

## 2016 LEGISLATION AFFECTING THE PRACTICE OF PHARMACY

The following is a summary of legislation passed during the 2016 Session of the Minnesota Legislature that affects the practice of pharmacy. Appendix A contains the actual changes in statutes that were developed by the Board of Pharmacy. Appendix B contains a change in statutes that was developed by other entities.

### COLLECTION OF PHARMACEUTICAL WASTE BY PHARMACIES

Effective May 20, 2016, a pharmacy licensed by the Board and located in Minnesota may collect a legend drug from an “ultimate user” (i.e. from a member of the public), or from a long-term care facility on behalf of an ultimate user (i.e. patient or resident) who resides or resided at the long-term care facility, for the purpose of disposing of the legend drug as pharmaceutical waste. In order to collect drugs for disposal as pharmaceutical waste, a pharmacy must comply with Drug Enforcement (DEA) Regulations for the collection of controlled substances by pharmacies. A pharmacy must comply with those regulations for all drugs collected – even for non-controlled substances. In addition, pharmacies must comply with statutes and rules administered by the Minnesota Pollution Control Agency (MPCA).

Although this law became effective on May 20, 2016, pharmacies cannot begin collecting unwanted pharmaceuticals for disposal until they meet certain DEA and MPCA requirements.

**Pharmacies should not begin collecting pharmaceuticals until those requirements are met.**

The Board is working with MPCA to develop a *Guidance for Collecting Pharmaceuticals from Households and Long Term Care Facilities (LTCF)*. That document will include all of the details that pharmacies which want to collect pharmaceuticals for disposal will need to know. However, here are a few points to consider:

- A pharmacy will need to modify its DEA registration to become an authorized collector.

- It will also need to ensure it has obtained a Hazardous Waste Identification Number (HWID) from the MPCA for each separate collection site, including LTCFs.
- A pharmacy must submit a Household Pharmaceutical Consolidation Site Application to the MPCA or obtain the equivalent license from its Metro County.
- Pharmacies may only collect pharmaceuticals inside their pharmacy site or inside a LTCF where they provide pharmacy services. Pharmacies may not conduct off-site ‘take-back’ events or install dropboxes off-site or that are accessible from outside their pharmacy.
- Pharmaceuticals must be collected in collection receptacles that meet the requirements of the above-mentioned DEA regulations. Patients or LTCF staff must place the unwanted pharmaceuticals into the collection receptacles. **Pharmacy staff may not take pharmaceuticals directly from the public or from LTCF staff and place them into the receptacles.**
- Other businesses and law enforcement agencies may not bring discarded pharmaceuticals they have collected to a pharmacy for disposal.

#### PRESCRIPTION MONITORING PROGRAM

The following changes were made related to the Board’s Prescription Monitoring Program (PMP).

These changes are effective August 1, 2016, unless otherwise noted.

- Gabapentin was added to the list of drugs for which prescriptions must be reported to the PMP.
- All health licensing boards were authorized to have access to PMP data for the purpose of investigating bona fide complaints involving their licensees and registrants. Boards may request data from the PMP when they are investigating complaints that allege that a specific licensee is impaired by use of a drug for which data is collected by the PMP, has engaged in a controlled substance crime, or has engaged in doctor-shopping. In addition,

Boards that license prescribers can request data from the PMP when they are investigating complaints that allege that a specific licensee is inappropriately prescribing controlled substances. (Previously, only the Board of Pharmacy had the authority to access PMP data when investigating complaints).

- Prescribers were authorized to obtain PMP data, without consent, for additional situations in which they are providing care and they have reason to believe that the patient is potentially abusing a controlled substance. That belief must be based on the presence of clinically valid indications. The Board fought to have similar language included for pharmacists, but certain members of the House of Representatives would not accept that language. Consequently, pharmacists may access the PMP when:
  - they are dispensing or considering the dispensing of a controlled substance; or
  - when they are consulted by a prescriber who is requesting data.
- A “sunset” provision that would have ended the ability of the Board to send out Controlled Substance Insight Alerts (CSIA) to prescribers and pharmacies was removed. The Board’s PMP Pharmacist will continue to send CSIA’s to prescribers and pharmacists when data suggests that an individual may be engaging in doctor-shopping.
- Prescribers and pharmacists practicing within Minnesota were required to register as PMP users. (But were not required to actually use the PMP). By July 1, 2017, every prescriber licensed by a Minnesota health-licensing board practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and *every pharmacist* licensed by the Board and *practicing within the state, must register and maintain a user account with the prescription monitoring program*. Pharmacists are strongly encouraged to establish a PMP account as soon as possible. Online registration is available at: <http://pmp.pharmacy.state.mn.us/pharmacist-rxentry-access-form.html>.

- The Board was allowed to keep the prescription data that it collects, in an identifiable manner, so that a study of the effectiveness of the PMP can be conducted. Data collected from January 1, 2015 through December 31, 2018 will be kept in an identifiable manner through December 31, 2019. That data will then be destroyed and subsequently collected data will be destroyed one year from the date on which it was provided to the Board.
- Language was added to clarify that the Prescription Monitoring Program Advisory Task Force does not expire.

### NALOXONE

The Board proposed legislation that would have allowed pharmacists to directly prescribe naloxone. Unfortunately, the legislation was vigorously opposed by the Minnesota Medical Association. The following provisions were ultimately passed and became effective May 20, 2016:

- Existing law already allows pharmacists to work under a protocol issued by a practitioner when initiating, modifying, managing or discontinuing any drug. Consequently, no change in law was necessary to allow pharmacists to work under a protocol with a practitioner and to prepare a legally valid prescription for naloxone. Nevertheless, the board is required to develop an opiate antagonist protocol that practitioners will be able to use when authorizing pharmacists who are working under that protocol to prepare legally valid prescriptions for naloxone. Note that pharmacists and practitioners, other than medical consultants for community based health boards or practitioners working for the Department of Health, are not required to use the protocol developed by the Board.
- The commissioner of health is required to provide the following items to medical consultants who are working for community based health boards:
  - educational materials concerning the need for, and opportunities to provide, greater access to opiate antagonists;
  - the opiate antagonist protocol developed by the board; and

- a notice that liability protections related to the prescribing of naloxone pursuant to a protocol that are extended to cover the use of the Board’s opiate antagonist protocol by CHB medical consultants.

The intent is to encourage these medical consultants to enter into protocols with local pharmacists who want to provide naloxone per protocol. However, nothing requires these medical consultants to enter into a protocol with any pharmacist.

- The commissioner of health is allowed, but not required, to designate a practitioner (prescriber) to enter into the Board’s naloxone protocol with pharmacists practicing within one or more community health service areas – but ONLY at the request of the applicable CHB. A CHB must make the request to the commissioner by October 1 for the subsequent calendar year. So, if the medical consultant for a CHB does not want to enter into a protocol with pharmacists and if the CHB does not request that a practitioner employed by the department of health enter into a protocol, pharmacists interested in providing naloxone by protocol would need to find some other willing prescriber.
- Immunity related to the prescribing of naloxone per protocol was extended to both the commissioner of health and to the designated practitioner when prescribing according to the protocol under this subdivision. The commissioner of health and the designated practitioner are both deemed to be acting within the scope of state employment when prescribing according to the protocol developed by the Board.

#### CONTROLLED SUBSTANCES SCHEDULING

Over a dozen synthetic, “designer” stimulants, hallucinogens, and cannabinoids were added to Schedule I. Eluxadoline (Viberzi), a federal Schedule IV drug, was added to Minnesota’s Schedule IV.

#### TEMPORARY SUSPENSION OF LICENSES

Language was amended in Chapter 214 to clarify the circumstances under which health-licensing

boards can temporarily suspend a registration or license when a regulated person has violated a statute or rule that the health-licensing board is empowered to enforce, and continued practice by the regulated person presents an imminent risk of serious harm. The procedures that a board must follow when issuing a temporary suspension were also clarified.

#### BOARD'S APPROPRIATION

The Board was granted a supplemental increase in its appropriation of \$115,000 for fiscal year 2016 and \$145,000 for fiscal year 2017. The increased expenditures can be covered with existing revenue, so no fee-increase was necessary.

#### 90-DAY SUPPLIES OF PRESCRIPTION DRUGS

Other groups pursued legislation that allows pharmacists to dispense a 90-day supply of a prescription drug under certain circumstances, even when the prescription was written for a smaller quantity. This provision is not effective until August 1, 2016. Due to ambiguity in the language, the Board may have to issue a guidance document. Any such guidance will be issued before that date.

### **APPENDIX A LEGISLATION DEVELOPED BY THE BOARD OF PHARMACY**

#### **CHAPTER 124 - S.F. No. 1425**

*An act relating to health; adding provisions to the definition of the "practice of pharmacy"; making changes concerning the collection and disposal of legend drugs as pharmaceutical waste; requiring an opiate antagonist protocol; amending Minnesota Statutes 2014, sections 151.01, by adding a subdivision; 151.37, subdivisions 6, 7, by adding subdivisions; Minnesota Statutes 2015 Supplement, sections 151.01, subdivision 27; 151.37, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 152.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2015 Supplement, section 151.01, subdivision 27, is amended to read:

Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

- (1) interpretation and evaluation of prescription drug orders;

(2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);

(3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;

(4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;

(5) participation in administration of influenza vaccines to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

(A) the name, dose, and route of each vaccine that may be given;

(B) the patient population for whom the vaccine may be given;

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

(E) the name, signature, and address of the physician, physician assistant, or advanced practice registered nurse;

(F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse can be contacted; and

(G) the date and time period for which the protocol is valid;

(ii) the pharmacist has successfully completed a program approved by the Accreditation Council for Pharmacy Education specifically for the administration of immunizations or a program approved by the board;

(iii) the pharmacist utilizes the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(iv) the pharmacist reports the administration of the immunization to the Minnesota Immunization Information Connection; and

(v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a

pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

(6) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(7) participation in the storage of drugs and the maintenance of records;

(8) patient counseling on therapeutic values, content, hazards, and uses of drugs and devices; ~~and~~

(9) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy.; ~~and~~

(10) participation in the initiation, management, modification, and discontinuation of therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

(i) a written protocol as allowed under clause (6); or

(ii) a written protocol with a community health board medical consultant or a practitioner designated by the commissioner of health, as allowed under section 151.37, subdivision 13.

Sec. 2. Minnesota Statutes 2014, section 151.01, is amended by adding a subdivision to read:

**Subd. 39. Ultimate user.**

"Ultimate user" means a natural person who possesses a legend drug that was lawfully obtained for personal use or for the use of a household member or for the use of an animal owned by the natural person or by a household member.

Sec. 3. Minnesota Statutes 2015 Supplement, section 151.37, subdivision 2, is amended to read:



## **Subd. 2. Prescribing and filing.**

(a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section [148.634](#); a nurse, pursuant to section [148.235](#), subdivisions 8 and 9; physician assistant; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of section [147A.18](#).

(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the conditions triggering section [144.4197](#) or [144.4198, subdivision 2](#), paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section [13.03](#). This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing

by a community health clinic when the profit from dispensing is used to meet operating expenses.

(d) A prescription drug order for the following drugs is not valid, unless it can be established that the prescription drug order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

- (1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;
- (2) drugs defined by the Board of Pharmacy as controlled substances under section 152.02, subdivisions 7, 8, and 12;
- (3) muscle relaxants;
- (4) centrally acting analgesics with opioid activity;
- (5) drugs containing butalbital; or
- (6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if an in-person examination has been completed in any of the following circumstances:

- (1) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;
- (2) the prescribing practitioner has performed a prior examination of the patient;
- (3) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;
- (4) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or
- (5) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine.

(f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a drug through the use of a guideline or protocol pursuant to paragraph (a).

(g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription or dispensing a legend drug in accordance with the Expedited Partner Therapy in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control.

(h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of legend drugs through a public health clinic or other distribution mechanism approved by the commissioner of health or a community health board in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.

(i) No pharmacist employed by, under contract to, or working for a pharmacy located within the state and licensed under section 151.19, subdivision 1, may dispense a legend drug based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(j) No pharmacist employed by, under contract to, or working for a pharmacy located outside the state and licensed under section 151.19, subdivision 2-1, may dispense a legend drug to a resident of this state based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner, or, if not a licensed practitioner, a designee of the commissioner who is a licensed practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of a communicable disease according to the Centers For Disease Control and Prevention Partner Services Guidelines.

Sec. 4. Minnesota Statutes 2014, section 151.37, subdivision 6, is amended to read:

**Subd. 6. Exclusion for course of employment.**

(a) Nothing in this chapter shall prohibit the possession of a legend drug by an employee, agent, or sales representative of a registered drug manufacturer, or an employee or agent of a registered drug wholesaler, or registered pharmacy, while acting in the course of employment.

(b) Nothing in this chapter shall prohibit an employee of the following entities, while acting in the course of employment, from possessing a legend drug for the purpose of disposing of the legend drug as pharmaceutical waste, provided that controlled substances listed in section 152.02, subdivisions 3 to 6, may only be collected and disposed of as allowed under section 152.105:

(1) a law enforcement ~~officer~~ agency;

(2) a hazardous waste transporter ~~licensed by the Department of Transportation that has notified the Pollution Control Agency of its activity~~;

(3) a facility permitted by the Pollution Control Agency to treat, store, or dispose of hazardous waste, including household hazardous waste;

(4) a facility licensed by the Pollution Control Agency or a metropolitan county, as defined in section 473.121, as a very small quantity generator collection program or a minimal generator or household hazardous waste collection program; or

~~(5) a county that collects, stores, transports, or disposes of a legend drug pursuant to a program in compliance with applicable federal law or a person authorized by the county to conduct one or more of these activities; or~~

(6) a sanitary district organized under chapter 115, or a special law.

Sec. 5. Minnesota Statutes 2014, section 151.37, is amended by adding a subdivision to read:

**Subd. 6a. Collection of legend drugs by pharmacies.**

A pharmacy licensed under section 151.19 may collect a legend drug from an ultimate user, or from a long-term care facility on behalf of an ultimate user who resides or resided at the long-term care facility, for the purpose of disposing of the legend drug as pharmaceutical waste, provided that:

(1) a pharmacy may collect and dispose of controlled substances listed in section 152.02, subdivision 3 to 6, only as allowed under section 152.105; and

(2) a pharmacy that has established a controlled substance disposal program pursuant to section 152.105 may also collect and dispose of noncontrolled substance legend and nonlegend drugs, but only in the same manner in which it collects and disposes of controlled substances.

Sec. 6. Minnesota Statutes 2014, section 151.37, subdivision 7, is amended to read:

**Subd. 7. Exclusion for prescriptions.**

(a) Nothing in this chapter shall prohibit the possession of a legend drug by a person for that person's use when it has been dispensed to the person in accordance with a valid prescription issued by a practitioner.

(b) Nothing in this chapter shall prohibit a person, for whom a legend drug has been dispensed in accordance with a written or oral prescription by a practitioner, from designating a family member, caregiver, or other individual to handle the legend drug for the purpose of assisting the person in obtaining or administering the drug or sending the drug for destruction.

~~(c) Nothing in this chapter shall prohibit a person for whom a prescription legend drug has been dispensed in accordance with a valid prescription issued by a practitioner from transferring the legend drug to a county that collects, stores, transports, or disposes of a legend drug pursuant to a program in compliance with applicable federal law or to a person authorized by the county to conduct one or more of these activities.~~ an entity identified in subdivision 6. Controlled substances listed in section 152.02, subdivision 3 to 6, may only be collected, stored, transported, and disposed of as allowed under section 152.105.

Sec. 7. Minnesota Statutes 2014, section 151.37, is amended by adding a subdivision to read:

**Subd. 13. Opiate antagonists protocol.**

(a) The board shall develop an opiate antagonist protocol. When developing the protocol, the board shall consult with the Board of Medical Practice, the Board of Nursing, the commissioner of health, and professional associations of pharmacists, physicians, physician assistants, and advanced practice registered nurses.

(b)The commissioner of health shall provide the following items to medical consultants appointed under section 145A.04, subdivision 2a:

(1)educational materials concerning the need for, and opportunities to provide, greater access to opiate antagonists;

(2) the opiate antagonist protocol developed by the board under paragraph (a);  
and (3) a notice of the liability protections under section 604A.04,  
subdivision 3, that

are extended to cover the use of the opiate antagonist protocol developed under this subdivision.

(c)The commissioner of health may designate a practitioner who is authorized to prescribe opiate antagonists to enter into the written protocol developed under paragraph (a) with pharmacists practicing within one or more community health service areas, upon the request of the applicable community health board. A community health board making a request to the commissioner under this section must do so by October 1 for the subsequent calendar year.

(d)The immunity in section 604A.04, subdivision 3, is extended to both the commissioner of health and to the designated practitioner when prescribing according to the protocol under this subdivision. The commissioner of health and the designated practitioner are both deemed to be acting within the scope of employment for purposes of section 3.736, subdivision 9, when prescribing according to the protocol under this subdivision.

**Sec. 8. [152.105] DISPOSAL.**

Controlled substances listed in section 152.02, subdivisions 3 to 6, may be collected and disposed of only pursuant to the provisions of Code of Federal Regulations, Title 21, parts 1300, 1301, 1304, 1305, 1307, and 1317, that are applicable to the disposal of controlled substances. Disposal of controlled substances and legend and nonlegend drugs must also comply with the requirements of section 116.07 governing the disposal of hazardous waste, and the rules promulgated thereunder.

**Sec. 9. EFFECTIVE DATE.** Sections 1 to 8 are effective the day following final enactment.

Presented to the governor May 17, 2016

Signed by the governor May 19, 2016, 10:57 a.m.

Effective May 20, 2016

## CHAPTER 185--S.F. No. 1440

*A bill for an act relating to health; making changes to the Minnesota prescription monitoring program; amending Minnesota Statutes 2014, section 152.126, subdivisions 1, 3, 5, 6; repealing Laws 2014, chapter 286, article 7, section 4*

Section 1. Minnesota Statutes 2014, section 152.126, subdivision 1, is amended to read:  
Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(c) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 6, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12. For the purposes of this section, controlled substances includes ~~tramadol and butalbital~~ and gabapentin.

(d) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(e) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

(f) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1 or 2.

(g) "Prescription" has the meaning given in section 151.01, subdivision ~~46-16a~~.

Sec. 2. Minnesota Statutes 2014, section 152.126, subdivision 3, is amended to read:

Subd. 3. **Prescription Monitoring Program Advisory Task Force.** (a) The board shall appoint an advisory task force consisting of at least one representative of:

2.9 (1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a professional nursing association;

(7) a professional dental association;

(8) a consumer privacy or security advocate;

(9) a consumer or patient rights organization; and

(10) an association of medical examiners and coroners.

(b) The advisory task force shall advise the board on the development and operation of the prescription monitoring program, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data;

(3) an evaluation process for the program; and

(4) criteria for the unsolicited provision of prescription monitoring data by the board to prescribers and dispensers.

(c) The task force is governed by section 15.059. Notwithstanding any other provisions of law to the contrary, the task force shall not expire.

Sec. 3. Minnesota Statutes 2014, section 152.126, subdivision 5, is amended to read:

**Subd. 5. Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. Except as otherwise allowed under subdivision 6, the database may be used by permissible users identified under subdivision 6 for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of use for those controlled substances, including standards accepted by national and international pain management associations; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.

(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate or ~~substantiate~~ a disciplinary action against a prescriber.

(d) Data reported under subdivision 4 shall be made available to permissible users for a 12-month period beginning the day the data was received and ending 12 months from the last day of the month in which the data was received, except that permissible users defined in subdivision 6, paragraph (b), clauses (6) and (7), may use all data collected under this section for the purposes of administering, operating, and maintaining the prescription monitoring program and conducting trend analyses and other studies necessary to evaluate the effectiveness of the program. ~~Data retained beyond 24 months must be de-identified.~~

~~(e) The board shall not retain data reported under subdivision 4 for a period longer than four years from the date the data was received.~~

(e) Data reported during the period January 1, 2015, through December 31, 2018, may be retained through December 31, 2019, in an identifiable manner. Effective January 1, 2020, data older than 24 months must be destroyed. Data reported on or after January 1, 2020, must be destroyed no later than 12 months from the date the data was received.

Sec. 4. Minnesota Statutes 2014, section 152.126, subdivision 6, is amended to read:

**Subd. 6. Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

- (i) prescribing or considering prescribing any controlled substance;
- (ii) providing emergency medical treatment for which access to the data may be necessary; ~~or~~
- (iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or
- ~~(iii)-(iv)~~ (iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;
- (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;
- (3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);
- (4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;
- (5) personnel or designees of ~~the a health-related licensing board specifically listed~~ in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);
- (6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;
- (7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);
- (8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;
- (9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;
- (10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph ~~(h)~~ (i); ~~and~~



(11) personnel of the health professionals services program established under section 214.31 , to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.

For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Only permissible user-users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

~~(d)~~ (e) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

~~(e)~~ (f) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

~~(f)~~ (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

~~(g)~~ (h) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph. ~~The board shall report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services policy and finance on the interstate prescription monitoring program by January 5, 2016.~~

~~(h)~~ (i) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

- (1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and
- (2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

~~(i)~~ (j) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met. ~~The board shall report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services policy and finance on the criteria established under this paragraph and the review process by January 5, 2016. This paragraph expires August 1, 2016.~~

Sec. 5. **REPEALER.**

Laws 2014, chapter 286, article 7, section 4, is repealed.

**CHAPTER 182--H.F. No. 3333**

*A bill for an act relating to health; modifying the schedules of controlled substances; amending Minnesota Statutes 2015 Supplement, section 152.02, subdivisions 2, 5.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2015 Supplement, section 152.02, subdivision 2, is amended to read:

**Subd. 2. Schedule I.**

(a) Schedule I consists of the substances listed in this subdivision.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following substances, including their analogs, isomers, esters, ethers, salts, and salts

of isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers, and salts is possible:

- (1) acetylmethadol;
- (2) allylprodine;
- (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl acetate);
- (4) alphameprodine;
- (5) alphamethadol;
- (6) alpha-methylfentanyl benzethidine;
- (7) betacetylmethadol;
- (8) betameprodine;
- (9) betamethadol;
- (10) betaprodine;
- (11) clonitazene;
- (12) dextromoramide;
- (13) diampromide;
- (14) diethylambutene;
- (15) difenoxin;
- (16) dimenoxadol;
- (17) dimepheptanol;
- (18) dimethylambutene;
- (19) dioxaphetyl butyrate;
- (20) dipipanone;
- (21) ethylmethylthiambutene;
- (22) etonitazene;
- (23) etoxeridine;
- (24) furethidine;
- (25) hydroxypethidine;
- (26) ketobemidone;
- (27) levomoramide;
- (28) levophenacylmorphane;
- (29) 3-methylfentanyl;
- (30) acetyl-alpha-methylfentanyl;
- (31) alpha-methylthiofentanyl;
- (32) benzylfentanyl beta-hydroxyfentanyl;
- (33) beta-hydroxy-3-methylfentanyl;
- (34) 3-methylthiofentanyl;
- (35) thenylfentanyl;
- (36) thiofentanyl;
- (37) para-fluorofentanyl;
- (38) morpheridine;
- (39) 1-methyl-4-phenyl-4-propionoxypiperidine;
- (40) noracetylmethadol;

- (41) norlevorphanol;
- (42) normethadone;
- (43) norpipanone;
- (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
- (45) phenadoxone;
- (46) phenampromide;
- (47) phenomorphan;
- (48) phenoperidine;
- (49) piritramide;
- (50) proheptazine;
- (51) properidine;
- (52) propiram;
- (53) racemoramide;
- (54) tilidine;
- (55) trimeperidine;
- (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl).

(c) Opium derivatives. Any of the following substances, their analogs, salts, isomers, and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

- (1) acetorphine;
- (2) acetyldihydrocodeine;
- (3) benzylmorphine;
- (4) codeine methylbromide;
- (5) codeine-n-oxide;
- (6) cyprenorphine;
- (7) desomorphine;
- (8) dihydromorphine;
- (9) drotebanol;
- (10) etorphine;
- (11) heroin;
- (12) hydromorphanol;
- (13) methyl-desorphine;
- (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) Hallucinogens. Any material, compound, mixture or preparation which contains any quantity of the following substances, their analogs, salts, isomers (whether optical, positional, or geometric), and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

- (1) methylenedioxy amphetamine;
- (2) methylenedioxymethamphetamine;
- (3) methylenedioxy-N-ethylamphetamine (MDEA);
- (4) n-hydroxy-methylenedioxyamphetamine;
- (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);
- (6) 2,5-dimethoxyamphetamine (2,5-DMA);
- (7) 4-methoxyamphetamine;
- (8) 5-methoxy-3, 4-methylenedioxyamphetamine;
- (9) alpha-ethyltryptamine;
- (10) bufotenine;
- (11) diethyltryptamine;
- (12) dimethyltryptamine;
- (13) 3,4,5-trimethoxyamphetamine;
- (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);
- (15) ibogaine;
- (16) lysergic acid diethylamide (LSD);
- (17) mescaline;
- (18) parahexyl;
- (19) N-ethyl-3-piperidyl benzilate;
- (20) N-methyl-3-piperidyl benzilate;
- (21) psilocybin;
- (22) psilocyn;
- (23) tenocyclidine (TCP or TCP);
- (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);
- (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);
- (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);
- (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);
- (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);
- (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);
- (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);
- (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);
- (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);
- (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);
- (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);
- (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);
- (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);
- (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

- (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine (2-CB-FLY);
- (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);
- (40) alpha-methyltryptamine (AMT);
- (41) N,N-diisopropyltryptamine (DiPT);
- (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);
- (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);
- (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);
- (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);
- (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);
- (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);
- (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);
- (49) 5-methoxy- $\alpha$ -methyltryptamine (5-MeO-AMT);
- (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);
- (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);
- (52) 5-methoxy-N-methyl-N-propyltryptamine (5-MeO-MiPT);
- (53) 5-methoxy- $\alpha$ -ethyltryptamine (5-MeO-AET);
- (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);
- (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);
- (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);
- (57) methoxetamine (MXE);
- (58) 5-iodo-2-aminoindane (5-IAI);
- (59) 5,6-methylenedioxy-2-aminoindane (MDAI);
- (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);
- (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);
- (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);
- (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);
- (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);
- (65) N,N-Dipropyltryptamine (DPT);
- (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);
- (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);
- (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);
- (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);
- (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylnorketamine, ethketamine, NENK); and
- (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA).

(e) Peyote. 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 the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds or extracts. The listing of peyote as a controlled substance in

Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian Church, and members of the American Indian Church are exempt from registration. Any person who manufactures peyote for or distributes peyote to the American Indian Church, however, is required to obtain federal registration annually and to comply with all other requirements of law.

(f) Central nervous system depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

- (1) mecloqualone;
- (2) methaqualone;
- (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;
- (4) flunitrazepam; and
- (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine, methoxyketamine).

(g) Stimulants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

- (1) aminorex;
- (2) cathinone;
- (3) fenethylamine;
- (4) methcathinone;
- (5) methylaminorex;
- (6) N,N-dimethylamphetamine;
- (7) N-benzylpiperazine (BZP);
- (8) methylmethcathinone (mephedrone);
- (9) 3,4-methylenedioxy-N-methylcathinone (methylone);
- (10) methoxymethcathinone (methedrone);
- (11) methylenedioxypropylone (MDPV);
- (12) 3-fluoro-N-methylcathinone (3-FMC);
- (13) methylethcathinone (MEC);
- (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- (15) dimethylmethcathinone (DMMC);
- (16) fluoroamphetamine;
- (17) fluoromethamphetamine;
- (18)  $\alpha$ -methylaminobutyrophenone (MABP or buphedrone);
- (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);
- (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);
- (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or naphyrone);
- (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);
- (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);

- (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);
- (25) 4-methyl-N-ethylcathinone (4-MEC);
- (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);
- (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);
- (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);
- (29) 4-fluoro-N-methylcathinone (4-FMC);
- (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);
- (31) alpha-pyrrolidinobutiophenone ( $\alpha$ -PBP);
- (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);
- (33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);
- ~~(33)~~ (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB); and

~~(34)~~ (35) any other substance, except bupropion or compounds listed under a different schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:

(i) 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;

(ii) by substitution at the 3-position with an acyclic alkyl substituent;

(iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or

(iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

(h) Marijuana, tetrahydrocannabinols, and synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any natural or synthetic material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

(1) marijuana;

(2) tetrahydrocannabinols naturally contained in a plant of the genus Cannabis, synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of the plant, or synthetic substances with similar chemical structure and pharmacological activity to those substances contained in the plant or resinous extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

(3) synthetic cannabinoids, including the following substances:

(i) Naphthoylindoles, which are any compounds containing a 3-(1-naphthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

(B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);



- (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);
- (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);
- (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);
- (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);
- (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);
- (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);
- (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);
- (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

(ii) Naphthylmethylindoles, which are any compounds containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

- (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);
- (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

(iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylpyrroles include, but are not limited to, (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

(iv) Naphthylmethylindenenes, which are any compounds containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindenenes include, but are not limited to, E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

(v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of phenylacetylindoles include, but are not limited to:

- (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);
- (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);
- (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);
- (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

(vi) Cyclohexylphenols, which are compounds containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,

1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not limited to:

(A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

(B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (Cannabicyclohexanol or CP 47,497 C8 homologue);

(C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]-phenol (CP 55,940).

(vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of benzoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

(B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

(C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN 48,098 or Pravadoline).

(viii) Others specifically named:

(A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

(B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

(C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

(D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

(E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (XLR-11);

(F) 1-pentyl-N-tricyclo[3.3.1.1<sup>3,7</sup>]dec-1-yl-1H-indazole-3-carboxamide (AKB-48(APINACA));

(G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5-Fluoro-AKB-48);

(H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

(I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

(J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide (AB-PINACA);

(K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-1H-indazole-3-carboxamide (AB-FUBINACA);

(L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide(AB-CHMINACA);

(M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate (5-fluoro-AMB);

(N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);  
(O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone  
(FUBIMINA);

(P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo  
[2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);

(Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)  
-1H-indole-3-carboxamide (5-fluoro-ABICA);

(R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)  
-1H-indole-3-carboxamide;

(S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)  
-1H-indazole-3-carboxamide; ~~and~~

(T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)  
-3,3-dimethylbutanoate;

(U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1  
H-indazole-3-carboxamide (MAB-CHMINACA);

(V)  
N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide  
(ADB-PINACA);

(W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);

(X)  
N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-3-  
carboxamide.  
(APP-CHMINACA); and

(Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22).

(i) A controlled substance analog, to the extent that it is implicitly or explicitly  
intended for human consumption.

Sec. 2. Minnesota Statutes 2015 Supplement, section 152.02, subdivision 5, is amended to  
read:

Subd. 5. **Schedule IV.** (a) Schedule IV consists of the substances listed in this subdivision.

(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 follows:

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

(2) dextropropoxyphene (Darvon and Darvocet);

(3) 2-[(dimethylamino)methyl]-1-(3-methoxyphenyl)cyclohexanol, its salts, optical  
and geometric isomers, and salts of these isomers (including tramadol); ~~and~~

(4) eluxadolone.

(c) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of the salts, isomers, and salts of isomers is possible:

- (1) alfaxalone (5 $\alpha$ -pregnan-3 $\alpha$ -ol-11,20-dione);
- (2) alprazolam;
- (3) barbital;
- (4) bromazepam;
- (5) camazepam;
- (6) carisoprodol;
- (7) chloral betaine;
- (8) chloral hydrate;
- (9) chlordiazepoxide;
- (10) clobazam;
- (11) clonazepam;
- (12) clorazepate;
- (13) clotiazepam;
- (14) cloxazolam;
- (15) delorazepam;
- (16) diazepam;
- (17) dichloralphenazone;
- (18) estazolam;
- (19) ethchlorvynol;
- (20) ethinamate;
- (21) ethyl loflazepate;
- (22) fludiazepam;
- (23) flurazepam;
- (24) fospropofol;
- (25) halazepam;
- (26) haloxazolam;
- (27) ketazolam;
- (28) loprazolam;
- (29) lorazepam;
- (30) lormetazepam mebutamate;
- (31) medazepam;
- (32) meprobamate;
- (33) methohexital;
- (34) methylphenobarbital;
- (35) midazolam;
- (36) nimetazepam;
- (37) nitrazepam;
- (38) nordiazepam;
- (39) oxazepam;

- (40) oxazolam;
- (41) paraldehyde;
- (42) petrichloral;
- (43) phenobarbital;
- (44) pinazepam;
- (45) prazepam;
- (46) quazepam;
- (47) suvorexant;
- (48) temazepam;
- (49) tetrazepam;
- (50) triazolam;
- (51) zaleplon;
- (52) zolpidem;
- (53) zopiclone.

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

(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) fencamfamine;
  - (4) fenproporex;
  - (5) mazindol;
  - (6) mefenorex;
  - (7) modafinil;
  - (8) pemoline (including organometallic complexes and chelates thereof);
  - (9) phentermine;
  - (10) pipradol;
  - (11) sibutramine;
  - (12) SPA (1-dimethylamino-1,2-diphenylethane).
- (f) lorcaserin.

## CHAPTER 125--H.F. No. 1036

*A bill for an act relating to health care; modifying provisions related to physician assistants, midwives, and nurses; modifying provisions related to license suspension and contested case hearings; amending Minnesota Statutes 2014, sections 147A.01, subdivisions 17a, 23; 147A.20, subdivisions 1, 2; 147D.05, subdivision 1; 147D.09; 147D.13, subdivision 2; 147D.25, subdivision 1; 148.271; 214.077; 214.10, subdivisions 2, 2a, by adding a subdivision; 214.32, subdivision 6; 256B.0625, subdivision 28a; repealing Minnesota Statutes 2014, sections 147A.01, subdivision 5; 147D.17, subdivision 4.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Sec. 10. Minnesota Statutes 2014, section 214.077, is amended to read:

### **214.077 TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF SERIOUS HARM.**

(a) Notwithstanding any provision of a health-related professional practice act, when a health-related licensing board receives a complaint regarding a regulated person and has probable cause to believe that the regulated person has violated a statute or rule that the health-related licensing board is empowered to enforce, and continued practice by the regulated person presents an imminent risk of serious harm, the health-related licensing board shall issue an order temporarily suspend suspending the regulated person's professional license authority to practice. The temporary suspension order shall take effect upon written notice to the regulated person and shall specify the reason for the suspension, including the statute or rule alleged to have been violated. The temporary suspension order shall take effect upon personal service on the regulated person or the regulated person's attorney, or upon the third calendar day after the order is served by first class mail to the most recent address provided to the health-related licensing board for the regulated person or the regulated person's attorney.

(b) The temporary suspension shall remain in effect until the appropriate health-related licensing board or the commissioner completes an investigation, holds a contested case hearing pursuant to the Administrative Procedure Act, and issues a final order in the matter after a hearing as provided for in this section.

(c) At the time it issues the temporary suspension notice order, the appropriate health-related licensing board shall schedule a disciplinary contested case hearing, on the merits of whether discipline is warranted, to be held before the licensing board or pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any contested case hearing held pursuant to this section. The contested case hearing shall be scheduled to begin no later than 30 days after issuance the effective service of the temporary suspension order.

(d) The administrative law judge presiding over the contested case hearing shall issue a report and recommendation to the health-related licensing board no later than 30 days after the final day of the contested case hearing. The health-related licensing board shall issue a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations. Except as provided in paragraph (e), if the health-related licensing board has not issued a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations, the temporary suspension shall be lifted.

(e) If the board has not completed its investigation and issued a final order within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension

shall remain in place until the completion of the investigation. the regulated person requests a delay in the contested case proceedings provided for in paragraphs (c) and (d) for any reason, the temporary suspension shall remain in effect until the health-related licensing board issues a final order pursuant to sections 14.61 and 14.62.

(f) This section shall not apply to the Office of Unlicensed Complementary and Alternative Health Practice established under section 146A.02. The commissioner of health shall conduct temporary suspensions for complementary and alternative health care practitioners in accordance with section 146A.09.

Sec. 11. Minnesota Statutes 2014, section 214.10, subdivision 2, is amended to read:

Subd. 2. **Investigation and hearing.** The designee of the attorney general providing legal services to a board shall evaluate the communications forwarded by the board or its members or staff. If the communication alleges a violation of statute or rule which the board is to enforce, the designee is empowered to investigate the facts alleged in the communication. In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director, executive secretary, or, if the board determines, a member of the board who has been appointed by the board to assist the designee. The designee may also consult with or seek the assistance of any other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation. The executive director, executive secretary, or the consulted board member may attempt to correct improper activities and redress grievances through education, conference, conciliation and persuasion, and in these attempts may be assisted by the designee of the attorney general. If the attempts at correction or redress do not produce satisfactory results in the opinion of the executive director, executive secretary, or the consulted board member, or if after investigation the designee providing legal services to the board, the executive director, executive secretary, or the consulted board member believes that the communication and the investigation suggest illegal or unauthorized activities warranting board action, the person having the belief shall inform the executive director or executive secretary of the board who shall schedule a disciplinary contested case hearing in accordance with chapter 14. Before directing the holding of a disciplinary contested case hearing, the executive director, executive secretary, or the designee of the attorney general shall have considered the recommendations of the consulted board member. Before scheduling a disciplinary contested case hearing, the executive director or executive secretary must have received

a verified written complaint from the complaining party. A board member who was consulted during the course of an investigation may participate at the hearing but may not vote on any matter pertaining to the case. The executive director or executive secretary of the board shall promptly inform the complaining party of the final disposition of the complaint. Nothing in this section shall preclude the board from scheduling, on its own motion, a disciplinary contested case hearing based upon the findings or report of the board's executive director or executive secretary, a board member or the designee of the attorney general assigned to the board. Nothing in this section shall preclude a member of the board, executive director, or executive secretary from initiating a complaint.

Sec. 12. Minnesota Statutes 2014, section 214.10, subdivision 2a, is amended to read:

Subd. 2a. **Proceedings.** A board shall initiate proceedings to suspend or revoke a license or shall refuse to renew a license of a person licensed by the board who is convicted in a court of competent jurisdiction of violating section 609.224, subdivision 2 609.2231, subdivision 8, paragraph (c), 609.23, 609.231, 609.2325, 609.233, 609.2335, 8609.234, 609.465, 609.466, 609.52, or 609.72, subdivision 3.

Sec. 14. Minnesota Statutes 2014, section 214.32, subdivision 6, is amended to read:

Subd. 6. **Duties of a participating board.** Upon receiving a report from the program manager in accordance with section 214.33, subdivision 3, that a regulated person has been discharged from the program due to noncompliance based on allegations that the regulated person has engaged in conduct that might cause risk to the public, when and if the participating health-related licensing board has probable cause to believe continued practice by the regulated person presents an imminent risk of serious harm, the health-related licensing board shall temporarily suspend the regulated person's professional license until the completion of a disciplinary investigation. The board must complete the disciplinary investigation within 30 days of receipt of the report from the program. If the investigation is not completed by the board within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation proceed pursuant to the requirements in section 214.077.

**HF 2749**

*A bill for an act relating to state  
government*

**Subd. 5. Board of Pharmacy**

**115,000**

**145,000**

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**APPENDIX B  
LEGISLATION DEVELOPED BY OTHER**

**GROUPS CHAPTER 122 - S.F. No. 2548**

*An act relating to health; allowing pharmacists to dispense a 90-day supply of a prescription drug under certain circumstances; amending Minnesota Statutes 2014, section 151.21, by adding a subdivision.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 151.21, is amended by adding a subdivision to read:

Subd. 9. **Extended supply.** (a) After a patient has obtained an initial 30-day supply of a prescription drug, and the patient returns to the pharmacy to obtain a refill, a pharmacist may dispense up to a 90-day supply of that prescription drug to the patient when the following requirements are met:

(1)the total quantity of dosage units dispensed by the pharmacist does not exceed the total quantity of dosage units of the remaining refills authorized by the prescriber; and

(2)the pharmacist is exercising the pharmacist's professional judgment. \_

(b)The initial 30-day supply requirement in paragraph (a) is not required if the prescription has previously been filled with a 90-day supply. \_

(c) Notwithstanding paragraph (a), a pharmacist may not exceed the number of dosage units authorized by a prescriber for an initial prescription or subsequent refills if: \_

(1)the prescriber has specified on the prescription that, due to medical necessity, the pharmacist may not exceed the number of dosage units identified on the prescription; or \_

(2)the prescription drug is a controlled substance, as defined in section 152.01, subdivision 4.

Presented to the governor May 17, 2016

Signed by the governor May 19, 2016, 10:55 a.m.

Effective August 1, 2016