

Introduction

Missouri Advanced Practice Registered Nurses (APRNs) have been prescribing medications with the exception of controlled substances since 1993. APRNs are authorized to prescribe through a collaborative practice agreement and can only prescribe those medications used within their scope of practice. However, APRNs are educated to prescribe controlled substances along with other medications. Proposed legislation would grant APRNs the authority to prescribe medications that they are thoroughly competent to manage.

The federal Controlled Substances Act in 1971 gave the Drug Enforcement Agency (DEA) the power to enforce control of potentially abusive drugs. The DEA issued regulations in 1993 permitting APRNs to obtain DEA numbers for the purpose of prescribing controlled substances. Controlled substances are regulated in Chapter 195 of MO Statutes under the administration of the Missouri Department of Health and Senior Services. They are regulated because they have the potential for addiction and abuse, not because they have more serious side effects or adverse effects than other prescription drugs.

The inability of APRNs to prescribe controlled substances has a significant impact on Missouri citizens. Many Missouri citizens receive delays in care and experience untreated or under-treated pain. This results in lost time and wages from work. Many patients are forced to accept a lack of comprehensive care and treatment with less effective pain management medications (Tumolo, 2003). These disparities result in reduced quality of care for many Missouri citizens (Kaplan, L., & Brown, M., 2004).

The remainder of this document provides detailed information regarding the scope of practice and education of APRNs. Information regarding other states' experiences allowing APRNs to prescribe controlled substances is provided as well as studies documenting the cost-effectiveness and quality of care provided by APRNs.

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Advanced Practice Registered Nurses

APRNs represent a group of nurses with advanced educational preparation at the graduate level as well as certification by a nationally recognized certifying body. These nurses provide nursing care and some care that has traditionally been associated with the practice of medicine. This group includes nurse practitioners, nurse midwives, clinical nurse specialists, and registered nurse anesthetists.

Nurse practitioners are certified in several specialty areas including family, adult, acute care, pediatric, women's health, neonatal, and geriatric care. They provide care to individuals, families and groups in a variety of settings including offices, clinics, hospitals, schools and community agencies. Nurse practitioners provide a wide range of services including obtaining medical histories; performing physical examinations; diagnosing and treating acute and chronic health conditions; and prescribing medications. Nurse practitioner services are focused on health promotion and disease prevention (Sherwood et al., 1997).

Certified nurse midwives provide women's health care focusing particularly on gynecologic needs including prenatal care, childbirth and postpartum care. These services are provided in collaboration with obstetricians (American College of Nurse-Midwives, 2004).

Clinical nurse specialists provide direct patient care and education services, and are involved in interdisciplinary consultation. They usually work in specialty clinics or hospitals, and help manage individuals with chronic health conditions.

Nurse anesthetists provide anesthesia for patients undergoing surgery. These services are usually provided in a hospital or outpatient surgical center in collaboration with an anesthesiologist.

Nurse practitioners are responsible for the majority of prescriptions written by APRNs. Therefore, the remainder of this document will focus on nurse practitioners.

APRN Education

A master's degree in nursing is the standard education for APRNs. The American Academy of Nurse Practitioners has declared that this is the entry level for advanced practice. The clinical education of nurse practitioners includes several courses that pertain to prescribing medications, including advanced physical assessment, pathophysiology, and pharmacology (American Academy of Nurse Practitioners, 2002).

In 1998, the United States department of Health and Human Services published *Curriculum Guidelines and Regulatory Criteria for Family Nurse Practitioners Seeking Prescriptive Authority to Manage Pharmacotherapeutics in Primary Care*. These guidelines recommend that APRN education include a discrete course in pharmacology totaling forty-five contact hours. This is equivalent to a three-credit hour course. This course should include information on controlled substances used in the management of pain and anxiety. The recommendations also specify that this course should be taught by faculty with a graduate degree in pharmacology (Health Resources and Services Administration, 1998).

While clinical experience in medical programs is more extensive than in APRN programs, the clinical experience related to controlled substances may be less different than it appears. Nurses entering advanced practice programs have prior experience administering and monitoring controlled substances. Medical students generally lack this experience (Baker, Perry, Jenkins, & Nikolova-Kirilova, 2004).

Background of APRN Prescriptive Authority

In 1971, Idaho amended its Nurse Practice Act to abolish the statutory prohibition preventing nurses from engaging in diagnosis and treatment. This action signaled the first recognition of an expanded role for nursing (Hadley, 1990). Since that time, all fifty states have recognized the role of advanced practice nurses. All states grant some form of prescriptive authority; although the specific statutes vary greatly from state to state (Appendix A). APRNs have been prescribing controlled substances in some states for over twenty-five years. In 1978, the Alaska Board of Nursing granted independent prescriptive authority to prescribe all drugs, including controlled substances, to APRNs. Some form of physician involvement is required in forty states (Appendix B and Appendix C). The particular requirements for collaboration differ among states; however, the collaborative practice agreement usually establishes the provisions for referral and consultation between the physician and the APRN.

In 1993, statutory legitimacy for advanced practice nursing was guaranteed in Missouri by the passage of House Bill 564 (HB 564). HB 564 represented a decade of struggle by APRNs to legitimize an expanded scope of authorized nursing practice beginning with the landmark Missouri Supreme Court decision *Sermchief v. Gonzales* (1983). Since the passage of HB 564, Missouri APRNs have been legally entering into collaborative practice agreements with physicians. Through these collaborative practice agreements, Missouri APRNs have been exercising prescriptive authority for over a decade. Prescriptive authority for controlled substances by APRNs in Missouri would occur through these previously established collaborative practice agreements between physicians and APRNs.

Missouri is among three states that have not granted APRNs the legal authority to prescribe controlled substances. Kentucky was the last contiguous state to grant APRNs prescriptive authority for controlled substances in the 2006 legislative session. In thirty-eight states and the District of Columbia, APRNs have the authority to prescribe Schedules II-V. Nine states limit the prescriptive authority to Schedules III-V.

Opponents of APRN prescriptive authority of controlled substances cite the potential for an additional mechanism for the illegal diversion of prescription drugs. States in which APRNs have prescriptive authority for controlled substances report that disciplinary actions for APRNs are rare. In a survey of thirty-six states and the District of Columbia, only one disciplinary action related to controlled substances was reported (Baker et al., 2004).

APRN Quality of Care

Numerous studies indicate that APRNs provide high quality patient care. The first major meta-analysis was conducted by the Office of Technology Assessment (OTA) in 1986 at the request of the United States Congress. A multidisciplinary panel reviewed the literature on nurse practitioners and certified nurse midwives. They concluded that APRN care was equivalent to physician care. Reviewers also concluded that in areas of communication and preventive care, APRNs performed better than physicians (OTA, 1986).

A second major review evaluated 248 documents for nurse practitioner effectiveness. The researchers compared the effects of nurse-provided care and physician-provided care in similar settings with similar patients on procedures of care, cost-effectiveness, and clinical outcomes. Nurse practitioners achieved similar clinical outcomes to physicians on most variables. The investigators also found that patients displayed a higher level of compliance to treatment when care was provided by nurse practitioners as compared to physicians, and that nurse practitioners spent more time with patients during visits, although the average number of visits between the two groups was equal (Brown & Grimes, 1992).

Safriet (1992) reviewed two decades of research and determined that APRNs clearly provide care of comparable quality and at a lower cost than physicians. APRNs typically prescribe fewer drugs, select lower cost treatments, and use less expensive tests than physicians. The reviewer recommended reducing restrictive barriers to practice such as prescriptive authority to better utilize APRNs to improve access to healthcare (Safriet, 1992).

In addition to the previously mentioned studies, randomized trials have been conducted to measure nurse practitioner quality of care. A multidisciplinary group of researchers compared the outcomes of 1,316 patients who received primary care from nurse practitioner as compared to physicians in several community based clinics. In this study, patients were randomly assigned to receive care from either a nurse practitioner or physician. The researchers found that in an ambulatory care environment where nurse practitioners had the same authority, responsibilities, productivity and administrative requirements, and patient population as physicians, outcomes were comparable. There was no significant difference in the patient's health status after six months. There was no difference in outcomes for patients with several major diagnoses, and no difference in patient satisfaction or utilization of services (Munding et al., 2000).

Conclusions

Missouri APRNs have been prescribing medications with the exception of controlled substances since 1993. The passage of HB 564 legitimized an expanded scope of practice for nurses, and since that time, Missouri APRNs have been entering into collaborative practice agreements with physicians. APRN prescriptive authority for controlled substances would not change that collaborative practice arrangement.

APRNs are educationally prepared to prescribe controlled substances. A master's degree in nursing is the entry level standard degree for APRNs. The clinical education of nurse practitioners includes a discrete pharmacology course in which principles of the prescription and management of controlled substances are taught. The educational program of nurse practitioners also includes courses such as physical assessment and pathophysiology in which the pharmacologic management of diseases are discussed.

Numerous studies indicate that APRNs are qualified to provide cost-effective, high-quality patient care. Nurse practitioners achieve similar clinical outcomes as physicians. Patients display a high level of compliance with treatment plans and a high level of satisfaction when care is provided by nurse practitioners.

The inability of Missouri APRNs to prescribe controlled substances negatively impacts Missouri citizens. This barrier to practice results in reduced quality of care for patients and unmet health care needs in treatment of acute and chronic pain. Dovey (2001), in an opinion for the *American Family Physician*, wrote that professional turf battles over prescriptive authority have resulted in limitations in the scope of practice for nurse practitioners that obstruct collaboration with physicians. Patients would be better served if APRNs and physicians worked together to integrate their skills and services to improve access to healthcare in this country (Dovey, 2001).

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Appendix B

State Regulation of APRN Prescriptive Authority for Controlled Substances

STATE	N P	NM	CNS	CNA
Alabama	N/A	N/A	N/A	N/A
Alaska	II-V	II-V	Not a Category	II-V
Arizona	II-V	II-V	N/A	N/A
Arkansas	III-V	III-V	III-V	III-V
California	II-V	II-V	N/A	N/A
Colorado	II-V	II-V	II-V	II-V
Connecticut	II-V	II-V	II-V	N/A
Delaware	II-V	II-V	II-V	II-V
Washington, DC	II-V	II-V	II-V	II-V
Florida	N/A	N/A	Not a Category	N/A
Georgia	III-V	III-V	III-V	N/A
Hawaii	II-V	II-V	II-V	II-V
Idaho	II-V	II-V	II-V	II-V
Illinois	III-V	III-V	III-V	III-V
Indiana	II-V	II-V	II-V	N/A
Iowa	II-V	II-V	II-V	II-V
Kansas	II-V	II-V	II-V	N/A
Kentucky	II-V	II-V	II-V	II-V
Louisiana	III-V	III-V	III-V	N/A
Maine	II-V	II-V	N/A	N/A
Maryland	II-V	II-V	N/A	N/A
Massachusetts	II-V	II-V	II-V	N/A
Michigan	II-V	II-V	Not a Category	N/A
Minnesota	II-V	II-V	II-V	II-V
Mississippi	II-V	II-V	N/A	II-V
Montana	II-V	II-V	II-V	II-V
Nebraska	II-V	II-V	Not a Category	II-V
Nevada	II-V	Not a sep. title	Not a Category	N/A
New Hampshire	II-V	II-V	Not a Category	II-V
New Jersey	II-V	II-V	II-V	N/A
New Mexico	II-V	II-V	II-V	II-V
New York	II-V	II-V	Not a Category	N/A
North Carolina	II-V	II-V	N/A	N/A
North Dakota	II-V	II-V	II-V	II-V
Ohio	II-V	II-V	II-V	II-V
Oklahoma	III-V	III-V	III-V	II-V
Oregon	II-V	II-V	N/A	N/A
Pennsylvania	II-V	Not a Category	Not a Category	N/A
Rhode Island	II-V	II-V	II-V	N/A
South Carolina	III-V	III-V	III-V	N/A
South Dakota	II-IV	II-IV	N/A	N/A
Tennessee	II-V	II-V	II-V	N/A
Texas	III-V	III-V	III-V	II-V
Utah	II-V	II-V	II-V	II-V
Vermont	II-V	II-V	II-V	II-V
Virginia	III-V	III-V	N/A	NA
Washington	II-V	II-V	II-V	II-V
West Virginia	III-V	III-V	III-V	III-V
Wisconsin	II-V	II-V	II-V	II-V
Wyoming	II-V	II-V	II-V	II-V

N/A = No Authority

Appendix C

States Requirements Related to APRN Prescriptive Authority for Controlled Substances

State	Limitations on APRN Prescribing
Alabama	<ul style="list-style-type: none"> • Not authorized to prescribe controlled substances.
Alaska	<ul style="list-style-type: none"> • Must apply for prescriptive authority • 1 year experience prescribing legend drugs within 5 years prior to application • ID number on prescription
Arizona	<ul style="list-style-type: none"> • Must apply for prescriptive authority • File DEA number with Board of Nursing • Schedule II – no refills • Schedule II-IV – refills limited to five in six months • Schedule V – may refill for 1 year • Must examine patient
Arkansas	<ul style="list-style-type: none"> • Must apply for prescriptive authority • Prescriptive Authority Advisory Committee • 300 hours of prescribing experience of legend drugs prior to application • 1,000 hours of post-APN education work experience
California	<ul style="list-style-type: none"> • Physicians and NPs name on container • ID number issued by Board • Six months supervised experience in ordering drugs
Colorado	<ul style="list-style-type: none"> • Must apply for prescriptive authority • Post graduate experience of 1,800 hours in immediate 5 years prior to prescribing • Limited to patients within practice area • May prescribe for acute self-limiting disease, stable chronic condition or terminal comfort care • Advise patient that symptoms or purpose of medications is put on order
Delaware	<ul style="list-style-type: none"> • To continue licensure, must practice at least 1,500 hours last 5 years or no less than 600 hours in past 2 years in area of specialization • Must register biennially with the Office of Narcotics and Dangerous Drugs • Application to prescribe to the Joint Practice Committee • Prescribed prior to legislation under a waiver from Board of Medicine
District of Columbia	<ul style="list-style-type: none"> • CRNA – no refills
Florida	<ul style="list-style-type: none"> • Not authorized to prescribe controlled substances
Georgia	<ul style="list-style-type: none"> • Formulary of controlled substances developed by the Board of Medical Examiners
Hawaii	<ul style="list-style-type: none"> • Must document a collegial working relationship with a physician with the Department of Commerce and Consumer Affairs (not required for legend drugs) • Prescription must include name and phone number of the physician with whom the APRN has the collegial working relationship • Board of Medical Examiners provides exclusionary formulary to Board of Nursing annually • Must apply for prescriptive authority • 1,000 hours of clinical practice within 3 years of application for prescriptive authority
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Idaho	<ul style="list-style-type: none"> • For renewal of prescriptive authority, must have 200 hours of advanced practice during preceding 2 years • May apply for prescriptive authority as part of initial licensure or separately • Must complete continuing competency assessment program of the American College of Nurse Midwives within 5 years of initial certification
Illinois	<ul style="list-style-type: none"> • Name of collaborating physician on all prescriptions • Obtain a midlevel practitioner controlled substance license • Medication orders reviewed periodically by collaborating physician • Collaborating physician required to file notice with the Department of Professional Regulation of delegation of prescriptive authority prior to license being issued • Collaborative physician on site 1 time per month
Indiana	<ul style="list-style-type: none"> • Apply for prescriptive authority • Supply proof of collaborative agreement • Review of at least 5% of charts by physician in which controlled substances were prescribed
Iowa	<ul style="list-style-type: none"> • Registration with Iowa Board of Pharmacy Examiners
Kansas	<ul style="list-style-type: none"> • Prescription to include the name, address, and phone number of collaborating physician
Kentucky	<ul style="list-style-type: none"> • Registered as APRN for 1 year with Kentucky Board of Nursing or with another state • Enter into a written “Collaborative Agreement for the Advanced Registered Nurse Practitioner’s Prescriptive Authority for Controlled Substances” (CAPA-CS) with a physician and notify the Board of Nursing of the existence of the CAPA-CS and the name of the collaborating physician • Send a copy of the CAPA-CS to the DEA with the application for prescriptive authority • Schedule II – limited to 72 hour supply without refills • Schedule III – limited to 30 day supply without refills • Schedule IV-V – refills not to exceed a 6 month supply • Psychostimulants may only be prescribed by psych/mental health NPs working in certain approved healthcare facilities and only for a 30 day supply • Controlled Substances Formulary Development Committee places limitations on specific controlled substances with the greatest potential for abuse or diversion
Louisiana	<ul style="list-style-type: none"> • Joint Administrative Committee approves the schedules of drugs that may be prescribed-Medical and Nursing Boards • Prescribing controlled substances for chronic intractable pain, obesity, or for oneself or family is prohibited • 500 hours of patient care within past 6 months of applying for prescriptive authority • Must apply for prescriptive authority • Name, address, and phone number of collaborating physician on prescription
Maine	<ul style="list-style-type: none"> • Joint Practice Council on Advanced Practice Registered Nursing
Maryland	<ul style="list-style-type: none"> • Regulation on prescribing adopted by state Board of Nursing and state Board of Physicians • CNM – prescribe based on formulary mutually developed by BON, BOM and BOP
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Massachusetts	<ul style="list-style-type: none"> • Schedule II – no refills • Prescriptions electronically transmitted or written • State registration for prescriber • Name of supervising physician on prescription
Michigan	<ul style="list-style-type: none"> • III-V – limited to 5 refills in 6 months • Physician may delegate authority to prescribe Schedule II if nurse and physician practice within a health facility, free standing outpatient surgical outpatient hospital or hospice and the patient is in the facility • May prescribe Schedule II at discharge of patient – limited to 7 day supply
Minnesota	<ul style="list-style-type: none"> • None listed
Mississippi	<ul style="list-style-type: none"> • Use caution for weight loss • Stimulants – may prescribe for two 30 day supplies in any 12 month period. Up to 5 refills • Must apply for prescriptive authority for controlled substances • Maintenance of patient record required – Board may audit • Prohibited from pre-signing a prescription pad • Only one controlled substance per prescription blank • E-mailing or faxing prescriptions for controlled substances prohibited
Missouri	<ul style="list-style-type: none"> • Not authorized to prescribe controlled substances
Montana	<ul style="list-style-type: none"> • 400 hours experience with writing prescriptions and 250 hours didactic experience prior to licensure • Must apply for prescriptive authority • Prescribing controlled substances for self or family prohibited • Schedule II – not exceed FDA quantities • Schedule III-V – not exceed 3 months • Refills must be in writing • Quality Assurance – 15 charts or 5% of charts audited by APRN or physician in same specialty
Nebraska	<ul style="list-style-type: none"> • 2,080 hours practice within previous 5 years immediately preceding renewal application
Nevada	<ul style="list-style-type: none"> • Must apply to issue prescriptions for controlled substances • Controlled substances prescribed must be listed in the APRNs protocols approved by the collaborating physician • This list must be reviewed annually by physician and APRN • Must pass examination on Nevada law related to prescriptions
New Hampshire	<ul style="list-style-type: none"> • Apply for certification to prescribe controlled substances • Minimum of 480 hours of clinical practice as an undergraduate
New Jersey	<ul style="list-style-type: none"> • Identifying information on prescription pad and DEA number and licensure of collaborating physician • May prescribe controlled substances to reissue and order of a collaborating physician or to adjust the dosage of a controlled substances order of a collaborating physician or for a terminal illness • Must place on prescription whether –reissue, dosage change, or information related to terminally ill
New Mexico	<ul style="list-style-type: none"> • Must apply for prescriptive authority for controlled substances • 400 hours work experience prescribing controlled substances with a preceptor (NP, CNS, MD) within 2 years of application • Register with Board of Pharmacy
New York	<ul style="list-style-type: none"> • Schedule II – limited to 72 hour supply and no refills • Must be certified for authority to prescribe • III-V – refills limited to 6 months
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North Carolina	<ul style="list-style-type: none"> • Schedule II-III – limited to 30 days and no refills • Schedule IV – limited to 5 refills in 6 months • Schedule V may be refilled for 1 year • Prescription must have name of supervising physician • APRN and supervising physician must have written plan for review of care
North Dakota	<ul style="list-style-type: none"> • Must apply for prescriptive authority • Schedule II may be dispensed in emergency situations based upon oral prescription promptly replaced in written form • Schedule III-V – limited to 5 refills in 6 months • Must collaborate with physician regarding prescriptive authority at least every 2 months
Ohio	<ul style="list-style-type: none"> • Must be certified to prescribe • Must complete 1,500 hours extensive internship experience with direct supervision for 500 of the hours • Anabolic steroids prohibited
Oklahoma	<ul style="list-style-type: none"> • Schedule III-V – limited to 7 day supply • Name of supervising physician on prescription • Schedule III-IV – limited to 5 refills in 6 months • Separate registration with BNDD • CRNA controlled substances only during perioperative or peribstretical period
Oregon	<ul style="list-style-type: none"> • Schedule II – no refills/written prescription required • Must apply for prescriptive authority • Application to dispense to board • Schedule III-V – limited to 5 refills in 6 months • Prescriptions for weight reduction, methadone for narcotic addiction, and marijuana are prohibited • Prescribing controlled substances for chronic pain requires history and assessment to rule out substance abuse • Intractable pain requires APRN to document diagnosis of pain by practitioner specializing in treatment of the body area and consultation and review of pain management plan with a pain management expert • Only one controlled substance per prescription • Prescribing controlled substances for self is prohibited – may prescribe for family or friends if client/provider relationship is established
Pennsylvania	<ul style="list-style-type: none"> • Schedule II – limited to 72 hours and collaborating physician must be notified within 24 hours • Schedule III-IV – 30 day supply without refills unless authorized by physician • The collaborating physician must be identified on the prescription
Rhode Island	<ul style="list-style-type: none"> • Psychiatric and mental health CNSs cannot prescribe controlled substances in independent practice
South Carolina	<ul style="list-style-type: none"> • Must register with Department of Health and Environmental Control • Prescription must include collaborating physician’s name, address, and phone number
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South Dakota	<ul style="list-style-type: none"> • Register as dispenser
Tennessee	<ul style="list-style-type: none"> • Preprinted pad with name of APRN and supervising physician • Must apply for certification to prescribe
Texas	<ul style="list-style-type: none"> • 400 hours in current practice within last 2 years prior to prescribing • “Intended use of drugs”, name, address, and phone number of APRN printed or stamped on prescription • Controlled substances prescriptions must have DEA number of delegating physician • Must consult with physician prior to refill • No controlled substance prescription for a child less than 2 years without consulting with a physician
Utah	<ul style="list-style-type: none"> • None listed in laws
Vermont	<ul style="list-style-type: none"> • Triplicate prescription for controlled substances
Virginia	<ul style="list-style-type: none"> • Must disclose that the nurse is an NP and provide the name, phone number, and address of supervising physician • State certification with the Board of Pharmacy • 1,000 hours of practice prior to initial approval for prescriptive authority • Monthly random reviewing of charts on which APRN has entered a prescription
Washington	<ul style="list-style-type: none"> • Must submit an application for approval to prescribe • Dispensing is limited to a 72 hour supply of II-IV but does not apply to prescribing • May not be filled or refilled after 6 months after issue • May not be refilled more than 5 times
West Virginia	<ul style="list-style-type: none"> • Schedule IV-V – limited to 30 days with no more than 5 refills; prescription expires in 6 months • State issued prescription identification number • Must apply to prescribe • Schedule III limited to 72 hour supply • Prohibited from prescribing Schedule I & II , general anesthetics, radiopharmaceuticals, antineoplastics, anticoagulants, parenteral preparations except insulin and epinephrine • Prescriptions for phenodiazepines and benzodiazepines limited to 72 hours one time within 30 days and must record evaluation of the effectiveness of controlled substances prescribed • Prescribing controlled substances for self or immediate family prohibited
Wisconsin	<ul style="list-style-type: none"> • Prescription certification number issued by Board of Nursing • Prohibited from prescribing any amphetamine, sympathomimetic amine drug in Schedule II • Schedule II only for treatment of cancer-related pain, narcolepsy, hyperkinesia, drug-induced brain dysfunction, epilepsy, and depression • Anabolic steroids prescription prohibited • Prescription of controlled substances to self and family prohibited
Wyoming	<ul style="list-style-type: none"> • Must apply for prescriptive authority • 400 hours practice within last 2 years prior to application

(Baker et al., 2004; Kentucky Legislative Research Commission, 2006; Phillips, 2006)

Controlled Substances Prescriptive Privileges
For Advanced Practice Registered
Nurses

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