Revised June 25, 2018

Understanding the STOP Act's 5- and 7-day prescribing limits

The STOP Act's limits on prescriptions for acute pain and post-operative pain took effect Jan. 1, 2018. This FAQs collection focuses on this provision of the Act.

Q: Does the STOP Act limit prescriptions for chronic pain?

A: No. The Act limits certain prescriptions for acute pain (this includes post-operative pain). Prescriptions for chronic pain are not affected.

Q: How does the STOP Act define "acute pain"?

A: Pain from disease, accident, intentional trauma, or other cause that is expected to last for three months or less. However, NCMB does not consider acute pain stemming from an established chronic condition to be "acute pain" as contemplated by the STOP Act. For example, the Board does not consider a patient with rheumatoid arthritis who experiences an acute flare of the disease to be subject to the Act's 5-day prescribing limit. Prescribers should exercise caution, however, when prescribing opioids in any circumstances and avoid authorizing an excessive supply.

Q: How does the STOP Act limit opioid prescriptions for post-operative pain?

A: Pain medication administered in a health care facility (e.g. hospital or surgery center) is not subject to the STOP Act's prescribing limits. Upon discharge, initial prescriptions for Schedule II and Schedule III opioids are limited to no more than a 7-day supply for all types of procedures.

Q: How does the STOP Act limit opioid prescriptions for non-surgical acute pain?

A: The Act limits prescriptions for Schedule II and Schedule III opioids to no more than a 5-day supply when the prescription is issued after an initial consultation for acute pain.

Q: Is it the initial prescription for opioids written for acute pain that is limited or is it any opioid prescription written after the initial consultation?

A: The STOP Act states that a prescriber may not prescribe more than a 5- or 7-day supply of opioids following "initial consultation and treatment" of a patient for acute pain. Therefore, the limits apply when a Schedule II or Schedule III opioid is written after an "initial consultation" for acute pain.

Example: A patient presents with severe shoulder pain resulting from a sports injury. After the initial consultation, the clinician recommends ibuprofen, ice and rest. The patient comes back the following week with continued complaints of severe shoulder pain. The clinician recommends treatment with opioids. Because the opioid prescription is issued after a "subsequent consultation for the same pain" the prescriber may lawfully issue a prescription for any amount, consistent with current accepted standards of care. Note: If the clinician in the shoulder pain scenario prescribed opioids after seeing the patient for the first time (e.g. following the initial consultation) then the STOP Act limits would apply and the prescription would be limited to no more than a 5-day supply.

Regardless of whether the STOP Act limits on acute pain prescriptions apply, prescribers are urged to avoid authorizing excessive amounts of opioids for acute pain.

Q: Is there a quick way to know if the 5- or 7-day limits apply when prescribing opioids to patients?

A: It may be helpful to remember that both of the following must be true for the STOP Act prescribing limits to apply:

1. The prescription is for a Schedule II or Schedule III opioid or narcotic; AND

2. The prescription is written after an initial consultation for acute pain. If writing for post-operative pain, the limit applies to the initial prescription written at discharge (regardless of whether the procedure is performed an inpatient or outpatient setting).

Q: Does pain from a fracture fall under post-operative pain (7 days) or acute pain (5 days)?

A: It is the Board's opinion that fracture care, regardless of whether there was actual surgery involved, should be considered a surgical procedure (it is billed as such). Therefore, a patient evaluated for a fracture could receive an initial prescription for up to 7 days of pain medication.

Q: Is it acceptable to issue a new prescription sooner than five or seven days if the patient did not tolerate the initial prescription?

A: Yes, as long as the issuance of the new prescription is consistent with good medical practice and the rationale for issuing a replacement prescription is documented.

Q: Is it acceptable to prescribe *less* than a 5- or 7-day supply of opioids?

A: Yes, as long as the decision to prescribe less than a 5- or 7-day supply is consistent with good medical practice. The *CDC Guideline for Prescribing Opioids for Chronic Pain*, for example, recommends prescribing opioids no more than three days for acute pain and five days for post-surgical pain. The Board recognizes that such guidelines may not meet the needs of all patients.

Q: Is it acceptable to issue a refill or a prescription for a different pain medication if the patient needs more than a 5- or 7-day supply of pain medication to treat the same pain?

A: Yes. The law states: "Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription..."

Q: Do I need to physically see the patient back in the office in order to renew/refill the prescription or to issue a new prescription for a different amount and/or different drug?

A: Not necessarily. "Follow up consultation" may not require an in-person visit for the same issue before a refill/renewed prescription or a new prescription may be authorized, depending on the specific circumstances. In some instances (e.g. when symptoms of infection are reported by the patient, or when a patient reports worsening pain or other symptoms that are not indicative of healthy recovery) the prescriber may need to see the patient in person. Prescribers should determine these situations in a manner consistent with current accepted standards of care and good medical practice.

In situations where an in person consultation is not indicated, a patient might submit a request for a prescription for the same pain via phone or online portal. The patient or patient representative would still need to come to the office to pick up Schedule II prescriptions unless the practice has the capability to e-prescribe controlled substances.

Q: Is it appropriate to give the patient, at the time of the initial prescription, an additional prescription for an opioid that does not permit the prescription to be filled until seven days after the initial prescription?

A: No. The STOP Act states "Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance." (Emphasis added) This language requires the prescriber to decide, based on the circumstances at a later time, whether it is necessary to continue opioid therapy.

Q: What medications are subject to the 5- and 7-day limits imposed by the STOP Act?:

A: The limits apply ONLY to Schedule II and Schedule III opioids or narcotics listed in N.C. Gen. Stat. § 90-90(1), (2) and 90-91(d), only when prescribed for acute pain as described in this document. Benzodiazepines (such as Xanex) are not subject to the prescribing limits, nor are stimulant medications prescribed for attention disorders. The specific medications subject to the prescribing limits are listed below:

N.C. Gen. Stat. § 90-90(1)

Any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, unless specifically excepted or unless listed in another schedule:

a. Opium and opiate, and any salt, compound, derivative, or preparation of opium and opiate, excluding apomorphine, nalbuphine, dextrorphan, naloxone, naltrexone and nalmefene, and their respective salts, but including the following:

   1. Raw opium.
   2. Opium extracts.
   3. Opium fluid extracts.
   4. Powdered opium.
   5. Granulated opium.
   6. Tincture of opium.
   7. Codeine.
   8. Ethylmorphine.
   9. Etorphine hydrochloride.
   10. Hydrocodone.
   11. Hydromorphone.
   12. Metopon.
   13. Morphine.
   14. Oxycodone.
   15. Oxymorphone.
   16. Thebaine.
   17. Dihydroetorphine.

b. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph 1 of this subdivision, except that these substances shall not include the isoquinoline alkaloids of opium.

c. Opium poppy and poppy straw.

d. Cocaine and any salt, isomer, salts of isomers, compound, derivative, or preparation thereof, or coca leaves and any salt, isomer, salts of isomers, compound, derivative, or preparation of coca leaves, or any salt, isomer, salts of isomers, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocanized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine.

e. Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid or powder form which contains the phenanthrine alkaloids of the opium poppy).

N.C. Gen. Stat. § 90-90(2)

Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation unless specifically exempted or listed in other schedules:

a. Alfentanil.
b. Alphaprodine.
c. Anileridine.
d. Bezitramide.
e. Carfentanil.
f. Dihydrocodeine.
g. Diphenoxylate.
h. Fentanyl.
i. Isomethadone.
j. Levo-alphacetylmethadol. Some trade or other names: levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM.
k. Levomethorphan.
l. Levorphanol.
m. Metazocine.
n. Methadone.
o. Methadone - Intermediate, 4-cyano-2-dimethylamino-4, 4/y- diphenyl butane.
p. Moramide -Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid.
q. Pethidine.
r. Pethidine - Intermediate - A, 4-cyano-1-methyl-4/y-phenylpiperidine.
s. Pethidine - Intermediate - B, ethyl-4-phenylpiperidine-4-carboxylate.
t. Pethidine - Intermediate - C, 1-methyl-4-phenylpiperidine-4-carboxylic acid.
u. Phenazocine.
v. Piminodine.
w. Racemethorphan.
x. Racemorphan.
y. Remifentanil.
z. Sufentanil.
aa. Tapentadol.

N.C. Gen. Stat. § 90-91(d)

Any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof unless specifically exempted or listed in another schedule:

1. Not more than 1.80 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit with an equal or greater quantity of an isoquinoline alkaloid of opium.

2. Not more than 1.80 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
3. Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit with a four-fold or greater quantity of an isoquinoline alkaloid of opium.
4. Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
5. Not more than 1.80 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
6. Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
7. Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
8. Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

Q: How will the 5- or 7-day limits on prescriptions apply to patients who are being discharged from an inpatient hospital or nursing home and who received opioid pain medication during their hospitalization?

A: The STOP Act specifically exempts prescribers who order or administer Schedule II/III opioids in a hospital, nursing home, hospice facility, or residential care facility from the 5- and 7-day limits on initial prescriptions for pain. However, prescribers for these patients must comply with the limits at discharge. NCMB interprets the Act's intent to be that no patient treated for acute pain in an outpatient setting (e.g. at home) receive an initial or hospital discharge prescription that exceeds the limits stated in the law. If the patient requires additional treatment for the pain after the initial 5- or 7-day hospital discharge prescription runs out, then a subsequent prescription may be issued by the prescriber, consistent with good medical practices.

Q: Do the 5- and 7-day limits still apply if the patient being treated is also a chronic pain patient?

A: Yes, the 5- and 7-day limits apply – to the prescription for acute or post-operative pain. A prescriber treating acute or post-operative pain for a patient with chronic pain should consider all clinical information he or she has about the patient in selecting pain medications, dosage, and medication scheduling consistent with good medical practices. Referral for consultation with a pain specialist may be required to assist with medication selection, dosing, and management.

Q: What are the consequences of noncompliance with the prescribing limits established by the STOP Act?

A: The law does not establish a specific penalty for noncompliance. However, NCMB is empowered under North Carolina law to pursue disciplinary action against any licensee who has been found to have violated a law concerning the practice of medicine. NCMB is considering how best to determine how licensee prescribing patterns have changed in response to the STOP Act's prescribing limits, but has yet to implement a specific program to encourage compliance with the limits and address instances of noncompliance. The Board expects licensees who prescribe opioids to educate themselves about the prescribing limits and comply with them when applicable.

NCMB is aware that some health insurance companies have adopted policies to deny or require prior authorization for opioid prescriptions that exceed a 7-day supply.