OPTOMETRY EXAMINING BOARD

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Optometry Examining Board
Best Practices for Prescribing Controlled Substances Guidelines
(approved March 16, 2017)

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

The purpose of these guidelines are to provide guidance to optometrists prescribing controlled substances, but not replace the optometrist's clinical judgment.

Optometrists provide care treating acute pain issues on a short term, non-chronic basis. Optometrists who have a valid DEA registration number may only prescribe when treating pain based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction. While standards of care permit the prescription of narcotic medications in the legitimate treatment of severe pain, optometrists are not obligated to use opioids or other controlled substances when a favorable risk to benefit balance cannot be documented.

Optometrists may prescribe the following controlled substances:
1. Schedule III, IV and V controlled substances.
2. Only the following schedule II controlled substances:
    1. Not more than 300 milligrams of hydrocodone per 100 milliliters or per 100 grams or not more than 15 milligrams per dosage unit, with a four-fold or greater quantity of an isoquinoline alkaloid of opium.
    2. Not more than 300 milligrams of hydrocodone per 100 milliliters or per 100 grams or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

Optometrists should utilize the prescription drug monitoring program (PDMP) prior to prescribing or dispensing controlled substances to determine whether the patient is receiving opioid dosages or dangerous combinations that put the patient at high risk, minimize the potential for prescription drug abuse and misuse, and reduce the number of unintentional complications associated with controlled substances. As of April 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three day supply.

Optometrists must have a valid provider-patient relationship prior to prescribing controlled substances.

1. Assessment – Complete medical history and physical examination, including pregnancy status. Determine the location, intensity, severity and associated symptoms with the pain.

Consider psychological factors, including personal\family history of addiction. Risk assessment includes patient medication history, and health conditions that could aggravate adverse reactions (including COPD, CHF, sleep apnea). Observe the patient for any aberrant drug-related behaviors.

2. Develop a plan – Educate the patient and family about the goals of treatment. Discuss the risks and benefits of non-pharmacologic and pharmacologic therapies. Set patient expectations for the degree and the duration of the pain. The goal should be improvement of function to baseline as opposed to complete resolution of pain.

3. Non-pharmacological and/or non-opioid therapy should be strongly considered prior to prescribing opioids. Non-steroidal anti-inflammatory drugs (NSAIDs) should be the first-line analgesic therapy. NSAIDs have demonstrated to be very effective for the treatment of pain, if not more effective than opioids. Opioids should be used only if the expected benefits for pain and function outweigh risk to the patients. If opioids are prescribed, non-pharmacologic and/or non-opioid therapy should also be utilized as part of a multimodal approach.

4. The decision to prescribe controlled substances may be made only after a proper diagnosis and complete evaluation which should include a risk assessment, pain assessment and review of the relevant PDMP data.

5. If prescribing opioids, provide the patient with the least potent opioid to effectively manage pain and prescribe the minimum quantity needed with no refills. Avoid prescribing long-acting opioids for acute pain. If pain continues beyond the expected duration, the patient should be revaluated and/or consider referring the patient.

6. A patient should not be prescribed opioid and benzodiazepines concurrently, whether the prescribing is done by one practitioner or multiple practitioners. Benzodiazepines triple the already high increases in respiratory depression and annual mortality rates from opioids. If a patient is taking opioids and benzodiazepines concurrently, clear clinical rationale must exist.

7. Educate the patient on the proper storage and disposal of controlled substances. Remind patients it is unsafe and unlawful to give away or sell their medications.

8. It is important to discuss with patients the effect the prescribed medication may have on their ability to safely operate machinery or a vehicle in any mode of transportation.

9. Coordinate care and communication of patients with other health care providers.