

1 A bill to be entitled
 2 An act relating to electronic prescribing; amending s.
 3 456.42, F.S.; requiring certain health care
 4 practitioners to electronically generate and transmit
 5 prescriptions for medicinal drugs upon license renewal
 6 or by a specified date; providing exceptions;
 7 authorizing the Department of Health, in consultation
 8 with the Board of Medicine, the Board of Osteopathic
 9 Medicine, the Board of Podiatric Medicine, the Board
 10 of Dentistry, the Board of Nursing, and the Board of
 11 Optometry, to adopt rules; amending s. 456.43, F.S.;
 12 revising the definitions of the terms "prescribing
 13 decision" and "point of care"; revising the authority
 14 for electronic prescribing software to display
 15 information regarding a payor's formulary under
 16 certain circumstances; amending ss. 409.912, 456.0392,
 17 458.3265, 458.331, 459.0137, and 459.015, F.S.;
 18 conforming provisions to changes made by the act;
 19 providing an effective date.

20
 21 Be It Enacted by the Legislature of the State of Florida:

22
 23 Section 1. Section 456.42, Florida Statutes, is amended to
 24 read:
 25 456.42 Written prescriptions for medicinal drugs.—

26 (1) A written prescription for a medicinal drug issued by
27 a health care practitioner licensed by law to prescribe such
28 drug must be legibly printed or typed so as to be capable of
29 being understood by the pharmacist filling the prescription;
30 must contain the name of the prescribing practitioner, the name
31 and strength of the drug prescribed, the quantity of the drug
32 prescribed, and the directions for use of the drug; must be
33 dated; and must be signed by the prescribing practitioner on the
34 day when issued. However, a prescription that is electronically
35 generated and transmitted must contain the name of the
36 prescribing practitioner, the name and strength of the drug
37 prescribed, the quantity of the drug prescribed in numerical
38 format, and the directions for use of the drug and must contain
39 the date and an electronic signature, as defined in s.
40 668.003(4), ~~be dated and signed~~ by the prescribing practitioner
41 only on the day issued, ~~which signature may be in an electronic~~
42 ~~format as defined in s. 668.003(4).~~

43 (2) A written prescription for a controlled substance
44 listed in chapter 893 must have the quantity of the drug
45 prescribed in both textual and numerical formats, must be dated
46 in numerical, month/day/year format, or with the abbreviated
47 month written out, or the month written out in whole, and must
48 be either written on a standardized counterfeit-proof
49 prescription pad produced by a vendor approved by the department
50 or electronically prescribed as that term is used in s.

51 408.0611. As a condition of being an approved vendor, a
52 prescription pad vendor must submit a monthly report to the
53 department that, at a minimum, documents the number of
54 prescription pads sold and identifies the purchasers. The
55 department may, by rule, require the reporting of additional
56 information.

57 (3) A health care practitioner licensed by law to
58 prescribe a medicinal drug who maintains a system of electronic
59 health records as defined in s. 408.051(2) (a), or who prescribes
60 medicinal drugs as an owner, an employee, or a contractor of a
61 licensed health care facility or practice that maintains such a
62 system and who is prescribing in his or her capacity as such an
63 owner, an employee, or a contractor, may only electronically
64 transmit prescriptions for such drugs. This requirement applies
65 to such a health care practitioner upon renewal of the health
66 care practitioner's license or by July 1, 2021, whichever is
67 earlier, but does not apply if:

68 (a) The practitioner and the dispenser are the same
69 entity;

70 (b) The prescription cannot be transmitted electronically
71 under the most recently implemented version of the National
72 Council for Prescription Drug Programs SCRIPT Standard;

73 (c) The practitioner has been issued a waiver by the
74 department, not to exceed 1 year in duration, from the
75 requirement to use electronic prescribing due to demonstrated

76 economic hardship, technological limitations that are not
77 reasonably within the control of the practitioner, or another
78 exceptional circumstance demonstrated by the practitioner;

79 (d) The practitioner reasonably determines that it would
80 be impractical for the patient in question to obtain a medicinal
81 drug prescribed by electronic prescription in a timely manner
82 and such delay would adversely impact the patient's medical
83 condition;

84 (e) The practitioner is prescribing a drug under a
85 research protocol;

86 (f) The prescription is for a drug for which the federal
87 Food and Drug Administration requires the prescription to
88 contain elements that may not be included in electronic
89 prescribing; or

90 (g) The prescription is issued to an individual receiving
91 hospice care or who is a resident of a nursing home facility.

92 (h) The practitioner determines that it is in the best
93 interest of the patient, or the patient determines that it is in
94 his or her own best interest, to compare prescription drug
95 prices among area pharmacies. The practitioner must document
96 such determination in the patient's medical record.

97
98 The department, in consultation with the Board of Medicine, the
99 Board of Osteopathic Medicine, the Board of Podiatric Medicine,
100 the Board of Dentistry, the Board of Nursing, and the Board of

101 Optometry, may adopt rules to implement this subsection.

102 Section 2. Section 456.43, Florida Statutes, is amended to
 103 read:

104 456.43 Electronic prescribing for medicinal drugs.—

105 (1) Electronic prescribing may ~~shall~~ not interfere with a
 106 patient's freedom to choose a pharmacy.

107 (2) Electronic prescribing software may ~~shall~~ not use any
 108 means or permit any other person to use any means to influence
 109 or attempt to influence, through economic incentives or
 110 otherwise, the prescribing decision of a prescribing
 111 practitioner or his or her agent at the point of care,
 112 including, but not limited to, means such as advertising,
 113 instant messaging, ~~and~~ pop-up ads, and similar means ~~to~~
 114 ~~influence or attempt to influence, through economic incentives~~
 115 ~~or otherwise, the prescribing decision of a prescribing~~
 116 ~~practitioner at the point of care. Such means shall not be~~
 117 triggered by or in specific response to the input, selection, or
 118 act of a prescribing practitioner or his or her agent in
 119 prescribing a certain medicinal drug ~~pharmaceutical~~ or directing
 120 a patient to a certain pharmacy. For purposes of this
 121 subsection, the term:

122 (a) ~~The term~~ "Prescribing decision" means a prescribing
 123 practitioner's or his or her agent's decision to prescribe any
 124 medicinal drug ~~a certain pharmaceutical~~.

125 (b) ~~The term~~ "Point of care" means the time at which ~~that~~

126 a prescribing practitioner or his or her agent prescribes any
127 medicinal drug ~~is in the act of prescribing a certain~~
128 ~~pharmaceutical.~~

129 (3) Electronic prescribing software may display ~~show~~
130 information regarding a payor's formulary if ~~as long as~~ nothing
131 is designed to preclude or make more difficult the selection of
132 ~~the act of a prescribing practitioner or patient selecting any~~
133 particular pharmacy by a patient or the selection of a certain
134 medicinal drug by a prescribing practitioner or his or her agent
135 ~~pharmaceutical.~~

136 Section 3. Paragraph (a) of subsection (5) of section
137 409.912, Florida Statutes, is amended to read:

138 409.912 Cost-effective purchasing of health care.—The
139 agency shall purchase goods and services for Medicaid recipients
140 in the most cost-effective manner consistent with the delivery
141 of quality medical care. To ensure that medical services are
142 effectively utilized, the agency may, in any case, require a
143 confirmation or second physician's opinion of the correct
144 diagnosis for purposes of authorizing future services under the
145 Medicaid program. This section does not restrict access to
146 emergency services or poststabilization care services as defined
147 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
148 shall be rendered in a manner approved by the agency. The agency
149 shall maximize the use of prepaid per capita and prepaid
150 aggregate fixed-sum basis services when appropriate and other

151 alternative service delivery and reimbursement methodologies,
152 including competitive bidding pursuant to s. 287.057, designed
153 to facilitate the cost-effective purchase of a case-managed
154 continuum of care. The agency shall also require providers to
155 minimize the exposure of recipients to the need for acute
156 inpatient, custodial, and other institutional care and the
157 inappropriate or unnecessary use of high-cost services. The
158 agency shall contract with a vendor to monitor and evaluate the
159 clinical practice patterns of providers in order to identify
160 trends that are outside the normal practice patterns of a
161 provider's professional peers or the national guidelines of a
162 provider's professional association. The vendor must be able to
163 provide information and counseling to a provider whose practice
164 patterns are outside the norms, in consultation with the agency,
165 to improve patient care and reduce inappropriate utilization.
166 The agency may mandate prior authorization, drug therapy
167 management, or disease management participation for certain
168 populations of Medicaid beneficiaries, certain drug classes, or
169 particular drugs to prevent fraud, abuse, overuse, and possible
170 dangerous drug interactions. The Pharmaceutical and Therapeutics
171 Committee shall make recommendations to the agency on drugs for
172 which prior authorization is required. The agency shall inform
173 the Pharmaceutical and Therapeutics Committee of its decisions
174 regarding drugs subject to prior authorization. The agency is
175 authorized to limit the entities it contracts with or enrolls as

176 Medicaid providers by developing a provider network through
177 provider credentialing. The agency may competitively bid single-
178 source-provider contracts if procurement of goods or services
179 results in demonstrated cost savings to the state without
180 limiting access to care. The agency may limit its network based
181 on the assessment of beneficiary access to care, provider
182 availability, provider quality standards, time and distance
183 standards for access to care, the cultural competence of the
184 provider network, demographic characteristics of Medicaid
185 beneficiaries, practice and provider-to-beneficiary standards,
186 appointment wait times, beneficiary use of services, provider
187 turnover, provider profiling, provider licensure history,
188 previous program integrity investigations and findings, peer
189 review, provider Medicaid policy and billing compliance records,
190 clinical and medical record audits, and other factors. Providers
191 are not entitled to enrollment in the Medicaid provider network.
192 The agency shall determine instances in which allowing Medicaid
193 beneficiaries to purchase durable medical equipment and other
194 goods is less expensive to the Medicaid program than long-term
195 rental of the equipment or goods. The agency may establish rules
196 to facilitate purchases in lieu of long-term rentals in order to
197 protect against fraud and abuse in the Medicaid program as
198 defined in s. 409.913. The agency may seek federal waivers
199 necessary to administer these policies.

200 (5) (a) The agency shall implement a Medicaid prescribed-

201 drug spending-control program that includes the following
202 components:

203 1. A Medicaid preferred drug list, which shall be a
204 listing of cost-effective therapeutic options recommended by the
205 Medicaid Pharmacy and Therapeutics Committee established
206 pursuant to s. 409.91195 and adopted by the agency for each
207 therapeutic class on the preferred drug list. At the discretion
208 of the committee, and when feasible, the preferred drug list
209 should include at least two products in a therapeutic class. The
210 agency may post the preferred drug list and updates to the list
211 on an Internet website without following the rulemaking
212 procedures of chapter 120. Antiretroviral agents are excluded
213 from the preferred drug list. The agency shall also limit the
214 amount of a prescribed drug dispensed to no more than a 34-day
215 supply unless the drug products' smallest marketed package is
216 greater than a 34-day supply, or the drug is determined by the
217 agency to be a maintenance drug in which case a 100-day maximum
218 supply may be authorized. The agency may seek any federal
219 waivers necessary to implement these cost-control programs and
220 to continue participation in the federal Medicaid rebate
221 program, or alternatively to negotiate state-only manufacturer
222 rebates. The agency may adopt rules to administer this
223 subparagraph. The agency shall continue to provide unlimited
224 contraceptive drugs and items. The agency must establish
225 procedures to ensure that:

226 a. There is a response to a request for prior consultation
227 by telephone or other telecommunication device within 24 hours
228 after receipt of a request for prior consultation; and

229 b. A 72-hour supply of the drug prescribed is provided in
230 an emergency or when the agency does not provide a response
231 within 24 hours as required by sub-subparagraph a.

232 2. Reimbursement to pharmacies for Medicaid prescribed
233 drugs shall be set at the lowest of: the average wholesale price
234 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
235 plus 1.5 percent, the federal upper limit (FUL), the state
236 maximum allowable cost (SMAC), or the usual and customary (UAC)
237 charge billed by the provider.

238 3. The agency shall develop and implement a process for
239 managing the drug therapies of Medicaid recipients who are using
240 significant numbers of prescribed drugs each month. The
241 management process may include, but is not limited to,
242 comprehensive, physician-directed medical-record reviews, claims
243 analyses, and case evaluations to determine the medical
244 necessity and appropriateness of a patient's treatment plan and
245 drug therapies. The agency may contract with a private
246 organization to provide drug-program-management services. The
247 Medicaid drug benefit management program shall include
248 initiatives to manage drug therapies for HIV/AIDS patients,
249 patients using 20 or more unique prescriptions in a 180-day
250 period, and the top 1,000 patients in annual spending. The

251 agency shall enroll any Medicaid recipient in the drug benefit
252 management program if he or she meets the specifications of this
253 provision and is not enrolled in a Medicaid health maintenance
254 organization.

255 4. The agency may limit the size of its pharmacy network
256 based on need, competitive bidding, price negotiations,
257 credentialing, or similar criteria. The agency shall give
258 special consideration to rural areas in determining the size and
259 location of pharmacies included in the Medicaid pharmacy
260 network. A pharmacy credentialing process may include criteria
261 such as a pharmacy's full-service status, location, size,
262 patient educational programs, patient consultation, disease
263 management services, and other characteristics. The agency may
264 impose a moratorium on Medicaid pharmacy enrollment if it is
265 determined that it has a sufficient number of Medicaid-
266 participating providers. The agency must allow dispensing
267 practitioners to participate as a part of the Medicaid pharmacy
268 network regardless of the practitioner's proximity to any other
269 entity that is dispensing prescription drugs under the Medicaid
270 program. A dispensing practitioner must meet all credentialing
271 requirements applicable to his or her practice, as determined by
272 the agency.

273 5. The agency shall develop and implement a program that
274 requires Medicaid practitioners who issue written prescriptions
275 for medicinal ~~prescribe~~ drugs to use a counterfeit-proof

276 prescription pad for Medicaid prescriptions. The agency shall
277 require the use of standardized counterfeit-proof prescription
278 pads by ~~Medicaid-participating prescribers or~~ prescribers who
279 issue written ~~write~~ prescriptions for Medicaid recipients. The
280 agency may implement the program in targeted geographic areas or
281 statewide.

282 6. The agency may enter into arrangements that require
283 manufacturers of generic drugs prescribed to Medicaid recipients
284 to provide rebates of at least 15.1 percent of the average
285 manufacturer price for the manufacturer's generic products.
286 These arrangements shall require that if a generic-drug
287 manufacturer pays federal rebates for Medicaid-reimbursed drugs
288 at a level below 15.1 percent, the manufacturer must provide a
289 supplemental rebate to the state in an amount necessary to
290 achieve a 15.1-percent rebate level.

291 7. The agency may establish a preferred drug list as
292 described in this subsection, and, pursuant to the establishment
293 of such preferred drug list, negotiate supplemental rebates from
294 manufacturers that are in addition to those required by Title
295 XIX of the Social Security Act and at no less than 14 percent of
296 the average manufacturer price as defined in 42 U.S.C. s. 1936
297 on the last day of a quarter unless the federal or supplemental
298 rebate, or both, equals or exceeds 29 percent. There is no upper
299 limit on the supplemental rebates the agency may negotiate. The
300 agency may determine that specific products, brand-name or

301 generic, are competitive at lower rebate percentages. Agreement
302 to pay the minimum supplemental rebate percentage guarantees a
303 manufacturer that the Medicaid Pharmaceutical and Therapeutics
304 Committee will consider a product for inclusion on the preferred
305 drug list. However, a pharmaceutical manufacturer is not
306 guaranteed placement on the preferred drug list by simply paying
307 the minimum supplemental rebate. Agency decisions will be made
308 on the clinical efficacy of a drug and recommendations of the
309 Medicaid Pharmaceutical and Therapeutics Committee, as well as
310 the price of competing products minus federal and state rebates.
311 The agency may contract with an outside agency or contractor to
312 conduct negotiations for supplemental rebates. For the purposes
313 of this section, the term "supplemental rebates" means cash
314 rebates. Value-added programs as a substitution for supplemental
315 rebates are prohibited. The agency may seek any federal waivers
316 to implement this initiative.

317 8. The agency shall expand home delivery of pharmacy
318 products. The agency may amend the state plan and issue a
319 procurement, as necessary, in order to implement this program.
320 The procurements must include agreements with a pharmacy or
321 pharmacies located in the state to provide mail order delivery
322 services at no cost to the recipients who elect to receive home
323 delivery of pharmacy products. The procurement must focus on
324 serving recipients with chronic diseases for which pharmacy
325 expenditures represent a significant portion of Medicaid

326 pharmacy expenditures or which impact a significant portion of
327 the Medicaid population. The agency may seek and implement any
328 federal waivers necessary to implement this subparagraph.

329 9. The agency shall limit to one dose per month any drug
330 prescribed to treat erectile dysfunction.

331 10.a. The agency may implement a Medicaid behavioral drug
332 management system. The agency may contract with a vendor that
333 has experience in operating behavioral drug management systems
334 to implement this program. The agency may seek federal waivers
335 to implement this program.

336 b. The agency, in conjunction with the Department of
337 Children and Families, may implement the Medicaid behavioral
338 drug management system that is designed to improve the quality
339 of care and behavioral health prescribing practices based on
340 best practice guidelines, improve patient adherence to
341 medication plans, reduce clinical risk, and lower prescribed
342 drug costs and the rate of inappropriate spending on Medicaid
343 behavioral drugs. The program may include the following
344 elements:

345 (I) Provide for the development and adoption of best
346 practice guidelines for behavioral health-related drugs such as
347 antipsychotics, antidepressants, and medications for treating
348 bipolar disorders and other behavioral conditions; translate
349 them into practice; review behavioral health prescribers and
350 compare their prescribing patterns to a number of indicators

351 that are based on national standards; and determine deviations
352 from best practice guidelines.

353 (II) Implement processes for providing feedback to and
354 educating prescribers using best practice educational materials
355 and peer-to-peer consultation.

356 (III) Assess Medicaid beneficiaries who are outliers in
357 their use of behavioral health drugs with regard to the numbers
358 and types of drugs taken, drug dosages, combination drug
359 therapies, and other indicators of improper use of behavioral
360 health drugs.

361 (IV) Alert prescribers to patients who fail to refill
362 prescriptions in a timely fashion, are prescribed multiple same-
363 class behavioral health drugs, and may have other potential
364 medication problems.

365 (V) Track spending trends for behavioral health drugs and
366 deviation from best practice guidelines.

367 (VI) Use educational and technological approaches to
368 promote best practices, educate consumers, and train prescribers
369 in the use of practice guidelines.

370 (VII) Disseminate electronic and published materials.

371 (VIII) Hold statewide and regional conferences.

372 (IX) Implement a disease management program with a model
373 quality-based medication component for severely mentally ill
374 individuals and emotionally disturbed children who are high
375 users of care.

376 11. The agency shall implement a Medicaid prescription
 377 drug management system.

378 a. The agency may contract with a vendor that has
 379 experience in operating prescription drug management systems in
 380 order to implement this system. Any management system that is
 381 implemented in accordance with this subparagraph must rely on
 382 cooperation between physicians and pharmacists to determine
 383 appropriate practice patterns and clinical guidelines to improve
 384 the prescribing, dispensing, and use of drugs in the Medicaid
 385 program. The agency may seek federal waivers to implement this
 386 program.

387 b. The drug management system must be designed to improve
 388 the quality of care and prescribing practices based on best
 389 practice guidelines, improve patient adherence to medication
 390 plans, reduce clinical risk, and lower prescribed drug costs and
 391 the rate of inappropriate spending on Medicaid prescription
 392 drugs. The program must:

393 (I) Provide for the adoption of best practice guidelines
 394 for the prescribing and use of drugs in the Medicaid program,
 395 including translating best practice guidelines into practice;
 396 reviewing prescriber patterns and comparing them to indicators
 397 that are based on national standards and practice patterns of
 398 clinical peers in their community, statewide, and nationally;
 399 and determine deviations from best practice guidelines.

400 (II) Implement processes for providing feedback to and

401 educating prescribers using best practice educational materials
 402 and peer-to-peer consultation.

403 (III) Assess Medicaid recipients who are outliers in their
 404 use of a single or multiple prescription drugs with regard to
 405 the numbers and types of drugs taken, drug dosages, combination
 406 drug therapies, and other indicators of improper use of
 407 prescription drugs.

408 (IV) Alert prescribers to recipients who fail to refill
 409 prescriptions in a timely fashion, are prescribed multiple drugs
 410 that may be redundant or contraindicated, or may have other
 411 potential medication problems.

412 12. The agency may contract for drug rebate
 413 administration, including, but not limited to, calculating
 414 rebate amounts, invoicing manufacturers, negotiating disputes
 415 with manufacturers, and maintaining a database of rebate
 416 collections.

417 13. The agency may specify the preferred daily dosing form
 418 or strength for the purpose of promoting best practices with
 419 regard to the prescribing of certain drugs as specified in the
 420 General Appropriations Act and ensuring cost-effective
 421 prescribing practices.

422 14. The agency may require prior authorization for
 423 Medicaid-covered prescribed drugs. The agency may prior-
 424 authorize the use of a product:

425 a. For an indication not approved in labeling;

- 426 b. To comply with certain clinical guidelines; or
- 427 c. If the product has the potential for overuse, misuse,
- 428 or abuse.

429

430 The agency may require the prescribing professional to provide

431 information about the rationale and supporting medical evidence

432 for the use of a drug. The agency shall post prior

433 authorization, step-edit criteria and protocol, and updates to

434 the list of drugs that are subject to prior authorization on the

435 agency's Internet website within 21 days after the prior

436 authorization and step-edit criteria and protocol and updates

437 are approved by the agency. For purposes of this subparagraph,

438 the term "step-edit" means an automatic electronic review of

439 certain medications subject to prior authorization.

440 15. The agency, in conjunction with the Pharmaceutical and

441 Therapeutics Committee, may require age-related prior

442 authorizations for certain prescribed drugs. The agency may

443 preauthorize the use of a drug for a recipient who may not meet

444 the age requirement or may exceed the length of therapy for use

445 of this product as recommended by the manufacturer and approved

446 by the Food and Drug Administration. Prior authorization may

447 require the prescribing professional to provide information

448 about the rationale and supporting medical evidence for the use

449 of a drug.

450 16. The agency shall implement a step-therapy prior

451 authorization approval process for medications excluded from the
452 preferred drug list. Medications listed on the preferred drug
453 list must be used within the previous 12 months before the
454 alternative medications that are not listed. The step-therapy
455 prior authorization may require the prescriber to use the
456 medications of a similar drug class or for a similar medical
457 indication unless contraindicated in the Food and Drug
458 Administration labeling. The trial period between the specified
459 steps may vary according to the medical indication. The step-
460 therapy approval process shall be developed in accordance with
461 the committee as stated in s. 409.91195(7) and (8). A drug
462 product may be approved without meeting the step-therapy prior
463 authorization criteria if the prescribing physician provides the
464 agency with additional written medical or clinical documentation
465 that the product is medically necessary because:

466 a. There is not a drug on the preferred drug list to treat
467 the disease or medical condition which is an acceptable clinical
468 alternative;

469 b. The alternatives have been ineffective in the treatment
470 of the beneficiary's disease; or

471 c. Based on historic evidence and known characteristics of
472 the patient and the drug, the drug is likely to be ineffective,
473 or the number of doses have been ineffective.

474

475 The agency shall work with the physician to determine the best

476 alternative for the patient. The agency may adopt rules waiving
477 the requirements for written clinical documentation for specific
478 drugs in limited clinical situations.

479 17. The agency shall implement a return and reuse program
480 for drugs dispensed by pharmacies to institutional recipients,
481 which includes payment of a \$5 restocking fee for the
482 implementation and operation of the program. The return and
483 reuse program shall be implemented electronically and in a
484 manner that promotes efficiency. The program must permit a
485 pharmacy to exclude drugs from the program if it is not
486 practical or cost-effective for the drug to be included and must
487 provide for the return to inventory of drugs that cannot be
488 credited or returned in a cost-effective manner. The agency
489 shall determine if the program has reduced the amount of
490 Medicaid prescription drugs which are destroyed on an annual
491 basis and if there are additional ways to ensure more
492 prescription drugs are not destroyed which could safely be
493 reused.

494 Section 4. Section 456.0392, Florida Statutes, is amended
495 to read:

496 456.0392 Prescription labeling.-

497 (1) A prescription issued ~~written~~ by a practitioner who is
498 authorized under the laws of this state to prescribe ~~write~~
499 ~~prescriptions for~~ drugs that are not listed as controlled
500 substances in chapter 893 but who is not eligible for a federal

501 Drug Enforcement Administration number shall include that
 502 practitioner's name and professional license number. The
 503 pharmacist or dispensing practitioner must include the
 504 practitioner's name on the container of the drug that is
 505 dispensed. A pharmacist shall be permitted, upon verification by
 506 the prescriber, to document any information required by this
 507 section.

508 (2) A prescription for a drug that is not listed as a
 509 controlled substance in chapter 893 which is issued ~~written~~ by
 510 an advanced practice registered nurse licensed under s. 464.012
 511 is presumed, subject to rebuttal, to be valid and within the
 512 parameters of the prescriptive authority delegated by a
 513 practitioner licensed under chapter 458, chapter 459, or chapter
 514 466.

515 (3) A prescription for a drug that is not listed as a
 516 controlled substance in chapter 893 which is issued ~~written~~ by a
 517 physician assistant licensed under chapter 458 or chapter 459 is
 518 presumed, subject to rebuttal, to be valid and within the
 519 parameters of the prescriptive authority delegated by the
 520 physician assistant's supervising physician.

521 Section 5. Paragraph (d) of subsection (3) of section
 522 458.3265, Florida Statutes, is amended to read:

523 458.3265 Pain-management clinics.—

524 (3) PHYSICIAN RESPONSIBILITIES.—These responsibilities
 525 apply to any physician who provides professional services in a

526 pain-management clinic that is required to be registered in
527 subsection (1).

528 (d) A physician authorized to prescribe controlled
529 substances who practices at a pain-management clinic is
530 responsible for maintaining the control and security of his or
531 her prescription blanks or electronic prescribing software ~~and~~
532 ~~any other method~~ used for prescribing controlled substance pain
533 medication. A ~~The~~ physician who issues written prescriptions
534 shall comply with the requirements for counterfeit-resistant
535 prescription blanks in s. 893.065 and the rules adopted pursuant
536 to that section. A ~~The~~ physician shall notify, in writing, the
537 department within 24 hours after ~~following~~ any theft or loss of
538 a prescription blank or breach of his or her electronic
539 prescribing software used ~~any other method~~ for prescribing pain
540 medication.

541 Section 6. Paragraph (qq) of subsection (1) of section
542 458.331, Florida Statutes, is amended to read:

543 458.331 Grounds for disciplinary action; action by the
544 board and department.—

545 (1) The following acts constitute grounds for denial of a
546 license or disciplinary action, as specified in s. 456.072(2):

547 (qq) Failing to timely notify the department of the theft
548 of prescription blanks from a pain-management clinic or a breach
549 of a physician's electronic prescribing software ~~other methods~~
550 ~~for prescribing~~ within 24 hours as required by s. 458.3265(3).

551 Section 7. Paragraph (d) of subsection (3) of section
 552 459.0137, Florida Statutes, is amended to read:

553 459.0137 Pain-management clinics.—

554 (3) PHYSICIAN RESPONSIBILITIES.—These responsibilities
 555 apply to any osteopathic physician who provides professional
 556 services in a pain-management clinic that is required to be
 557 registered in subsection (1).

558 (d) An osteopathic physician authorized to prescribe
 559 controlled substances who practices at a pain-management clinic
 560 is responsible for maintaining the control and security of his
 561 or her prescription blanks or electronic prescribing software
 562 ~~and any other method~~ used for prescribing controlled substance
 563 pain medication. An ~~The~~ osteopathic physician who issues written
 564 prescriptions shall comply with the requirements for
 565 counterfeit-resistant prescription blanks in s. 893.065 and the
 566 rules adopted pursuant to that section. An ~~The~~ osteopathic
 567 physician shall notify, in writing, the department within 24
 568 hours after ~~following~~ any theft or loss of a prescription blank
 569 or breach of his or her electronic prescribing software used ~~any~~
 570 ~~other method~~ for prescribing pain medication.

571 Section 8. Paragraph (ss) of subsection (1) of section
 572 459.015, Florida Statutes, is amended to read:

573 459.015 Grounds for disciplinary action; action by the
 574 board and department.—

575 (1) The following acts constitute grounds for denial of a

576 | license or disciplinary action, as specified in s. 456.072(2):
577 | (ss) Failing to timely notify the department of the theft
578 | of prescription blanks from a pain-management clinic or a breach
579 | of an osteopathic physician's electronic prescribing software
580 | ~~other methods for prescribing~~ within 24 hours as required by s.
581 | 459.0137(3).

582 | Section 9. This act shall take effect January 1, 2020.