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

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

**Q: Will all provisions of the STOP Act be in effect Jan. 1?**

A: No. Jan. 1 is just when limits on initial scripts for acute and post-operative pain take effect. Other provisions, including e-prescribing and mandatory use of the NC Controlled Substances Reporting System, will become effective at a later time.

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

A: No. The Act limits initial scripts for acute pain and/or post-operative pain. Chronic pain scripts 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.

**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 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 five or seven-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 a targeted controlled substance 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 on initial prescriptions for acute and post-surgical pain 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). The specific medications 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 initial prescriptions for acute and post-operative pain 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 on initial prescriptions for acute or post-operative pain still apply if the patient being treated is also a chronic pain patient?**

A: Yes, the 5- and 7-day limits apply – to the initial 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: Is there a quick way to know if the 5- or 7-day limits apply when prescribing opioids to patients?**

A: Yes. First, ask "Is this prescription being written to treat acute pain (defined as pain lasting 3 months or less)?" If NO, the STOP Act limits on initial prescriptions do not apply.

If YES, then ask, "Is this medication a Schedule II or Schedule III opioid or narcotic?" If YES then the STOP Act limits on initial prescriptions DO apply. If NO, the limits do not apply.