WEST VIRGINIA LEGISLATURE

JOINT COMMITTEE ON HEALTH

2017- 2018 Interims

MEMBERSHIP

SENATE MEMBERS

Senator Tom Takubo, Chair
Senator Mike Maroney, Vice Chair
Senator Mike Azinger
Senator Charles H. Clements
Senator Robert L. Karnes
Senator Patricia Rucker
Senator Charles S. Trump IV
Senator Ryan Weld
Senator Corey Palumbo
Senator Robert H. Plymale
Senator Roman W. Prezioso, Jr.
Senator Ron Stollings
Senator John R. Under II

HOUSE MEMBERS

Delegate Joe Ellington, Chair
Delegate Amy Summers, Vice Chair
Delegate Lynne Arvon
Delegate Martin "Rick" Atkinson, III
Delegate Jim Butler
Delegate Roy Cooper
Delegate Vernon Criss
Delegate Mark Dean
Delegate Jordan C. Hill
Delegate Ray Hollen
Delegate Eric L. Householder
Delegate Ben Queen
Delegate Matthew Rorhbach
Delegate Ruth Rowan
Delegate Kelli Sobonya
Delegate Brad White
Delegate Mick Bates
Delegate Jeff Campbell
Delegate Barbara Evans Fleischauer
Delegate Shawn Fluharty
Delegate Richard J. Iaqunita
Delegate Linda Longstreth
Delegate Shirley Love
Delegate Mike Pushkin
Delegate Ralph Rodighiero

Final Report of

JOINT COMMITTEE ON HEALTH

The Joint Committee on Health was appointed by the Joint Committee on Government and Finance, following the 2017 Regular Session of the 83rd Legislature. The Committee was assigned the following topics for study during the course of the 2017-2018 Interim Period:

Medical Malpractice Peer Review Panel

Recodification and reorganization of Chapter 16 on Public Health

Indigent Overdoses

The Committee **REPORTS** as follows:

ASSIGNED STUDY TOPICS

Medical Malpractice Peer Review Panel

The Committee heard from parties on both sides of this issue at their meeting in August. Draft legislation from the 2017 Regular Session of the Legislature was presented by Committee Counsel, Jeff Johnson. The draft bill would create a medical review panel. This panel would review available evidence prior to a plaintiff filing a civil action. They would offer findings as to whether the claim supports a conclusion that the standard of care was breached and whether this contributed to the adverse outcome. The opinion of the panel is not determinative as to whether the plaintiff may proceed. If, however,

the plaintiff receives an adverse expert opinion from the panel and opts to proceed and the action is either dismissed or results in a verdict adverse to the plaintiff, he or she must reimburse the health care provider all costs and fees associated with defending the litigation.

Following the presentation of the bill, the respective licensing boards presented their position on the bill and offered their thoughts on the concept. Mark A. Spangler, Executive Director of the Board of Medicine and Diane K. Shepard, Executive Director, Board of Osteopathic Medicine. It was the position of the licensing board that this concept could be cumbersome for the boards, costly to administer and had great potential for conflicting decisions between the complaint process and any civil proceeding.

The Committee next heard from Ben Salango, Attorney at Law. Mr. Salango expressed concerns about the operation of the process and felt that it would be difficult to find persons willing to serve as members of the panel.

Finally, the Committee heard from both the State Medical Association and The Osteopathic Association. Both of these groups relayed similar concerns regarding the potential legislation and expressed their groups opposition to proceeding with such a bill.

Following this presentation, the Committee **RECOMMENDS** that no action be taken on this legislation at the current time. Individual members may have some interest in some form of the legislation but the Committee will not be recommending interim legislation.

Recodification and reorganization of Chapter 16 on Public Health

At the November meeting of the Committee, Committee Counsel Jeff Johnson and Legislative Analyst Chris DeWitte presented on a three-year project to rework all of Chapter 16 on Public Health. The focus of this project is to better organize the chapter, standardize language, formatting and consistency and to provide room for future growth within the chapter.

The presentation stressed to the Committee this was a recodification and not a rewriting of the chapter. That being said, there are certain aspects of the chapter which are so outdated, archaic and not reflective of current medical practice that they must be

rewritten. The Department of Health and Human Resources, as well as other interested parties and advocates, will be consulted as this process proceeds to gain their input on any rewritten provisions.

The focus of the project is to create a standard hierarchy of the format and layout of articles and sections within the chapter. It is the goal to make Chapter 16 the model for future recodifications of various chapters within the code.

The project is envisioned to take at least three years. It is currently within its second year.

At this time, the Committee **RECOMMENDS** no action be taken on this topic. It further **RECOMMENDS** that it continue to monitor the progress of this project with an aim to potential legislation during the 2019 Regular Session of the Legislature.

Indigent Overdoses

During the month of December, the Committee focused on the issue of indigent overdoses and the opioid crisis in this state. Dr. Brad Henry, President of the West Virginia State Medical Association appeared before the Committee. Dr. Harvey attempted to put the epidemic in context by offering a statistical overview of the problem. This included, a comparison of the overdoes deaths for the past four years and a discussion of the demographics of the issue. He also provided a number of comparisons of how West Virginia stacked up with our sister states.

At the conclusion of his discussion he offered several thoughts on potential legislation. These included:

1. Limiting to seven (7) the number of days for which an opioid could be prescribed;

2. Move the potentially addictive drug Gabapentin to a Schedule IV drug on the list of Controlled Substances;

3. Required reporting of overdose treatments to the Controlled Substances Monitoring Database;

4. Limiting prescribing for chronic pain to a thirty day period;

5. Allowing providers to share substance abuse problems with prescribers, and;

6. Increased access to the Controlled Substance Monitoring Database.

The Committee next heard from Dr. Raul Gupta, Commissioner of the Bureau for Public Health. He provided the Committee with an update on disbursement of funds pursuant to the passage of House Bill 2428 last session. That bill established the Ryan Brown Addiction Prevention and Recover Fund. These funds were to be distributed to facilities residential for treatment beds within certain parameters. He outlined the process of how the Bureau got to the point where they were able to award funding to worthy programs. Dr. Gupta also provided the Committee with a list of the nine (9) programs which had been awarded funding.

Cabinet Secretary Bill Crouch also provided the Committee with an update on the creation of the Office of Drug Control Policy. This office was created with the passage of House Bill 2620 last session of the Legislature. He indicated that the office was proceeding to develop a comprehensive strategic plan on moving forward within the state to address the opioid problem. This included the filing of Emergency and Legislative Rules dealing with data collection, integrating the Governor's Advisory Council on Substance Abuse and the hiring of Jim Johnson as Director. The Secretary also gave the Committee some insight into the approach the office would take, the objectives of the office and provided the Committee with some statistics on the burden this crisis is putting upon our state and the nation.

Finally, the Committee heard from Mike Goff, Interim Executive Director of the West Virginia Board of Pharmacy. Mr. Goff provided an update on improvements to the Controlled Substances Monitoring Database. These included adding morphine equivalent dose capabilities, adding gabapentin as a drug of concern, allowing hospital and medical school administrators to have supervisor capabilities for prescriber employees, allowing prescribers to monitor mid-level practitioners using the database and, as of January 2018, creating prescriber report cards regarding prescribing habits and allowing reports of non-fatal overdose information. Mr. Goff also recommend potential legislation. This included:

1. Adding all Schedule V drugs to the data collected by the Controlled Substances Monitoring Database, and;

2. Mandating that prescribers run a database report on each patient prior to prescribing pain medication – with some exceptions.

Based upon these presentation Committee **RECOMMENDS** a bill entitled the Opioid Reduction Act for passage during the 2018 Regular Session of the Legislature. This bill would provide that:

1. Patients be permitted to sign a form indicating they do not wish to be prescribed opioids;

2. Notifying the patient of the quantity and risks of taking an opioid;

3. Limitations on opioid prescriptions to three days – with limitations on refilling the prescription;

4. Required referral to a pain clinic upon a third refill of an opioid for chronic pain;

5. Required less invasive approaches such as physical therapy, chiropractic services, occupational therapy, acupuncture and massage therapy prior to prescribing an opioid – also required insurance coverage of these procedures;

6. Giving search capability to licensing boards to allow them to access the Controlled Substances Monitoring Database to determine unusual prescribing practices of licensees;

7. Requiring the Board of Pharmacy to share a quarterly report on unusual prescribing practices with various licensing boards;

8. Adding Gabapentin as a Schedule V drug; and

9. Adding Fentanyl isotopes and derivatives as a Schedule I drug.

MISCELLANEOUS

At the September meeting of the Committee. The Committee heard from Raul Gupta, Commissioner of the Bureau for Public Health on the newly passed Medical Cannabis Act. The Commissioner provided an overview of the provisions of the act which allow

the use of medical cannabis to treat specifically delineated medical conditions. This overview included the provisions of the law related to growers, distributors and dispensaries. It provided the Committee with some idea about monitoring and the exclusions that are provided in our law. He discussed the advisory committee and their functions and discussed the ongoing meetings of this group. He also discussed the creation of the Office of Medical Cannabis within the Bureau for Public Health. This office will have the function of overseeing this program, including all rulemaking authority granted in the legislation.

The Committee also received an update from Cindy Beane, Commissioner of the Bureau for Medical Services on the operation and current status of the Medicaid IDD Waiver program.

The Committee did not meet during the month of October due to conflicts with a Special Session called by Governor Justice.

Copies of all proposed legislation for passage during the 2018 Regular Session of the Legislature are attached to this report.

Respectfully submitted:

Senator Tom Takubo
Co-Chair

Delegate Joe Ellington
Co-Chair

WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Introduced

House Bill Number

BY DELEGATE

[Enter References]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §16-52-1, §16-52-2, §16-52-3, §16-52-4, §16-52-5, §16-52-6,§16-52-7, §16-52-8 and §16-52-9; to amend and reenact §30-3-14 of said code; to amend and reenact §30-3A-1, §30-3A-2, §30-3A-3 and §30-3A-4 of said code; to amend and reenact §30-4-19 of said code; to amend and reenact §30-5-6 of said code; to amend and reenact §30-7-11 of said code; to amend and reenact §30-14-12a of said code; to amend and reenact §30-36-2 of said code; to amend and reenact §60A-2-204, §60A-2-206 and §60A-2-210 of said code; and to amend and reenact §60A-9-4, §60A-9-5 and §60A-9-5a of said code, all relating to reducing the use of certain prescription drugs; limiting the amount of opioid prescription; providing reports to licensing boards regarding abnormal prescribing practices; changing the standard of evidence required to discipline a physician; requiring insurance coverage to treat chronic pain; requiring the Board of Pharmacy to report quarterly to various licensing boards; exempting the Board of Pharmacy to certain purchasing requirement; permitting the investigation and discipline for abnormal prescribing and dispensing of prescription drugs, updating the schedule of controlled substances; and allowing licensing boards who regulate prescribers to investigate abnormal prescribing and dispensing of prescription drugs based upon information.

Be it enacted by the Legislature of West Virginia:

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 52. OPIOID REDUCTION ACT.

§16-52-1. Definitions.

(a) As used in this section:

"Acute pain" means a time limited pain caused by a specific disease or injury.

"Chronic pain" means a noncancer non-end of life pain lasting more than three months or longer than the duration of normal tissue healing.

"Health care practitioner" means

A physician licensed pursuant to the provisions of §30-3-1 and §30-14-1 *et seq.*;

A physician assistant with prescriptive authority as set forth in §30-3E-1 *et seq.*;

An advanced practice registered nurse with prescriptive authority as set forth in §30-7-15a;

A dentist licensed pursuant to the provisions of §30-4-1 *et seq.*; and

An optometrist licensed pursuant to the provisions of §30-8-1 *et seq.*

(4) "Office" means the office of Drug Control Policy.

§16-52-2. Voluntary Non-Opiate Advanced Directive Form.

The office shall establish a voluntary non-opiate advanced directive form. The form shall be available on the office's web site. The form shall indicate to a health care practitioner that an individual may not be administered or offered a prescription or medication order for an opiate. The form may be submitted to the Board of Pharmacy and the board shall make a notation of the directive on the controlled substance monitoring database. The indication may also be added to the individual's electronic health record. An individual may revoke the voluntary non-opiate advanced directive form for any reason and may do so by written or oral means.

§16-52-3. Opioid Prescription Notifications.

Prior to issuing a prescription for an opioid, a practitioner shall:

(1) Consult with the patient regarding the quantity of the opioid and a patient's option to fill the prescription in a lesser quantity; and

(2) Inform the patient of the risks associated with the opioid prescribed.

§16-52-4. Opioid Prescription limitations.

(a) When issuing a prescription for an opiate to an adult patient seeking treatment in an emergency room setting for outpatient use, a health care practitioner may not issue a prescription for more than a three-day supply.

(b) A health care practitioner may not issue an opiate prescription to a minor for more than

a three-day supply and shall discuss with the parent or guardian of the minor the risks associated with opiate use and the reasons why the prescription is necessary.

(c) A dentist or an optometrist may not issue an opiate prescription for more than a three-day supply at any time

(d) A physician may not issue an opiate prescription for more than a seven-day supply. The prescription shall be for the lowest effective dose.

(e) Prior to issuing an initial opiate prescription, a practitioner shall:

(1) Take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history;

(2) Conduct, as appropriate, and document the results of a physical examination;

(3) Develop a treatment plan, with particular attention focused on determining the cause of the patient's pain; and

(4) Access relevant prescription monitoring information under the controlled substances monitoring database.

§16-52-5. Subsequent prescriptions; limitations.

(a) No less than six days after issuing the initial prescription as set forth in section four, the practitioner, after consultation with the patient, the practitioner may issue a subsequent prescription for an opiate to the patient if:

(1) The subsequent prescription would not be deemed an initial prescription under this section;

(2) The practitioner determines the prescription is necessary and appropriate to the patient's treatment needs and documents the rationale for the issuance of the subsequent prescription; and

(3) The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction, or diversion and documents that determination.

(b) Prior to issuing the subsequent prescription of the course of treatment, a practitioner shall discuss with the patient, or the patient's parent or guardian if the patient is under 18 years of age, the risks associated with the drug being prescribed. This discussion shall include:

(1) The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

(2) The reasons why the prescription is necessary;

(3) Alternative treatments that may be available; and

(4) Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

(c) The discussion as set forth in subdivision (b) of this section shall be included in a notation in the patient's medical record.

§16-52-6. Ongoing treatment; referral to chronic pain clinic.

(a) At the time of the issuance of the third prescription for a prescription opiate, the practitioner shall refer to a chronic pain clinic.

(b) If the patient remains a patient of the practitioner and the practitioner continues to prescribe an opiate for pain, the practitioner shall:

(1) Review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain, and the patient's progress toward treatment objectives and document the results of that review;

(2) Assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with physical and psychological dependence and document the results of that assessment;

(3) Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken; and

(4) Review the Controlled Substance Monitoring Database as required by §60A-9-1 *et seq.*

§16-52-7. Exceptions.

(a) This article does not apply to a prescription for a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long-term care facility, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

(b) This article does not apply to an existing practitioner patient relationship established before January 1, 2018.

§16-52-8. Treatment of Chronic Pain.

(a) When patients seek treatment for any of the myriad conditions that cause chronic pain, a health care practitioner shall prescribe or recommend physical therapy, occupational therapy, acupuncture, massage therapy, and chiropractic care before starting a patient on an opioid.

(b) An insurance provider, Medicaid and PEIA shall provide coverage for twelve visits over 120 days of physical therapy, occupational therapy, and chiropractic care when ordered by a health care practitioner to treat conditions that cause chronic pain.

§16-52-9. Discipline.

(d) A violation of this article is grounds for disciplinary action by the board that regulates the health care practitioner who commits the violation.

CHAPTER 30. PROFESSIONS AND OCCUPATIONS.

ARTICLE 3. WEST VIRGINIA MEDICAL PRACTICE ACT.

§30-3-14. Professional discipline of physicians and podiatrists;

(a) The board may independently initiate disciplinary proceedings as well as initiate disciplinary proceedings based on information received from medical peer review committees, physicians, podiatrists, hospital administrators, professional societies, the Board of Pharmacy as required by *et seq.* and others.

The board may initiate investigations as to professional incompetence or other reasons for which a licensed physician or podiatrist may be adjudged unqualified based upon criminal convictions; complaints by citizens, pharmacists, physicians, podiatrists, peer review committees, hospital administrators, professional societies or others; or unfavorable outcomes arising out of medical professional liability. The board shall initiate an investigation if it receives notice that three or more judgments, or any combination of judgments and settlements resulting in five or more unfavorable outcomes arising from medical professional liability have been rendered or made against the physician or podiatrist within a five-year period. The board may not consider any judgments or settlements as conclusive evidence of professional incompetence or conclusive lack of qualification to practice.

(b) Upon request of the board, any medical peer review committee in this state shall report any information that may relate to the practice or performance of any physician or podiatrist known to that medical peer review committee. Copies of the requests for information from a medical peer review committee may be provided to the subject physician or podiatrist if, in the discretion of the board, the provision of such copies will not jeopardize the board's investigation. In the event that copies are provided, the subject physician or podiatrist is allowed fifteen days to comment on the requested information and such comments must be considered by the board.

The chief executive officer of every hospital shall, within sixty days after the completion of the hospital's formal disciplinary procedure and also within sixty days after the commencement of and again after the conclusion of any resulting legal action, report in writing to the board the name of any member of the medical staff or any other physician or podiatrist practicing in the hospital whose hospital privileges have been revoked, restricted, reduced or terminated for any cause, including resignation, together with all pertinent information relating to such action. The chief executive officer shall also report any other formal disciplinary action taken against any physician or podiatrist by the hospital upon the recommendation of its medical staff relating to professional ethics, medical incompetence, medical professional liability, moral turpitude or drug or alcohol abuse. Temporary suspension for failure to maintain records on a timely basis or failure to attend staff or section meetings need not be reported. Voluntary cessation of hospital privileges for reasons unrelated to professional competence or ethics need not be reported.

Any managed care organization operating in this state which provides a formal peer review process shall report in writing to the board, within sixty days after the completion of any formal peer review process and also within sixty days after the commencement of and again after the conclusion of any resulting legal action, the name of any physician or podiatrist whose credentialing has been revoked or not renewed by the managed care organization. The managed care organization shall also report in writing to the board any other disciplinary action taken against a physician or podiatrist relating to professional ethics, professional liability, moral turpitude or drug or alcohol abuse within sixty days after completion of a formal peer review process which results in the action taken by the managed care organization. For purposes of this subsection, "managed care organization" means a plan that establishes, operates or maintains a network of health care providers who have entered into agreements with and been credentialed by the plan to provide health care services to enrollees or insureds to whom the plan has the ultimate obligation to arrange for the provision of or payment for health care services through organizational arrangements for ongoing quality assurance, utilization review programs or dispute

resolutions.

Any professional society in this state comprised primarily of physicians or podiatrists which takes formal disciplinary action against a member relating to professional ethics, professional incompetence, medical professional liability, moral turpitude or drug or alcohol abuse shall report in writing to the board within sixty days of a final decision the name of the member, together with all pertinent information relating to the action.

Every person, partnership, corporation, association, insurance company, professional society or other organization providing professional liability insurance to a physician or podiatrist in this state, including the state Board of Risk and Insurance Management, shall submit to the board the following information within thirty days from any judgment or settlement of a civil or medical professional liability action excepting product liability actions: The name of the insured; the date of any judgment or settlement; whether any appeal has been taken on the judgment and, if so, by which party; the amount of any settlement or judgment against the insured; and other information required by the board.

Within thirty days from the entry of an order by a court in a medical professional liability action or other civil action in which a physician or podiatrist licensed by the board is determined to have rendered health care services below the applicable standard of care, the clerk of the court in which the order was entered shall forward a certified copy of the order to the board.

Within thirty days after a person known to be a physician or podiatrist licensed or otherwise lawfully practicing medicine and surgery or podiatry in this state or applying to be licensed is convicted of a felony under the laws of this state or of any crime under the laws of this state involving alcohol or drugs in any way, including any controlled substance under state or federal law, the clerk of the court of record in which the conviction was entered shall forward to the board a certified true and correct abstract of record of the convicting court. The abstract shall include the name and address of the physician or podiatrist or applicant, the nature of the offense committed and the final judgment and sentence of the court.

Upon a determination of the board that there is probable cause to believe that any person, partnership, corporation, association, insurance company, professional society or other organization has failed or refused to make a report required by this subsection, the board shall provide written notice to the alleged violator stating the nature of the alleged violation and the time and place at which the alleged violator shall appear to show good cause why a civil penalty should not be imposed. The hearing shall be conducted in accordance with §29A-5-1 et seq. After reviewing the record of the hearing, if the board determines that a violation of this subsection has occurred, the board shall assess a civil penalty of not less than $1,000 nor more than $10,000 against the violator. The board shall notify any person so assessed of the assessment in writing and the notice shall specify the reasons for the assessment. If the violator fails to pay the amount of the assessment to the board within thirty days, the Attorney General may institute a civil action in the circuit court of Kanawha County to recover the amount of the assessment. In any civil action, the court's review of the board's action shall be conducted in accordance with §29A-5-4. ~~Notwithstanding any other provision of this article to the contrary, when there are conflicting views by recognized experts as to whether any alleged conduct breaches an applicable standard of care, the evidence must be clear and convincing before the board may find that the physician or podiatrist has demonstrated a lack of professional competence to practice with a reasonable degree of skill and safety for patients.~~

Any person may report to the board relevant facts about the conduct of any physician or podiatrist in this state which in the opinion of that person amounts to medical professional liability or professional incompetence.

The board shall provide forms for filing reports pursuant to this section. Reports submitted in other forms shall be accepted by the board.

The filing of a report with the board pursuant to any provision of this article, any investigation by the board or any disposition of a case by the board does not preclude any action by a hospital, other health care facility or professional society comprised primarily of physicians

or podiatrists to suspend, restrict or revoke the privileges or membership of the physician or podiatrist.

(c) The board may deny an application for license or other authorization to practice medicine and surgery or podiatry in this state and may discipline a physician or podiatrist licensed or otherwise lawfully practicing in this state who, after a hearing, has been adjudged by the board as unqualified due to any of the following reasons:

(1) Attempting to obtain, obtaining, renewing or attempting to renew a license to practice medicine and surgery or podiatry by bribery, fraudulent misrepresentation or through known error of the board;

(2) Being found guilty of a crime in any jurisdiction, which offense is a felony, involves moral turpitude or directly relates to the practice of medicine. Any plea of nolo contendere is a conviction for the purposes of this subdivision;

(3) False or deceptive advertising;

(4) Aiding, assisting, procuring or advising any unauthorized person to practice medicine and surgery or podiatry contrary to law;

(5) Making or filing a report that the person knows to be false; intentionally or negligently failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record required by state or federal law; or inducing another person to do any of the foregoing. The reports and records covered in this subdivision mean only those that are signed in the capacity as a licensed physician or podiatrist;

(6) Requesting, receiving or paying directly or indirectly a payment, rebate, refund, commission, credit or other form of profit or valuable consideration for the referral of patients to any person or entity in connection with providing medical or other health care services or clinical laboratory services, supplies of any kind, drugs, medication or any other medical goods, services or devices used in connection with medical or other health care services;

(7) Unprofessional conduct by any physician or podiatrist in referring a patient to any

clinical laboratory or pharmacy in which the physician or podiatrist has a proprietary interest unless the physician or podiatrist discloses in writing such interest to the patient. The written disclosure shall indicate that the patient may choose any clinical laboratory for purposes of having any laboratory work or assignment performed or any pharmacy for purposes of purchasing any prescribed drug or any other medical goods or devices used in connection with medical or other health care services;

As used in this subdivision, "proprietary interest" does not include an ownership interest in a building in which space is leased to a clinical laboratory or pharmacy at the prevailing rate under a lease arrangement that is not conditional upon the income or gross receipts of the clinical laboratory or pharmacy;

(8) Exercising influence within a patient-physician relationship for the purpose of engaging a patient in sexual activity;

(9) Making a deceptive, untrue or fraudulent representation in the practice of medicine and surgery or podiatry;

(10) Soliciting patients, either personally or by an agent, through the use of fraud, intimidation or undue influence;

(11) Failing to keep written records justifying the course of treatment of a patient, including, but not limited to, patient histories, examination and test results and treatment rendered, if any;

(12) Exercising influence on a patient in such a way as to exploit the patient for financial gain of the physician or podiatrist or of a third party. Any influence includes, but is not limited to, the promotion or sale of services, goods, appliances or drugs;

(13) Prescribing, dispensing, administering, mixing or otherwise preparing a prescription drug, including any controlled substance under state or federal law, other than in good faith and in a therapeutic manner in accordance with accepted medical standards and in the course of the physician's or podiatrist's professional practice. A physician who discharges his or her professional obligation to relieve the pain and suffering and promote the dignity and autonomy of

dying patients in his or her care and, in so doing, exceeds the average dosage of a pain relieving controlled substance, as defined in Schedules II and III of the Uniform Controlled Substance Act, does not violate this article;

(14) Performing any procedure or prescribing any therapy that, by the accepted standards of medical practice in the community, would constitute experimentation on human subjects without first obtaining full, informed and written consent;

(15) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities that the person knows or has reason to know he or she is not competent to perform;

(16) Delegating professional responsibilities to a person when the physician or podiatrist delegating the responsibilities knows or has reason to know that the person is not qualified by training, experience or licensure to perform them;

(17) Violating any provision of this article or a rule or order of the board or failing to comply with a subpoena or subpoena duces tecum issued by the board;

(18) Conspiring with any other person to commit an act or committing an act that would tend to coerce, intimidate or preclude another physician or podiatrist from lawfully advertising his or her services;

(19) Gross negligence in the use and control of prescription forms;

(20) Professional incompetence;

(21) The inability to practice medicine and surgery or podiatry with reasonable skill and safety due to physical or mental impairment, including deterioration through the aging process, loss of motor skill or abuse of drugs or alcohol. A physician or podiatrist adversely affected under this subdivision shall be afforded an opportunity at reasonable intervals to demonstrate that he or she may resume the competent practice of medicine and surgery or podiatry with reasonable skill and safety to patients. In any proceeding under this subdivision, neither the record of proceedings nor any orders entered by the board shall be used against the physician or podiatrist in any other

proceeding; or

(22) Knowingly failing to report to the board any act of gross misconduct committed by another licensee of the board.

(d) The board shall deny any application for a license or other authorization to practice medicine and surgery or podiatry in this state to any applicant who, and shall revoke the license of any physician or podiatrist licensed or otherwise lawfully practicing within this state who, is found guilty by any court of competent jurisdiction of any felony involving prescribing, selling, administering, dispensing, mixing or otherwise preparing any prescription drug, including any controlled substance under state or federal law, for other than generally accepted therapeutic purposes. Presentation to the board of a certified copy of the guilty verdict or plea rendered in the court is sufficient proof thereof for the purposes of this article. A plea of nolo contendere has the same effect as a verdict or plea of guilt. Upon application of a physician that has had his or her license revoked because of a drug related felony conviction, upon completion of any sentence of confinement, parole, probation or other court-ordered supervision and full satisfaction of any fines, judgments or other fees imposed by the sentencing court, the board may issue the applicant a new license upon a finding that the physician is, except for the underlying conviction, otherwise qualified to practice medicine: *Provided,* That the board may place whatever terms, conditions or limitations it deems appropriate upon a physician licensed pursuant to this subsection.

(e) The board may refer any cases coming to its attention to an appropriate committee of an appropriate professional organization for investigation and report. Except for complaints related to obtaining initial licensure to practice medicine and surgery or podiatry in this state by bribery or fraudulent misrepresentation, any complaint filed more than two years after the complainant knew, or in the exercise of reasonable diligence should have known, of the existence of grounds for the complaint shall be dismissed: *Provided,* That in cases of conduct alleged to be part of a pattern of similar misconduct or professional incapacity that, if continued, would pose risks of a serious or substantial nature to the physician's or podiatrist's current patients, the

investigating body may conduct a limited investigation related to the physician's or podiatrist's current capacity and qualification to practice and may recommend conditions, restrictions or limitations on the physician's or podiatrist's license to practice that it considers necessary for the protection of the public. Any report shall contain recommendations for any necessary disciplinary measures and shall be filed with the board within ninety days of any referral. The recommendations shall be considered by the board and the case may be further investigated by the board. The board after full investigation shall take whatever action it considers appropriate, as provided in this section.

(f) The investigating body, as provided in subsection (e) of this section, may request and the board under any circumstances may require a physician or podiatrist or person applying for licensure or other authorization to practice medicine and surgery or podiatry in this state to submit to a physical or mental examination by a physician or physicians approved by the board. A physician or podiatrist submitting to an examination has the right, at his or her expense, to designate another physician to be present at the examination and make an independent report to the investigating body or the board. The expense of the examination shall be paid by the board. Any individual who applies for or accepts the privilege of practicing medicine and surgery or podiatry in this state is considered to have given his or her consent to submit to all examinations when requested to do so in writing by the board and to have waived all objections to the admissibility of the testimony or examination report of any examining physician on the ground that the testimony or report is privileged communication. If a person fails or refuses to submit to an examination under circumstances which the board finds are not beyond his or her control, failure or refusal is prima facie evidence of his or her inability to practice medicine and surgery or podiatry competently and in compliance with the standards of acceptable and prevailing medical practice.

(g) In addition to any other investigators it employs, the board may appoint one or more licensed physicians to act for it in investigating the conduct or competence of a physician.

(h) In every disciplinary or licensure denial action, the board shall furnish the physician or

podiatrist or applicant with written notice setting out with particularity the reasons for its action. Disciplinary and licensure denial hearings shall be conducted in accordance with §29A-5-1 *et seq.* However, hearings shall be heard upon sworn testimony and the rules of evidence for trial courts of record in this state shall apply to all hearings. A transcript of all hearings under this section shall be made, and the respondent may obtain a copy of the transcript at his or her expense. The physician or podiatrist has the right to defend against any charge by the introduction of evidence, the right to be represented by counsel, the right to present and cross-examine witnesses and the right to have subpoenas and subpoenas duces tecum issued on his or her behalf for the attendance of witnesses and the production of documents. The board shall determine by a preponderance of the evidence that a violation of this code or the legislative rules promulgated occurred. The board shall make all its final actions public. The order shall contain the terms of all action taken by the board.

(i) In disciplinary actions in which probable cause has been found by the board, the board shall, within twenty days of the date of service of the written notice of charges or sixty days prior to the date of the scheduled hearing, whichever is sooner, provide the respondent with the complete identity, address and telephone number of any person known to the board with knowledge about the facts of any of the charges; provide a copy of any statements in the possession of or under the control of the board; provide a list of proposed witnesses with addresses and telephone numbers, with a brief summary of his or her anticipated testimony; provide disclosure of any trial expert pursuant to the requirements of Rule 26(b)(4) of the West Virginia Rules of Civil Procedure; provide inspection and copying of the results of any reports of physical and mental examinations or scientific tests or experiments; and provide a list and copy of any proposed exhibit to be used at the hearing: *Provided,* That the board shall not be required to furnish or produce any materials which contain opinion work product information or would be a violation of the attorney-client privilege. Within twenty days of the date of service of the written notice of charges, the board shall disclose any exculpatory evidence with a continuing duty to do

so throughout the disciplinary process. Within thirty days of receipt of the board's mandatory discovery, the respondent shall provide the board with the complete identity, address and telephone number of any person known to the respondent with knowledge about the facts of any of the charges; provide a list of proposed witnesses with addresses and telephone numbers, to be called at hearing, with a brief summary of his or her anticipated testimony; provide disclosure of any trial expert pursuant to the requirements of Rule 26(b)(4) of the West Virginia Rules of Civil Procedure; provide inspection and copying of the results of any reports of physical and mental examinations or scientific tests or experiments; and provide a list and copy of any proposed exhibit to be used at the hearing.

(j) Whenever it finds any person unqualified because of any of the grounds set forth in subsection (c) of this section, the board may enter an order imposing one or more of the following:

(1) Deny his or her application for a license or other authorization to practice medicine and surgery or podiatry;

(2) Administer a public reprimand;

(3) Suspend, limit or restrict his or her license or other authorization to practice medicine and surgery or podiatry for not more than five years, including limiting the practice of that person to, or by the exclusion of, one or more areas of practice, including limitations on practice privileges;

(4) Revoke his or her license or other authorization to practice medicine and surgery or podiatry or to prescribe or dispense controlled substances for any period of time, including for the life of the licensee, that the board may find to be reasonable and necessary according to evidence presented in a hearing before the board or its designee;

(5) Require him or her to submit to care, counseling or treatment designated by the board as a condition for initial or continued licensure or renewal of licensure or other authorization to practice medicine and surgery or podiatry;

(6) Require him or her to participate in a program of education prescribed by the board;

(7) Require him or her to practice under the direction of a physician or podiatrist designated

by the board for a specified period of time; and

(8) Assess a civil fine of not less than $1,000 nor more than $10,000.

(k) Notwithstanding the provisions of §30-1-8, if the board determines the evidence in its possession indicates that a physician's or podiatrist's continuation in practice or unrestricted practice constitutes an immediate danger to the public, the board may take any of the actions provided in subsection (j) of this section on a temporary basis and without a hearing if institution of proceedings for a hearing before the board are initiated simultaneously with the temporary action and begin within fifteen days of the action. The board shall render its decision within five days of the conclusion of a hearing under this subsection.

(l) Any person against whom disciplinary action is taken pursuant to this article has the right to judicial review as provided in §29A-5-1 *et seq.* and §29A-6-1 *et seq.*: *Provided,* That a circuit judge may also remand the matter to the board if it appears from competent evidence presented to it in support of a motion for remand that there is newly discovered evidence of such a character as ought to produce an opposite result at a second hearing on the merits before the board and:

(1) The evidence appears to have been discovered since the board hearing; and

(2) The physician or podiatrist exercised due diligence in asserting his or her evidence and that due diligence would not have secured the newly discovered evidence prior to the appeal.

A person may not practice medicine and surgery or podiatry or deliver health care services in violation of any disciplinary order revoking, suspending or limiting his or her license while any appeal is pending. Within sixty days, the board shall report its final action regarding restriction, limitation, suspension or revocation of the license of a physician or podiatrist, limitation on practice privileges or other disciplinary action against any physician or podiatrist to all appropriate state agencies, appropriate licensed health facilities and hospitals, insurance companies or associations writing medical malpractice insurance in this state, the American Medical Association, the American Podiatry Association, professional societies of physicians or podiatrists

in the state and any entity responsible for the fiscal administration of Medicare and Medicaid.

(m) Any person against whom disciplinary action has been taken under this article shall, at reasonable intervals, be afforded an opportunity to demonstrate that he or she can resume the practice of medicine and surgery or podiatry on a general or limited basis. At the conclusion of a suspension, limitation or restriction period the physician or podiatrist may resume practice if the board has so ordered.

(n) Any entity, organization or person, including the board, any member of the board, its agents or employees and any entity or organization or its members referred to in this article, any insurer, its agents or employees, a medical peer review committee and a hospital governing board, its members or any committee appointed by it acting without malice and without gross negligence in making any report or other information available to the board or a medical peer review committee pursuant to law and any person acting without malice and without gross negligence who assists in the organization, investigation or preparation of any such report or information or assists the board or a hospital governing body or any committee in carrying out any of its duties or functions provided by law is immune from civil or criminal liability, except that the unlawful disclosure of confidential information possessed by the board is a misdemeanor as provided in this article.

(o) A physician or podiatrist may request in writing to the board a limitation on or the surrendering of his or her license to practice medicine and surgery or podiatry or other appropriate sanction as provided in this section. The board may grant the request and, if it considers it appropriate, may waive the commencement or continuation of other proceedings under this section. A physician or podiatrist whose license is limited or surrendered or against whom other action is taken under this subsection may, at reasonable intervals, petition for removal of any restriction or limitation on or for reinstatement of his or her license to practice medicine and surgery or podiatry.

(p) In every case considered by the board under this article regarding discipline or

licensure, whether initiated by the board or upon complaint or information from any person or organization, the board shall make a preliminary determination as to whether probable cause exists to substantiate charges of disqualification due to any reason set forth in subsection (c) of this section. If probable cause is found to exist, all proceedings on the charges shall be open to the public who are entitled to all reports, records and nondeliberative materials introduced at the hearing, including the record of the final action taken: *Provided,* That any medical records, which were introduced at the hearing and which pertain to a person who has not expressly waived his or her right to the confidentiality of the records, may not be open to the public nor is the public entitled to the records.

(q) If the board receives notice that a physician or podiatrist has been subjected to disciplinary action or has had his or her credentials suspended or revoked by the board, a hospital or a professional society, as defined in subsection (b) of this section, for three or more incidents during a five-year period, the board shall require the physician or podiatrist to practice under the direction of a physician or podiatrist designated by the board for a specified period of time to be established by the board.

(r) Notwithstanding any other provisions of this article, the board may, at any time, on its own motion, or upon motion by the complainant, or upon motion by the physician or podiatrist, or by stipulation of the parties, refer the matter to mediation. The board shall obtain a list from the West Virginia State Bar's mediator referral service of certified mediators with expertise in professional disciplinary matters. The board and the physician or podiatrist may choose a mediator from that list. If the board and the physician or podiatrist are unable to agree on a mediator, the board shall designate a mediator from the list by neutral rotation. The mediation shall not be considered a proceeding open to the public and any reports and records introduced at the mediation shall not become part of the public record. The mediator and all participants in the mediation shall maintain and preserve the confidentiality of all mediation proceedings and records. The mediator may not be subpoenaed or called to testify or otherwise be subject to

process requiring disclosure of confidential information in any proceeding relating to or arising out of the disciplinary or licensure matter mediated: *Provided,* That any confidentiality agreement and any written agreement made and signed by the parties as a result of mediation may be used in any proceedings subsequently instituted to enforce the written agreement. The agreements may be used in other proceedings if the parties agree in writing.

(s) A physician licensed under this article may not be disciplined for providing expedited partner therapy in accordance with §16-4F-1 *et seq.*

(t) Whenever the board receives credible information that a licensee of the board is engaging or has engaged in criminal activity or the commitment of a crime under state or federal law, the board shall report the information, to the extent that sensitive or confidential information may be publicly disclosed under law, to the appropriate state or federal law-enforcement authority and/or prosecuting authority. This duty exists in addition to and is distinct from the reporting required under federal law for reporting actions relating to health care providers to the United States Department of Health and Human Services.

ARTICLE 3A. MANAGEMENT OF INTRACTABLE PAIN.

§30-3A-1. Definitions.

For the purposes of this article, the words or terms defined in this section have the meanings ascribed to them. These definitions are applicable unless a different meaning clearly appears from the context.

(1) An "accepted guideline" is a care or practice guideline for pain management developed by a nationally recognized clinical or professional association or a specialty society or government-sponsored agency that has developed practice or care guidelines based on original research or on review of existing research and expert opinion. An accepted guideline also includes policy or position statements relating to pain management issued by any West Virginia board included in chapter thirty of the West Virginia Code with jurisdiction over various health care practitioners. Guidelines established primarily for purposes of coverage, payment or

reimbursement do not qualify as accepted practice or care guidelines when offered to limit treatment options otherwise covered by the provisions of this article.

(2) "Board" or "licensing board" means the West Virginia Board of Medicine, the West Virginia Board of Osteopathy, the West Virginia Board of Registered Nurses ~~or~~, the West Virginia Board of Pharmacy, the West Virginia Board of Optometry or the West Virginia Board of Dentistry.

(3) "Nurse" means a registered nurse licensed in the State of West Virginia pursuant to the provisions of §30-7-1 *et seq.*

(4) "Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

(5) "Pain-relieving controlled substance" includes, but is not limited to, an opioid or other drug classified as a Schedule II through V controlled substance and recognized as effective for pain relief, and excludes any drug that has no accepted medical use in the United States or lacks accepted safety for use in treatment under medical supervision including, but not limited to, any drug classified as a Schedule I controlled substance.

(6) "Pharmacist" means a registered pharmacist licensed in the State of West Virginia pursuant to the provisions of §30-5-1 *et seq.*

~~(7) "Physician" means a physician licensed in the State of West Virginia pursuant to the provisions of article three or article fourteen of this chapter.~~

(7) "Prescriber" shall mean:

(A) A physician licensed pursuant to the provisions of §30-3-1 or §30-14-1 *et seq*;

(B) An advanced practice registered nurse with prescriptive authority as set forth in §30-7-15a;

(C) A dentist licensed pursuant to the provisions of §30-4-1 *et seq.*; and

(D) An optometrist licensed pursuant to the provisions of §30-8-1 *et seq*

§30-3A-2. Limitation on disciplinary sanctions or criminal punishment related to management of pain.

(a) A ~~physician~~ prescriber is not subject to disciplinary sanctions by a licensing board or criminal punishment by the state for prescribing, administering or dispensing pain-relieving controlled substances for the purpose of alleviating or controlling pain if:

(1) In the case of a dying patient experiencing pain, the physician practices in accordance with an accepted guideline as defined in section one of this article and discharges his or her professional obligation to relieve the dying patient's pain and promote the dignity and autonomy of the dying patient; or

(2) In the case of a patient who is not dying and is experiencing pain, the ~~physician~~ prescriber discharges his or her professional obligation to relieve the patient's pain, if the ~~physician~~ prescriber can demonstrate by reference to an accepted guideline that his or her practice substantially complied with that accepted guideline. Evidence of substantial compliance with an accepted guideline may be rebutted only by the testimony of a clinical expert. Evidence of noncompliance with an accepted guideline is not sufficient alone to support disciplinary or criminal action.

(b) A health care provider, as defined in §55-7B-2, with prescriptive authority is not subject to disciplinary sanctions by a licensing board or criminal punishment by the state for declining to prescribe, or declining to continue to prescribe, any controlled substance to a patient which the health care provider with prescriptive authority is treating if the health care provider with prescriptive authority in the exercise of reasonable prudent judgment believes the patient is misusing the controlled substance in an abusive manner or unlawfully diverting a controlled substance legally prescribed for their use.

(c) A licensed registered professional nurse is not subject to disciplinary sanctions by a licensing board or criminal punishment by the state for administering pain-relieving controlled substances to alleviate or control pain, if administered in accordance with the orders of a licensed physician.

(d) A licensed pharmacist is not subject to disciplinary sanctions by a licensing board or criminal punishment by the state for dispensing a prescription for a pain-relieving controlled substance to alleviate or control pain, if dispensed in accordance with the orders of a licensed physician.

(e) For purposes of this section, the term "disciplinary sanctions" includes both remedial and punitive sanctions imposed on a licensee by a licensing board, arising from either formal or informal proceedings.

(f) The provisions of this section apply to the treatment of all patients for pain, regardless of the patient's prior or current chemical dependency or addiction. The board may develop and issue policies or guidelines establishing standards and procedures for the application of this article to the care and treatment of persons who are chemically dependent or addicted.

§30-3A-3. Acts subject to discipline or prosecution.

(a) Nothing in this article shall prohibit disciplinary action or criminal prosecution of a ~~physician~~ prescriber for:

(1) Failing to maintain complete, accurate, and current records documenting the physical examination and medical history of the patient, the basis for the clinical diagnosis of the patient, and the treatment plan for the patient;

(2) Writing a false or fictitious prescription for a controlled substance scheduled in §60A-2-1 *et seq.*; or

(3) Prescribing, administering, or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§801, *et seq.* or chapter sixty-a of this code; ~~or~~

(4) Diverting controlled substances prescribed for a patient to the physician's own personal use~~.~~; or

(5) Abnormal prescribing or dispensing patterns, or both as identified by the controlled

substance monitoring program set forth in §60A-9-1 *et seq.* These prescribing and dispensing patterns may be discovered either in the report filed with the appropriate board as required by section §60A-9-1 *et seq.* following notice as set forth in this article or, through an inquiry of the controlled substances monitoring database by the appropriate licensing board.

(b) Nothing in this article shall prohibit disciplinary action or criminal prosecution of a nurse or pharmacist for:

(1) Administering or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§801, *et seq.* or chapter sixty-a of this code; or

(2) Diverting controlled substances prescribed for a patient to the nurse's or pharmacist's own personal use.

§30-3A-4. ~~Construction of article.~~ Abnormal prescribing practices.

~~This article may not be construed to legalize, condone, authorize or approve mercy killing or assisted suicide~~

(a) Upon receipt of the quarterly report set forth in §60A-9-1 *et seq.*, the licensing board shall notify the prescriber that he or she has been identified as a potentially abnormal prescriber. The board may take no disciplinary action based upon the first notice.

(b) Upon receipt of a second consecutive quarterly report containing the same or substantially similar prescribing patterns the licensing board shall commence an investigation into the alleged abnormal prescribing practices of the prescriber.

(c) Upon receipt of a third consecutive quarterly report containing the same or substantially similar prescribing patterns the board shall commence disciplinary actions, if appropriate, pursuant to its disciplinary process. If a third consecutive quarterly report no longer lists the same or substantially similar prescribing practices the investigation set forth in subsection (b) of this section shall cease.

(d) A licensing board may upon receipt of credible and reliable information independent of the quarterly report as set forth in §60A-9-1 *et seq.* initiate an investigation into any alleged abnormal prescribing or dispensing practices of a licensee.

(e)The licensing boards and prescribers shall have all rights and responsibilities in their practice acts.

ARTICLE 4. WEST VIRGINIA DENTAL PRACTICE ACT.

§30-4-19. Complaints; investigations; due process procedure; grounds for disciplinary action.

(a) The board may initiate a complaint upon receipt of the quarterly report from the Board of Pharmacy as required by §60A-9-1 *et seq.* or upon receipt of credible information and shall, upon the receipt of a written complaint of any person, cause an investigation to be made to determine whether grounds exist for disciplinary action under this article or the legislative rules promulgated pursuant to this article.

(b) After reviewing any information obtained through an investigation, the board shall determine if probable cause exists that the licensee, certificate holder or permittee has violated subsection (g) of this section or rules promulgated pursuant to this article.

(c) Upon a finding of probable cause to go forward with a complaint, the board shall provide a copy of the complaint to the licensee, certificate holder or permittee.

(d) Upon a finding that probable cause exists that the licensee, certificate holder or permittee has violated subsection (g) of this section or rules promulgated pursuant to this article, the board may enter into a consent decree or hold a hearing for disciplinary action against the licensee, certificate holder or permittee. Any hearing shall be held in accordance with the provisions of this article and shall require a violation to be proven by a preponderance of the evidence.

(e) A member of the complaint committee or the executive director of the board may issue

subpoenas and subpoenas duces tecum to obtain testimony and documents to aid in the investigation of allegations against any person regulated by the article.

(f) Any member of the board or its executive director may sign a consent decree or other legal document on behalf of the board.

(g) The board may, after notice and opportunity for hearing, deny or refuse to renew, suspend, restrict or revoke the license, certificate or permit of, or impose probationary conditions upon or take disciplinary action against, any licensee, certificate holder or permittee for any of the following reasons:

(1) Obtaining a board authorization by fraud, misrepresentation or concealment of material facts;

(2) Being convicted of a felony or a misdemeanor crime of moral turpitude;

(3) Being guilty of unprofessional conduct which placed the public at risk, as defined by legislative rule of the board;

(4) Intentional violation of a lawful order or legislative rule of the board;

(5) Having had a board authorization revoked or suspended, other disciplinary action taken, or an application for a board authorization denied by the proper authorities of another jurisdiction;

(6) Aiding or abetting unlicensed practice;

(7) Engaging in an act while acting in a professional capacity which has endangered or is likely to endanger the health, welfare or safety of the public;

(8) Having an incapacity that prevents a licensee from engaging in the practice of dentistry or dental hygiene, with reasonable skill, competence and safety to the public;

(9) Committing fraud in connection with the practice of dentistry or dental hygiene;

(10) Failing to report to the board one's surrender of a license or authorization to practice dentistry or dental hygiene in another jurisdiction while under disciplinary investigation by any of

those authorities or bodies for conduct that would constitute grounds for action as defined in this section;

(11) Failing to report to the board any adverse judgment, settlement or award arising from a malpractice claim arising related to conduct that would constitute grounds for action as defined in this section;

(12) Being guilty of unprofessional conduct as contained in the American Dental Association principles of ethics and code of professional conduct. The following acts are conclusively presumed to be unprofessional conduct:

(A) Being guilty of any fraud or deception;

(B) Committing a criminal operation or being convicted of a crime involving moral turpitude;

(C) Abusing alcohol or drugs;

(D) Violating any professional confidence or disclosing any professional secret;

(E) Being grossly immoral;

(F) Harassing, abusing, intimidating, insulting, degrading or humiliating a patient physically, verbally or through another form of communication;

(G) Obtaining any fee by fraud or misrepresentation;

(H) Employing directly or indirectly, or directing or permitting any suspended or unlicensed person so employed, to perform operations of any kind or to treat lesions of the human teeth or jaws or correct malimposed formations thereof;

(I) Practicing, or offering or undertaking to practice dentistry under any firm name or trade name not approved by the board;

(J) Having a professional connection or association with, or lending his or her name to another, for the illegal practice of dentistry, or professional connection or association with any person, firm or corporation holding himself or herself, themselves or itself out in any manner contrary to this article;

(K) Making use of any advertising relating to the use of any drug or medicine of unknown formula;

(L) Advertising to practice dentistry or perform any operation thereunder without causing pain;

(M) Advertising professional superiority or the performance of professional services in a superior manner;

(N) Advertising to guarantee any dental service;

(O) Advertising in any manner that is false or misleading in any material respect;

(P) Soliciting subscriptions from individuals within or without the state for, or advertising or offering to individuals within or without the state, a course or instruction or course materials in any phase, part or branch of dentistry or dental hygiene in any journal, newspaper, magazine or dental publication, or by means of radio, television or United States mail, or in or by any other means of contacting individuals: *Provided*, That the provisions of this paragraph may not be construed so as to prohibit:

(i) An individual dentist or dental hygienist from presenting articles pertaining to procedures or technique to state or national journals or accepted dental publications; or

(ii) Educational institutions approved by the board from offering courses or instruction or course materials to individual dentists and dental hygienists from within or without the state; or

(Q) Engaging in any action or conduct which would have warranted the denial of the license.

(13) Knowing or suspecting that a licensee is incapable of engaging in the practice of dentistry or dental hygiene, with reasonable skill, competence and safety to the public, and failing to report any relevant information to the board;

(14) Using or disclosing protected health information in an unauthorized or unlawful manner;

(15) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of any licensing examination;

(16) Failing to furnish to the board or its representatives any information legally requested by the board or failing to cooperate with or engaging in any conduct which obstructs an investigation being conducted by the board;

(17) Announcing or otherwise holding himself or herself out to the public as a specialist or as being specially qualified in any particular branch of dentistry or as giving special attention to any branch of dentistry or as limiting his or her practice to any branch of dentistry without first complying with the requirements established by the board for the specialty and having been issued a certificate of qualification in the specialty by the board;

(18) Failing to report to the board within seventy-two hours of becoming aware thereof any life threatening occurrence, serious injury or death of a patient resulting from dental treatment or complications following a dental procedure;

(19) Failing to report to the board any driving under the influence and/or driving while intoxicated offense; or

(20) Violation of any of the terms or conditions of any order entered in any disciplinary action.

(h) For the purposes of subsection (g) of this section, ~~effective July 1, 2013,~~ disciplinary action may include:

(1) Reprimand;

(2) Probation;

(3) Restrictions;

(4) Suspension;

(5) Revocation;

(6) Administrative fine, not to exceed $1,000 per day per violation;

(7) Mandatory attendance at continuing education seminars or other training;

(8) Practicing under supervision or other restriction; or

(9) Requiring the licensee or permittee to report to the board for periodic interviews for a specified period of time.

(i) In addition to any other sanction imposed, the board may require a licensee or permittee to pay the costs of the proceeding.

(j) The board may defer disciplinary action with regard to an impaired licensee who voluntarily signs an agreement, in a form satisfactory to the board, agreeing not to practice dental care and to enter an approved treatment and monitoring program in accordance with the board's legislative rule: *Provided,* That this subsection does not apply to a licensee who has been convicted of, pleads guilty to, or enters a plea of nolo contendere to an offense relating to a controlled substance in any jurisdiction.

(k) A person authorized to practice under this article who reports or otherwise provides evidence of the negligence, impairment or incompetence of another member of this profession to the board or to any peer review organization is not liable to any person for making the report if the report is made without actual malice and in the reasonable belief that the report is warranted by the facts known to him or her at the time.

ARTICLE 5. PHARMACISTS, PHARMACY TECHNICIANS, PHARMACY INTERNS AND PHARMACIES.

§30-5-6. Powers and duties of the board.

(a) (1) The board has all the powers and duties set forth in this article, by rule, in §30-1-1 *et seq.* and elsewhere in law, including the power to:

~~(a)~~ (2) Hold meetings;

~~(b)~~ (3) Establish additional requirements for a license, permit and registration;

~~(c)~~ (4) Establish procedures for submitting, approving and rejecting applications for a license, permit and registration;

~~(d)~~ (5) Determine the qualifications of any applicant for a license, permit and registration;

~~(e)~~ (6) Establish a fee schedule;

~~(f)~~ (7) Issue, renew, deny, suspend, revoke or reinstate a license, permit, and registration;

~~(g)~~ (8) Prepare, conduct, administer and grade written, oral or written and oral examinations for a license and registration and establish what constitutes passage of the examination;

~~(h)~~ (9) Contract with third parties to administer the examinations required under the provisions of this article;

~~(i)~~ (10) Maintain records of the examinations the board or a third party administers, including the number of persons taking the examination and the pass and fail rate;

~~(j)~~ (11) Regulate mail order pharmacies

~~(k)~~ (12) Maintain an office, and hire, discharge, establish the job requirements and fix the compensation of employees and contract with persons necessary to enforce the provisions of this article. Inspectors shall be licensed pharmacists;

~~(l)~~ (13) Investigate alleged violations of the provisions of this article, legislative rules, orders and final decisions of the board;

~~(m)~~ (14) Conduct disciplinary hearings of persons regulated by the board;

~~(n)~~ (15) Determine disciplinary action and issue orders;

~~(o)~~ (16) Institute appropriate legal action for the enforcement of the provisions of this article;

~~(p)~~ (17) Maintain an accurate registry of names and addresses of all persons regulated by the board;

~~(q)~~ (18) Keep accurate and complete records of its proceedings, and certify the same as

may be necessary and appropriate;

~~(r)~~ (19) Propose rules in accordance with the provisions of §29A-3-1 *et seq.* to implement the provisions of this article;

~~(s)~~ (20) Sue and be sued in its official name as an agency of this state;

~~(t)~~ (21) Confer with the Attorney General or his or her assistant in connection with legal matters and questions; and

~~(u)~~ (22) Take all other actions necessary and proper to effectuate the purposes of this article.

(b) The Board is exempt from state purchasing laws, legislative rules and policies for the purposes of spending grant money if the grant is in relation to substance use and controlled substances.

ARTICLE 7. REGISTERED PROFESSIONAL NURSES.

§30-7-11. Denial, revocation or suspension of license; grounds for discipline.

(a) The board shall have the power to deny, revoke or suspend any license to practice registered professional nursing issued or applied for in accordance with the provisions of this article, or to otherwise discipline a licensee or applicant upon proof that he or she:

(1) Is or was guilty of fraud or deceit in procuring or attempting to procure a license to practice registered professional nursing; or

(2) Has been convicted of a felony; or

(3) Is unfit or incompetent by reason of negligence, habits or other causes; or

(4) Is habitually intemperate or is addicted to the use of habit-forming drugs; or

(5) Is mentally incompetent; or

(6) Is guilty of conduct derogatory to the morals or standing of the profession of registered nursing; or

(7) Is practicing or attempting to practice registered professional nursing without a license

or reregistration; or

(8) Has demonstrated abnormal prescribing or dispensing practices pursuant to §30-3A-4; or

~~(8)~~ (9) Has willfully or repeatedly violated any of the provisions of this article.

(b) An Advanced practice registered nurse licensed under this article may not be disciplined for providing expedited partner therapy in accordance with §16-4F-1 *et seq.*

ARTICLE 8. OPTOMETRISTS.

§30-8-18. Complaints; investigations; due process procedure; grounds for disciplinary action.

(a) The board may upon its own motion based on credible information or based upon the quarterly report from the Board of Pharmacy as required by §60A-9-1 *et seq.*, and shall upon the written complaint of any person cause an investigation to be made to determine whether grounds exist for disciplinary action under this article or the legislative rules of the board.

(b) Upon initiation or receipt of the complaint, the board shall provide a copy of the complaint to the licensee, certificate holder or permittee.

(c) After reviewing any information obtained through an investigation, the board shall determine if probable cause exists that the licensee or permittee has violated subsection (g) of this section or rules promulgated pursuant to this article.

(d) Upon a finding that probable cause exists that the licensee or permittee has violated subsection (g) of this section or rules promulgated pursuant to this article, the board may enter into a consent decree or hold a hearing for the suspension or revocation of the license, certificate or permit or the imposition of sanctions against the licensee, certificate holder or permittee. Any hearing shall be held in accordance with the provisions of this article, and the provisions of §29A-5-1- and §29A-6-1 *et seq.*

(e) Any member of the board or the executive secretary of the board may issue subpoenas

and subpoenas duces tecum on behalf of the board to obtain testimony and documents to aid in the investigation of allegations against any person regulated by the article.

(f) Any member of the board or its executive secretary may sign a consent decree or other legal document on behalf of the board.

(g) The board may, after notice and opportunity for hearing, deny or refuse to renew, suspend or revoke the license, certificate or permit of, impose probationary conditions upon or take disciplinary action against, any licensee, certificate holder or permittee for any of the following reasons once a violation has been proven by a preponderance of the evidence:

(1) Obtaining a license, certificate or permit by fraud, misrepresentation or concealment of material facts;

(2) Being convicted of a felony or other crime involving moral turpitude;

(3) Being guilty of unprofessional conduct which placed the public at risk;

(4) Intentional violation of a lawful order;

(5) Having had an authorization to practice optometry revoked, suspended, other disciplinary action taken, by the proper authorities of another jurisdiction;

(6) Having had an application to practice optometry denied by the proper authorities of another jurisdiction;

(7) Exceeded the scope of practice of optometry;

(8) Aiding or abetting unlicensed practice;

(9) Engaging in an act while acting in a professional capacity which has endangered or is likely to endanger the health, welfare or safety of the public; or

(10) False and deceptive advertising; this includes, but is not limited to, the following:

(A) Advertising "free examination of eyes," or words of similar import and meaning; or

(B) Advertising frames or mountings for glasses, contact lenses, or other optical devices which does not accurately describe the same in all its component parts.

(h) For the purposes of subsection (g) of this section disciplinary action may include:

(1) Reprimand;

(2) Probation;

(3) Administrative fine, not to exceed $1,000 per day per violation;

(4) Mandatory attendance at continuing education seminars or other training;

(5) Practicing under supervision or other restriction;

(6) Requiring the licensee or certificate holders to report to the board for periodic interviews for a specified period of time; or

(7) Other corrective action considered by the board to be necessary to protect the public, including advising other parties whose legitimate interests may be at risk.

ARTICLE 14. OSTEOPATHIC PHYSICIANS AND SURGEONS.

§30-14-12a. Complaint Proceedings.

(a) The board may independently initiate suspension or revocation proceedings as well as initiate suspension or revocation proceedings based on information received from any person, including but not limited to the Board of Pharmacy as required by §60A-9-1 *et seq*.

The board shall initiate investigations as to professional incompetence or other reasons for which a licensed osteopathic physician and surgeon may be adjudged unqualified if the board receives notice that three or more judgments or any combination of judgments and settlements resulting in five or more unfavorable outcomes arising from medical professional liability have been rendered or made against such osteopathic physician within a five-year period.

(b) Upon request of the board, any medical peer review committee in this state shall report any information that may relate to the practice or performance of any osteopathic physician known to that medical peer review committee. Copies of such requests for information from a medical peer review committee may be provided to the subject osteopathic physician if, in the discretion of the board, the provision of such copies will not jeopardize the board's investigation. In the event

that copies are provided, the subject osteopathic physician has fifteen days to comment on the requested information and such comments must be considered by the board.

After the completion of a hospital's formal disciplinary procedure and after any resulting legal action, the chief executive officer of such hospital shall report in writing to the board within sixty days the name of any member of the medical staff or any other osteopathic physician practicing in the hospital whose hospital privileges have been revoked, restricted, reduced or terminated for any cause, including resignation, together with all pertinent information relating to such action. The chief executive officer shall also report any other formal disciplinary action taken against any osteopathic physician by the hospital upon the recommendation of its medical staff relating to professional ethics, medical incompetence, medical malpractice, moral turpitude or drug or alcohol abuse. Temporary suspension for failure to maintain records on a timely basis or failure to attend staff or section meetings need not be reported.

Any professional society in this state comprised primarily of osteopathic physicians or physicians and surgeons of other schools of medicine which takes formal disciplinary action against a member relating to professional ethics, professional incompetence, professional malpractice, moral turpitude or drug or alcohol abuse, shall report in writing to the board within sixty days of a final decision the name of such member, together with all pertinent information relating to such action.

Every person, partnership, corporation, association, insurance company, professional society or other organization providing professional liability insurance to an osteopathic physician in this state shall submit to the board the following information within thirty days from any judgment, dismissal or settlement of a civil action or of any claim involving the insured: The date of any judgment, dismissal or settlement; whether any appeal has been taken on the judgment, and, if so, by which party; the amount of any settlement or judgment against the insured; and such other information required by the board.

Within thirty days after a person known to be an osteopathic physician licensed or

otherwise lawfully practicing medicine and surgery in this state or applying to be licensed is convicted of a felony under the laws of this state, or of any crime under the laws of this state involving alcohol or drugs in any way, including any controlled substance under state or federal law, the clerk of the court of record in which the conviction was entered shall forward to the board a certified true and correct abstract of record of the convicting court. The abstract shall include the name and address of such osteopathic physician or applicant, the nature of the offense committed and the final judgment and sentence of the court.

Upon a determination of the board that there is probable cause to believe that any person, partnership, corporation, association, insurance company, professional society or other organization has failed or refused to make a report required by this subsection, the board shall provide written notice to the alleged violator stating the nature of the alleged violation and the time and place at which the alleged violator shall appear to show good cause why a civil penalty should not be imposed. The hearing shall be conducted in accordance with the provisions of §29A-5-1 *et seq.* After reviewing the record of such hearing, if the board determines that a violation of this subsection has occurred, the board shall assess a civil penalty of not less than $1,000 nor more than $10,000 against such violator. The board shall notify anyone assessed of the assessment in writing and the notice shall specify the reasons for the assessment. If the violator fails to pay the amount of the assessment to the board within thirty days, the Attorney General may institute a civil action in the circuit court of Kanawha County to recover the amount of the assessment. In any such civil action, the court's review of the board's action shall be conducted in accordance with the provisions of §29A-5-4.

Any person may report to the board relevant facts about the conduct of any osteopathic physician in this state which in the opinion of such person amounts to professional malpractice or professional incompetence.

The board shall provide forms for filing reports pursuant to this section. Reports submitted in other forms shall be accepted by the board.

The filing of a report with the board pursuant to any provision of this article, any investigation by the board or any disposition of a case by the board does not preclude any action by a hospital, other health care facility or professional society comprised primarily of osteopathic physicians or physicians and surgeons of other schools of medicine to suspend, restrict or revoke the privileges or membership of such osteopathic physician.

(c) In every case considered by the board under this article regarding suspension, revocation or issuance of a license whether initiated by the board or upon complaint or information from any person or organization, the board shall make a preliminary determination as to whether probable cause exists to substantiate charges of cause to suspend, revoke or refuse to issue a license as set forth in subsection (a), section eleven of this article. If such probable cause is found to exist, all proceedings on such charges shall be open to the public who are entitled to all reports, records, and nondeliberative materials introduced at such hearing, including the record of the final action taken: *Provided,* That any medical records, which were introduced at such hearing and which pertain to a person who has not expressly waived his or her right to the confidentiality of such records, shall not be open to the public nor is the public entitled to such records. If a finding is made that probable cause does not exist, the public has a right of access to the complaint or other document setting forth the charges, the findings of fact and conclusions supporting such finding that probable cause does not exist, if the subject osteopathic physician consents to such access.

(d) If the board receives notice that an osteopathic physician has been subjected to disciplinary action or has had his or her credentials suspended or revoked by the board, a medical peer review committee, a hospital or professional society, as defined in subsection (b) of this section, for three or more incidents in a five-year period, the board shall require the osteopathic physician to practice under the direction of another osteopathic physician for a specified period to be established by the board.

(e) Whenever the board receives credible information that a licensee of the board is

engaging or has engaged in criminal activity or the commitment of a crime under state or federal law, the board shall report the information, to the extent that sensitive or confidential information may be publicly disclosed under law, to the appropriate state or federal law-enforcement authority and/or prosecuting authority. This duty exists in addition to and is distinct from the reporting required under federal law for reporting actions relating to health care providers to the United States Department of Health and Human Services.

ARTICLE 36. ACUPUNCTURISTS.

§30-36-2. Definitions.

(a) Unless the context in which used clearly requires a different meaning, as used in this article:

(1) "Acupuncture" means a form of health care, based on a theory of energetic physiology, that describes the interrelationship of the body organs or functions with an associated point or combination of points.

(2) "Board" means the West Virginia Acupuncture Board.

(3) "License" means a license issued by the board to practice acupuncture.

(4) "Moxibustion" means the burning of mugwort on or near the skin to stimulate the acupuncture point.

(5) "Practice acupuncture" means the use of oriental medical therapies for the purpose of normalizing energetic physiological functions including pain control, and for the promotion, maintenance and restoration of health.

(b) (1) "Practice acupuncture" includes:

~~(1)~~ (A) Stimulation of points of the body by the insertion of acupuncture needles;

~~(2)~~ (B) The application of moxibustion; and

~~(3)~~ (C) Manual, mechanical, thermal or electrical therapies only when performed in accordance with the principles of oriental acupuncture medical theories.

(2) The practice of acupuncture does not include the procedure of auricular acupuncture

when used in the context of a chemical dependency treatment program when the person is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

CHAPTER 60A. UNIFORM CONTROLLED SUBSTANCES ACT.

ARTICLE 2. STANDARDS AND SCHEDULES.

§60A-2-204. Schedule I.

(a) Schedule I shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section including their isomers, esters, ethers, salts and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation.

(b) Opiates. ~~Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation (for purposes of subdivision (34) of this subsection only, the term isomer includes the optical and geometric isomers):~~

~~(1)~~ Acetyl-alpha-methylfentanyl (N-[1-(1-methyl-2-phenethyl) -4-piperidinyl]-- phenylacetamide);

~~(2)~~ Acetylmethadol;

~~(3)~~ Allylprodine;

~~(4)~~ Alphacetylmethadol (except levoalphacetylmethadol also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM);

~~(5)~~ Alphameprodine;

~~(6)~~ Alphamethadol;

~~(7)~~ Alpha-methylfentanyl (N-[1-(alpha-methyl-beta-phenyl) ethyl-4-piperidyl]

propionanilide; 1-(1-methyl-2-phenylethyl)-4-(– propanilido) piperidine);

~~(8)~~ Alpha-methylthiofentanyl (N-[1-methyl-2-(2-thienyl) ethyl- 4-piperidinyl]--phenylpropanamide);

~~(9)~~ Benzethidine;

~~(10)~~ Betacetylmethadol;

~~(11)~~ Beta-hydroxyfentanyl (N-[1-(2-hydroxy-2-phenethyl) -4- piperidinyl]-N-phenylpropanamide);

~~(12)~~ Beta-hydroxy-3-methylfentanyl (other name: N-[1-(2- hydroxy-2-phenethyl)-3-methyl-4-piperidinyl]-N-phenylpropanamide);

~~(13)~~ Betameprodine;

~~(14)~~ Betamethadol;

~~(15)~~ Betaprodine;

~~(16)~~ Clonitazene;

~~(17)~~ Dextromoramide;

~~(18)~~ Diampromide;

~~(19)~~ Diethylthiambutene;

~~(20)~~ Difenoxin;

~~(21)~~ Dimenoxadol;

~~(22)~~ Dimepheptanol;

~~(23)~~ Dimethylthiambutene;

~~(24)~~ Dioxaphetyl butyrate;

~~(25)~~ Dipipanone;

~~(26)~~ Ethylmethylthiambutene;

~~(27)~~ Etonitazene;

~~(28)~~ Etoxeridine;

~~(29)~~ Furethidine;

~~(30)~~ Hydroxypethidine;

~~(31)~~ Ketobemidone;

~~(32)~~ Levomoramide;

~~(33)~~ Levophenacylmorphan;

~~(34)~~ 3-Methylfentanyl (N-[3-methyl-1-(2-phenylethyl)-4- piperidyl]-N-phenylpropanamide);

~~(35)~~ 3-methylthiofentanyl (N-[3-methyl-1-(2-thienyl) ethyl-4- piperidinyl]--phenylpropanamide);

~~(36)~~ Morpheridine;

~~(37)~~ MPPP (1-methyl-4-phenyl-4-propionoxypiperidine);

~~(38)~~ Noracymethadol;

~~(39)~~ Norlevorphanol;

~~(40)~~ Normethadone;

~~(41)~~ Norpipanone;

~~(42)~~ Para-fluorofentanyl (N-(4-fluorophenyl)-N-[1-(2- phenethyl)-4-piperidinyl] propanamide);

~~(43)~~ PEPAP(1-(-2-phenethyl)-4-phenyl-4-acetoxypiperidine);

~~(44)~~ Phenadoxone;

~~(45)~~ Phenampromide;

~~(46)~~ Phenomorphan;

~~(47)~~ Phenoperidine;

~~(48)~~ Piritramide;

~~(49)~~ Proheptazine;

~~(50)~~ Properidine;

~~(51)~~ Propiram;

~~(52)~~ Racemoramide;

~~(53)~~ Thiofentanyl (N-phenyl-N-[1-(2-thienyl)ethyl-4- piperidinyl]-propanamide);

~~(54)~~ Tilidine;

~~(55)~~ Trimeperidine.

(c) *Opium derivatives:* ~~-- Unless specifically excepted or unless listed in another schedule, any of the following opium immediate derivatives, its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:~~

~~(1)~~ Acetorphine;

~~(2)~~ Acetyldihydrocodeine;

~~(3)~~ Benzylmorphine;

~~(4)~~ Codeine methylbromide;

~~(5)~~ Codeine-N-Oxide;

~~(6)~~ Cyprenorphine;

~~(7)~~ Desomorphine;

~~(8)~~ Dihydromorphine;

~~(9)~~ Drotebanol;

~~(10)~~ Etorphine (except HCl Salt);

~~(11)~~ Heroin;

~~(12)~~ Hydromorphinol;

~~(13)~~ Methyldesorphine;

~~(14)~~ Methyldihydromorphine;

~~(15)~~ Morphine methylbromide;

~~(16)~~ Morphine methylsulfonate;

~~(17)~~ Morphine-N-Oxide;

~~(18)~~ Myrophine;

~~(19)~~ Nicocodeine;

~~(20)~~ Nicomorphine;

~~(21)~~ Normorphine;

~~(22)~~ Pholcodine;

~~(23)~~ Thebacon.

(d) *Hallucinogenic substances.* ~~-- Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this subsection only, the term "isomer" includes the optical, position and geometric isomers):~~

~~(1)~~ Alpha-ethyltryptamine; some trade or other names: etryptamine; Monase; alpha-ethy-1H-indole-3-ethanamine; 3-(2- aminobutyl) indole; alpha-ET; and AET;

~~(2)~~ 4-bromo-2, 5-dimethoxy-amphetamine; some trade or other names: 4-bromo-2,5-dimethoxy-alpha-methylphenethylamine; 4-bromo- 2,5-DMA;

~~(3)~~ 4-Bromo-2,5-dimethoxyphenethylamine; some trade or other names: 2-(4-bromo-2,5-dimethoxyphenyl)-1-aminoethane; alpha- desmethyl DOB; 2C-B, Nexus;

~~(4)(A)~~ N-(2-Methoxybenzyl)-4-bromo-2, 5-dimethoxyphenethylamine. The substance has the acronym 25B-NBOMe.

~~(B)~~ 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25C-NBOMe)

~~(C)~~ 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25I-NBOMe)

~~(5)~~ 2,5-dimethoxyamphetamine; some trade or other names: 2,5-dimethoxy-alpha-methylphenethylamine; 2,5-DMA;

~~(6)~~ 2,5-dimethoxy-4-ethylamphet-amine; some trade or other names: DOET;

~~(7)~~ 2,5-dimethoxy-4-(n)-propylthiophenethylamine (other name: 2C-T-7);

~~(8)~~ 4-methoxyamphetamine; some trade or other names: 4-methoxy-alpha-methylphenethylamine; paramethoxyamphetamine; PMA;

~~(9)~~ 5-methoxy-3, 4-methylenedioxy-amphetamine;

~~(10)~~ 4-methyl-2,5-dimethoxy-amphetamine; some trade and other names: 4-methyl-2,5-dimethoxy-alpha-methylphenethylamine; "DOM"; and "STP";

~~(11)~~ 3,4-methylenedioxy amphetamine;

~~(12)~~ 3,4-methylenedioxymethamphetamine (MDMA);

~~(13)~~ 3,4-methylenedioxy-N-ethylamphetamine (also known as – ethyl-alpha-methyl-3,4 (methylenedioxy) phenethylamine, N-ethyl MDA, MDE, MDEA);

~~(14)~~ N-hydroxy-3,4-methylenedioxyamphetamine (also known as – hydroxy-alpha-methyl-3,4 (methylenedioxy) phenethylamine, and – hydroxy MDA);

~~(15)~~ 3,4,5-trimethoxy amphetamine;

~~(15)~~ ~~(16)~~ 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

~~(17)~~ Alpha-methyltryptamine (other name: AMT);

~~(18)~~ Bufotenine; some trade and other names: 3-(beta-Dimethylaminoethyl)-5-hydroxyindole;3-(2-dimethylaminoethyl) -5-indolol; N, N-dimethylserotonin; 5-hydroxy-N,N-dimethyltryptamine; mappine;

~~(19)~~ Diethyltryptamine; sometrade and other names: N, N-Diethyltryptamine; DET;

~~(20)~~ Dimethyltryptamine; some trade or other names: DMT;

~~(21)~~ 5-Methoxy-N,N-diisopropyltryptamine (5-MeO-DIPT);

~~(22)~~ Ibogaine; some trade and other names: 7-Ethyl-6, 6 Beta, 7, 8, 9, 10, 12, 13-octahydro-2-methoxy-6, 9-methano-5H- pyrido [1', 2': 1, 2] azepino [5,4-b] indole; Tabernanthe iboga;

~~(23)~~ Lysergic acid diethylamide;

~~(24)~~ Marihuana;

~~(25)~~ Mescaline;

Mitragynine, 7-hydroxymitragynine (Kratom);

~~(26)~~ Parahexyl-7374; some trade or other names: 3-Hexyl -1-hydroxy-7, 8, 9, 10-

tetrahydro-6, 6, 9-trimethyl-6H-dibenzo [b,d] pyran; Synhexyl;

~~(27)~~ Peyote; meaning all parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of such plant, and every compound, manufacture, salts, immediate derivative, mixture or preparation of such plant, its seeds or extracts;

~~(28)~~ N-ethyl-3-piperidyl benzilate;

~~(29)~~ N-methyl-3-piperidyl benzilate;

~~(30)~~ Psilocybin;

~~(31)~~ Psilocyn;

~~(32)~~ Tetrahydrocannabinols; synthetic equivalents of the substances contained in the plant, or in the resinous extractives of Cannabis, sp. and/or synthetic substances, immediate derivatives and their isomers with similar chemical structure and pharmacological activity such as the following:

delta-1 Cis or trans tetrahydrocannabinol, and their optical isomers;

delta-6 Cis or trans tetrahydrocannabinol, and their optical isomers;

delta-3,4 Cis or trans tetrahydrocannabinol, and its optical isomers;

(Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions covered.)

~~(33)~~ Ethylamine analog of phencyclidine; some trade or other names: N-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, N-(1-phenylcyclohexyl) ethylamine, cyclohexamine, PCE;

~~(34)~~ Pyrrolidine analog of phencyclidine; some trade or other names: 1-(1-phenylcyclohexyl)-pyrrolidine, PCPy, PHP;

~~(35)~~ Thiophene analog of phencyclidine; some trade or other names: 1-[1-(2-thienyl)-cyclohexyl]-piperidine, 2-thienylanalog of phencyclidine; TPCP, TCP;

~~(36)~~ 1[1-(2-thienyl)cyclohexyl]pyrroldine; some other names: TCPy.

~~(37)~~ 4-methylmethcathinone (Mephedrone);

~~(38)~~ 3,4-methylenedioxypyrovalerone (MDPV);

~~(39)~~ 2-(2,5-Dimethoxy-4-ethylphenyl)ethanamine (2C-E);

~~(40)~~ 2-(2,5-Dimethoxy-4-methylphenyl)ethanamine (2C-D)

~~(41)~~ 2-(4-Chloro-2,5-dimethoxyphenyl)ethanamine (2C-C)

~~(42)~~ 2-(4-Iodo-2,5-dimethoxyphenyl)ethanamine (2C-I)

~~(43)~~ 2-[4-(Ethylthio)-2,5-dimethoxyphenyl]ethanamine (2C-T-2)

~~(44)~~ 2-[4-(Isopropylthio)-2,5-dimethoxyphenyl]ethanamine (2C-T-4)

~~(45)~~ 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H)

~~(46)~~ 2-(2,5-Dimethoxy-4-nitro-phenyl)ethanamine (2C-N)

~~(47)~~ 2-(2,5-Dimethoxy-4-(n)-propylphenyl)ethanamine (2C-P)

~~(48)~~ 3,4-Methylenedioxy-N-methylcathinone (Methylone)

~~(49)~~ 2,5-dimethoxy-4-(n)-propyltghiophenethylamine (2C-T-7, itsoptical isomers, salts and salts of isomers

~~(50)~~ 5-methoxy-N,N-dimethyltryptamine some trade or other names: 5-methoxy-3-[2-(dimethylamino)ethyl]indole; 5-MeO-DMT(5-MeO-DMT)

~~(51)~~ Alpha-methyltryptamine (other name: AMT)

~~(52)~~ 5-methoxy-N,N-diisopropyltryptamine (other name: 5-MeO-DIPT)

~~(53)~~ Synthetic Cannabinoids as follows:

~~(A)~~ 2-[(1R,3S)-3-hydroxycyclohexyl]-5- (2-methyloctan-2-yl)phenol) {also known as CP 47,497 and homologues};

~~(B)~~ rel-2-[(1S,3R)-3-hydroxycyclohexyl] -5-(2-methylnonan-2-yl)phenol {also known as CP 47,497-C8 homolog};

~~(C)~~ [(6a*R*)-9-(hydroxymethyl)-6, 6-dimethyl-3-(2-methyloctan-2-yl)-6a, 7,10,10a-

tetrahydrobenzo[c]chromen-1-ol)] {also known as HU-210};

~~(D)~~ (dexanabinol);

(6a*S*,10a*S*)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzol[c]chromen-1-ol) {also known as HU-211};

~~(E)~~ 1-Pentyl-3-(1-naphthoyl)indole {also known as JWH-018};

~~(F)~~ 1-Butyl-3-(1-naphthoyl)indole {also known as JWH-073};

~~(G)~~ (2-methyl-1-propyl-1H-indol-3-yl)-1-napthalenyl-methanone {also known as JWH-015};

~~(H)~~ (1-hexyl-1H-indol-3-yl)-1-naphthalenyl-methanone {also known as JWH-019};

~~(I)~~ [1-[2-(4-morpholinyl) ethyl] -1H-indol-3-yl]-1-naphthalenyl-methanone {also known as JWH-200};

~~(J)~~ 1-(1-pentyl-1H-indol-3-yl)-2-(3-hydroxyphenyl)-ethanone {also known as JWH-250};

~~(K)~~ 2-((1S,2S,5S)-5-hydroxy-2- (3-hydroxtpropyl)cyclohexyl) -5-(2-methyloctan-2-yl)phenol {also known as CP 55,940};

~~(L)~~ (4-methyl-1-naphthalenyl) (1-pentyl-1H-indol-3-yl) -methanone {also known as JWH-122};

~~(M)~~ (4-methyl-1-naphthalenyl) (1-pentyl-1H-indol-3-yl) -methanone {also known as JWH-398;

~~(N)~~ (4-methoxyphenyl)(1-pentyl-1H-indol-3-yl)methanone {also known as RCS-4};

~~(O)~~ 1-(1-(2-cyclohexylethyl) -1H-indol-3-yl) -2-(2-methoxyphenyl) ethanone {also known as RCS-8};

~~(P)~~ 1-pentyl-3-[1-(4-methoxynaphthoyl)]indole (JWH-081);

~~(Q)~~ 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM2201); and

~~(R)~~ 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM694).

~~(54)~~ Synthetic cannabinoids: ~~or any material, compound, mixture or preparation which~~

~~contains any quantity of the following substances, including their analogues, congeners, homologues, isomers, salts and salts of analogues, congeners, homologues and isomers, as follows:~~

~~(A)~~ CP 47,497 AND homologues, 2-[(1R,3S)-3-Hydroxycyclohexyl]-5-(2-methyloctan-2-YL)phenol);

~~(B)~~ HU-210, [(6AR,10AR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-Methyloctan-2-YL)-6A,7,10, 10A-tetrahydrobenzo[C] chromen-1-OL)];

~~(C)~~ HU-211, (dexanabinol, (6AS,10AS)-9-(hydroxymethyl)-6,6-Dimethyl-3-(2-methyloctan-2-YL)-6A,7,10,10atetrahydrobenzo[C]chromen-1-OL);

~~(D)~~ JWH-018, 1-pentyl-3-(1-naphthoyl)indole;

~~(E)~~ JWH-019, 1-hexyl-3-(1-naphthoyl)indole;

~~(F)~~ JWH-073, 1-butyl-3-(1-naphthoyl)indole;

~~(G)~~ JWH-200, (1-(2-morpholin-4-ylethyl)indol-3-yl)- Naphthalen-1-ylmethanone;

~~(H)~~ JWH-250, 1-pentyl-3-(2-methoxyphenylacetyl)indole.]

Methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate (5F-ADB);

Methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate (5F-AMB);

Methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3-methylbutanoate (FUB-AMB);

N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5F-APINACA);

N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide (ADB-FUBINACA);

Methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate (MDMB-CHMICA);

Methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate

(MDMB-FUBINACA);

~~(55) Synthetic cannabinoids including any material, compound, mixture or preparation that is not listed as a controlled substance in Schedule I through V, is not a federal Food and Drug Administration approved drug or used within legitimate and approved medical research and which contains any quantity of the following substances, their salts, isomers, whether optical positional or geometric, analogues, homologues and salts of isomers, analogues and homologues, unless specifically exempted, whenever the existence of these salts, isomers, analogues, homologues and salts of isomers, analogues and homologues if possible within the specific chemical designation:~~

~~(A)~~ Tetrahydrocannabinols: ~~meaning tetrahydrocannabinols which are naturally contained in a plant of the genus cannabis as well as synthetic equivalents of the substances contained in the plant or in the resinous extractives of cannabis or synthetic substances, derivatives and their isomers with analogous chemical structure and or pharmacological activity such as the following:~~

~~(i)~~ DELTA-1 CIS OR trans tetrahydrocannabinol and their Optical isomers.

~~(ii)~~ DELTA-6 CIS OR trans tetrahydrocannabinol and their optical isomers.

~~(iii)~~ DELTA-3,4 CIS or their trans tetrahydrocannabinol and their optical isomers.

~~(56)~~ Synthetic Phenethylamines ~~(including their optical, positional, and geometric isomers, salts and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers):~~

~~(A)~~ 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe/ 2C-I-NBOMe);

~~(B)~~ 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe/2C-C-NBOMe);

~~(C)~~ 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe/ 2C-B-NBOMe);

~~(57)~~ Synthetic Opioids (icluding their isomers, esters, ethers, salts and salts of isomers,

esters and ethers):

~~(A)~~ N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);

~~(B)~~ furanyl fentanyl;

~~(C)~~ 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide (also known as U-47700);

~~(D)~~ N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide, also known as N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide, (butyryl fentanyl);

~~(E)~~ N-[1-[2-hydroxy-2-(thiophen-2-yl)ethylpiperidin-4-yl]-N-phenylpropionamide, also known as N-[1-[2-hydroxy-2-(2-thienyl)ethyl]-4-piperidinyl]-N-phenylpropanamide, (beta-hydroxythiofentanyl).

N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl)

N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl)

N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopropyl fentanyl)

2-(2,4-dichlorophenyl)-N-((1S,2S)-2-(dimethylamino)cyclohexyl)-N-methylacetamide (also known as

U-48800)

Trans-3,4-dichloro-N-[2-(diethylamino)cyclohexyl]-N-methyl-benzamide (also known as U-49900)

Trans-3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methyl-benzeneacetamide (also known as

U-51754)

~~(58)~~ Opioid Receptor Agonist ~~(including its isomers, esters, ethers, salts, and salts of isomers, esters and ethers):~~

~~(A)~~ AH-7921 (3,4-dichloro-N- (1dimethylamino)cyclohexylmethyl]benzamide).

~~(B)~~ Naphthoylindoles or any compound containing a 3-(-1- Napthoyl) indole structure with

substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. This shall include the following:

~~(i)~~ JWH 015;

~~(ii)~~ JWH 018;

~~(iii)~~ JWH 019;

~~(iv)~~ JWH 073;

~~(v)~~ JWH 081;

~~(vi)~~ JWH 122;

~~(vii)~~ JWH 200;

~~(viii)~~ JWH 210;

~~(ix)~~ JWH 398;

~~(x)~~ AM 2201;

~~(xi)~~ WIN 55,212.

~~(59)~~ Naphylmethylindoles or any compound containing a 1hindol-3-yl-(1-naphthyl) methane structure with a substition at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. This shall include, but not be limited to, JWH 175 and JWH 184.

~~(60)~~ Naphthoylpyrroles or any compound containing a 3-(1- Naphthoyl) pyrrole structure with substitution at the nitrogen atom of the pyrrole ring whether or not further substituted in the pyrrole ring to any extent and whether or not substituted in the naphthyl ring to any extent. This shall include, but not be limited to, JWH 147 and JWH 307.

~~(61)~~ Naphthylmethylindenes or any compound containing a Naphthylideneindene structure with substitution at the 3- Position of the indene ring whether or not further substituted in the indene ring to any extent and whether or not substituted in the naphthyl ring to any extent.

This shall include, but not be limited to, JWH 176.

~~(62)~~ Phenylacetylindoles or any compound containing a 3- Phenylacetylindole structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. This shall include the following:

~~(A)~~ RCS-8, SR-18 OR BTM-8;

~~(B)~~ JWH 250;

~~(C)~~ JWH 203;

~~(D)~~ JWH 251;

~~(E)~~ JWH 302.

~~(63)~~ Cyclohexylphenols or any compound containing a 2-(3- hydroxycyclohexyl) phenol structure with a substitution at the 5-position of the phenolic ring whether or not substituted in the cyclohexyl ring to any extent. This shall include the following:

~~(A)~~ CP 47,497 and its homologues and analogs;

~~(B)~~ Cannabicyclohexanol;

~~(C)~~ CP 55,940.

~~(64)~~ Benzoylindoles or any compound containing a 3-(benzoyl) indole structure with substitution at the nitrogren atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. This shall include the following:

~~(A)~~ AM 694;

~~(B)~~ Pravadoline WIN 48,098;

~~(C)~~ RCS 4;

~~(D)~~ AM 679.

~~(62)~~ [2,3-dihydro-5 methyl-3-(4-morpholinylmethyl)pyrrolo [1,2,3-DE]-1, 4-benzoxazin-6-

YL]-1-napthalenymethanone. This shall include WIN 55,212-2.

~~(65)~~ Dibenzopyrans or any compound containing a 11-hydroxydelta 8-tetrahydrocannabinol structure with substitution on the 3-pentyl group. This shall include HU-210, HU-211, JWH 051 and JWH 133.

~~(66)~~ Adamantoylindoles or any compound containing a 3-(-1- Adamantoyl) indole structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the adamantoyl ring system to any extent. This shall include AM1248.

~~(67)~~ Tetramethylcyclopropylindoles or any compound containing A 3-tetramethylcyclopropylindole structure with substitution at the nitrogen atom of the indole ring whether or not further substituted in the indole ring to any extent and whether or not substituted in the tetramethylcyclopropyl ring to any extent. This shall include UR-144 and XLR-11.

~~(68)~~ N-(1-Adamantyl)-1-pentyl-1h-indazole-3-carboxamide. This shall include AKB48.

~~(69)~~ Any other synthetic chemical compound that is a Cannabinoid receptor type 1 agonist as demonstrated by binding studies and functional assays that is not listed in Schedules II, III, IV and V, not federal Food and Drug Administration approved drug or used within legitimate, approved medical research. Since nomenclature of these substances is not internationally standardized, any immediate precursor or immediate derivative of these substances shall be covered.

~~(70)~~ Tryptamines:

~~(A)~~ 5- methoxy- N- methyl-N-isopropyltryptamine (5-MeO-MiPT)

~~(B)~~ 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT)

~~(C)~~ 4-hydroxy-N-methyl-N-isopropyltryptamine (4-HO-MiPT)

~~(D)~~ 4-hydroxy-N-methyl-N-ethyltryptamine (4-HO-MET)

~~(E)~~ 4-acetoxy-N,N-diisopropyltryptamine (4-AcO-DiPT)

~~(F)~~ 5-methoxy-α-methyltryptamine (5-MeO-AMT)

~~(G)~~ 4-methoxy-N,N-Dimethyltryptamine (4-MeO-DMT)

~~(H)~~ 4-hydroxy Diethyltryptamine (4-HO-DET)

~~(I)~~ 5- methoxy- N,N- diallyltryptamine (5-MeO-DALT)

~~(J)~~ 4-acetoxy-N,N-Dimethyltryptamine (4-AcO DMT)

~~(K)~~ 4-hydroxy Diethyltryptamine (4-HO-DET)

(e) *Depressants.* ~~-- Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:~~

~~(1)~~ Mecloqualone;

~~(2)~~ Methaqualone.

(f) *Stimulants.* ~~-- Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:~~

~~(1)~~ Aminorex; some other names: aminoxaphen; 2-amino-5- phenyl-2-oxazoline; or 4,5-dihydro-5-phenyl-2-oxazolamine;

~~(2)~~ Cathinone; some trade or other names: 2-amino-1-phenyl-1- propanone, alpha-aminopropiophenone, 2-aminopropiophenone and norephedrone;

~~(3)~~ Fenethylline;

~~(4)~~ Methcathinone, its immediate precursors and immediate derivatives, its salts, optical isomers and salts of optical isomers; some other names: (2-(methylamino)-propiophenone; alpha-(methylamino)propiophenone; 2-(methylamino)-1-phenylpropan-1- one; alpha---methylaminopropiophenone; monomethylpropion; 3,4-methylenedioxypyrovalerone and/or

mephedrone;3,4-methylenedioxypyrovalerone (MPVD); ephedrone; N-methylcathinone; methylcathinone; AL-464; AL-422; AL- 463 and UR1432;

~~(5)~~ (+-) cis-4-methylaminorex; ((+-)cis-4,5-dihydro-4-methyl- 5-phenyl-2-oxazolamine);

~~(6)~~ N-ethylamphetamine;

~~(7)~~ N,N-dimethylamphetemine; also known as N,N-alpha- trimethyl-benzeneethanamine; N,N-alpha-trimethylphenethylamine.

~~(8)~~ Alpha-pyrrolidinopentiophenone, also known as alpha-PVP, optical isomers, salts and salts of isomers.

~~(9)~~ Substituted amphetamines:

~~(A)~~ 2-Fluoroamphetamine

~~(B)~~ 3-Fluoroamphetamine

~~(C)~~ 4-Fluoroamphetamine

~~(D)~~ 2-chloroamphetamine

~~(E)~~ 3-chloroamphetamine

~~(F)~~ 4-chloroamphetamine

~~(G)~~ 2-Fluoromethamphetamine

~~(H)~~ 3-Fluoromethamphetamine

~~(I)~~ 4-Fluoromethamphetamine

~~(J)~~ 4-chloromethamphetamine

(g) Temporary listing of substances subject to emergency scheduling. Any material, compound, mixture or preparation which contains any quantity of the following substances:

~~(1)~~ N-[1-benzyl-4-piperidyl]-N-phenylpropanamide (benzylfentanyl), its optical isomers, salts, and salts of isomers.

~~(2)~~ N-[1-(2-thienyl)methyl-4-piperidyl]-N-phenylpropanamide (thenylfentanyl), its optical isomers, salts and salts of isomers.

~~(3)~~ N-benzylpiperazine, also known as BZP.

~~(4)~~ Cyclopentyl fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide);

~~(5)~~ 4-fluorobutyryl fentanyl (N-(4-fluorophenyl)-N-[1-(2-phenylethyl)piperidin-4-yl]-butyramide);

~~(6)~~ Isobutyryl fentanyl (2-methyl-N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]-propanamide);

~~(7)~~ Methoxyacetyl fentanyl (2-methoxy-N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]-acetamide);

~~(8)~~ 3-methylbutyryl fentanyl (N-[3-methyl-1-(2-phenylethyl)piperidin-4-yl]-N-phenylbutyramide);

~~(9)~~ 4-methoxybutyryl fentanyl (N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide);

~~(10)~~ Ocfentanil (N-(2-fluorophenyl)-2-methoxy-N-[1-(2-phenylethyl)piperidin-4-yl]-acetamide);

~~(11)~~ Tetrahydrofuran fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide);

~~(12)~~ Valeryl fentanyl (N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]pentanamide).

(h) The following controlled substances are included in Schedule I:

~~(1)~~ Synthetic Cathinones or any compound, except bupropion or compounds listed under a different schedule, or compounds used within legitimate and approved medical research, structurally derived from 2- Aminopropan-1-one by substitution at the 1-position with Monocyclic or fused polycyclic ring systems, whether or not the compound is further modified in any of the following ways:

~~(A)~~ By substitution in the ring system to any extent with Alkyl, alkylenedioxy, alkoxy,

haloalkyl, hydroxyl or halide Substituents whether or not further substituted in the ring system by one or more other univalent substituents.

~~(B)~~ By substitution at the 3-position with an acyclic alkyl substituent.

~~(C)~~ By substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl or methoxybenzyl groups.

~~(D)~~ By inclusion of the 2-amino nitrogen atom in a cyclic structure.

~~(2)~~ Any other synthetic chemical compound that is a Cannabinoid receptor type 1 agonist as demonstrated by binding studies and functional assays that is not listed in Schedules II, III, IV and V, not federal Food and Drug Administration approved drug or used within legitimate, approved medical research.

§60A-2-206. Schedule II.

(a) Schedule II consists of the drugs and other substances, by whatever official name, common or usual name, chemical name or brand name designated, listed in this section.

(b) *Substances, vegetable origin or chemical synthesis.* -- Unless specifically excepted or unless listed in another schedule, 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:

~~(1)~~ Opium and opiate, and any salt, compound, derivative or preparation of opium or opiate excluding apomorphine, thebaine-derived butorphanol, dextrorphan, nalbuphine, nalmefene, naloxone and naltrexone, and their respective salts, but including the following:

~~(A)~~ Raw opium;

~~(B)~~ Opium extracts;

~~(C)~~ Opium fluid;

~~(D)~~ Powdered opium;

~~(E)~~ Granulated opium;

~~(F)~~ Tincture of opium;

~~(G)~~ Codeine;

~~(H)~~ Dihydroetorphine;

~~(I)~~ Ethylmorphine;

~~(J)~~ Etorphine hydrochloride;

~~(K)~~ Hydrocodone;

~~(L)~~ Hydromorphone;

~~(M)~~ Metopon;

~~(N)~~ Morphine;

~~(O)~~ Oripavine;

~~(P)~~ Oxycodone;

~~(Q)~~ Oxymorphone; and

~~(R)~~ Thebaine;

~~(2)~~ Any salt, compound, derivative or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subdivision (1) of this subsection, except that these substances shall not include the isoquinoline alkaloids of opium;

~~(3)~~ Opium poppy and poppy straw;

~~(4)~~ Coca leaves and any salt, compound, derivative or preparation of coca leaves (including cocaine and ecgonine and their salts, isomers, derivatives and salts of isomers and derivatives), and any salt, compound, derivative or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extractions of coca leaves, which extractions do not contain cocaine or ecgonine;

~~(5)~~ Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid or powder form which contains the phenanthrene alkaloids of the opium poppy).

(c) *Opiates.* -- Unless specifically excepted or unless in another schedule, any of the following opiates, including its isomers, esters, ethers, salts and salts of isomers, esters and ethers whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation, dextrorphan and levopropoxyphene excepted:

~~(1)~~ Alfentanil;

~~(2)~~ Alphaprodine;

~~(3)~~ Anileridine;

~~(4)~~ Bezitramide;

~~(5)~~ Bulk dextropropoxyphene (nondosage forms);

~~(6)~~ Carfentanil;

~~(7)~~ Dihydrocodeine;

~~(8)~~ Diphenoxylate;

~~(9)~~ Fentanyl;

~~(10)~~ Isomethadone;

~~(11)~~ Levo-alphacetylmethadol; some other names: levo-alpha-acetylmethadol, levomethadyl acetate, LAAM;

~~(12)~~ Levomethorphan;

~~(13)~~ Levorphanol;

~~(14)~~ Metazocine;

~~(15)~~ Methadone;

~~(16)~~ Methadone-Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane;

~~(17)~~ Moramide-Intermediate, 2-methyl-3-morpholino-1,
1-diphenylpropane-carboxylic acid;

~~(18)~~ Pethidine; (meperidine);

~~(19)~~ Pethidine-Intermediate-A, 4-cyano-1-methyl-4- phenylpiperidine;

~~(20)~~ Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;

~~(21)~~ Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

~~(22)~~ Phenazocine;

~~(23)~~ Piminodine;

~~(24)~~ Racemethorphan;

~~(25)~~ Racemorphan;

~~(26)~~ Remifentanil;

~~(27)~~ Sufentanil;

~~(28)~~ Tapentadol

~~(29)~~ Thiafentanil (4-(methoxycarbonyl)-4-(N-phenmethoxyacetamido)-1-2-(thienyl)ethylpiperidine), including its isomers, esters, ethers, salts and salts of isomers, esters and ethers.

(d) *Stimulants.* -- Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

~~(1)~~ Amphetamine, its salts, optical isomers and salts of its optical isomers;

~~(2)~~ Methamphetamine, its salts, isomers and salts of its isomers;

~~(3)~~ Methylphenidate;

~~(4)~~ Phenmetrazine and its salts; and

~~(5)~~ Lisdexamfetamine.

(e) *Depressants.* -- Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:

~~(1)~~ Amobarbital;

~~(2)~~ Glutethimide;

~~(3)~~ Pentobarbital;

~~(4)~~ Phencyclidine;

~~(5)~~ Secobarbital.

(f) *Hallucinogenic substances*:

Dronabinol [(-)-delta-9-trans tetrahydrocannabinol] if in an FDA approved oral solution

Nabilone: [Another name for nabilone: (+-)-trans-3-(1, 1-dimethylheptyl)-6, 6a, 7, 8, 10, 10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo [b,d] pyran-9-one].

(g) *Immediate precursors.* -- Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances:

~~(1)~~ Immediate precursor to amphetamine and methamphetamine:

~~(A)~~ Phenylacetone;

~~(B)~~ Some trade or other names: phenyl-2-propanone; P2P; benzyl methyl ketone; methyl benzyl ketone;

~~(2)~~ Immediate precursors to phencyclidine (PCP):

~~(A)~~ 1-phenylcyclohexylamine; and

~~(B)~~ 1-piperidinocyclohexanecarbonitrile (PCC).

~~(3)~~ Immediate precursor to fentanyl:

4-anilino-N-phenethyl-4-piperidine (ANPP).

§60A-2-210. Schedule IV.

(a) Schedule IV shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) *Narcotic drugs.* — Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as set forth below:

~~(1)~~ Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit;

~~(2)~~ Dextropropoxyphene (alpha-(+)-4-dimethylamino-1,2-diphenyl-3-methyl-2-propionoxybutane).

(c) *Depressants.* — Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:

~~(1)~~ Alprazolam;

~~(2)~~ Barbital;

~~(3)~~ Bromazepam;

~~(4)~~ Camazepam;

~~(5)~~ Carisoprodol;

~~(6)~~ Chloral betaine;

~~(7)~~ Chloral hydrate;

~~(8)~~ Chlordiazepoxide;

~~(9)~~ Clobazam;

~~(10)~~ Clonazepam;

~~(11)~~ Clorazepate;

~~(12)~~ Clotiazepam;

~~(13)~~ Cloxazolam;

~~(14)~~ Delorazepam;

~~(15)~~ Diazepam;

~~(16)~~ Dichloralphenazone;

~~(17)~~ Estazolam;

~~(18)~~ Ethchlorvynol;

~~(19)~~ Ethinamate;

~~(20)~~ Ethyl loflazepate;

~~(21)~~ Fludiazepam;

~~(22)~~ Flunitrazepam;

~~(23)~~ Flurazepam;

~~(24)~~ Fospropofol;

~~(25)~~ Halazepam;

~~(26)~~ Haloxazolam;

~~(27)~~ Ketazolam;

~~(28)~~ Loprazolam;

~~(29)~~ Lorazepam;

~~(30)~~ Lormetazepam;

~~(31)~~ Mebutamate;

~~(32)~~ Medazepam;

~~(33)~~ Meprobamate;

~~(34)~~ Methohexital;

~~(35)~~ Methylphenobarbital (mephobarbital);

~~(36)~~ Midazolam;

~~(37)~~ Nimetazepam;

~~(38)~~ Nitrazepam;

~~(39)~~ Nordiazepam;

~~(40)~~ Oxazepam;

~~(41)~~ Oxazolam;

~~(42)~~ Paraldehyde;

~~(43)~~ Petrichloral;

~~(44)~~ Phenobarbital;

~~(45)~~ Pinazepam;

~~(46)~~ Prazepam;

~~(47)~~ Quazepam;

~~(48)~~ Temazepam;

~~(49)~~ Tetrazepam;

~~(50)~~ Triazolam;

~~(51)~~ Zaleplon;

~~(52)~~ Zolpidem;

~~(53)~~ Zopiclone'

~~(54)~~ Suvorexant ([(7R)-4-(5-chloro-1,3-benzoxazol-2-yl)-7-methyl-1,4-diazepan-1-yl] [5-methyl-2-(2H-1,2,3-triazol-2-yl)phenyl]methanone).

(d) Any material, compound, mixture or preparation which contains any quantity of the following substance, including its salts, isomers (whether optical, position or geometric) and salts of such isomers whenever the existence of such salts, isomers and salts of isomers is possible: Fenfluramine and Dexfenfluramine.

(e) *Stimulants.* — Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:

~~(1)~~ Cathine ((+)-norpseudoephedrine);

~~(2)~~ Diethylpropion;

~~(3)~~ Fencamfamin;

~~(4)~~ Fenproporex;

~~(5)~~ Mazindol;

~~(6)~~ Mefenorex;

~~(7)~~ Modafinil;

~~(8)~~ Pemoline (including organometallic complexes and chelates thereof);

~~(9)~~ Phentermine;

~~(10)~~ Pipradrol;

~~(11)~~ Sibutramine;

~~(12)~~ SPA ((-)-1-dimethylamino-1,2-diphenylethane);

~~(13)~~ Eluxadoline (5-[[[(2S)-2-amino-3-[4-aminocarbonyl)-2,6-dimethylphenyl]-1-oxopropyl [(1S)-1-(4-phenyl-1H-imidazol-2-yl)ethyl]amino]methyl]-2-methoxybenzoic acid);

(f) *Other substances.* — Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts:

~~(1)~~ Pentazocine;

~~(2)~~ Butorphanol;

~~(3)~~ Tramadol (2-[(dimethylamino)methyl]-1-(3-methoxyphenyl) cyclohexanol); and

Gabapentin.

Amyl nitrite, butyl nitrite, isobutyl nitrite and the other organic nitrites are controlled substances and no product containing these compounds as a significant component shall be possessed, bought or sold other than pursuant to a bona fide prescription or for industrial or manufacturing purposes.

ARTICLE 9. CONTROLLED SUBSTANCES MONITORING.

§60A-9-4. Required information.

~~Whenever a medical services provider dispenses a controlled substance listed in Schedule II, III or IV as established under the provisions of article two of this chapter or an opioid antagonist, or whenever a prescription for the controlled substance or opioid antagonist is filled by: (i) A pharmacist or pharmacy in this state; (ii) a hospital, or other health care facility, for outpatient use; or (iii) a pharmacy or pharmacist licensed by the Board of Pharmacy, but situated outside this state for delivery to a person residing in this state, the medical services provider, health care facility, pharmacist or pharmacy shall, in a manner prescribed by rules promulgated by the Board of Pharmacy pursuant to this article, report the following information, as applicable:~~

(a) The following individuals shall report the required information to the controlled substance monitoring database when:

(1) A medical services provider dispenses a controlled substance listed in Schedule II, III, IV, V or an opioid antagonist;

(2) A prescription for the controlled substance or opioid antagonist is filled by:

(A) A pharmacist or pharmacy in this state;

(B) A hospital, or other health care facility, for outpatient use; or

(C) A pharmacy or pharmacist licensed by the Board of Pharmacy, but situated outside this state for delivery to a person residing in this state; and

(3) A pharmacist or pharmacy sells an opioid antagonist.

(b) The above individuals shall in a manner prescribed by rules promulgated by the Board of Pharmacy pursuant to this article, report the following information, as applicable:

(1) The name, address, pharmacy prescription number and Drug Enforcement

Administration controlled substance registration number of the dispensing pharmacy or the dispensing physician or dentist;

(2) The full legal name, address and birth date of the person for whom the prescription is written;

(3) The name, address and Drug Enforcement Administration controlled substances registration number of the practitioner writing the prescription;

(4) The name and national drug code number of the Schedule II, III and IV controlled substance or opioid antagonist dispensed;

(5) The quantity and dosage of the Schedule II, III and IV controlled substance or opioid antagonist dispensed;

(6) The date the prescription was written and the date filled;

(7) The number of refills, if any, authorized by the prescription;

(8) If the prescription being dispensed is being picked up by someone other than the patient on behalf of the patient, information about the person picking up the prescription as set forth on the person's government-issued photo identification card shall be retained in either print or electronic form until such time as otherwise directed by rule promulgated by the Board of Pharmacy; and

(9) The source of payment for the controlled substance dispensed.

~~(b)~~ (c) Whenever a medical services provider treats a patient for an overdose that has occurred as a result of illicit or prescribed medication, the medical service provider shall report the full legal name, address and birth date of the person who is being treated, including any known ancillary evidence of the overdose. The Board of Pharmacy shall coordinate with the Division of Justice and Community Services and the Office of Drug Control Policy regarding the collection of overdose data.

~~(c)~~ (d) The Board of Pharmacy may prescribe by rule promulgated pursuant to this article the form to be used in prescribing a Schedule II, III and IV substance or opioid antagonist if, in

the determination of the Board of Pharmacy, the administration of the requirements of this section would be facilitated.

~~(d)~~ (e) Products regulated by the provisions of §60A-10-1 *et seq.* shall be subject to reporting pursuant to the provisions of this article to the extent set forth in said article.

~~(e)~~ (f) Reporting required by this section is not required for a drug administered directly to a patient by a practitioner. Reporting is, however, required by this section for a drug dispensed to a patient by a practitioner. The quantity dispensed by a prescribing practitioner to his or her own patient may not exceed an amount adequate to treat the patient for a maximum of seventy-two hours with no greater than two 72-hour cycles dispensed in any fifteen-day period of time.

~~(f)~~ (g) The Board of Pharmacy shall notify a physician prescribing buprenorphine or buprenorphine/naloxone within sixty days of the availability of an abuse deterrent form of buprenorphine or buprenorphine/naloxone if approved by the Food and Drug Administration as provided in FDA Guidance to Industry. Upon receipt of the notice, a physician may switch their patients using buprenorphine or buprenorphine/naloxone to the abuse deterrent form of the drug.

§60A-9-5. Confidentiality; limited access to records; period of retention; no civil liability for required reporting.

(a)(1) The information required by this article to be kept by the Board of Pharmacy is confidential and not subject to the provisions of chapter twenty-nine-b of this code or obtainable as discovery in civil matters absent a court order and is open to inspection only by inspectors and agents of the Board of Pharmacy, members of the West Virginia State Police expressly authorized by the Superintendent of the West Virginia State Police to have access to the information, authorized agents of local law-enforcement agencies as members of a federally affiliated drug task force, authorized agents of the federal Drug Enforcement Administration, duly authorized agents of the Bureau for Medical Services, duly authorized agents of the Office of the Chief Medical Examiner for use in post-mortem examinations, duly authorized agents of the Office of Health Facility Licensure and Certification for use in certification, licensure and regulation of health

facilities, duly authorized agents of licensing boards of practitioners in this state and other states authorized to prescribe Schedules II, III and IV controlled substances, prescribing practitioners and pharmacists, a dean of any medical school or his or her designee located in this state to access prescriber level data to monitor prescribing practices of faculty members, prescribers and residents enrolled in a degree program at the school where he or she serves as dean, a physician reviewer designated by an employer of medical providers to monitor prescriber level information of prescribing practices of physicians, advance practice registered nurses or physician assistant in their employ, and a chief medical officer of a hospital or a physician designated by the chief executive officer of a hospital who does not have a chief medical officer, for prescribers who have admitting privileges to the hospital or prescriber level information, and persons with an enforceable court order or regulatory agency administrative subpoena. All law-enforcement personnel who have access to the Controlled Substances Monitoring Program database shall be granted access in accordance with applicable state laws and the Board of Pharmacy's rules, shall be certified as a West Virginia law-enforcement officer and shall have successfully completed training approved by the Board of Pharmacy. All information released by the Board of Pharmacy must be related to a specific patient or a specific individual or entity under investigation by any of the above parties except that practitioners who prescribe or dispense controlled substances may request specific data related to their Drug Enforcement Administration controlled substance registration number or for the purpose of providing treatment to a patient: *Provided*, That the West Virginia Controlled Substances Monitoring Program Database Review Committee established in subsection (b) of this section is authorized to query the database to comply with said subsection.

(2) Subject to the provisions of subdivision (1) of this subsection, the Board of Pharmacy shall also review the West Virginia Controlled Substance Monitoring Program database and issue reports that identify abnormal or unusual practices of patients who exceed parameters as determined by the advisory committee established in this section. The Board of Pharmacy shall communicate with practitioners and dispensers to more effectively manage the medications of

their patients in the manner recommended by the advisory committee. All other reports produced by the Board of Pharmacy shall be kept confidential. The Board of Pharmacy shall maintain the information required by this article for a period of not less than five years. Notwithstanding any other provisions of this code to the contrary, data obtained under the provisions of this article may be used for compilation of educational, scholarly or statistical purposes, and may be shared with the West Virginia Department of Health and Human Resources for those purposes, as long as the identities of persons or entities and any personally identifiable information, including protected health information, contained therein shall be redacted, scrubbed or otherwise irreversibly destroyed in a manner that will preserve the confidential nature of the information. No individual or entity required to report under section four of this article may be subject to a claim for civil damages or other civil relief for the reporting of information to the Board of Pharmacy as required under and in accordance with the provisions of this article.

(3) The Board of Pharmacy shall establish an advisory committee to develop, implement and recommend parameters to be used in identifying abnormal or unusual usage patterns of patients in this state. This advisory committee shall:

(A) Consist of the following members: A physician licensed by the West Virginia Board of Medicine, a dentist licensed by the West Virginia Board of Dental Examiners, a physician licensed by the West Virginia Board of Osteopathic Medicine, a licensed physician certified by the American Board of Pain Medicine, a licensed physician board certified in medical oncology recommended by the West Virginia State Medical Association, a licensed physician board certified in palliative care recommended by the West Virginia Center on End of Life Care, a pharmacist licensed by the West Virginia Board of Pharmacy, a licensed physician member of the West Virginia Academy of Family Physicians, an expert in drug diversion and such other members as determined by the Board of Pharmacy.

(B) Recommend parameters to identify abnormal or unusual usage patterns of controlled substances for patients in order to prepare reports as requested in accordance with subdivision

(2) of this subsection.

(C) Make recommendations for training, research and other areas that are determined by the committee to have the potential to reduce inappropriate use of prescription drugs in this state, including, but not limited to, studying issues related to diversion of controlled substances used for the management of opioid addiction.

(D) Monitor the ability of medical services providers, health care facilities, pharmacists and pharmacies to meet the 24-hour reporting requirement for the Controlled Substances Monitoring Program set forth in section three of this article, and report on the feasibility of requiring real-time reporting.

(E) Establish outreach programs with local law enforcement to provide education to local law enforcement on the requirements and use of the Controlled Substances Monitoring Program database established in this article.

(b) The Board of Pharmacy shall create a West Virginia Controlled Substances Monitoring Program Database Review Committee of individuals consisting of two prosecuting attorneys from West Virginia counties, two physicians with specialties which require extensive use of controlled substances and a pharmacist who is trained in the use and abuse of controlled substances. The review committee may determine that an additional physician who is an expert in the field under investigation be added to the team when the facts of a case indicate that the additional expertise is required. The review committee, working independently, may query the database based on parameters established by the advisory committee. The review committee may make determinations on a case-by-case basis on specific unusual prescribing or dispensing patterns indicated by outliers in the system or abnormal or unusual usage patterns of controlled substances by patients which the review committee has reasonable cause to believe necessitates further action by law enforcement or the licensing board having jurisdiction over the practitioners or dispensers under consideration. The licensing board having jurisdiction over the practitioner or dispenser under consideration shall report back to the Board of Pharmacy regarding any findings,

investigation or discipline resulting from the findings of the review committee within thirty days of resolution of any action taken by the licensing board resulting from the information provided by the Board of Pharmacy. The review committee shall also review notices provided by the chief medical examiner pursuant to §61-12-10(h) of this code and determine on a case-by-case basis whether a practitioner who prescribed or dispensed a controlled substance resulting in or contributing to the drug overdose may have breached professional or occupational standards or committed a criminal act when prescribing the controlled substance at issue to the decedent. Only in those cases in which there is reasonable cause to believe a breach of professional or occupational standards or a criminal act may have occurred, the review committee shall notify the appropriate professional licensing agency having jurisdiction over the applicable practitioner or dispenser and appropriate law-enforcement agencies and provide pertinent information from the database for their consideration. The number of cases identified shall be determined by the review committee based on a number that can be adequately reviewed by the review committee. The information obtained and developed may not be shared except as provided in this article and is not subject to the provisions of chapter twenty-nine-b of this code or obtainable as discovering in civil matters absent a court order.

(c) The Board of Pharmacy is responsible for establishing and providing administrative support for the advisory committee and the West Virginia Controlled Substances Monitoring Program Database Review Committee. The advisory committee and the review committee shall elect a chair by majority vote. Members of the advisory committee and the review committee may not be compensated in their capacity as members but shall be reimbursed for reasonable expenses incurred in the performance of their duties.

(d) The Board of Pharmacy shall promulgate rules with advice and consent of the advisory committee, in accordance with the provisions of §29A-3-1 *et seq.* The legislative rules must include, but shall not be limited to, the following matters:

(1) Identifying parameters used in identifying abnormal or unusual prescribing or

dispensing patterns;

(2) Processing parameters and developing reports of abnormal or unusual prescribing or dispensing patterns for patients, practitioners and dispensers;

(3) Establishing the information to be contained in reports and the process by which the reports will be generated and disseminated; ~~and~~

(4) Dissemination of these reports at least quarterly to:

(A) The West Virginia Board of Medicine codified at §30-3-1 *et seq.*;

(B) The West Virginia Board of Osteopathic Medicine codified at §30-14-1 *et seq.*;

(C) The West Virginia Board of Examiners for Registered Professional Nurses codified at §30-7-1 *et seq.*;

(D) The West Virginia Board of Dentistry codified at §30-4-1 *et seq.*;

(E) The West Virginia Board of Optometry codified at §30-8-1 *et seq.*; and

(F) The West Virginia Department of Health and Human Resources Office of Drug Control Policy; and

~~(4)~~ (5) Setting up processes and procedures to ensure that the privacy, confidentiality, and security of information collected, recorded, transmitted and maintained by the review committee is not disclosed except as provided in this section.

(e) Persons or entities with access to the West Virginia Controlled Substances Monitoring Program database pursuant to this section may, pursuant to rules promulgated by the Board of Pharmacy, delegate appropriate personnel to have access to said database.

(f) Good faith reliance by a practitioner on information contained in the West Virginia Controlled Substances Monitoring Program database in prescribing or dispensing or refusing or declining to prescribe or dispense a Schedule II, III or IV controlled substance shall constitute an absolute defense in any civil or criminal action brought due to prescribing or dispensing or refusing or declining to prescribe or dispense.

(g) A prescribing or dispensing practitioner may notify law enforcement of a patient who,

in the prescribing or dispensing practitioner's judgment, may be in violation of §60A-4-410, based on information obtained and reviewed from the controlled substances monitoring database. A prescribing or dispensing practitioner who makes a notification pursuant to this subsection is immune from any civil, administrative or criminal liability that otherwise might be incurred or imposed because of the notification if the notification is made in good faith.

(h) Nothing in the article may be construed to require a practitioner to access the West Virginia Controlled Substances Monitoring Program database except as provided in section five-a of this article.

(i) The Board of Pharmacy shall provide an annual report on the West Virginia Controlled Substance Monitoring Program to the Legislative Oversight Commission on Health and Human Resources Accountability with recommendations for needed legislation no later than January 1 of each year.

§60A-9-5a. Practitioner requirements to access database and conduct annual search of the database; search by licensing boards for investigative purposes; required rulemaking.

(a) All practitioners, as that term is defined in §60A-2-101 who prescribe or dispense Schedule II, III or IV controlled substances shall register with the West Virginia Controlled Substances Monitoring Program and obtain and maintain online or other electronic access to the program database: *Provided*, That compliance with the provisions of this subsection must be accomplished within thirty days of the practitioner obtaining a new license: *Provided, however,* That the Board of Pharmacy may renew a practitioner's license without proof that the practitioner meet the requirements of this subsection.

(b) Upon initially prescribing or dispensing any pain-relieving controlled substance for a patient for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness and at least annually thereafter should the practitioner or dispenser continue to treat the patient with

controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and, who are licensed by the Board of Medicine as set forth in §30-3-1 *et seq.*, the Board of Registered Professional Nurses as set forth in §30-7-1 *et seq.*, the Board of Dental Examiners as set forth in §30-7-1 *et seq.*, ~~and~~ the Board of Osteopathic Medicine as set forth in §30-14-1 *et seq.* and , the West Virginia Board of Optometrists as set forth in §30-8-1- et seq. shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program database for the patient shall be documented in the patient's medical record maintained by a private prescriber or any inpatient facility licensed pursuant to the provisions of chapter sixteen of this code. A pain-relieving controlled substance shall be defined as set forth in §30-3A-1.

(c) The licensing boards mentioned in subsection (b) of this section shall have access to the monitoring program database to search and query the database for purposes of investigating the prescribing practices of any prescriber for whom the board has issued or may a license. Any information obtained by the board shall be kept confidential and is subject to the same disclosure requirements as set forth in §60A-9-5 of this code.

~~(c)~~ (d) The various board mentioned in subsection (b) of this section shall promulgate both emergency and legislative rules pursuant to the provisions of §29A-3-1 *et seq.* to effectuate the provisions of this article.

NOTE: The purpose of this bill is to reduce the prescription drugs.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.