



FREQUENTLY ASKED QUESTIONS ABOUT PRESCRIBING CONTROLLED SUBSTANCES

How do I know if I am eligible to prescribe controlled substances?

The Board of Nursing should have information about the state's laws that determine if you are eligible to prescribe controlled substances (CSs). Alabama and Florida do not authorize any Advanced Practice Registered Nurses (APRNs) to prescribe CS. In some states prescribing CSs may be limited to a certain APRN role such as a nurse practitioner. In states where there is delegation of prescriptive authority or that require collaboration or supervision for APRN prescribing there may be special requirements for eligibility.

What is the process for obtaining authority to prescribe controlled substances?

First obtain prescriptive authority in your state. In some states, prescriptive authority is part of licensure while in other states it requires a separate application. If state registration or a license for prescribing CSs is required, you will need to complete that process before applying to the Drug Enforcement Administration (DEA) for registration. *DEA registration is required for anyone who prescribes CSs.* If a written agreement or other documentation is required to prescribe CSs that must also be finalized before you can prescribe CSs.

How do I apply for DEA registration?

Apply for DEA registration online at <http://www.deadiversion.usdoj.gov/drugreg/index.html>. You must have prescriptive authority for controlled substances and meet all state requirements. You must provide the state registration or license number for prescribing controlled substances if one is required. Registration costs \$551 and is valid for 3 years. You will register with your work site and you will need to change the registration location for new employment. You must register for each state in which you practice which requires a new application and fee for each state. You may use a hospital or institutional registration rather than obtaining an individual registration if you are an employee or 'agent' of the facility. The requirement of registration is waived for any official of the U.S. Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, or Bureau of Prisons who is authorized to prescribe, dispense, or administer CSs in the course of his/her official duties.

What are Schedule I drugs?

Substances in Schedule I have no currently accepted medical use in treatment in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse. Some examples of substances listed in Schedule I are heroin; lysergic acid diethylamide (LSD); marijuana (cannabis); peyote; methaqualone; and methylene-dimethoxy-methamphetamine ("ecstasy"). *Schedule I drugs are illegal to prescribe.*

What are Schedule II drugs?

Schedule II drugs have a high potential for abuse that may lead to severe psychological or physical dependence. Examples include:

- Morphine, methadone (Dolophine®), meperidine (Demerol®), fentanyl (Duragesic®)
- Oxycodone (Percocet®, Oxycontin®), hydromorphone (Dilaudid®)
- Amphetamines (Ritalin®, Concerta®)
- Cocaine, amobarbital and pentobarbital

What are Schedule III drugs?

Schedule III drugs have less potential for abuse than Schedule II drugs. Abuse may lead to moderate or low physical dependence but high psychological dependence. Examples include:

- Combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin®)
- Products containing not more than 90 milligrams of codeine per dosage unit (Tylenol® with Codeine No. 3)
- Butalbital (Fiorinal®, Fioricet®)
- Testosterone

What are Schedule IV drugs?

Schedule IV drugs have less potential for abuse relative to Schedule III. Abuse leads to less physical or psychological dependence relative to Schedule III. Examples include:

- Benzodiazepines (e.g. Valium®, Xanax®, Ativan®)
- Zolpidem (Ambien®)
- Pentazocine (Talwin®)
- Temazepam (Restoril®)

What are Schedule V drugs?

Schedule V drugs have a low potential for abuse relative to other controlled substances. Abuse leads to limited physical or psychological dependence relative to drugs in Schedule IV. Examples include:

- Cough syrup with codeine (Robitussin AC®)
- Diphenoxylate preparations (Lomotil®)

What is required on the prescription for a CS?

Federal requirements for a prescription for a CS are:

- Prescriber's name, address, DEA registration number
- Patient's name and address
- Date
- Drug name, strength, dosage form, quantity, directions for use, number of refills, if any, or indicate no refills
- Manual signature

States that require collaboration or supervision for prescribing may require the name of the collaborating or supervising physician on the prescription. You should also determine if your state has other requirements such as your state controlled substances license/registration number.

What date goes on the prescription for a CS?

Prescriptions must have the date when written. They cannot be post-dated. If you need to write a prescription for future use, enter the date written and then note "Do Not Fill Until . . ." and enter a date. Even though the expiration date for prescriptions vary by state, if a pharmacist receives a prescription that has a date that is not current, he or she should use professional judgment to decide whether to fill a prescription or contact the clinician. For example, a prescription by an emergency department clinician for an opioid medication that is more than a week old may need to be verified.

What are some of the legal issues to consider when writing a prescription for a CS?

A legitimate purpose for prescribing a CS must exist and there must be a patient-provider relationship. Federal law prohibits pre-signed prescriptions. You may have an individual prepare a prescription for your signature however you are legally responsible if the prescription does not conform to legal requirements. Document the prescriptions you write. Some states, such as Virginia and Washington State, prohibit self-prescribing of CSs. Some states may also prohibit prescribing CSs for family members. Even if prescribing a CS for oneself or a family member is permitted under certain circumstances, this may not be advisable for professional reasons.

What are the policies when I write a prescription for a Schedule II CS?

A prescription for a Schedule II CS must be written with ink, indelible pencil, typed, or generated by an electronic system and hand signed. Oral prescriptions are only allowed in an emergency. There are no refills for a Schedule II CSs however there is no limit on the quantity unless specified by state law or health plan policy. In Pennsylvania APRNs may only prescribe a 30 day supply of Schedule II CSs while in Kentucky the law limits Schedule II prescribing to a 72 hour supply. In addition, some health plans may only cover a 30 day supply. There is no expiration date for a Schedule II CS unless specified by state law. In many states all prescriptions expire in one year however this varies. The option to prescribe an unlimited amount of Schedule II drugs needs to be balanced with patient safety. Large quantities of any CS could lead to overuse, misuse or diversion. The use of future dated prescriptions discussed below offers the prescriber an alternative to prescribing large quantities of medication.

What changes can a pharmacist make to a Schedule II prescription?

The DEA has published rules that have resulted in confusion regarding what changes a pharmacist can make to a Schedule II prescription. A specific issue is whether a pharmacist can add the prescriber's DEA registration number to the prescription. Until the DEA writes new rules to clarify this situation, pharmacists have been advised to adhere to state regulations or policy regarding changes a pharmacist may make to a Schedule II prescription after oral consultation with the prescriber. *Under federal law, a pharmacist may never change a patient's name, the controlled substance prescribed, or a prescriber's signature.*

What are the rules for an emergency oral prescription for a Schedule II drug?

In an emergency, a pharmacist may receive an oral prescription for a Schedule II drug if certain conditions are met. An "emergency prescription" means that there is an immediate need for the drug to assure proper treatment, no alternative treatment is available, and it is not possible for the prescribing practitioner to provide a written prescription for the drug at that time. This type of situation may occur on a weekend or evening. The pharmacist must create a written form of the prescription. The provider must then submit a written prescription within 7 days on which it is noted: "Authorization for Emergency Dispensing". The pharmacist may dispense an amount appropriate for the period of the emergency. A pharmacist must verify an unknown prescriber such as by using a callback to business phone.

What is the DEA policy on future dated prescriptions for Schedule II drugs?

While there are no refills for Schedule II drugs, a prescriber may write multiple prescriptions during a patient encounter for up to a 90 day supply of medication. This is important when state law or health plans limit the quantity prescribed or for patient safety considerations. One prescription is written for immediate use. The subsequent prescriptions must indicate the earliest date to be filled by writing: "Do Not Fill Until . . ." with the date specified. Each prescription must have the date it is written. Writing multiple prescriptions should be used only if there is no risk for diversion or abuse and only if allowed by state law. The use of multiple prescriptions is not a mandate or encouragement to issue multiple prescriptions or to see patients only once every 90 days if patient safety and quality of care requires otherwise.

What are the policies when prescribing a Schedule III-V CS?

A prescription for a Schedule III-V CS may be written or oral. The pharmacist must convert an oral order to a written prescription. The prescription may include up to five refills within a six month period and is only valid for 6 months. There is no limit on the quantity unless specified by state law or a health plan. For example, Oklahoma limits APRNs to prescribing a 30 day supply of Schedule III-V CSs.

What changes may a pharmacist make to a prescription written for a controlled substance in Schedules III-V?

The pharmacist may add or change the dosage form, drug strength, drug quantity, directions for use, or issue date only after consultation with and the agreement of the prescribing practitioner. A pharmacist may add or change the patient's address and may add the prescriber's DEA registration number to the prescription without consulting the prescriber. The pharmacist should note all consultations and corresponding changes on the prescription. Pharmacists and practitioners must comply with any state/local laws, regulations, or policies prohibiting any of these changes to controlled substance prescriptions.

Am I able to fax prescriptions for controlled substances?

You may fax a prescription for any Schedule III, IV or V prescription. A prescription for a Schedule II CS may be faxed to a pharmacist as an alert that the patient is coming with a written prescription. A Schedule II prescription may be faxed for long term care residents, Medicare certified or state licensed hospice patients, or for direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion routes.

Can I electronically prescribe prescriptions for controlled substances?

No. The DEA authorized electronic prescribing (eRx) of controlled substances in 2010 however there is no process in place for implementation of the rules. The implementation will require that eRx or electronic health record systems be reviewed by a qualified third party auditor or certification body to assure compliance with DEA rules. There is also a requirement that providers undergo 'identity proofing' for secure prescribing. Until the process to implement these requirements is finalized there is *no* electronic prescribing of CSs at this time.

How can I avoid tampering with prescriptions for controlled substances?

There are a variety of strategies you can use to avoid tampering with prescriptions for CSs. Use tamper resistant pads. They are required for prescriptions for Medicaid patients and required by law in some states. It is important to know the laws of your state and Medicaid to assure prescription pads meet the requirements. Tamper resistant pads have features such as preventing unauthorized photocopying of a completed or blank prescription; preventing the erasure or modification of a completed prescription; preventing counterfeiting; and use of a watermark or similar feature. There are other ways to prevent tampering. Write numbers in words, e.g. Percocet 5/325 (five/three hundred twenty-five) #30 (thirty). This may be required by state law. Lock up your supply of prescription pads and never leave them in an exam room. Number the prescriptions on each pad to monitor whether blanks have been taken. Do not use prescription blanks for notes to patients.

Can pharmacies in other states accept prescriptions for controlled substances written by an APRN?

Laws or policies allow pharmacists in most states to accept out-of-state APRN prescriptions however there are some restrictions. Here are some examples. Pharmacies in Texas will not accept prescriptions for Schedule II CS which Texas APRNs are not authorized to prescribe. In Kentucky where there are limitations on the quantity of CSs that can be prescribed, prescriptions from out-of-state APRNs must comply with Kentucky state law for APRN prescribing. Due to a technical error in a 2010 law, pharmacists in Washington State cannot accept prescriptions for CSs from out-of-state APRNs.

Can I monitor prescriptions for controlled substances that patients receive from multiple providers?

Prescription monitoring programs (PMPs) allow you to monitor prescriptions for CSs that patients receive from multiple providers. In some states drugs of concern such as carisoprodol are also monitored. There is a PMP authorized in almost every state however they are not all operational. PMPs collect, analyze and monitor prescribing and dispensing of controlled substances. The schedules covered vary by state. For example, Pennsylvania collects data only for Schedule II while Colorado collects data for Schedules II-V. Data is available only to authorized individuals such as healthcare professionals. More information can be obtained from The Alliance of States with Prescription Monitoring Programs at <http://www.pmpalliance.org/>.

Can I prescribe drugs used for treating opiate addiction?

No. Federal law restricts methadone for the treatment of dependence to legally authorized Opioid Treatment Programs (OTPs). At these sites methadone is administered or dispensed, not prescribed, to patients. NPs may be part of the OTP team if allowed by state law. Methadone is a Schedule II CS that *can* be prescribed by APRNs for pain if authorized by state law. Federal law only allows physicians to offer office based opioid addiction treatment using buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®). Buprenorphine is a Schedule III CS that *can* be prescribed by NPs for pain if legally authorized by the state.

What are some of the requirements for prescribing controlled substances that states may have?

As noted above, there are a variety of requirements or restrictions states may impose on APRNs who prescribe CSs. For example, states may:

- Require controlled drug substances registration or licensure
- Require a written agreement between a physician and an APRN
- Restrict the types of CSs that may be prescribed
- Limit or prohibit prescribing CS
- Limit the quantity of a CS prescribed
- Limit the duration for which a CS may be prescribed
- Have a formulary for prescribing CS
- Have guidelines for managing patients receiving opioids for noncancer chronic pain