DATE: August 16, 2007

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

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.\textsuperscript{1} 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:

\begin{itemize}
  \item \textbf{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.}
  \item \textbf{2. Prescribing naloxone to ODUs in this state is fully consistent with state and federal laws regulating drug prescribing.}
\end{itemize}

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 ODU patient?
2. May an allied health professional other than physician prescribe naloxone to an ODU 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 who, upon examination, 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; and the recipient of a vial of naloxone for which she has no prescription could be found guilty of illegal possession of a prescription drug. (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

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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.
lay persons, and to protect medical professionals from tort and other liability. 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 ODU Patient?

A. Professional Licensure Law

The practice of medicine in New Hampshire is governed by the Medical Practice Act, with regulations found in the New Hampshire Code of Administrative Rules. The Board of Medicine has the authority to license physicians, and to punish licensed physicians who behave in ways that violate the law or fall beneath the standards of good faith and regular practice of medicine. The law has been interpreted to authorize the New Hampshire Board of Medicine 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. Therefore, a prescription for naloxone must meet the same standards as a prescription for any other drug.

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.

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5 N.H. ADC Med 101.01 (2007), et. seq.
10 N.H. ADC HE-C 501.03(a) (2007) (“Substances that are designated, rescheduled, or deleted as controlled drugs or controlled drug analogs pursuant to 21 CFR 1308.11-15 shall be recognized as a controlled substance by the commissioner in accordance with RSA 318-B:1-a, V”); 21 CFR 1308.12 (Naloxone is excluded from Schedule II of the Controlled Substances Act, so it is a prescription drug).
11 According to our research, no lawsuits challenging the legality of naloxone prescription have been brought anywhere in the US.
New Hampshire does not have a specific provision that defines the requirements for a valid prescription, but the code of conduct for licensed practitioners provides general guidelines:

(d) A licensee shall maintain a complete and accurate medical record of all patient encounters.
(e) Records shall be entirely legible and include but not be limited to:
   (1) A history, an exam, a diagnosis and a plan appropriate for the licensee's specialty; and
   (2) Documentation of all drug prescriptions including name and dose.\textsuperscript{12}

The law and regulations governing the prescription of controlled substances and drugs also sets out a standard under which a prescription is valid if it is written in good faith, for a legitimate medical purpose, and in the normal course of professional practice.\textsuperscript{13} In determining whether a prescription arises within the usual course of professional practice, courts generally consider such matters as whether a bona fide physician-patient relationship existed, 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.\textsuperscript{14}

B. Analysis

Physicians are advised to follow certain procedures when issuing prescriptions for all prescription drugs, including providing an appropriate physical examination, documenting a history, discussing the treatment plan and its alternatives with the patient, and ensuring adequate follow-up care. The law does not specify the length or intensity of these interactions, leaving the precise contours of the examination and discussion to the judgment of the physician. 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 ODU patient is consistent with the standard for a valid prescription under New Hampshire laws governing

\textsuperscript{12} N.H. ADC Med 501.02 (2007).
\textsuperscript{14} See generally, United States v. Moore, 423 U.S. 122 (1975).
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 with a supervising physician,15 who may delegate prescriptive authority to the PA.16 The supervising physician does not need to be on-site with the PA, but must at least be available by some form of electronic communication.17 Advanced registered nurse practitioners (ARNPs) may independently prescribe medication.18

15 N.H. ADC Med 602.01 (2007):
   (a) The RSP [Registered Supervisory Physician] or ARSP [Alternate Registered Supervisory Physician] shall be available for consultation with the physician assistant and shall be responsible for assuring that appropriate directions are given to, and understood and executed by, the physician assistant.
   (b) The RSP or ARSP shall not be required to be physically present while the physician assistant is providing care, so long as the RSP or ARSP and the physician assistant are or can easily be in contact with each other by an electronic communication device.
   (c) The RSP shall establish a regular, ongoing evaluation of a representative sample of patient records as part of a review of the physician assistant's performance.
   (d) The RSP shall file a written acceptance of supervisory responsibility with the board. The RSP shall designate in writing all of the alternate supervising physicians whose scope of practice encompasses the PA's scope of practice, and such alternates shall assume responsibility for the supervision of the physician assistant when the RSP is unavailable. Alternates shall sign a written acceptance of supervisory responsibility with the board.

N.H. ADC Med 602.03 (2007):
   (a) The RSP and the PA shall develop a specific written job description which shall conform to the requirements for supervision set forth in Med 602.01, and shall be signed by all parties, including the PA, RSP and all ARSPs.
   (b) The delegation agreement shall constitute the authority for the physician assistant to provide medical care under the supervision of the RSP and ARSP.

16 N.H. ADC Med 612.01 (2007):
   (a) Physician assistants shall transmit prescriptions for any patient only in accordance with a delegation agreement, or a patient specific order of the RSP or ARSP, and in compliance with all requirements of RSA 318 and RSA 318-B.
   ... 
   (d) A licensed physician assistant may prescribe, dispense and administer drugs and medical devices to the extent delegated by the supervising physician in compliance with RSA 318 and RSA 318-B.

17 Supra, fn. 15. 17 N.H. ADC Med 612.01 (2007):
B. Analysis

We have concluded above that a physician's prescription for naloxone, issued under the procedures outlined in Part I, is valid under New Hampshire law. In the same way, a prescription issued by an allied health professional in accordance with the relevant regulations is valid. An overdose prevention program including prescription could be staffed by an ARNP, or by a PA who has been delegated prescriptive authority by a supervising physician.

Conclusion: Allied health professionals may replace a physician in specific functions during the prescription process. A program can operate using an ARNP; a PA can dispense prescriptions but only with a supervising physician’s authorization. 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

According to the licensure law described in sections I and II, a healthcare provider must maintain a record that shows the diagnosis of a patient, a therapeutic plan, and the drugs that have been prescribed as part of the treatment plan. ¹⁹

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

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An ARNP shall have plenary authority to possess, compound, prescribe, administer, and dispense and distribute to clients… controlled and non-controlled drugs in accordance with the formulary established by the joint health council and within the scope of the ARNP's practice as defined by this chapter. Such authority may be denied, suspended, or revoked by the board after notice and the opportunity for hearing, upon proof that the authority has been abused.

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 New Hampshire 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.

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 Act, with regulations found in the New Hampshire Code of Administrative Rules, pharmacists are expected to fill a prescription that meets regulatory guidelines. Physicians, PAs, and ARNPs may dispense the agent at the point of service; however, PAs may

\[21\] N.H. ADC Ph. 101.01 (2007), et seq.
Drugs shall be dispensed only by or in the presence of and under the supervision of a pharmacist, physician, advanced registered nurse practitioner, [or] physician assistant...as identified in RSA 318:42, VII (a), in compliance with state and federal pharmacy-related laws and rules.
N.H. Rev. Stat. Ann. § 318:42 (2007): It shall be unlawful for any person who is not a licensed pharmacist in a pharmacy registered in accordance with the provisions of this chapter to manufacture, compound, dispense, sell, offer for sale or have in possession any prescription drug as defined in RSA 318:1, XVII, provided that this section shall not prevent the following:
only dispense medication within the authority delegated to them by their supervising physician.\textsuperscript{23} We were unable to locate specific labeling and record-keeping requirements for health care professionals who dispense drugs directly from their offices, but we recommend that they dispense according to local custom.

**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. Physicians, PAs, and ARNPs could staff an overdose prevention program that dispenses naloxone.

**Conclusion:** Dispensing naloxone by valid prescription does not violate New Hampshire 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.

\textsuperscript{23} N.H. ADC Med 612.01 (2007):

\begin{itemize}
  \item (b) Physician assistants, acting in accordance with a delegation agreement as the agent of the RSP or ARSP, may dispense samples of prescription drugs as necessary and appropriate for patient care.
  \item (d) A licensed physician assistant may prescribe, dispense and administer drugs and medical devices to the extent delegated by the supervising physician in compliance with RSA 318 and RSA 318-B.
  \item (e) Physician assistants may request, receive, and sign for professional samples and may distribute professional samples to patients.
\end{itemize}
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.\(^{24}\) 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\(^{25}\) or unlawfully dispensing prescription drugs.\(^{26}\) 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. Finally, the unauthorized recipient of the drug could be charged with illegal possession of a prescription (legend) drug, subject to fines.\(^{27}\) Even a minor crime can have serious repercussions for a person with a record of drug convictions or who is on probation or parole.

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?

Non-compliance with prescription and other professional practice rules may carry license sanctions and fines.\(^{28}\) There 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.

\(^{25}\) N.H. Rev. Stat. § 329:1 (2007) (Practice of medicine includes treating patients and prescribing drugs); § 329:24 (A person who practices medicine without a license is guilty of a felony); § 651:2 (Felonies are punishable by fines and imprisonment).
\(^{26}\) N.H. Rev. Stat. § 318:42 (2007) (“It shall be unlawful for any person who is not a licensed pharmacist in a pharmacy registered in accordance with the provisions of this chapter to…dispense…any prescription drug as defined in RSA 318:1, XVII).

It shall be unlawful for any person who is not a licensed pharmacist in a pharmacy registered in accordance with the provisions of this chapter to…have in possession any prescription drug as defined in RSA 318:1, XVII, provided that this section shall not prevent the following:

I. Persons from possessing prescription drugs dispensed to them pursuant to a lawful prescription.

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. Blatant non-compliance, cutting corners, cover-ups, and sloppy record-keeping have resulted in the imposition of professional censure and criminal charges.

**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.” The essence of the inquiry is whether the provider’s treatment decisions were reasonable and consistent with accepted medical principles, considering all the circumstances.

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**

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29 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).
Naloxone is the drug of choice for overdose. Assuming that the patient is an ODU 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.

“Loss of chance” doctrine in tort law establishes liability when negligent or otherwise harmful behavior substantially contributes to an injury, even if the injury may have also occurred from other causes. A plaintiff could also allege that the provision of naloxone led to delay or failure to summon medical help, leading to the “loss of a chance” to receive medical care. However, the imposition of liability under this doctrine would be highly problematic if programs explicitly instruct patients not to rely wholly on the effects of naloxone, but rather to use it as a stop-loss measure before medical help can be summoned.

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 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. New Hampshire state law provides similar liability protections from damages caused by volunteers at a “nonprofit organization or government entity” for any “act or omission resulting in damage or injury to any person.” This is effective so long as the volunteer is acting in good faith and within his or her scope of duties, and the injury is not a result of “willful, wanton, or grossly negligent

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I. Any person who is a volunteer of a nonprofit organization or government entity shall be immune from civil liability in any action brought on the basis of any act or omission resulting in damage or injury to any person if:
(a) The nonprofit organization or government entity has a record indicating that the person claiming to be a volunteer is a volunteer for such organization or entity; and
(b) The volunteer was acting in good faith and within the scope of his official functions and duties with the organization; and
(c) The damage or injury was not caused by willful, wanton, or grossly negligent misconduct by the volunteer.
II. Liability of a nonprofit organization for damage or injury sustained by any one person in actions brought against the organization alleging negligence on the part of an organization volunteer is limited to $250,000. Such limit applies in the aggregate to any and all actions to recover for damage or injury sustained by one person in a single incident or occurrence. Liability of a nonprofit organization for damage or injury sustained by any number of persons in a single incident or occurrence involving negligence on the part of an organization volunteer is limited to $1,000,000.
III. Nothing in this section shall be construed to affect any civil action brought by any nonprofit organization against any volunteer of such organization.
negligent misconduct.”38 It appears that under New Hampshire law, 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.

The following is a summary of the program guidelines dictated by New Hampshire 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

38 Id.
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.\(^{39}\)

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 ODUs.

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[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.