall not] be prescribed [~~or administered~~] for chronic pain [~~in formulation and dosages that are FDA approved for that purpose~~].

D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

E. The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated.

18VAC90-40-200. Treatment plan for chronic pain.

A. The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities.

B. The treatment plan shall include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

C. The prescriber shall record in the medical records the presence or absence of any indicators for medication misuse [~~abuse~~,] or diversion and take appropriate action.

18VAC90-40-250. General provisions.

A. Practitioners engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a waiver from SAMHSA and the appropriate U.S. Drug Enforcement Administration registration.

B. Practitioners shall abide by all federal and state laws and regulations governing the prescribing of buprenorphine for the treatment of opioid use disorder.

C. Nurse practitioners who have obtained a SAMHSA waiver shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a SAMHSA-waivered doctor of medicine or doctor of osteopathic medicine.

D. Practitioners engaged in medication-assisted treatment shall either provide counseling in their practice or refer the patient to a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance [~~abuse~~ misuse] counseling. The practitioner shall document provision of counseling or referral in the medical record.

18VAC90-40-260. Patient assessment and treatment planning.

A. A practitioner shall perform and document an assessment that includes a comprehensive medical and psychiatric history, substance [~~abuse~~ misuse] history, family history and psychosocial supports, appropriate physical examination, urine drug screen, pregnancy test for women of childbearing age and ability, a check of the Prescription Monitoring Program, and, when clinically indicated, infectious disease testing for human immunodeficiency virus, hepatitis B, hepatitis C, and tuberculosis.

B. The treatment plan shall include the practitioner's rationale for selecting medication assisted treatment, patient education, written informed consent, how counseling will be accomplished, and a signed treatment agreement that outlines the responsibilities of the patient and the practitioner.

18VAC90-40-270. Treatment with buprenorphine.

A. Buprenorphine without naloxone (buprenorphine mono-product) shall not be prescribed except:

1. When a patient is pregnant;
2. When converting a patient from methadone or buprenorphine mono-product to buprenorphine containing naloxone for a period not to exceed seven days; [~~or~~]
3. In formulations other than tablet form for indications approved by the FDA [; or
4. For patients who have a demonstrated intolerance to naloxone, such prescriptions for the mono-product shall not exceed 3.0% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record].

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opiate treatment programs. With the exception of those conditions listed in subsection A

of this section, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use off site from the program.

C. The evidence for the decision to use buprenorphine mono-product shall be fully documented in the medical record.

D. Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

E. Prior to starting medication-assisted treatment, the practitioner shall perform a check of the Prescription Monitoring Program.

F. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on no more than eight milligrams of buprenorphine per day. The patient shall be seen by the prescriber at least once a week.

G. During the stabilization phase, the prescriber shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.

H. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum medication levels at least every three months for the first year of treatment and at least every six months thereafter.

I. Documentation of the rationale for prescribed doses exceeding 16 milligrams of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 milligrams of buprenorphine per day shall not be prescribed.

J. The practitioner shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance abuse counseling.

18VAC90-40-280. Special populations.

A. Pregnant women [~~shall~~ may] be treated with the buprenorphine mono-product, usually 16 milligrams per day or less.

B. Patients younger than the age of 16 years shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.

C. The progress of patients with chronic pain shall be assessed by reduction of pain and functional objectives that can be identified, quantified, and independently verified.

D. Practitioners shall (i) evaluate patients with medical comorbidities by history, physical exam, and appropriate laboratory studies and (ii) be aware of interactions of buprenorphine with other prescribed medications.

E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and is not stable. A patient who is determined by the practitioner to be psychiatrically unstable shall be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.