LEGAL AND PRACTICAL IMPLICATIONS IN PRESCRIPTIVE AUTHORITY FOR THE APRN

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SCOPE OF PRACTICE

Full Practice: 24 States and the District of Columbia give APRN's the authority to diagnose, treat, and prescribe medications without the requirement of physician collaboration or oversight

Limited Practice: 16 States limit the ability of the APRN to engage in at least one element of advanced practice and require the APRN to have a regulated, collaborative agreement with a physician to provide patient care

Restrictive Practice: The State of Georgia and 10 other states are considered to have restrictive scopes of practice for APRN's. Both the state statutory authority and Nursing Board Rules, Regulations, and By-laws restrict the APRN from engaging in at least one element of advanced practice. The laws, rules and regulations require that the APRN is supervised, delegated to act, or otherwise controlled by a collaborating physician in order to provide patient care.

Authority to Practice

Statutory Authority and Creation:

O.G.C.A. Title 43 Chapter 26 Article 1, *et. seq* (2013)
Georgia Registered Professional Nurse Practice Act

O.G.C.A. Title 43 Chapter 26 Article 2, *et. seq* (2013)
Georgia Licensed Practical Nurse Act

O.G.C.A. Title 43 Chapter 26 Article 3, *et. seq* (2013)
Mandatory Reporting Requirements For Nurses

Administrative Code: Rules and Regulations

Department 410: Rules and Regulations of the Georgia Board of Nursing

Department 360: Rules and Regulations of the Georgia Composite Medical Board

Prescriptive Authority

APRNs in Georgia may participate in the prescribing of medications in one of two ways:

O.G.C.A. Title 43 Chapter 34, Subpart 23 (2010). Originally enacted in 1988, this authority is overseen by the Georgia Board of Nursing.

- This may be referred to as Collaboration without Prescriptive Authority

O.G.C.A. Title 43 Chapter 34, Subpart 25 (2010). Originally enacted in 2006, APRN's are given the authority to write prescriptions for Schedule III-V drugs under a written agreement with a delegating physician.

- This may be referred to as Collaboration with Prescriptive Authority

O.C.G.A. Title 43 Chapter 34, Subpart 23 (2010)

A physician may delegate the APRN to assess the patient, determine the medication needed, and write an order in the chart.

Under the physician's name, the APRN may also transmit orders for legend drugs and Schedule II-V drugs and diagnostic tests.

A Drug Enforcement Association (DEA) is not required. However, all written prescriptions and diagnostic orders must be signed by the delegating physician.

O.C.G.A. Title 43 Chapter 34, Subpart 25 (2010)

Georgia APRNs may write prescriptions for legend drugs and Schedule III-V drugs under an agreement with a delegating physician.

The APRN's ability to prescribe medications under this authority is governed by both the Board of Nursing and the Composite Board of Medicine.

APRNs may sign for legend and Schedule III-V drugs under their own name, but may do so only by protocol approved by the delegating physician and submitted to the Composite Board of Medicine.

A DEA is required for scheduled drugs.

DEA Schedule of Medications

Drugs and other substances that are considered controlled substances under the Controlled Substance Act ("CSA") are divided into five schedules.

An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations ("C.F.R.") §§ 1308.11 through 1308.15.

Substances are typically classified based on three factors:

- whether they have a currently accepted medical use in treatment in the United States;
- their relative abuse potential; and
- likelihood of causing dependence when abused

Schedule I

Substances in this schedule have no currently accepted medical use in the United States; a lack of accepted safety for use under medical supervision; and a high potential for abuse.

Examples: heroin, lysergic acid diethylamide ("LSD"), marijuana (cannabis), peyote, methaquinolone, and 3,4 menthylenedioxy-methamphetamine ("Ecstacy").

Schedule II, IIN

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

Examples – Schedule II: hydromorphone (Dilaudid), methadone (Dolophine), meperidine (Demerol), oxycodone (OxyCotin, Percocet), and fentanyl (Sublimate, Duragesic). Others include morphine, opium, and codeine.

Examples – Schedule IIN: amphetamine (Dexedrine, Adderall), methamphetamine (Desoxyn) and methylphenidate (Ritalin).

Other Schedule II substances include: amobarbital, glutethimide, and pentobarbital.

Schedule III, IIIN

Substances in this schedule have a potential for abuse less than substances in Schedules I or II and may have lead to moderate or low physical dependence or high psychological dependence.

Examples – Schedule III: 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) and buprenorphine (Suboxone).

Examples – Schedule IIIN: benzphetamine (Didrex), phendimetrazine, ketamine, and anabolic steroids such as Depo-Testosterone.

Schedule IV

Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

Examples: alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam (Halcion)

Schedule V

Substances in this schedule have a low potential for abuse relative to substances in Schedule IV; consist primarily of preparations containing limited quantities of certain narcotics.

Examples - cough preparations containing not more than 200 milligrams of codeine per 100 millileters or per 100 grams (Robitussin AC, Phenergan with Codeine) and ezogabine.

DEA Registration

Application can made online through the Drug Enforcement Agency website. Note the DEA is a division under the Department of Justice.

Application fee: $731 for initial registration - good for three years

Typical Processing Time: 4 – 6 weeks

APRN Responsibilities in Writing Prescriptions

SCRIPT ANALYSIS:

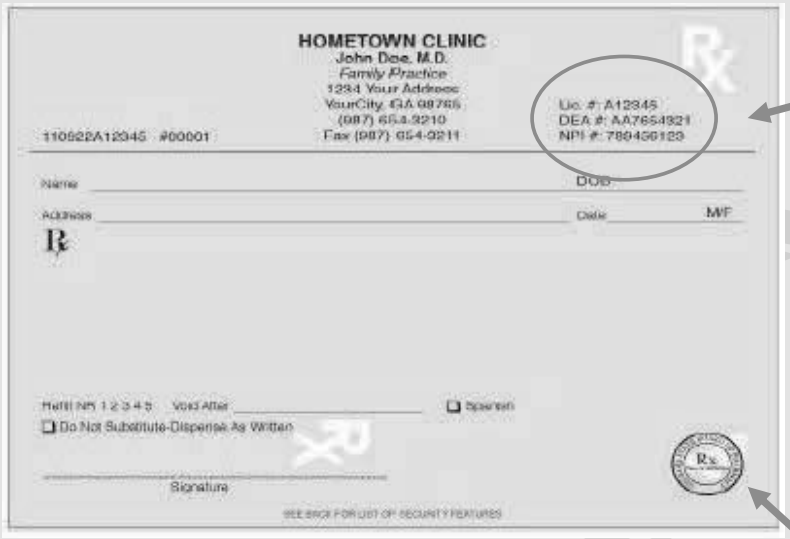
S = Side Effects

R = Right Medication, Right Dose, Right Frequent, Right Route

I = Interactions

P = Precautions

T = Transmittal



NOTE: When issuing a prescription for a controlled substance Schedule III, IV, or V, the prescription must include the APRN's DEA number.

When using preprinted prescriptions for issuing controlled substances Schedule III, IV or V, it is recommended that "Prescription is void if more than one controlled substance is issued per prescription blank" at the bottom of the script.

Practical Guidelines for Collaborative Agreements

O.C.G.A § 43-34-25:

- Initial Protocol signed by APRN, Delegating/Designated Physician
- Submitted to the Georgia Composite Medical Board for review
- Annually updated with Review signed and dated by APRN and Physician

Records Review:

- 100% of patient records receiving prescriptions for controlled substances
  - Review must occur at least quarterly. Must be documented.
- 100% of patient records in which in adverse outcome has occurred
  - Review must occur NOT MORE THAN 30 DAYS after discovery
- 10% of all other patient records - documented at least annually.

Consultation with Delegating or Designated Physician

O.C.G.A § 43-34-25

- Requires that the Delegating Physician MUST be available for immediate consultation by DIRECT COMMUNICATION (In person, telephone, or "other mode").
- If the Delegating Physician is not available, then the Designated Physician must be available.
- Consultation must be documented in the medical record.

Consultation Required:

On-site or telephone consultation is generally required in the following situations:

1. Immediate Threat to the patient's life or bodily function
2. Failure to respond to the management plan with an appropriate amount of time.
3. Unusual or unexplained findings
4. If the patient requests physician consultation
5. Materially adverse outcomes
6. Circumstances outside the APRN's scope of practice

Georgia Prescription Drug Monitoring Program (GA PDMP)

In July 2017, management of the GA PDMP past from the Georgia Drugs and Narcotics Agency (GDNA) to the Georgia Department of Public Health (DPH).

Effective January 2018, each GA prescriber with a DEA must be registered with the PDMP. New prescribers are required to be registered within 30 days of obtaining a DEA permit.

GA PDMP Monitoring

Effective July 2018: Any prescriber writing for a SCHEDULE II OPIOD OR BENZODIAZEPINE must review the patient's PDMP information at the time of the initial prescription and then at least once every 90 days thereafter, unless:

- RX is for no more than 3 day supply and more than 26 pills
- Patient is an inpatient in a hospital, LTCF, hospice, personal care home and medication is to be used and administered on the premises
- Patient had outpatient surgery and the RX is for no more than 10 day supply or 40 pills
- Patient is terminally ill and in an outpatient hospice
- Patient is being treated for cancer

Current Trends and Future Directions: Closing Remarks

APRN practice is expanding and will continue to do so. Prescriptive authority will also expand and with it greater responsibility and liability.

APRN education and training will reflect the need for greater expertise in pharmacology and medication management. As states and the federal government allow for greater independence in practice, there will be greater emphasis on research and practice patterns associated APRN utilization and prescribing habits.

QUESTIONS & ANSWERS

CONCLUDING REMARKS

References

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