



New York State  
Department of Health  
**Bureau of Emergency Medical Services**

**POLICY STATEMENT**

*Supersedes/Updates:* New

**No. 07 - 02**

**Date: 06/11/07**

**Re: Fentanyl for  
Prehospital EMS  
Services**

**Page 1 of 3**

**History:**

At the request of the State Emergency Medical Advisory Committee (SEMAC) and a number of air medical service physician medical directors, the Department was approached requesting that fentanyl be added to the formulary approved by the controlled substance 3C license. This request was reviewed by the Departments Division of Legal Affairs and the Bureau of Narcotics Enforcement (BNE)

Based on the potency of fentanyl and the serious issues of diversion and abuse, the Department initially approved its use by New York States air medical service providers under specific conditions. At the May 2007 meeting of the SEMAC, the use of fentanyl was approved for all advanced life support (ALS) EMS agencies possessing a current Department of Health EMS Agency Certification and Prehospital Controlled Substance License, under the specific conditions indicated below.

**Conditions for Approval:**

In order for the Department to approve the addition of fentanyl to an EMS agency with a current Prehospital Controlled Substance License, the following conditions must be met and the Department must review and issue written approvals.

- The Regional Medical Advisory Committee (REMAC) must develop protocols for the administration of fentanyl and a periodic evaluation of its use on the regional level. The protocols must also be approved by the SEMAC.
- The service medical director must approve, in writing, fentanyl for use by the EMS service.
- Only those individuals certified at the critical care or paramedic level may utilize a controlled substance medication.
- The EMS agency must submit an amendment to their controlled substance operational plan to include, but not be limited to the following:
  - ▶ A detailed description of the procurement; inventory process and security of fentanyl.
  - ▶ A program for 100% quality assurance by the service medical director for instances where fentanyl has been administered.
  - ▶ The training program used to in-service all appropriate staff on the inventory, security and administration of fentanyl.
  - ▶ A separate Quarterly Report (attached) for fentanyl stock and administrations.

- Only **two (2)** - 2ml glass ampules containing 50mcg/ml, totaling 100 mcg may be carried in each sub-stock.
- The program must insure that the formulary includes an appropriate antagonist necessary to reverse the effects of a fentanyl administration.
- **FENTANYL MAY ONLY BE ADMINISTERED UNDER DIRECT ON-LINE MEDICAL CONTROL.**
- As a part of the reporting process, the agency medical director is required to provide a report of the service's use of fentanyl by December 31<sup>st</sup> of each year.
- The report should include, but not be limited to the following items:
  - ▶ The total number of administrations, amount or medication used and dose.
  - ▶ The amount of fentanyl wasted.
  - ▶ A summary of the patient presenting problems.
  - ▶ A narrative summary highlighting the Quality Assurance reviews conducted for each fentanyl administration.
- All instances where a theft, loss or diversion, are suspected **MUST BE REPORTED TO THE DEPARTMENT IMMEDIATELY**. This report must be made to the BEMS Central Office.
- Prior to including fentanyl in the EMS agency's formulary, the medical director must receive written approval from the Department.

The Department will closely monitor the EMS agencies that maintain a prehospital (3C) controlled substance license to insure that there is the strictest compliance with all of the applicable sections of Public Health Law, the Codes, Rules and Regulations – Part 800 and Part 80.136 as well as the EMS service's approved Controlled Substance Operations Plan.

This report must be submitted pursuant to PHL Article 33 within 30 days of the end of each Quarter. Reports must be submitted regardless of usage. Retain a copy of this Quarterly Report for a period of 5 years from the date of filing.

Quarterly Reporting Period: \_\_\_\_\_

|                        |                 |                     |     |                |
|------------------------|-----------------|---------------------|-----|----------------|
| Agency Name            | NYS-EMS ID No.  | NYS-BNE License No. |     |                |
| Address                | City            | State               | Zip | Business Phone |
| Name of DEA Registrant | DEA License No. | Day Phone           |     |                |

|  | <b>FENTANYL</b>   |   | <b>RESPONSE/<br/>TRANSPORT<br/>HISTORY</b>         |
|--|---|---|--|
| Total Quantity at Start of Quarter                 | Stock: _____<br>Substock: _____<br>TOTAL<br>of above: _____ | Total Number of EMS Response/Transports this Quarter                          |  |
| Total Quantity Received from DEA Registrant        |   | Total Number of Patients Receiving Fentanyl this Quarter                      |  |
| Total Quantity Administered                        |   | Number of Fentanyl Administrations pursuant to Direct Medical Control         |  |
| Total Quantity Wasted                              |   | Number of Quality Assurance reviews conducted by the service medical director |  |
| Total Quantity Lost (Attach copy of DOH Form 2094) |   | Number of Adverse Reactions to Fentanyl Administration                        |  |
| Total Quantity Remaining at End of Quarter         |   | Number of EMS Personnel Authorized to Administer Fentanyl                     | Flight Nurses _____<br>EMT-P _____<br>EMT-CC _____ |

I certify that on \_\_\_\_\_ I conducted an actual physical inventory of the controlled substance listed above. Losses have been reported on a "Loss of Controlled Substances Report" DOH Form 2094 and have been submitted to BNE and a copy of the form has been enclosed. Overages are explained on a separate attached report.

I affirm that this is a true and accurate record of the controlled substance utilization by the above named agency.

\_\_\_\_\_  
 Name of Agent (print)

\_\_\_\_\_  
 Signature of Agent

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name of CEO (print)

\_\_\_\_\_  
 Signature of CEO

\_\_\_\_\_  
 Date

Sent completed report by due date to:

**New York State Department of Health, Bureau of Emergency Medical Services**  
 433 River Street 6th Fl., Troy, NY 12180  
 Telephone 518-402-0996 x2