Alabama State Board of Medical Examiners and Medical Licensure Commission

MEDICAL DIGEST

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THE PRESCRIBING ISSUE

Treatment of Acute Pain

Author: George C. Smith, Jr., M.D.

Long-term opioid use often begins with the treatment of acute pain. This fact was demonstrated by a recent Morbidity and Mortality Weekly Report that showed 6% of opioid naïve patients who took one day of opioids were still taking opioids in a year and 2.9% were still using them in three years. This research is concerning to the CDC and numerous state and specialty societies, including the Board of Medical Examiners. In addition, current research indicates that taking opioids for more than five days greatly increases the risk of chronic opioid use. There appears to be a linear relationship between total morphine milliequivalents (MMEs) and long-term use, with the dividing line approximately a total of 700 MME, or about one month of Norco 7.5 three times a day. This research is greatly concerning to all of us who treat acute pain, both in the outpatient and the inpatient setting. To this end, numerous specialty societies have developed recommendations regarding the treatment of acute pain.

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Treating Postoperative Pain - A Better Way

Author: William Jay Suggs, M.D.

You might be surprised that your post-op patients require fewer oral pain medications than you think. Many opioid-naïve patients are first exposed to opioids in a surgical setting. A rather shocking statistic is that approximately 6% of surgical patients who are prescribed opioids become long-term users.

Nearly half of patients who do not take opioids at all on their last surgical hospitalization day are prescribed opioids at discharge. Some studies suggest that 70% to 80% of opioids are not used after surgery, likely contributing to diversion or misuse. New persistent opioid use does not differ among patients undergoing minor and major surgical procedures, suggesting that prolonged opioid use is not entirely due to surgical pain.

Persistent opioid use after surgery represents a poor long-

Treatment of Treating Postoperative Pain continued on page 4...

Patients should be assessed for risk factors such as addiction to anything (including tobacco), mood disorder, pre-injury pain disorders, or psychiatric disorders, and special attention should be paid to these factors in order to prescribe less and more effective pain relief.

Specialty societies and numerous state boards recommend that pharmacological treatment should also begin with non-opioid therapy and non-pharmacological therapy.

Pharmacological treatment should often begin with nonopioids:

- Consider the use of NSAIDs and acetaminophen for mild to moderate pain
- Consider the use of regional blocks
- IV lidocaine may be useful for renal colic, radiculopathy, neuralgia, and migraine syndromes
- IV ketamine in sub-dissociative doses may be used alone or as a multimodal approach (inform the patient about side effects prior to use)
- Topical lidocaine patches may be useful for herpetic or myofascial pain
- Talk to patients about alternatives and counsel them about safe storage and disposal
- Other modalities:
  - Ice/heat
  - Topical sprays
  - Relaxation therapy
  - Effective empathy and communication have been documented to reduce pain scores
  - Cognitive, behavioral, physical, spiritual, and educational interventions
  - Promote self-care
  - Treat depression
  - Encourage exercise
  - Address sleep disturbances

If the decision is made to treat acute pain with opioids, it is very important to utilize the following recommendations:

- Avoid or reconsider use in patients with risk factors for sedation, respiratory depression, tolerance, and opioid use disorder
- Avoid use with other CNS depressants

Treatment of Acute Pain continued on page 3...

- Access the PDMP
- Use caution when prescribing opioids at any dosage
- Evidence of individual benefits and risks should be carefully reassessed when increasing dosage to more than 50 morphine milligram equivalents (MME) per day and avoid increasing dosage to over 90 MME per day
- A decision to titrate dosage to over 90 MME/day must be carefully justified and documented in the record
- Never use long-acting medications for acute pain

When opioids are used for acute pain, clinicians should:

- Prescribe the lowest effective dose of immediate-release opioids
- Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids (three days or fewer will often be sufficient; more than seven days will rarely be needed)

If the total opioid dosage is greater than 50 MME/day, physicians should:

- Reassess pain, function, and treatment plan
- Increase frequency of follow up visits
- Consider offering naloxone

If considering an escalation in dosage, physicians should:

- Discuss other pain therapies with the patient
- Consider working with the patient to taper opioids down or off
- Consider consulting a pain specialist

The risk of an overdose event approximately doubles when increasing dosage from under 20 MME/day to 20-49 MME/day, doubles again when raising to 50-99 MME/day, and triples when prescribing over 100 MME/day.

Other considerations:

- Do not prescribe additional opioids "just in case"
- Do not prescribe extended-release or long-acting opioids for treatment of acute pain
- Concurrently prescribing opioid pain medication and benzodiazepines should be avoided whenever possible (risk of overdose increases dramatically)
- If a patient experiences opioid use disorder, physicians should offer or arrange for evidence-based treatment, usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies
- Pharmacies and third-party payors are modifying their requirements in response to the opioid crisis; physicians should be aware of these changes and prescribe accordingly

Treating Postoperative Pain – A Better Way *(cont.)*

term outcome and should be classified as an adverse event. If a surgeon had unacceptably high complication rates such as a 6% anastomotic leak rate, or a 6% pulmonary embolism rate, or a 6% joint infection rate, wouldn't he or she want to improve that?

The use of opioids for postoperative pain should be reduced or eliminated entirely where appropriate. The benefits of decreased opioid use postoperatively include:

- Decreased constipation
- Shorter recovery time, quicker back to work time
- Less nausea
- Better mobility and functionality
- Less risk of addiction
- BETTER pain control

When prescribing discharge medications for postoperative pain, recommendations include:

- Consider the patient's wishes and the effectiveness of the medications they have taken in the past and while in the hospital before discharge
- Do not prescribe opioids to patients who express the desire to avoid them after surgery
- Do not prescribe opioids to patients whose postsurgical pain is comfortably managed with NSAIDs and/or acetaminophen alone before discharge; these patients should be provided detailed discharge instructions to optimize nonopioid medications and instructed what to do if pain becomes unmanageable
- Patients should share in the decision-making process about outpatient opioid prescribing and the risks and benefits of opioids
- Consider the patient's potential medical contraindications, body weight, response to multimodal pain therapy, addiction potential, and risk aversion
- Don't make changes to opioids which were prescribed by another physician prior to surgery - leave it to that physician
- Tailor discharge medications based on procedure. Examples:

  - No opioids following procedures such as uncomplicated vaginal delivery, cochlear implant, and cardiac catheterization

  - One to fifteen 7.5 morphine milligram equivalent (MME) tablets (with acetaminophen) following procedures such as laparoscopic cholecystectomy, unilateral open and laparoscopic inguinal hernia repair, partial mastectomy, uncomplicated cesarean delivery, minimally invasive hysterectomy, arthroscopic partial meniscectomy, and thyroidectomy

  - Sixteen to twenty 7.5 MME tablets (with acetaminophen) following procedures such as arthroscopic ligament repair surgery, arthroscopic rotator cuff surgery, open reduction and internal fixation of the ankle, video assisted thoracoscopic wedge resection, coronary artery bypass grafting, and open hysterectomy

To achieve postoperative opioid reduction:

- Set realistic expectations concerning postoperative pain and its management; patients should be counseled concerning "normal" levels of pain; they should not expect to be completely pain free but to expect daily improvement
- EHRs often have prescribing defaults that are not procedure specific; changing the defaults and providing easy access to published guidelines within a patient's chart may reduce overprescribing
- Consider enlisting the aid of other specialists, such as anesthesiologists, to treat acute postoperative pain

Treating Postoperative Pain continued on page 5...

Action Items:

- Try reducing your post-op number of pain pills by ½, then try reducing by ½ again
- Give limited numbers of pain meds at discharge from the hospital or outpatient surgical center
- Making a follow-up phone call in 1-2 days to assess pain and realistic expectations is invaluable
- Follow up with your patient within a week to assess for ongoing acute pain and for potential complications
- Use multimodal postop pain management:
    - Local anesthetics/regional nerve blocks
    - Preemptively strike with gabapentin and celecoxib the morning before surgery
    - Intraoperative IV ketorolac, reduction of intraoperative narcotics
    - Nonnarcotic medications such as acetaminophen and NSAIDs
    - Physical therapy
- Create your own postoperative opioid-free pain management protocol

How I Do It: Dr. Suggs' Post-op Abdominal Surgery Pain Management Protocol

Pre-op Morning of Surgery (with a small sip of water): Celecoxib capsule 200 mg 2 capsules po, Gabapentin capsule 300 mg po, Scopalamine patch apply behind ear on arrival at the hospital

Intra-op: Ketorolac 30 mg IV Acetaminophen 1000 mg IV(or orally in preop holding), Transversus Abdominus Plane Block/local anesthetic with 0.5% bupivacaine (no other additives)

Post-op in Hospital: Ketorolac 30 mg IV q 6 hrs, Acetaminophen 1000 mg IV q 6 hrs, or po q 6 hrs, Morphine or other IV narcotic for breakthrough pain

Post-op at Home:

Week 1: Gabapentin 300 mg by mouth twice a day, Celecoxib 200 mg by mouth twice a day, OTC Acetaminophen 1000 mg by mouth every 6 hours prn

Week 2: Gabapentin 300 mg by mouth daily, Celecoxib 200 mg by mouth daily, OTC Acetaminophen 1000 mg by mouth every 6 hours prn

Week 3: Celecoxib 200 mg by mouth daily as needed or Ibuprofen 400 mg by mouth every 6 hours prn, OTC Acetaminophen 1000 mg by mouth every 6 hours prn

Week 4: OTC Acetaminophen 1000 mg by mouth every 6 hours prn for additional pain

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Contact with Patients Before Prescribing

When prescribing medications, the physician should, when possible, personally examine the patient.

Before prescribing a medication, a physician should make an informed medical judgment based on:

- Appropriate medical history
- The circumstances of the situation
- His or her training and experience (this process must be documented appropriately)

Prescribing medications for a patient whom the physician has not personally examined may be suitable under certain circumstances which may include, but not be limited to:

- Electronic encounters such as those in telemedicine
- Admission orders for a patient newly admitted to a health care facility
- Prescribing for a patient of another physician for whom the prescriber is taking call
- Continuing medication on a short-term basis for a new patient prior to the patient's first appointment.

Licensees are expected to adhere to all federal and state statutes regarding the prescribing of controlled substances and all Alabama State Board of Medical Examiners' Rules regarding the prescribing of controlled substances.

NOTICE

Beginning in April, all licensees will receive the ALBME/MLC Medical Bulletin quarterly newsletter electronically via email to their email address of record.

To continue to receive a printed copy of the official newsletter please email your request with preferred mailing address to newsletterrequest@albme.org.

Rules for Dispensing Physicians

Who is a dispensing physician?

- Orders for and delivers a controlled substance to a patient
- Patient consumes the medication off the premises
- Does not matter whether patient pays for medication or not
- Medications labeled as samples and are not for resale are excluded

Who is not a dispensing physician?

- Distributes prepackaged samples and starter packs
- Administers oral or injectable controlled substances in the office
- Dispenses non-controlled substances
- Dispenses controlled substances purchased with hospital's or clinic's DEA registration

Registration as a dispensing physician

- Dispensing physicians are required to register with the Board
- Registration is accomplished by completing and returning the dispensing registration form
- Every location where medications are dispensed must be registered and the separate DEA number listed
- Physicians are responsible for updating address changes, additional sites, additional DEA numbers, and removal of sites
- Do not submit a dispensing registration form if you do not purchase controlled substances (other than prepackaged samples and starter packs) to be dispensed to your patients. Doing so may result in false information being provided to the Alabama Department of Public Health's Prescription Drug Monitoring Program database and may result in an unnecessary investigation into your practice

Prescription Drug Monitoring Program (PDMP) Database

- Dispensing physicians must report to the Alabama Department of Public Health's PDMP those controlled substances dispensed from the office
- The Board of Medical Examiners is required to provide to the PDMP a list of licensees who have registered as dispensing physicians (this is why it is important to have only physicians who are truly dispensing physicians registered with the Board as such)
- Dispensing physicians who fail to report to the PDMP as required may be assessed a fine

For more information, please see www.albme.org.

PDMP EHR Integration

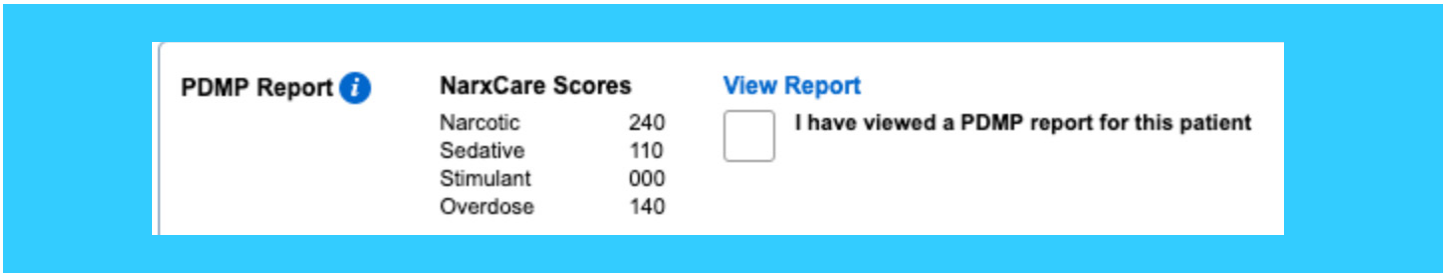
Author: Jorge A. Alsip, M.D.

The Alabama Prescription Drug Monitoring Program (PDMP) has partnered with Appriss Health to integrate direct access to the PDMP from the electronic health record (EHR) systems of all eligible prescribers and pharmacists in Alabama via Appriss Health's PMP Gateway and NarxCare platforms. Once access is integrated within your EHR workflow, you will be able to open a patient's PDMP report directly from a link within their electronic chart, eliminating the need to login to the PDMP and perform a patient search.

The Alabama Board of Medical Examiners' Risk and Abuse Mitigation Strategies for physicians, PAs, CRNPs, and CNMs include specific requirements to check a patient's PDMP record based on the number of morphine milligram equivalents (MME) and/or lorazepam milligram equivalents (LME) they are receiving (visit https://www.albme.org/riskabusemit.html for details). Alabama physicians who have already taken advantage of this PDMP integration report significant time savings that has facilitated their compliance with these patient safety requirements.

Although your EHR vendor may charge an implementation fee to set up the PDMP integration, the Alabama Department of Public Health is underwriting the monthly fees prescribers would typically pay for this integrated access through Appriss Health Gateway.

For more detailed information about the integration process and to request an integration with your EHR, visit: https://info.apprisshealth.com/alabamagatewayintegrationrequest.



Risk & Abuse Mitigation Strategies

• All controlled substances, including but not limited to, opiates, benzodiazepines, stimulants, anticonvulsants, and sedative hypnotics, have a risk of addiction, misuse, and diversion

• Best practice when prescribing controlled substances includes medically appropriate risk and abuse mitigation strategies, which will vary from patient to patient

• Additional care should be used by practitioners when prescribing medication to a patient from multiple controlled substance drug classes

• Every practitioner must provide his or her patient with risk education prior to initiating controlled substances therapy and prior to continuing the controlled substances therapy initiated by another practitioner

• Every practitioner must utilize medically appropriate risk and abuse mitigation strategies when prescribing controlled substances, including, but not limited to:

Risk & Abuse Mitigation Strategies continued on page 9...

- Pill counts

- Urine drug screening

- PDMP checks

- Consideration of abuse-deterrent medications

- Monitoring the patient for aberrant behavior

- Using validated risk-assessment tools

- Co-prescribing naloxone to patients receiving opioid prescriptions when determined to be appropriate in the clinical judgment of the treating practitioner

• The Board adopts the Morphine Milligram Equivalency (MME) daily standard as set out by the Centers for Disease Control and Prevention for calculating the morphine equivalence of opioid dosages and the Lorazepam Milligram Equivalency (LME) daily standard for calculating sedative dosing

• For the purpose of preventing controlled substance diversion, abuse, misuse, addiction, and doctor-shopping, the Board sets forth the following requirements for the use of Alabama's Prescription Drug Monitoring Program (PDMP):

- For controlled substance prescriptions totaling less than 30 MME or 3 LME per day, practitioners are expected to use the PDMP in a manner consistent with good clinical practice

- When prescribing to a patient controlled substances of more than 30 MME or 3 LME per day, practitioners shall review that patient's prescribing history through the PDMP at least two (2) times per year, and each physician is responsible for documenting the use of risk and abuse mitigation strategies in the patient's medical record

- Practitioners shall query the PDMP to review a patient's prescribing history every time a prescription for more than 90 MME or 5 LME per day is written, on the same day the prescription is written

- FDA-approved daily dosage thresholds are higher for Tapentadol and other atypical opioids; the Board has not placed limits on dosage amounts but does require RMS and PDMP checks for dosages over certain MMEs

• Exemptions: the Board's PDMP requirements do not apply to physicians writing controlled substance prescriptions for:

- Nursing home patients

- Hospice patients, where the prescription indicates hospice on the physical prescription

- When treating a patient for active, malignant pain

- Intra-operative patient care

• Due to the heightened risk of adverse events associated with the concurrent use of opioids and benzodiazepines, physicians should reconsider a patient's existing benzodiazepine prescriptions or decline to add one when prescribing an opioid and consider alternative forms of treatment

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[1]VALIDATED RISK-ASSESSMENT TOOLS

The use of validated risk assessment tools as a part of your risk and abuse mitigation strategies is a suggestion by the Board for best practices. Their use will vary from patient to patient. For some practices, their use may not be appropriate at all.

Not using the validated risk assessment tools is not a violation of the rule; however, failure to incorporate any risk and abuse mitigation strategies could be used to determine a practice pattern and whether it is within the recognized standard of care.

The following are examples of validates risk-assessment tools. This is not an exhaustive list. There may be other validated risk-assessment tools that you prefer.

BRI - Brief Risk Interview

DIRE - Diagnosis, Intractability, Risk, Efficacy score

ORT - Opioid Risk Tool

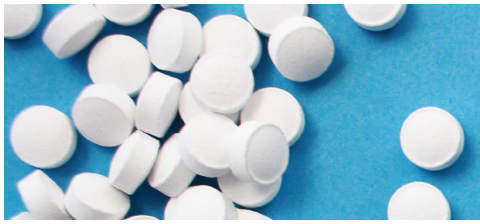
PMQ - Pain Medication Questionnaire

SOAPP - Screener and Opioid Assessment for Patients with Pain

SOAPP-R - Screener and Opioid Assessment for Patients with Pain - Revised

BRQ - Brief Risk Questionnaire

A PDMP query is not required for future fills of Schedule II prescriptions for over 90 MME with delayed fill instructions. However, it may be appropriate as a part of risk and abuse mitigation strategies to query some patients' prescription histories more frequently.



Requirements for the Use of Controlled Substances for the Treatment of Pain (Board Rule 540-X-4-.09)

• Effective pain management is part of quality medical practice for all patients with pain, acute or chronic, and is especially important for patients experiencing pain as a result of terminal illness

• Physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances

• These requirements were developed to alleviate physician uncertainty and to encourage better pain management

• The medical management of pain should be based on current knowledge and research and should include both pharmacologic and non-pharmacologic modalities

• Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not synonymous with addiction

• The inappropriate prescribing of controlled substances may lead to drug diversion and abuse, and physicians should be diligent in preventing the diversion of drugs for illegitimate purposes

• Physicians should not fear disciplinary action from the Board for prescribing, dispensing, or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice (based on accepted medical knowledge and clear documentation and in compliance with applicable state or federal law)

• The validity of prescribing is judged based on the treatment of the patient and on available documentation (the goal is to reduce pain and/or improve patients' function)

REQUIREMENTS:

• Evaluation of the patient – medical history and physical examination must be conducted and documented in the medical record, which should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse

• Evaluation of the patient – medical record should document the presence of one or more recognized medical indications for the use of a controlled substance

• Treatment plan – written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved function

• Treatment plan – indicate if any further diagnostic evaluations or other treatments are planned

• Treatment plan – after treatment begins, physician should adjust drug therapy to the individual needs of the patient; alternative non-opioid treatment modalities or a rehabilitation program may be necessary and should be considered

• Informed consent and agreement for treatment – discuss with patient the risks and benefits of the use of controlled substances or with persons designated by the patient/patient's surrogate or guardian

• Informed consent and agreement for treatment – written agreements outlining patient responsibilities should be utilized for all patients with chronic pain and should include:

- Drug screening with appropriate confirmation
- Prescription refill policy
- Reasons for which drug therapy may be discontinued (e.g., violation of agreement)
- Patient should receive prescriptions from one physician and one pharmacy where possible

• Periodic review – at reasonable intervals based on the individual circumstances of the patient, review the course of treatment and any new information about the etiology of the pain; monitor patient compliance in medication usage and related treatment plans

• Consultation – be willing to refer the patient as necessary for additional evaluation and treatment

• Consultation – special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or division

• Consultation – the management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients

• Medical records – keep accurate and complete records to include:

- Medical history and physical examination
- Diagnostic, therapeutic and laboratory results
- Evaluations and consultations
- Treatment objectives
- Discussion of risk and benefits
- Treatments
- Medications (including date, type, dosage, and quantity prescribed)
- Instructions and agreements
- Periodic reviews
- Records shall remain current, be maintained in an accessible manner, and be readily available for review

Use of Controlled Substances for Weight Reduction (Board Rule Chapter 540-X-17)

• Prescribing or dispensing a controlled substance for weight reduction or the treatment of obesity should be based on accepted scientific knowledge, sound clinical grounds, and evidence-based medicine (for example Bariatric Practice Guidelines established by the Obesity Medicine Association)

• The Board considers the promotion and use for weight reduction of controlled and non-controlled substances which have not been scientifically validated to be of questionable benefit (e.g., HCG)

• The promotion and use of these substances is under scrutiny by the Board for possible sanctions for non-legitimate medical use violations

Schedule II controlled substances

• A physician may not order, prescribe, dispense, supply, administer, or otherwise distribute any Schedule II amphetamine or Schedule II amphetamine-like anorectic drug, or Schedule II sympathomimetic amine drug or compound thereof or any salt, compound, isomer, derivative or preparation of the foregoing which is chemically equivalent thereto or other non-narcotic Schedule II stimulant drug to any person for the purpose of weight control, weight loss, weight reduction, or treatment of obesity

Schedule III, IV, and V controlled substances

• Only a licensed physician may order, prescribe, dispense, supply, administer, or otherwise distribute a controlled substance in Schedule III, IV, or V to a person for the purpose of weight control, weight loss, weight reduction, or treatment of obesity, except that a Physician Assistant, Certified Registered Nurse Practitioner or Certified Nurse Midwife may prescribe Belviq or Qsymia for such purpose, and shall comply with the guidelines and standards set forth in these rules

• A written prescription or written order for any controlled substance for a patient for the purpose of weight reduction or treatment of obesity must be signed by the prescribing physician on the date the medication is to be dispensed or the prescription is provided to the patient

• The prescribing/ordering physician must be present at the facility when he or she prescribes, orders, or dispenses a controlled substance for a patient for the purpose of weight reduction or treatment of obesity

Initial requirements

• Before initiating treatment for weight reduction or obesity utilizing any Schedule III – V controlled substance, the physician should comply with the following:

- An initial evaluation of the patient should be conducted by and recorded by the prescribing physician, and the evaluation should include:

- Appropriate physical and complete history

- Appropriate tests related to medical treatment for weight reduction

- Appropriate medical referrals as indicated by the physical, history, and testing

• Relative contraindications to the use of anorectic drugs should be addressed prior to prescribing or dispensing these medications

• The patient should have:

- A Body Mass Index (BMI) of 30 or above, or

- A BMI of greater than 25 with at least one comorbidity factor, or

- A measurable body fat content equal to or greater than 25% of total body weight for male patients or 30% of body weight for female patients, or

- An abdominal girth of at least 40 inches for male patients or an abdominal girth of at least 35 inches for female patients

• The prescribing physician should assess and document the patient's freedom from signs of drug or alcohol abuse and the presence or absence of contraindications and adverse side effects

Continued use of a controlled substance for weight reduction or treatment of obesity:

• An amount greater than a 35-day supply should not be prescribed, ordered or dispensed

• Within the first 35 days following initiation of the controlled substance, the patient should be seen by the prescribing physician or mid-level practitioner supervised by or collaborating with the prescribing physician, and weight, blood pressure, pulse, and any other tests necessary for monitoring potential adverse effects should be recorded

• Continuation of a controlled substance should only occur if the patient has continued progress toward achieving or maintaining medically established goals and has no significant adverse effects from the medication

• A patient continued on a controlled substance should undergo an in-person re-evaluation at least once every 35 days

• Once medically established goals have been met, it is strongly recommended that reduced dosing and drug holidays be implemented

• The prescribing physician should personally review the medical records documenting re-evaluation by a mid-level practitioner

Use of Controlled Substances for Weight Reduction continued on page 11...

• Refills of Qsymia and Belviq are allowed after an initial prescription and one follow up visit

• For Qsymia and Belviq, five refills are allowed, and shall not extend past a period of six months from the date of issue of the original prescription

Medical records

• Adequate medical documentation should be kept so that progress, as well as the success or failure of any modality, is easily ascertained

• At a minimum, every 35 days, the physician or mid-level practitioner should record in the patient record information demonstrating the patient's continuing efforts to lose weight, the patient's dedication to the treatment program and response to treatment, and the presence or absence of contraindications, adverse effects, and indicators of possible substance abuse

Conditions warranting discontinuance of a controlled substance

• A physician should not initiate or should discontinue utilizing a controlled substance for weight reduction or treatment of obesity immediately upon ascertaining or having reason to believe:

- The patient has failed to progress toward medically established goals over a period of 70 days which determination should be made by assessing the patient every 35 days

- The patient has developed tolerance to the anorectic effects of the medication

- The patient has a history of or shows propensity for alcohol or drug abuse or has made any false or misleading statement relating to the patient's use of drugs or alcohol

- The patient has consumed or disposed of a controlled substance other than in compliance with directions

- The patient has repeatedly failed to comply with treatment recommendations

Each case of prescribing or dispensing a controlled substance for weight reduction or the treatment of obesity will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines if good cause is shown for such deviation. Whether the drug used is medically and/or pharmacologically recognized to be appropriate for the patient's

Use of Controlled Substances for Weight Reduction
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individual needs will be considered by the Board in evaluating individual cases. The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation.

FAQs

May a physician prescribe a Schedule II prescription for weight reduction?

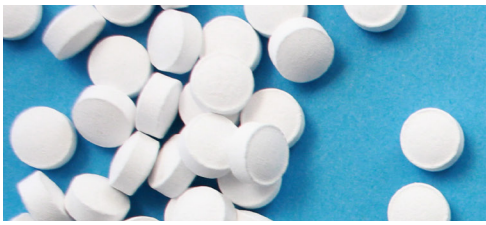
A physician shall not prescribe any Schedule II amphetamine or Schedule II amphetamine-like anorectic drug, or Schedule II sympathomimetic amine drug or compound thereof or any salt, compound, isomer, derivative or preparation of the foregoing which is chemically equivalent thereto or other non-narcotic Schedule II stimulant drug, which drugs or compounds are classified under Schedule II of the Alabama Uniform Controlled Substances Act, to any person for the purpose of weight control, weight loss, weight reduction or treatment of obesity.

What is the rule for call-in orders to pharmacies?

Prescriptions or orders for any controlled substance for a patient for the purpose of weight reduction or treatment of obesity may not be called in to a pharmacy by the physician or an agent of the physician.

May a PA or NP prescribe controlled substances for weight reduction?

The legend and controlled drugs a PA or NP is authorized to prescribe are specified in the registration/ collaboration agreements and formularies. Currently, PAs/NPs may only prescribe certain medications for the treatment of obesity.



Maintenance of Records and Inventories (Board Rule 540-X-4-.04)

Inventory requirement:

• All Schedule II – V controlled substances which are purchased and maintained in a physician's office must be inventoried at least every two years

• The inventory must account for all controlled substances purchased, maintained, and dispensed in the office of the physician

• The inventory requirement applies to Schedule II prepackaged samples and starter packs but does not apply to Schedule III – V prepackaged samples and starter packs

Dispensing Record:

every physician who dispenses controlled substances (purchases, maintains, and dispenses in the office) must maintain a separate dispensing record of all controlled substances dispensed or distributed. The record must contain the following:

• Date the controlled substance (c.s.) was dispensed

• Name and quantity of the c.s. dispensed

• Name of the patient to whom the c.s. was dispensed

• For all Schedule II amphetamines, amphetamine-like anorectic drugs, or sympathomimetic amine drugs dispensed in the treatment of narcolepsy, hyperkinesis, brain dysfunction, epilepsy, or depression, dispensing records shall include the diagnoses and reason for prescribing the Schedule II amphetamine

Labeling requirement:

• All controlled substances dispensed from the physician's

Maintenance of Records & Inventories continued on page 14...

office must be labeled and contain the following:

- Name of the patient to whom the c.s. was dispensed
- Date the c.s. was dispensed
- Name and quantity of the c.s.
- Instructions for taking or administering the c.s.
- Name of physician dispensing the c.s.
- Label shall be in legible handwriting or typed and be permanently affixed to the package or container in which the c.s. is dispensed
- Labeling requirement does not apply to prepackaged sample or starter packs in their original packages or containers

Schedule II amphetamines

A physician who prescribes a Schedule II amphetamine and/or a Schedule II amphetamine like anorectic drug and/or a Schedule II sympathomimetic amine drug or compound thereof and/or any salt, compound, isomer, derivative or preparation of the foregoing which are chemically equivalent thereto, and/or other non-narcotic Schedule II stimulant drugs, for the treatment of narcolepsy, hyperkinesis, brain dysfunction, epilepsy, or depression shall maintain a complete record of:

- The treatment of the patient which must include documentation of the diagnosis and reason for prescribing the Schedule II amphetamine
- The name, dose, strength, and quantity of the controlled substance prescribed and the date that the controlled substance was prescribed
- The record required by this subsection may be maintained in the patient's medical records, provided that such medical records are maintained at the office of the physician and are available for inspection by the representatives of the Board of Medical Examiners.

The inventory, separate dispensing record, and Schedule II amphetamine prescribing record required by this rule must be maintained in the physician's office for five years from the date the inventory is completed or the controlled substances are dispensed

Report of Public Actions of the Medical Licensure Commission and Board of Medical Examiners

Mission: The Alabama Board of Medical Examiners and the Medical Licensure Commission are charged with protecting the health and safety of the citizens of the state of Alabama.

BME - December 2019

• On Dec. 11, the Board placed on probation the license to practice as a physician assistant of Katie A. Riegle, P.A., lic. no. PA.811, Enterprise AL.

• On Dec. 5, the Board issued an Order reinstating the Alabama Controlled Substances Certificate of Marie C. Cebert, DO, lic. no. DO.656, Harvest AL.

• Effective Dec. 2, the Alabama Controlled Substances Certificate of David Rick Brown, MD, lic. no. 10423, Birmingham AL, is temporarily suspended until a hearing is held and a decision rendered.

MLC - December 2019

• None to Date

BME - November 2019

• On Nov. 21, the Board reinstated with restrictions the Alabama Controlled Substances Certificate of Kenneth E. Roberts, MD, lic. no. MD.9562, Dothan AL.

MLC - November 2019

• Effective Nov. 29, the Commission denied the request of Amjad I. Butt, MD, lic. no. MD.29003, Valley Grande AL, to lift the restrictions currently attached to his license to practice medicine in Alabama.

• Effective Nov. 29, the Commission denied the request of Michelle Snyder Jackson, MD, lic. no. MD.18274, Mobile AL, to lift the probation of her license to practice medicine in Alabama.

• Effective Nov. 29, the license to practice medicine in Alabama of Herbert W. Jones, MD, lic. no. SP.139, Minneapolis MN, is placed on indefinite probation.

• Effective Nov. 29, the license to practice medicine in Alabama of Duane W. King, MD, lic. no. MD.11133, is revoked.

• Effective Nov. 26, the license to practice medicine in Alabama of George E. S. Hipp, MD, lic. no. MD.28785, Vestavia AL, is temporarily suspended until such time as a hearing is held and a decision rendered.

• Effective Nov. 26, the license to practice medicine in Alabama of Ronald Tai Young Moon, Jr., DO, lic. no. DO.419, Birmingham AL, is temporarily suspended until such time as a hearing is held and a decision rendered.

Actions for CME (reprimand, fine, additional CME required):

• Aubrey P. Schinnerer, MD, lic. no. MD.35088, Birmingham AL.

• Joseph A. Zarzaur, MD, lic. no. MD.5659, Mountain Brook AL.

Actions on ACSC for not being registered for PDMP (administrative fine):

None to date.

Actions on ACSC for prescribing controlled substances with expired ACSC (administrative fine):

• None to date.

Actions for not being registered for Office Based Surgery (administrative fine):

None to date.

Actions for not obtaining/ renewing Pain Management Services registration (administrative fine):

• Jonathan R. Moore, MD, lic. no. MD.30077, Birmingham AL.

Alabama State Board of Medical Examiners

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Upcoming BME Meeting Dates

Jan. 15 • Feb. 19 • Mar. 18 • Apr. 16

The public portion of each meeting is scheduled for 10 a.m. CT (unless otherwise indicated) in the Dixon-Parker Building at 848 Washington Avenue in Montgomery, AL.

Meeting agendas and a full list of meeting dates and times can be found online at **www.albme.org**.

Upcoming MLC Meeting Dates

Jan. 22 • Feb. 26 • Mar. 25 • Apr. 22

Meetings are held in the Dixon-Parker Building at 848 Washington Avenue in Montgomery, AL.

Have questions or need assistance?

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About MedicalDigest...

MedicalDigest is the official publication of the Alabama Board of Medical Examiners and Medical Licensure Commission. It is published four times per year.

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Questions? Please contact the Board of Medical Examiners at (334) 242-4116.