Georgia Department of Public Health
District 4 Public Health

MAG Fact Sheet

H.B. 249 – Georgia PDMP

Signed into law in 2017, H.B. 249 was designed to reduce prescription drug misuse in the state.

H.B. 249 moved the Prescription Drug Monitoring Program (PDMP) from the Georgia Drugs and Narcotics Agency to the Department of Public Health (DPH).

Under H.B. 249, a prescriber may delegate their authority check the PDMP to two members of their medical staff. including licensed and unlicensed employees. A health care facility (e.g., hospital or ambulatory surgery center) may select two employees to serve as delegates per shift or rotation. And at hospitals that provide emergency services. each prescriber may designate two individuals who are employed by that hospital per shift or rotation. The delegates will be required to sign up as users of the POMP and obtain their own log in credentials.

Any unauthorized use of PDMP data by a delegate can result in civil or criminal liability for the prescriber. Delegates may only use PDMP data for the purpose of providing medical care or to inform the prescriber of a patients potential use. misuse. abuse or underutilization of a prescribed medication.

By January 1. 2018. every prescriber in Georgia who had a DEA registration number was required to be enrolled as a PDMP user. Georgia prescribers who obtain(ed) a DEA license after January 1. 2018 are (were) required to enroll with the PDMP within 30 days at https://dpt.georgla.gov/pdmp.

Between January 1, 2018 and May 31, 2018, the DPH is required to randomly test the PDMP to confirm that it is accessible and operational at least 99.5 percent of the time. Assuming that DPH has certified that the PDMP has met these standards, prescribers or their delegates must review the information from the POMP when prescribing a con trolled substance that is listed in paragraph (1) or (2) of Code Section 16-13-26 (see the code section language that is at the bottom of this fact sheet) or a benzodiazepine beginning July 1. 2018. This review is limited to the first time the prescriber issues a prescription for the given patient and at least every go days thereafter.

Exemptions from checking the PDMP include...

- Prescriptions for no more than a three-day supply of a covered substance and no more than 26 pills
- The patient is in a hospital or health care facility, including -but not limited to – a nursing home, an intermediate care home, a personal care home, or a hospice program that provides patient care and whereby the prescriptions are to be administered and used by a patient on the premises of the facility
- The patient has had outpatient surgery at a hospital or ambulatory surgical center and the prescription is for no more than a 10-day supply of a covered substance and no more than 40 pills

- The patient is terminally ill or under the supervised care of an outpatient hospice program

- The patient is receiving treatment for cancer

Prescribers or their delegate must make a notation in the patient's medical record that the PDMP was consulted and identify the individual who conducted the PDMP patient search. If the PDMP does not allow the prescriber/delegate to gain access to the patient's information for any reason, the prescriber/delegate should note the time and date and the prescriber/delegate's name in the patient's medical record.

Prescribers may now include PDMP prescription information in a patient's electronic health or medical record.

If a prescriber fails to check the PDMP as outlined above. he or she will be held administratively accountable to the Georgia Medical Composite Board, but the prescriber may not be held civilly liable or criminally responsible.

When prescribing an opiate, opioid, opioid analgesic, or opioid derivative, the prescriber must provide the patient with information on the drug's addictive risks and the options that are available for safely disposing of any unused medications. This information may be provided in either verbal or written form.

A health care provider. coroner. or medical examiner must report all incidents of neonatal abstinence syndrome to DPH, which will submit an annual report – including findings and recommendations on how to reduce the number of infants born with neonatal abstinence syndrome – to the president of the Georgia Senate, the speaker of the Georgia House of Representatives, and the chairs of both the Georgia House and Senate Health and Human Services committees.

Other H.B. 249 provisions include codifying the Gov. Deal's executive order to make naloxone available on an over-the-counter basis. annual inspections of narcotic treatment programs. and a requirement that calls for the Department of Community Health and the Department of Behavioral Health and Developmental Disabilities to report the number of patients who are enrolled in or have been discharged from a treatment program.

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OCGA 16-13-26 Paragraphs 1 and 2

The following are paragraphs 1 and 2 of Code Section 16-13-26, as of May 5, 2017. This is subject to change during each legislative session. Go to wwwlexi.sn xis
version of this language.

Paragraph 1

Any of the following substances, or salts thereof, except those narcotic drugs specifically exempted or listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis:

(A) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding naloxone hydrochloride, but including the following:

(i) Raw opium;
(ii) Opium extracts;
(iii) Opium fluid extracts;
(iv) Powdered opium;
(v) Granulated opium;
(vi) Tincture of opium;
(vii) Codeine;
(viii) Ethylmorphine;
(ix) Hydrocodone;
(x) Hydromorphone;
(xi) Metopon;
(xii) Morphine;
(xiii) Oripavine;
(xiv) Oxycodone;
(xv) Oxymorphone;
(xvi) Thebaine;

(B) Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (A) of this paragraph, except that these substances shall not include the isoquinoline alkaloids of opium;

(C) Opium poppy and poppy straw;

(D) Cocaine, coca leaves, any salt, compound, derivative, stereoisomers of cocaine, or preparation of coca leaves, and any salt, compound, derivative, stereoisomers of cocaine, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions which do not contain cocaine or ecgonine;

Paragraph 2

Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(A) Alfentanil;
(A.1) Alphaprodine;
(B) Anileridine;
(C) Bezitramide;
(D) Dihydrocodeine;
(E) Diphenoxylate;
(F) Fentanyl;
(G) Isomethadone;
(G.s) Levo alphacetylmethadol
(H) Levomethorphan;
(I) Levorphanol;
(J) Methazocine;
(K) Methadone;
(L) Methadone-Intermediate, 4-cyano-2-dimethylamino-4, 4-di-phenyl butane;
(M) Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid;
(N) Pethidine (meperidine);
(0) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpi-peridine;
(P) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;
(Q) Pethidine-Intermediate-C, l-methyl-4-phenylpiperidine-4·Carboxylic acid;
(R) Phenazocine;
(S) Piminodine;
(T) Racemethorphan;
(U) Racemorphan;
(U.1) Remifentanil;
M Sufentanil;
(V.1) Tapentadol;
0/'l) 4-anilino-N-phenethyl-4-piperidine (ANPP)