DATE: August 8, 2007

RE: Legality of Prescribing Take-Home Naloxone to Treat Opiate Overdose in Maine

INTRODUCTION

Naloxone, the standard treatment for heroin overdose, is a safe and effective prescription drug typically administered by emergency room personnel or first responders acting under standing orders of physicians. High numbers of overdose deaths and evidence that witnesses to heroin overdose are often unwilling or unable to call for help has motivated some public health professionals to institute programs that distribute naloxone directly to opiate drug users (ODUs). In such programs, drug users, their partners, or others are instructed in resuscitation techniques and provided a “take-home” dose of naloxone for administration in cases when medical help is not immediately available.

Evidence from US and abroad indicates that naloxone distribution helps reduce opiate overdose deaths and results in cost-savings to society. Despite the high and rising incidence of overdose events in many US locales, however, both the number and the scope of overdose programs remain inadequate. Legal concerns about provider and program liability act as one of the most important limiting factors, often complicating or derailing authorization, expansion, funding and implementation of these programs.

We were funded by the Drug Policy Alliance to analyze the legal issues for naloxone distribution programs in the fifty United States. Our analysis finds that:

1. **Naloxone is not a controlled substance as defined by federal or state law, but is a prescription drug subject to the general laws and regulations that govern all prescriptions in regular medical practice.**
2. **Prescribing naloxone to ODUs in this state is fully consistent with state and federal laws regulating drug prescribing.**

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3. Teaching overdose response techniques, including the administration of naloxone, to naloxone recipients and others who might be in a position to administer it to an ODU to whom it has been prescribed is legal and appropriate.

4. Naloxone may not be given to patients or participants in an overdose prevention program with the explicit purpose of encouraging them to distribute or administer the drug to other ODUs who are not patients.

5. Any legal risks in distributing naloxone in this state are not substantial and can be mitigated by informed program design; the risks of malpractice liability are consistent with those generally associated with providing healthcare, and can be further minimized by following the guidelines we describe.

This Memorandum addresses the following specific questions:

1. May a physician legally prescribe naloxone to an IDU patient?
2. May an allied health professional other than physician prescribe naloxone to an IDU patient?
3. What instructions should accompany naloxone prescription/dispensation?
4. How may naloxone be dispensed?
5. Is it legal to prescribe or dispense naloxone for recipients to give or administer to third parties who have not been prescribed the drug by a licensed professional?
6. What is the risk of disciplinary action by a professional board arising from naloxone prescription or distribution, and how can the risk be minimized?
7. What kind of malpractice liability may arise from naloxone prescription or distribution, and how can the risk of liability be minimized?
Executive Summary

From a legal standpoint, naloxone is no different than any other prescription drug. Authorized medical professionals can prescribe and dispense naloxone in the same way they would any other drug. Naloxone is indicated for patients\(^2\) who, upon examination,\(^3\) are at risk of opiate overdose and who are judged by the professional to be capable of benefiting from naloxone administration. The amount of naloxone prescribed or dispensed depends upon the prescriber’s assessment of need. (See Parts I & II describing who may prescribe naloxone.)

As part of the process of prescribing, the patient should be given information about when and how to use the drug, as well as other steps that are advisable in responding to an overdose. Because a person suffering an overdose may not be able to administer the drug him or herself, it is also appropriate to (1) teach groups of patients how to administer the drug so that they can assist each other in an overdose emergency; and (2) instruct—in person, or through written materials—friends, family members and others who may witness an overdose how to administer the drug to a patient. It is not uncommon for third parties to assist patients in administering their drugs, for all sorts of reasons. The key legal requirement is that the recipient have a valid prescription for the drug. (See Parts III & IV.)

Because a legal prescription requires some examination and a specific medical indication, naloxone may not be prescribed or dispensed to patients or program participants to hand out or administer to other ODUs who are not patients of the prescriber. A program based on this model would be legally vulnerable in this state. A professional distributing naloxone in this way could be found to be violating professional licensure laws, and the patient or program participant distributing or administering the drug could be found to be guilty of the crime of practicing medicine without a license. (See Part V.)

Assuming the provider does not violate regulations that generally apply to drug prescription in this state, acts competently, and follows the additional guidelines we set out, criminal or civil liability is very unlikely to arise out of naloxone prescription activities. (See Parts VI and VII.) Presumably, few prosecutors would be hard-hearted enough to punish a person for saving a life, but an ODU who uses his or her own naloxone to save the life of a person who has not been prescribed the drug does, technically, break the law. A few states have taken positive action to clearly legalize emergency administration of naloxone by lay persons, and to protect medical professionals from tort and other liability.

\(^2\) We will refer to a person who has received a legal prescription for naloxone as a “patient.”\(^3\) We will define examination, generally, as an interaction sufficient to allow the physician to determine the patient’s diagnosis and treatment needs in the context of the service being sought or medical issues being raised.
Such legislation can help lower legal barriers and increase access to naloxone here. (See “Conclusion.”)

The Legal Analysis in Detail

I. May a Physician Legally Prescribe Naloxone to an IDU Patient?

A. Professional Licensure Law

The practice of medicine in Maine is governed by the Medical Practice Act and regulations found in the Administrative Code. No provision of the Medical Practice Act explicitly defines the basis or scope of the physician's general authority to prescribe, but the law has been interpreted to authorize the Maine Board of Medical Examiners (“the Board”) to set limits on allowable practices, either by enacting specific regulations banning certain practices, or through the disciplinary process.

Naloxone is labeled for administration to reverse opiate overdose in clinical settings, such as hospitals, but is often administered by first responders acting on standing orders of physicians in the field. Federal and state law affords physicians broad discretion to prescribe drugs for off-label uses, and such prescriptions are a routine part of medical practice. Naloxone is not a controlled substance under state or federal law.

Using standard research techniques, we identified no case-law discussing physicians’ general authority to prescribe drugs and devices in the state, nor is there case-law challenging the legality of prescription of naloxone specifically. This reflects physicians’ broad discretion in prescribing and dispensing medical agents such as naloxone in this state and elsewhere in the US.

State law offers no explicit standards for prescribing a prescription drug, but presumably the generic standards applicable to controlled substances provide a basic framework. These standards look to see if there is a bona fide physician-patient relationship and if the physician is acting within the usual course of professional practice. In determining whether a prescription arises within the

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4 32 M.R.S.A. § 3263 (West 2007), et seq.
5 ME ADC 02-373 Ch. 1, § 1 (West 2007), et seq.
6 Board of Registration in Medicine v. Fiorica, 488 A.2d 1371 (Me. 1985).
9 According to our research, no lawsuits challenging the legality of naloxone prescription have been brought anywhere in the US.
10 22 M.R.S.A. § 2383-B (West 2007).
usual course of professional practice, courts may consider such matters as whether
other care was provided, whether proper records were kept of the encounter,
whether the prescription was based on a proper history or individualized
assessment of the patient's risk factors, efforts to provide other harm reducing
services, follow up and so on. A physician prescribing naloxone to patients in
his regular office or in a clinic, keeping records and providing other treatment
services, would not be at risk of failing this test.

B. Analysis

While not explicitly required by Maine statutes, it is prudent for
physicians to establish a bona fide physician-patient relationship and act within
the usual course of professional practice. That involves following certain
procedures when issuing prescriptions, including providing a physical
examination, documenting a history, discussing the treatment plan and its
alternatives with the patient, and ensuring adequate follow-up care. Physicians
have broad discretion about dosage of non-controlled drugs, and may decide to
prescribe whatever amount of the agent they reasonably deem necessary to meet
the patient’s needs. Physicians who have an on-going relationship with the
patient do not have to conduct a physical examination every time they issue or
renew a prescription. By law, physicians are also authorized to delegate some
aspects of the prescription process to other health professionals (see Part II
below).

Conclusion: A prescription for naloxone to an IDU patient is consistent with
the standard for a valid prescription under Maine laws governing the
physician's authority to prescribe. The same rules that apply to any
prescription drug in this state apply to naloxone.

II. May Anyone Other Than Physician Issue A Prescription For Naloxone?

A. Professional Licensure Law

Allied health professionals in this state are authorized to replace
physicians in some or all aspects of a prescription program. Physician assistants
(“PAs”) must work under the supervision of a physician, and may practice
medicine in accordance with a written plan of supervision. PAs may issue

exceeded the bounds of 'professional practice.' As detailed above, he gave inadequate physician
examinations or none at all. He ignored the results of the tests he did make. ... He did not regulate
the dosage at all, prescribing as much and as frequently as the patient demanded.”).
12 ME ADC 02-373 Ch. 2, § 7 (West 2007):
Supervision shall be continuous but shall not be construed as necessarily
requiring the physical presence of the supervising physician at the time and
place that the services are rendered. … Physician assistants may practice
prescriptions, as delegated by the supervising physician.\textsuperscript{13} Certified nurse practitioners (“CNPs”) can be authorized by the Board of Medicine to prescribe medications without the supervision or authorization of a physician.\textsuperscript{14}

**B. Analysis**

We have concluded above that a physician's prescription for naloxone, issued under the procedures outlined in Part I, is valid under Maine law. In the same way, a prescription issued by an allied health professional in accordance with the relevant regulations is valid. A non-physician healthcare provider may eliminate the need for the patient to be seen by a physician before a naloxone prescription is issued. CNPs can prescribe medicine without the supervision or authorization of a supervising physician. However, PAs must be supervised by physicians to prescribe medications.

\textsuperscript{13} ME ADC 02-373 Ch. 2, § 6 (West 2007):

Physician assistants may perform only those medical activities that have been delegated to the physician assistant by a supervising physician. Medical activities that may be delegated include the following: 1. the ordering of diagnostic, therapeutic and other medical services; 2. the prescribing and dispensing of drugs and medical devices to the extent permitted by state and federal law. Prescribing and dispensing drugs may include … all legend drugs… Physician assistants may request, receive, and sign for professional samples and may distribute professional samples to patients; and 3. the performance of tasks that are not routinely within the practice or regularly performed by the PSP so long as adequate oversight, secondary supervisory, and referral arrangements are in place to ensure competent provision of services by the physician assistant.

\textsuperscript{14} ME ADC 02-380 Ch. 8, § 7 (West 2007) (“Certified nurse practitioners … are authorized to prescribe the following: (1) over-the-counter drugs … (3) drugs related to the specialty area of certification. (4) drugs prescribed off label according to common and established standards of practice”); Survey of Pharmacy Law 2002-2003, National Association of Boards of Pharmacy (2002) (nurse practitioner may independently prescribe prescription drugs); ME ADC 02-380 Ch. 8, § 1 (West 2007):

[Nurses may] complete [a] health data base that includes a health history, physical examination, and screening and diagnostic evaluation (2) interpreting health data by identifying wellness and risk factors and variations from norms (3) diagnosing and treating common diseases and human responses to actual and potential health problems (5) consulting and/or collaborating with other health care providers and community resources (6) referring client to other health care providers and community resources.
Conclusion: The same rules that govern the prescription and/or dispensation of any other prescription drug apply to naloxone.

III. What Instructions Should Accompany Naloxone Prescription or Dispensing?

A. The Regulatory Scheme

As noted in the licensure law described in sections I and II, in general it is recommended that a healthcare provider formulate a therapeutic plan for their patient and discuss such plan, along with the basis for the plan and the risks and benefits of various treatment options, with the patient before issuing a prescription.\(^\text{15}\)

B. Analysis

The intended use of naloxone is to prevent opiate overdose. Indications for and methods of administration should be explained to patients, along with risks and benefits. Because of the nature of overdose, patients may not always be able to self-administer the necessary dose. Some overdose prevention programs properly instruct pairs or groups of patients in naloxone administration and other emergency measures so that patients can assist each other. Prescribing staff may also provide written and oral instructions that patients can relay to their friends, family, or others who can help administer the drug in an event of an overdose. Such instructions parallel information given to patients who may need emergency injections of insulin or epinephrine and are entirely consistent with the legal prescription of the drug. These instructions should include:

1. information on how to spot symptoms of an overdose;
2. instruction in basic resuscitation techniques;
3. instruction on proper naloxone administration, and
4. the importance of calling 911 for help.

Naloxone distribution programs in Maine should not instruct clients to administer naloxone to persons who do not have a prescription for the drug (see Part V below).

Conclusion: Program participants receiving a take-home dose of naloxone should receive verbal and written instructions on how and when to use this drug. Program staff should not instruct patients to administer naloxone to persons who do not have a valid prescription for the drug.

\(^{15}\) Cf. 22 M.R.S.A. § 2383-B (West 2007) (prescription standard for controlled substances).
IV. How May Naloxone be Dispensed?

A. The Regulatory Scheme

Naloxone is subject to the general rules covering dispensing of prescription drugs under state law. Under the pharmacy laws, with regulations found in the administrative code, pharmacists are expected to fill a prescription that meets regulatory guidelines. Physicians, PAs and CNPs may also dispense the agent to their patients. If naloxone is to be dispensed from the point of service, there are standards of labeling and record-keeping that must be followed.

B. Analysis

Pharmacists should and ordinarily will fill a valid prescription for naloxone. Provided that the healthcare provider has followed the prescription guidelines, she or another licensed professional so authorized (see part II) can dispense the drug directly to the clients. If a program decides to dispense naloxone on premises, it must follow standard dispensation rules, which include the requirement to maintain a dispensation record, and proper labeling of the agent, including the patient’s name and other essential information.

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16 32 M.R.S.A. § 13701 (West 2007), et seq.
17 ME ADC 02-392 Ch. 1, § 1 (2007), et seq.
18 32 M.R.S.A. § 13795 (West 2007) (“A pharmacist or person acting at the direction of a pharmacist may exercise discretion and refuse to fill any prescription or dispense any drug if unsatisfied as to the legitimacy or appropriateness of any prescription presented.”).
19 ME ADC 02-373 Ch. 2, § 6 (West 2007) (PA may dispense drugs).
21 32 M.R.S.A. § 13794 (West 2007):
Every drug dispensed pursuant to prescription, whether for a legend drug or not, must carry on the label the following information: the prescription number; the date of filling; the patient's name; directions for use; the name and strength of the drug and the amount dispensed, including either the brand name of the drug or, if a generic and therapeutically equivalent drug is dispensed it must be in accordance with section 13781; the beyond use date of the drug; the name of the practitioner prescribing the drug; and the name, address and telephone number of the pharmacy where the prescription was compounded and dispensed. For purposes of this section, “beyond use date” means a date beyond which the contents of the prescription are not recommended to be used.
22 ME ADC 02-392 Ch. 19, § 1 (West 2007):
Prescription drug orders shall contain, at a minimum, the following information: A. Date of issuance by practitioner; B. Name and address of the patient [or patient location if an institution]; C. Name and address of the practitioner [if not a staff physician at an institution]; … E. Name, strength, dosage form and quantity [or stop date, and route of administration] of drug prescribed; F. Refills authorized; and G. Directions for use by patient.
Conclusion: Dispensing naloxone by valid prescription does not violate Maine law and may be done on premises of the distribution program.

V. Is It Legal To Prescribe Or Dispense Naloxone For Recipients To Give Or Administer To Third Parties Who Have Not Been Prescribed The Drug By A Licensed Professional?

A legal prescription requires a specific patient who has been examined and found to have a medical indication for the drug. Before the drug can properly be dispensed, the patient must be given information about the indications for the drug, its proper use, and its risks and benefits. Naloxone could not properly be prescribed to a person who was not an ODU at risk of overdose, even if that person promised to give it to or use it on a person in need. Although a physician may prescribe multiple doses to a patient for whom they are indicated, the physician may not prescribe “extra” naloxone to a patient with explicit instructions to give it to or use it on a person in need.

A licensed professional who distributed naloxone in this way could be subject to charges of professional misconduct (see section VI) and be subject to fines. The patient or volunteer who distributed or administered naloxone to recipients who were not prescribed this agent could be charged with practicing medicine without a license. We cannot say that a person who saved a life in this way would actually be charged with a crime or harshly punished if convicted, but the act would be technically illegal. We found no provision that made it a crime to possess a legend drug without a prescription.

None of this should be taken as suggesting that a program cannot teach patients to properly administer the drug on others. Such training is necessary, as discussed above, to deal with the fact that patients may be unable to self-administer in an overdose situation, or may be called upon to assist another patient. But a program in this state that explicitly encouraged distribution to or administration upon non-patients would be open to legal challenge. Legislatures in a few states have taken action to eliminate legal barriers to emergency use of naloxone among non-patients. These are discussed in the Conclusion, below.

VI. What Is The Risk Of Disciplinary Action By A Professional Board Arising Kind Of Medical Discipline Or Criminal Liability May Arise From Naloxone Prescription Or Distribution, And How Can The Risk Of Liability Be Minimized?

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23 32 M.R.S.A. § 3282-A (West 2007).
24 32 M.R.S.A. § 3270 (West 2007) (Practicing medicine without a license is a crime.).
Non-compliance with prescription and other professional practice rules may carry license sanctions and fines.\textsuperscript{25} There is no risk of professional censure for participating in a naloxone prescription program run as described here. Our analysis above makes clear that prescribing naloxone to ODU patients is well within the normal parameters of medical practice.

Of course, naloxone prescribing might give rise to political controversy in a particular place, exposing the professionals and the program to closer scrutiny by potentially hostile regulators. Program managers and staff have to be prepared to produce clear and detailed documentation of proper physician involvement, specific and detailed protocols, and licensure information. Case law confirms the general notion that courts defer to the judgment of licensed medical professionals, so long as they produce clear factual evidence of reasonable efforts to comply with the rules and regulations of professional conduct.\textsuperscript{26} Blatant non-compliance, cutting corners, cover-ups, and sloppy record-keeping have resulted in the imposition of professional censure and criminal charges.\textsuperscript{27}

VII. What Kind of Tort or Civil Liability May Arise from Naloxone Prescription or Distribution; What Remedies Exist to Minimize Such Risk?

A. The Legal Scheme

Any practice of medicine implies a risk that something may go wrong. In the context of a naloxone prescription/dispensing program, a patient may suffer one of the rare side effects from the drug. An error in administration by a patient’s companion, a failure to seek timely medical help after the administration of naloxone, or re-injection of opiates after naloxone might all lead to death or serious injury.

Generally, every tort claimant must establish that he or she suffered an injury that was actually caused by the defendant healthcare provider. A healthcare provider is required to practice his or her profession in a reasonably competent manner. Particular conduct is assessed by reference to the customary behavior of the relevant segment of the profession under the same or similar circumstances, which is said to establish the “standard of care.”\textsuperscript{28} The essence of the inquiry is whether the provider’s treatment decisions were reasonable and consistent with accepted medical principles, considering all the circumstances.

\textsuperscript{25} 32 M.R.S.A. § 3282-A (West 2007) (Actions may include probation, license denial or license revocation).
\textsuperscript{26} Williams v. Ohio Bd. of Nursing, 1993 WL 69465 (Ohio App. 10 Dist. Mar. 9, 1993); Sermchief v. Gonzales, 660 S.W.2d 683 (Mo. banc 1983).
In order to prove negligence, the plaintiff must prove that (1) the provider’s failure to meet the professional standard of care (2) caused an injury, and that the defendant provider (3) had a duty to avoid harming the plaintiff. Tort doctrine requires the plaintiff to prove that the injury would not have occurred ‘‘but for’’ the healthcare provider’s unreasonable behavior.

B. Analysis

Naloxone is the drug of choice for overdose. Assuming that the patient is an IDU at risk of a fatal overdose, and is properly instructed in the administration and risks of the drug, a simple risk–benefit analysis would suggest that the provider’s decision to prescribe was reasonable and not negligent. The reasonableness of the decision would be supported by the public health and clinical literature discussing take-home naloxone, and, in an actual case, by expert testimony from clinicians and public health experts. If the prescription of naloxone is reasonable, there can be no tort liability even if the other elements of the case are established.

“But for” causation will be extremely difficult to establish where the injury results from overdose, because at the moment naloxone was administered serious injury was already likely to happen. Where the injury is caused by the rare occurrence of side effects of naloxone, the causal connection is still tenuous: the behavior of the injured party, in overdosing on heroin, is the key causal factor that necessitated treatment with the agent. Injury was likely to be as severe, if not more so, had naloxone not been administered. It is not considered malpractice to prescribe a drug that carries a low risk of side effects to avert death or severe impairment, particularly if the patient is adequately informed of the risks. Even in the unlikely cases in which “but for” factual causation may be established, the provider’s actions must represent a major contributing factor to the injury for liability to arise. It is hardly fair to blame a prescribing professional for a harm primarily caused by a patient’s decision to inject heroin; courts have usually applied the rule of “superseding cause” to hold that people who voluntarily use dangerous drugs cannot blame others for the harm the drugs cause.

Programs and providers cannot be found liable for actions of clients who administer naloxone to third parties who were not prescribed the drug, unless the program or provider have expressly instructed clients to administer naloxone in this manner. Program and providers should not issue such instructions. The

30 14 M.R.S.A. § 156 (West 2007).
actions by third parties are superseding cause of injury, not connected directly to
the actions of providers or the program. Under doctrine, the court would likely
ask if such an outcome was reasonably foreseeable. A death or injury resulting
from an unauthorized administration of a low risk medication prescribed to a non-
patient is arguably too unforeseeable a result to establish liability. Informing
clients of the need to contact first responders and administer the necessary
resuscitation procedures to overdose victims can further mitigate the risk of any
liability under these circumstances.

Any practice within the scope of the practitioner’s usual duties is covered
by malpractice insurance, which will pay for any litigation arising out of that
practice according to the terms of the insurance contract. Naloxone prescription
to prevent opiate overdose is a practice accepted by a significant number of
physicians and is within the scope of practice for providers working with the
general population.

In the case of volunteer providers, the US Volunteer Protection Act shields
volunteers for acts committed within the scope for their work for a non-profit or
government agency, so long as the acts are not criminal, reckless or grossly
negligent.\(^{32}\) Maine state law provides similar immunity for volunteers in a
charitable organization.\(^{33}\) This is effective so long as the agent responsible is a
licensed health care provider acting voluntarily and without pay in the scope of
his or her license. It appears that volunteers working with naloxone distribution
programs would be immune from any liability, except for in cases involving gross
negligence and wanton, and reckless conduct.

Conclusion: The risk of tort liability in a naloxone program is low.
Conceptually, this risk is no different from any other healthcare context. By
following state rules and general standards of practice, providers can protect
themselves from the imposition of tort liability. Malpractice insurance and
laws that apply specifically to volunteer providers may provide additional
protection.

CONCLUSION

A. Guidelines

Naloxone prescription is legal in this state. However, as with any
healthcare practice, institutions and professionals providing this service should
follow the relevant rules and regulations that govern their practice to avoid
professional, civil, and criminal liability.

\(^{33}\) 14 M.R.S.A. § 158-A (West 2007).
The following is a summary of the program guidelines dictated by Maine law we have outlined above:

1. Each patient receiving naloxone must be issued a prescription for the drug by a physician, a advanced nurse practitioner, or a licensed medical provider working in collaboration with a physician.

2. In order to receive a prescription, each patient must undergo an examination that is reasonable in light of professional standards to produce a proper diagnosis and treatment plan.

3. The prescription must be made out to the specific patient and must contain all the information required by law.

4. Each prescription should be accompanied by oral and/or written information on the following:
   • information on how to spot symptoms of an overdose;
   • instruction in basic resuscitation techniques;
   • instruction on proper naloxone administration, and
   • the importance of calling 911 for help.

B. Changes in State Law

Under the current law of this state, dispensing or administering naloxone to third parties who have not been prescribed the drug is illegal. Passing legislation to allow these practices would help reduce overdose deaths and ease the concerns of providers and clients about possible legal penalties. New York’s legislature recently passed a law to provide clear authorization of medical providers to “prescribe” or “dispense” naloxone to unknown ODUs via trained patients or volunteers (“Trained Overdose Responders” under NYS law); establish immunity for providers participating in such programs; and establish immunity for patients and volunteers using naloxone in providing first aid to victims of heroin overdose.  

C. Cooperation with First Responders

Programs should also work with police and EMTs to inform them about program goals and practices. Alerting first responders to the presence of take-home naloxone can help inform their work and alleviate resistance or roadblocks to program implementation. By building their programs according to the regulatory schemes we have referenced above, programs can successfully navigate the legal questions around dispensation of this life-saving agent to IDUs.


[T]he purchase, acquisition, possession or use of an opioid antagonist by an Opioid Overdose Prevention Program or a Trained Overdose Responder in accordance with this section and the training provided by an authorized Opioid Overdose Prevention Program shall not constitute the unlawful practice of a professional or other violation under title eight of the education law or article 33 of the public health law.