CONTROLLED SUBSTANCES COMMITTEE
BOARD OF NURSING

Room 121B, 1400 East Washington Avenue, Madison WI
Contact: Sharon Henes (608) 266-2112
January 11, 2017

Notice: The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a description of the actions and deliberations of the Committee. A quorum of the Board may be present during the committee meeting.

10:00 A.M.

AGENDA

CALL TO ORDER – ROLL CALL – OPEN SESSION

A. Approval of Agenda (1)

B. Controlled Substances Guidelines – Discussion and Consideration (2-11)
   1) Board of Nursing Guideline Draft
   2) Wisconsin Nursing Association APRN Principles for Prescribing Controlled Substances

C. Public Comments

ADJOURNMENT
# State of Wisconsin
## Department of Safety & Professional Services

**AGENDA REQUEST FORM**

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<td>1) Name and Title of Person Submitting the Request:</td>
<td>2) Date When Request Submitted:</td>
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| Sharon Henes  
Administrative Rules Coordinator | 29 December 2016 |

**Items will be considered late if submitted after 12:00 p.m. on the deadline date:**

- 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

BON Controlled Substances Committee

4) Meeting Date: 11 Jan. 2017

5) Attachments: [ ] Yes  [ ] No

6) How should the item be titled on the agenda page?

- Legislation and Rule Matters – Discussion and Consideration
  - Approval of Agenda
  - Controlled Substances Guidelines – Discussion and Consideration
    1. Board of Nursing Guideline Draft
    2. Wisconsin Nursing Association APRN Principles for Prescribing Controlled Substances
  - Public Comments
  - Adjournment

7) Place Item in:

- [x] Open Session
- [ ] Closed Session
- [ ] Both

8) Is an appearance before the Board being scheduled?

- [ ] Yes (Fill out Board Appearance Request)
- [ ] No

9) Name of Case Advisor(s), if required:

10) Describe the issue and action that should be addressed:

11) Authorization

**Sharon Henes**  
29 December 2016

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<td>Signature of person making this request</td>
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**Executive Director signature** (indicates approval to add post agenda deadline item to agenda)

Date

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.
Board of Nursing  
Guidelines: Best Practices for Prescribing Controlled Substances

2015 Wisconsin Act 269 granted authority to the Board of Nursing to issue guidelines regarding best practices in prescribing controlled substances, as defined in s. 961.01 (4), Stats., for persons credentialed by the Board of Nursing who are authorized to prescribe controlled substances.

The purpose of these guidelines are to provide guidance to advanced practice nurse prescribers for prescribing controlled substances. These guidelines are intended to supplement and not replace the individual advanced practice nurse prescriber’s clinical judgment. The guidelines are not intended to address prescribing practices related to patients who are in active cancer treatment, palliative care, or end-of-life care.

It is important for advanced practice nurse prescribers to routinely discuss with patients the effect their diagnosed medical conditions or recommended drugs may have on their ability to safely operate a vehicle in any mode of transportation. Patients should be informed that there could be an increased effect when the patient is sick or there is a change in medication dosage.

Prior to prescribing controlled substances, there should be a well-documented evaluation which includes reason to treat and a history and physical. A review of the prescription drug monitoring program (PDMP) should also be completed. The patient should be provided with a notice regarding use of controlled substances including risks, benefits and how to properly dispose of controlled substances.

Opioid Prescribing

1. Nonpharmacologic or nonopioid therapy should be strongly considered prior to prescribing opioids. Opioids should be used only if the expected benefits for pain and function outweigh risk to the patient. If opioids are prescribed, nonpharmacologic or nonopioid therapy should also be utilized as part of a multimodal approach.

2. Before starting opioid therapy for chronic pain, advance practice nurse prescribers should establish treatment goals with all patients, including realistic goals for pain and function. An advanced practice nurse prescriber should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. The advanced practice nurse prescriber should consider a controlled substances agreement in chronic pain situations. The management plan should incorporate strategies to mitigate risk. The advanced practice nurse prescribers may consider ordering naloxone in individual cases based upon the advanced practice nurse prescriber’s nursing judgement.

4. When starting opioid therapy for chronic pain, advanced practice nurse prescribers should prescribe immediate-release opioids instead of extended-release or long-acting opioids. Extended-release or long-acting opioids should not be prescribed for acute pain.
5. Advanced practice nurse prescribers should do all of the following:
   a. Use caution when prescribing at any dosage.
   b. Prescribe the lowest effective dosage.
   c. Carefully reassess individual benefits and risks when considering increasing dosage to \( \geq 50 \) morphine milligram equivalents per day.
   d. Avoid increasing dosage to \( \geq 90 \) morphine milligram equivalents per day unless the advanced practice nurse prescriber carefully justifies and document the decision.
   e. Consider opioid taper, opioid detoxification, or pain management consultation prior to increasing to high doses.

6. When opioids are prescribed for acute pain, the quantity prescribed should be no greater than the expected duration of pain. Three days or less will often be sufficient.

7. If acute pain requires ongoing opioid therapy beyond the expected duration, the patient should be re-evaluated or referred to a pain management specialist.

8. Before opioid dose changes, the advanced practice nurse prescriber should re-evaluate the patient, including benefits, harms and whether another drug is appropriate. The patient should also be re-evaluated at least every 3 months. If the harms outweigh the benefits of continued opioid therapy, the advanced practice nurse prescriber should use other therapies and work with patient to taper opioids to lower dose or discontinue.

9. Prior to starting and during opioid therapy, advanced practice nurse prescribers should evaluate risk factors for opioid related harms.

10. Advanced practice nurse prescribers should review the patient’s history of controlled substance prescriptions through the PDMP to determine whether the patient is receiving opioid dosages or dangerous combination that put the patient at high risk. The PDMP data should be reviewed prior to starting a patient on opioid therapy and frequently during the opioid therapy.

11. Advanced practice nurse prescribers should use random urine drug testing, including chromatography and random pill counts. The frequency shall be based upon the patient’s risk factors. A high risk patient should have observed urine drops.

12. A patient should not be prescribed opioid and benzodiazepines concurrently, whether the prescribing is done by one practitioner or multiple practitioners. If a patient is taking opioids and benzodiazepines concurrently, clear clinical rationale must exist.

13. Advanced practice nurse prescribers should offer or arrange evidence-based treatment, including detox, for patients with opioid use disorder.
Benzodiazepines Prescribing

1. Nonpharmacologic therapy should be tried prior to prescribing benzodiazepines. Benzodiazepines should be used only if the expected benefits outweigh risk to the patient. If Benzodiazepines are prescribed, nonpharmacologic therapy should be used also be utilized as appropriate.

2. Before starting benzodiazepine therapy, advance practice nurse prescribers should establish treatment goals with all patients. The advanced practice nurse prescriber should utilize a contract. An advanced practice nurse prescriber should continue benzodiazepine therapy only if there is clinical benefit that outweighs risks to patient safety.

3. The advanced practice nurse prescriber should continually re-evaluate during benzodiazepine therapy.

4. When starting benzodiazepine therapy, advanced practice nurse prescribers should prescribe short-acting benzodiazepines instead of long-acting benzodiazepines.

5. The advanced practice nurse prescriber should re-evaluate the patient before dose escalation. Instead of continual increase of benzodiazepines, the advanced practice nurse prescriber should consider trying something different.

6. Prior to starting and during benzodiazepine therapy, advanced practice nurse prescribers should evaluate risk factors for benzodiazepine related harms.

7. Advanced practice nurse prescribers should review the patient’s history of controlled substance prescriptions through the prescription drug monitoring program (PDMP) to determine whether the patient is receiving benzodiazepines or dangerous combinations that put the patient at high risk. The PDMP data should be reviewed prior to starting a patient on benzodiazepine therapy and frequently during the benzodiazepine therapy.

8. Advanced practice nurse prescribers should use random urine drug testing, including chromatography and random pill counts. The frequency shall be based upon the patient’s risk factors. A high risk patient should have observed urine drops.

9. A patient should not be prescribed benzodiazepines and opioids concurrently, whether the prescribing is done by one practitioner or multiple practitioners. If a patient is taking opioids and benzodiazepines concurrently, clear clinical rationale must exist.

10. Advanced practice nurse prescribers should offer or arrange evidence-based treatment, including detox, for patients with benzodiazepine use disorder.

Stimulants Prescribing
1. Advanced practice nurse prescribers should ensure there is adequate testing, assessment and diagnoses prior to prescribing stimulants.

2. Before starting stimulant therapy, advance practice nurse prescribers should establish treatment goals with all patients. The advanced practice nurse prescriber should utilize a contract.

3. Advanced practice nurse prescribers should use random urine drug testing to ensure the patient is actually taking the stimulant.

4. Advanced practice nurse prescribers should review the patient’s history of controlled substance prescriptions through the prescription drug monitoring program (PDMP).
TO: Jeff Miller, DNP, ACRN, APNP, Chairperson, State of Wisconsin Board of Nursing and Members of the Board Controlled Substance Committee

FROM: Gina Dennik-Champion, MSN, RN, MSHA, Executive Director, Wisconsin Nurses Association

DATE: November 29, 2016

RE: WNA APRN Principles for Prescribing Controlled Substances

The Wisconsin Nurses Association is aware of 2015 Wisconsin Act 269. Statute Section 440.035 (2m), provided for the authority of the Board of Nursing to issue guidelines regarding best practices in prescribing controlled substances, as defined in s. 961.01 (4), for persons credentialed by that board who are authorized to prescribe controlled substances.

WNA is appreciative of the Board of Nursing’s desire to develop best practices in prescribing controlled substances guidelines for nurses. We believe guidelines that are developed by nurses for nurses will support quality nursing practice and patient safety.

In response to the Board’s efforts we would like to share the WNA APRN Forum’s APRN Principles for Prescribing Controlled Substances. There are two main areas of focus one for prescribing opioids and the other for prescribing ADHD-related medications. We hope that the Board of Nursing Controlled Substance Committee will find our work helpful to your project.

We are interested in discussing these with you at your upcoming December 12, 2016 Controlled Substance Committee meeting.

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Suite 136
Madison, WI 53718
http://www.wisconsinnurses.org
WNA APRN Principles for Prescribing Controlled Substances

BACKGROUND
Controlled substances including opioids are prescribed for a number of medical reasons by a variety of approved providers. The number of opioid prescriptions alone has increased by 7.3% per capita from 2007 to 2012 (CDC, Recommendations and Report, March 18, 2016/65 (1); 1-49). There are serious risks associated with prescribing controlled substances. Some of these risks include overdose, diversion and substance abuse disorders. In the United States from 1999 to 2014, there were more than 165,000 individuals who died from opioid overdose due to the use of opioid medications (CDC, March 18, 2016). Additionally, there have been more than 420,000 ER visits due to the misuse or abuse of chronic pain medications (CDC, March 18, 2016).

GENERAL INFORMATION
These guidelines for prescribing controlled substances are only voluntary recommendations, which provide some structure for prescribing these medications, but still require clinical decision making. This guideline intended for both short and long term controlled substance use. This guideline is not intended for use with active cancer treatment, palliative care, and end-of life care. Remember each patient is an individual and this must be taken into consideration when clinical decisions are made in the provider-patient relationship.

Evidence supports that the use of long-term opioids provides no more benefit than non-opioids.
- No evidence shows a long-term benefit of opioids in pain and function versus no opioids for chronic pain with outcomes examined at least 1 year later.
- Extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose and motor vehicle injury).
- Extensive evidence suggests some benefits of nonpharmacologic and nonopioid pharmacologic treatments compared with long-term opioid therapy, with less harm.
  (CDC, March 18, 2016)

When prescribing stimulants for the treatment of ADHD, providers need to look at all options for treatment with their patient’s in collaboration with the patient or patient’s caregiver. Prior to starting stimulants, the provider needs to be sure that the patient has been evaluated for other conditions which can impact the treatment course including but not limited to anxiety, behavior/conduct disorders, peer problems and learning disorders. ADHD treatment options include: behavioral therapy including training of primary caregivers; medications; and school/work accommodations and interventions (http://www.cdc.gov/ncbddd/adhd/treatment.html).

STANDARD INITIAL WORK FLOW FOR PRESCRIBING CONTROLLED SUBSTANCES

1. Knowing the patient
   - Medical history including personal and family history of substance abuse; current and past treatments with response to specific treatment; and co-morbid medical conditions
that may impact/complicate treatment. “Factors associated with increased risk for misuse include history of substance use disorder, younger age, major depression and use of psychotropic medications.” (CDC, March 18, 2016)

- Comprehensive physical examination in medical record
- Past medical records from outside facilities utilized by the patient. Aid in verifying medications, dosages, past diagnostics testing, and identify potential problems
- Evaluation by other specialists including mental health providers to aid in diagnosis of ADHD.
- Recommend delaying prescriptions or limited prescriptions until full history is obtained
- Review patient’s use of controlled substances on the Wisconsin Prescription Drug Monitoring Program (PDMP). As of April, 2017, Wisconsin state law requires prescribers to review the PDMP when prescribing controlled substances for greater than a three-day supply. May need to check other States PDMP.

2. Recommend use of controlled substance agreements
   - Be specific on treatment plan and engage patient early in the treatment plan
   - Controlled substance agreement may include:
     - Provide patient with information regarding controlled substances including possible addictive properties
     - Random drug screens and random pill counts
     - Do not give early refills
     - Do not refill if medication is stolen or lost
     - Need for follow-up office visits
     - Discontinuation of controlled substances if using illicit drugs
     - Having prescription filled only at one pharmacy and by one provider
     - Patient is responsible for making other providers aware of any other controlled substances that he or she may receiving from other providers
     - The need to participate in other treatments/therapies as recommended by provider to continue prescription and augment treatment (physical therapy, occupational therapy, mental health providers)
     - Failure to comply with agreement will result in discontinuation of the controlled substance by the provider and provider group

3. General principles of prescribing controlled substances
   - Start at low dose
   - Go slow when titrating
   - Avoid prescribing opioids and benzodiazepines together
   - Avoid prescribing medications from multiple controlled substance categories together
   - Methadone and suboxone requires special training to prescribe for addiction
   - Oxycodone first-line is NOT recommended and should be reserved for those who cannot tolerate other opioids
   - Regularly monitor patients to assess effectiveness of the treatment
   - Check the Prescription Drug Monitoring Program (PDMP) regularly
   - Do not prescribe opioids unless the condition is expected to cause pain severe enough to limit the patient’s ability to complete expected ADLs.
4. Acute pain treatment
- Evidence for use of opioids is weak in acute pain
- Utilize other treatments including but not limited to NSAIDs, acetaminophen, and non-pharmacological options such as ice, warm/moist compresses, rest, splinting, compression, physical therapy, yoga and massage.
- If opioids are necessary, use the lowest dose and for the fewest days. Usually less than 3 days are needed and rarely more than 5 days. (CDC, March 16, 2016)
- Avoid use of long-acting opioids
- If using opioids, would recommend combination therapy with nonpharmacological options
- If/when acute pain lasts longer than expected, re-evaluate for complications which may not have been evident initially or other complications which may have been related to surgery or other problems.
- When acute pain lasts longer than expected, switch patient to other pharmacological options that aid in the treatment of pain such as anticonvulsants, tricyclics, SSRIs or SNRIs.
- Re-evaluate frequently such as every couple of weeks or sooner

5. Chronic pain treatment
- Evidence for treatment with opioids is poor.
- Recommendation for a pain specialist to be involved in care
- Utilize nonpharmacological options such as physical/occupational therapy, yoga, exercise, biofeedback and complementary options.
- Utilize NSAIDs, acetaminophen ant topical preparations as part of plan
- Patients not willing to participate in non-opioid treatment or nonpharmacological options should be re-evaluated as to if opioid treatment is appropriate for this individual.
- Use short-acting initially, when dose is stable then transition to long-acting preparation
- Re-evaluate at least every 3 months if not sooner due to patient characteristics

6. Emergency treatment consideration/needs
- When ordering opioids, consideration needs to be given to ordering naloxone for home use for overdose
- Family members/caregivers should be trained in use.
- Individuals at greater risk for overdose include:
  - Depression
  - History of previous overdose or attempted overdose
  - Use of high doses—especially greater than 50 morphine milligram equivalents
  - Family history of overdose
  - Polypharmacy
- Naloxone dose is 0.4 mg IM or intranasal use with a second dose available if needed.

7. ADHD Management
- Utilization of specialist, such as mental health provider to aid in diagnosis, co-morbid mental health issues and possible treatment options
- First line treatment of ADHD is behavioral modification both in home and outside settings
• Medication options include stimulants and non-stimulants, which do not work as quickly as stimulants
• School accommodations and interventions which may include an individualized educational program (IEP)
• Utilization of contract if using stimulant
• Utilization of adjunctive medications if necessary