

# **WHITE PAPER**

Prescription Drug Monitoring Program and Proposed Legislation  
State of Florida

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This paper was prepared by: Florida Regional Prescription Drug Abuse Task Force -A  
*Task Force of the Hillsborough County Anti-Drug Alliance (HCADA).*

## Introduction

Prescription drug monitoring programs (PDMPs) are among the most important components of government efforts to prevent and reduce controlled substance diversion and abuse. The Drug Enforcement Administration estimates 7 million Americans are abusing prescription drugs, an increase of 80 percent since 2002. In Florida, the rate of deaths (per 100,000 residents) caused by prescription drugs is over three times as high as the rate of deaths caused by all illicit drugs combined. In addition, according to the 2008 Florida Youth Substance Abuse Survey, among Florida's 12<sup>th</sup> graders, the past 30 day prevalence rates for abuse of depressants and prescription pain relievers are greater than for all other illegal drugs, excluding marijuana.

Controlled substances are potentially beneficial medications, but they also have the capacity to be abused, misused, and sold for profit as well as contribute to behavior such as "doctor shopping." Prescription drug diversion costs lives, increases crime and misery from drug addiction, and accelerates costs connected to treatment, medical expenses and Medicaid fraud. In Florida, drug-related deaths continue to increase:

2007: 8,620  
2006: 7,741  
2005: 7,573  
2004: 7,128  
2003: 6,676

Prescription Drug Monitoring Programs are an important tool for prescribers, dispensers, and law enforcement in combating the prescription drug abuse problem. Drug monitoring programs were developed in response to the misuse of prescription drugs. They are readily diverted to the black market due to the lack of controls that would be mandated by a prescription drug monitoring program. It is not an uncommon practice for individuals abusing prescription medication to participate in doctor and pharmacy shopping, illegally purchase medication without a prescription over the Internet, steal drugs from family or friends, and forge or alter prescription forms. PDMPs are intended to reduce or eliminate the flow of controlled substances from legitimate medical sources to nonmedical users or dealers. Currently, 38 states have a PDMP in place and 5 out of the remaining 12 states are introducing legislation this year. Fortunately, Florida is one of the states working diligently to create legislation that prohibits illegal provision and receipt of prescription drugs by health care professionals and patients.

### **Prescription Drugs in Florida - Priority Problem**

A report by the Florida Medical Examiners Commission has concluded that prescription drugs have outstripped illegal drugs as a cause of death in Florida. In addition, the number of drug overdose deaths in the United States continues to increase,

representing a serious threat to public health. Many experts in the field attribute the trend to the increasing popularity among doctors in the practice of prescribing painkillers, combined with aggressive marketing techniques by pharmaceutical companies.

In Florida, physicians directly dispensing Schedule II narcotics (for example: morphine, methadone, oxycodone) are frequently associated with so called “Pain Clinics” offering “pills for pay” unlike legitimate pain management doctors. Unfortunately, Florida leads the nation with the top 25 dispensing practitioners of “oxycodone.” These practitioners are located in 5 counties within the state: Broward, Palm Beach, Miami-Dade, Hillsborough, and Manatee. Furthermore, lack of a PDMP contributes to the existing problem of drug diversion and the transmission of licit pharmaceuticals for illegal purposes or abuse. State authorities in states with PDMPs have indicated that after a PDMP goes into effect, “doctor shopping” patients often move their criminal activities to bordering states that do not have this program. Law enforcement in Florida are receiving reports that drug dealers from Alabama, Kentucky and other states (which have a monitoring program) are coming to Florida to obtain prescription drugs because they are not controlled in our state. Unfortunately, Florida is such a “target” state and has yet to pass legislation to introduce a PDMP to date. Florida is now the most populous state without a Prescription Drug Monitoring Program. Florida is seen as a key state in preventing drug abuse and our legislative efforts are having national impact.

### **Goals of Prescription Drug Monitoring in Florida**

The goals of PDMPs are unique for each state but are generally based on a number of possible major objectives of prescription monitoring, namely:

- Education and Information
- Public Health Initiatives
- Early Intervention and Prevention
- Investigations and Enforcement
- Protection of Confidentiality
- Eliminate Forgery and Counterfeiting of Prescription Forms
- Reduce the Number of Deaths that are Prescription-Drug-Related
- Reduce Criminal Activity Associated with Addiction and Diversion
- Reduce Suffering and Addiction caused by Misuse and Abuse

The goals of the PDMP encompass both the promotion to free up resources with access to appropriate pharmaceutical care and the deterrence of pharmaceutical diversion. Therefore, the emphasis is on preventing drug abuse, increasing patient safety and ensuring public trust in the system.

## **Components of State Prescription Drug Monitoring Programs**

- Submission of data for Schedules II, III, IV and V drugs. Doctors, pharmacists and occupational licensing officials have access to the database
- Access to collected data by federal, state, and local law enforcement personnel who are statutorily authorized to access the information by traditional, manual methods.
- Databases are not subject to public or open records laws.
- Individuals using state prescription drug monitoring programs receive adequate training on the system as well as training on proper prescribing practices, pharmacology, and referral of addicted and abusing patients.
- Legislation frequently includes penalties for the unauthorized use of the data.
- Out-of-state Internet or mail order pharmacies can be required to submit reports.
- Programs provide information for research, policy and educational purposes only if personally identifiable information is removed.

## **Proposed Legislation – 2009**

### **HB 143/SB 614 (Representative Domino/Senator Aronberg)**

**Monitoring the Dispensing of Controlled Substances:** Requires DOH to establish electronic system to monitor dispensing of certain controlled substances and biometric identifiers of recipients; requires health care practitioners and pharmacies who dispense certain controlled substances to have biometric scanning device connected to database and submit specified information before dispensing; requires database to provide specified information concerning conflicting or overlapping prescriptions; provides exceptions to reporting requirements; provides for data retention; requires that data transmissions comply with privacy and security laws; provides for rulemaking; provides penalties for violations.

Effective Date: July 1, 2009

**HB 145/SB 612 (Representative Domino/Senator Aronberg)**

**Public Records/DOH/Controlled Substances:** Exempts from public records requirements information and records reported to DOH under electronic monitoring system for dispensing of certain controlled substances; authorizes certain persons and entities access to information; provides guidelines for use of such information and penalties for violations; provides for future legislative review and repeal; provides finding of public necessity.

Contingent Effective Date: March 1, 2011, if HB 143 or similar legislation establishing an electronic system for monitoring Schedule II, Schedule III, and Schedule IV is adopted and becomes law prior thereto.

**HB 583/SB 1356 (Representative Skidmore/Senator Bennett)**

**Controlled Substances/Monitoring and Dispensing:** Requires the DOH to establish a comprehensive electronic system to monitor the dispensing of certain controlled substances; requires those who dispense certain controlled substances to submit specified information to the DOH; requires that information be submitted in an approved electronic format; provides time periods for information submission; provides criminal penalties for violations; provides requirements for system funding, etc.

Effective Date: July 1, 2009

**HB 585/SB 1354 (Representative Skidmore/Senator Bennett)**

**Public Records/DOH/Controlled Substances Monitoring:** Exempts from public records requirements information and records reported to the DOH under the electronic system for monitoring the dispensing of certain controlled substances; authorizes certain persons and entities access to information; provides restrictions on the use of such information and criminal penalties for violations; authorizes agreements with other states to exchange prescription drug monitoring information, etc.

Contingent Effective Date: July 1, 2009, if HB 583 or similar legislation establishing an electronic system for monitoring the dispensing of controlled substances listed in Schedule II, Schedule III, and Schedule IV is adopted in the same legislative session or an extension thereof and becomes law.

**HB 897/SB 462 (Representative Llorente/Senator Fasano)**

**Controlled Substances:** Requires AHCA to establish statewide, comprehensive electronic system to monitor prescribing and dispensing of controlled substances in Schedules II-IV; provides reporting requirements; provides exemptions; requires prescribing or dispensing pharmacists and practitioners to submit information in certain format; requires DOH and regulatory boards to adopt rules; requires that AHCA costs be paid through federal, private, or grant funding sources.

Effective Date: July 1, 2009

**SB 440 (Senator Fasano)**

**Public Records/Controlled Substance Prescriptions/AHCA [SPSC]:** Exempts from public records requirements information and records reported to the AHCA under the electronic-monitoring system for the tracking of prescriptions of controlled substances listed in Schedules II-IV; authorizes certain persons and entities access to patient-identifying information; provides guidelines for the use of such information and penalties for violations; provides for future legislative review and repeal, etc.

Contingent Effective Date: July 1, 2009, if other conditions precedent occur.

**HB 937 (Representative Llorente)**

**Public records/Controlled Substances:** exempts from public records requirements information and records reported to the Agency for Health Care Administration under the electronic-monitoring system for the tracking of prescriptions of controlled substances listed in Schedules II-IV; authorizes certain persons and entities access to patient-identifying information; provides guidelines for the use of such information and penalties for violations; provides for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; provides a finding of public necessity.

Contingent Effective Date: July 1, 2009, if House Bill 897, or similar legislation establishing an electronic system to monitor the prescribing of controlled substances, is adopted in the same legislative session or an extension thereof and becomes law.

**HB 893 (Representative Renault)**

**Drug Donation Program:** Creates Drug Donation Program for state correctional system; provides conditions for donation of drugs & supplies to program; provides conditions for acceptance of drugs & supplies into program, inspection of drugs & supplies, & dispensing of drugs & supplies to eligible prisoners; requires participant facility that accepts donated drugs & supplies through program to comply with certain state & federal laws; authorizes participant facility to charge fees under certain conditions; requires DOH, upon recommendation of DOC & Board of Pharmacy, to adopt certain rules; requires DOH to establish & maintain participant facility registry; provides for contents & availability of participant facility registry; provides immunity from civil & criminal liability for DOC, donors, & pharmaceutical manufacturers in certain circumstances; provides that provisions of act control in event of conflict between provisions of act & ch. 465 or ch. 499, F.S.; authorizes position & provides appropriation. Effective Date: July 1, 2009.

**SB 984 (Senator Wise)**

**Drug Donation Program Act [SPSC]:** Cites this act as the "Drug Donation Program Act." Creates said act for the state correctional system; provides conditions for the acceptance of drugs and supplies into the program, inspection of drugs and supplies, and dispensing of drugs and supplies to eligible prisoners; requires the Department of Health to establish and maintain a participant facility registry, etc.

Effective Date: July 1, 2009

**HB 1015 (Representative Kelly)**

**Prescription Drug Validation Program:** Requires DOH to establish prescription drug validation program to establish comprehensive electronic system to monitor prescribing & dispensing of certain controlled substances; requires prescribing & dispensing of such controlled substances to be reported; provides exemptions; provides for data retention; limits access to system; requires compliance with state & federal privacy & security laws; provides for healthcare licensure board sanctions for violation; requires that all costs incurred by DOH for program be paid through federal grant or through available private funding sources; establishes direct-support organization; requires certain persons to present positive identification to obtain prescriptions; provides for AHCA's use of e-Prescribing resources & clearinghouse; requires DOH to develop rules for data requirements in conjunction with specified organizations; establishes Program Implementation & Oversight Workgroup.

Effective Date: July 1, 2009.

**HB 1017 (Representative Kelly)**

**Public Records/Controlled Substances/DOH:** Exempts from public records requirements information & records reported to DOH under electronic prescription drug validation program for monitoring prescribing & dispensing of certain controlled substances; authorizes certain persons & entities access to patient-identifying information; provides guidelines for use of such information & penalties for violations; provides for future legislative review & repeal; provides finding of public necessity.

Contingent Effective Date: July 1, 2009, if HB 1015 or similar legislation establishing an electronic system to monitor the prescribing and dispensing of controlled substances is adopted in the same legislative session or an extension thereof and becomes law

**Prescription Drug Monitoring Task Force Recommendations**

- Funding – Private or Federal Grant
- Limit personal identification information – Social Security Number (Keep infrastructure with regard to input into the fraudulent system).
- System Standards consistent with the American Society for Pharmacy Automation. Highlights of the 2007 version are:
  - The standard now contains only four core-reporting segments. These capture information on the patient; the details of the actual prescription itself, including payment type; information on the prescriber; and the details of a compound where an ingredient is a reportable drug.

- Data looping has been added for more efficient reporting where more than one reportable drug is dispensed to a patient or where a compound may include more than one reportable ingredient.
  - The standard can be used for real-time reporting as well as batch-file reporting.
  - A data element has been added for identification of reportable prescriptions dispensed for animals.
  - More detailed instructions are included on the correct use of segments and data elements.
  - There is greater consistency in the use of code values throughout.
  - Examples have been improved on how to structure a transaction.
  - Several examples are included on how to report prescriptions with decimal quantities.
  - As with the 2005 standard the latest version is rules based, meaning data elements are classified as either required or situational. Where situational, the situation for use is clearly defined.
  - The Prescription-Monitoring Program Model Act of 2002, developed by the Alliance of States with Prescription-Monitoring Programs and the National Association of State Controlled Substances Authorities was used as the basis for the essential reporting requirements. “This latest version of the ASAP standard represents a number of improvements over the 2005 version, which should allow prescription-monitoring programs to be more effective in reducing fraud, abuse, and misuse of these drugs.
  - Participants in the ASAP workgroup included representatives from several states with prescription monitoring programs as well as system vendors and pharmacy stakeholders. The standard was thoroughly vetted over a four-month period by the workgroup.
- Health Insurance Portability and Accountability Act (HIPPA) – All exemptions on current proposed legislation are acceptable.
  - Penalties for Violations – All penalties proposed are acceptable.
  - Purge – conditions – HB 585/SB 462 revise language in bill draft from “may” retain to “shall” retain.

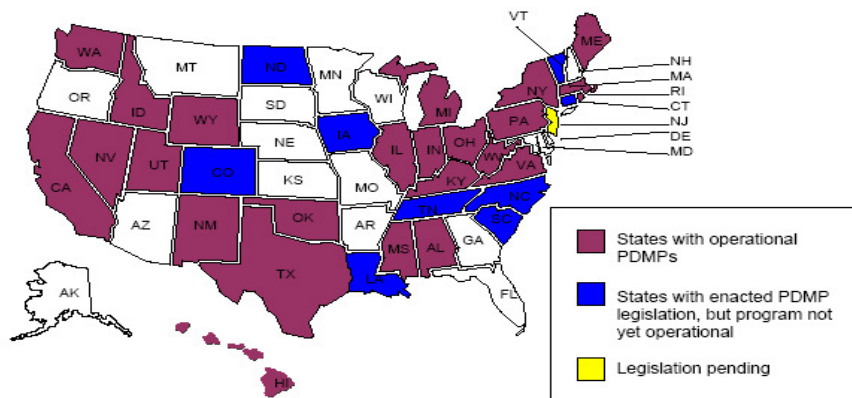
- State Surgeon – agreement with other states – HB 585 (Representative Skidmore).
- Mandatory reporting for all prescribing and dispensing.
- Real-time reporting goal.
- Pass a “Phase 1” bill with basic monitoring and amend future legislation.

## Frequently Asked Questions

### Are other states planning to implement prescription drug monitoring programs?

Eleven states are in the process of proposing, preparing, or considering legislation. These states include Arkansas, Delaware, Florida, Georgia, Maryland, Missouri, Montana, Nebraska, New Hampshire, Oregon, and South Dakota.

Status of State Prescription Drug Monitoring Programs (PDMPs)



Prepared by the National Alliance for Model State Drug Laws, current through October 11, 2006.  
Washington's PMP applies to licensed practitioners and is used for disciplinary purposes or for disciplinary board supervision of a practitioner's practice.



Only one state (Wisconsin) and the District of Columbia have done nothing to implement a program.

**Has monitoring program data been used to target potential subjects of investigations?**

Program officials state their systems are not used to target subjects for an investigation. Prescription drug monitoring data regarding specific healthcare professionals may be reviewed after an official complaint is received. The PDMP system may also be programmed to highlight significant deviations regarding prescriptions. The states use the data to identify that a problem exists and to determine the extent of the diversion or abuse. The systems are also queried for patients who are found to be "doctor shoppers"-- one individual visiting numerous doctors and pharmacies to obtain pharmaceutical controlled substances.

### **Is the accessibility to controlled substance prescription data a violation of patient confidentiality?**

Every prescription drug monitoring program provides safeguards to protect patient confidentiality. Only those individuals who are authorized by statute or regulation can access the controlled substance prescription information.

### **Who is authorized to review the data and once the data is collected, what is done with it?**

Each state has legislation that determines who can access the PDMP data. PDMP officials are not privy to information that is not part of the PDMP. The significance of the monitoring programs is to facilitate access to prescription information in a more user friendly format.

### **What impact do monitoring programs have on bordering states that do not operate a monitoring program?**

State authorities report that after a prescription drug monitoring program goes into effect, "doctor shopping" patients often move their criminal activities to bordering states that do not have a PDMP. PDMP information can be shared with other states if state statutes and regulations permit it. The National Alliance for Model State Drug Laws has drafted a Model Interstate Compact to assist states in their efforts to share prescription information across state lines. More information on the National Alliance for Model State Drug Laws can be found at [www.natlalliance.org](http://www.natlalliance.org).

Additionally, the Integrated Justice Information Systems (IJIS) Institute is leading a project funded by the Bureau of Justice Assistance (BJA) to develop a system for the interstate exchange of prescription drug monitoring program data. IJIS created a pilot project between California and Nevada to share state PDMP information. In May 2007, a test of the pilot project was successful with the exchange of information. This is the first time states have exchanged PDMP data in an automated fashion.

Currently, IJIS is working to implement a prototype system that will prove the value of a shared hub server used to centrally facilitate and broker data exchanges. The hub server would provide for a centralized enabling system with which each state PDMP system could communicate more economically than having each and every state

manage 49 exchange pipelines on a one-by-one basis. The Ohio Board of Pharmacy has agreed to serve as the host agency that would work under the guidance of the IJIS PDMP Committee to acquire and operate the hub for the duration of the prototype. Ohio, Kentucky, and Nevada have agreed to participate in this phase of the project to exchange data via the hub.

For these projects, IJIS is working closely with the practitioners from the Alliance of States with Prescription Monitoring Programs, the Bureau of Justice Assistance, and the Drug Enforcement Administration. The goal is to provide recommendations on how to implement the data exchanges based on the new open standards emerging from the Global Justice XML Data Model. More information on the IJIS Interstate PDMP exchange project can be found at [www.IJIS.org](http://www.IJIS.org).

### **What additional time, if any, is required to submit prescription data to state authorities?**

The majority of pharmacies submit prescription information electronically. States have generally expressed satisfaction with the electronic system since it markedly reduced the paperwork burden that existed when pharmacies manually submitted prescription data.

### **How can a state initiate a prescription drug monitoring program?**

The Harold Rogers Prescription Drug Monitoring grant program provides financial assistance to state authorities who want to create or enhance a prescription drug monitoring program. Additional information can be found at [www.ojp.usdoj.gov/bja](http://www.ojp.usdoj.gov/bja)

### **What are some of the beneficial uses of prescription drug monitoring programs?**

Historically, investigators needed to visit each location to obtain prescription information for routine pharmacy inspections or investigations. The PDMP database eliminates this tedious process by requiring prescription information be maintained electronically. This allows investigators to obtain pharmacy data from multiple locations without having to visit each and every pharmacy.

Prescription drug monitoring programs are being used to deter and identify illegal activity such as prescription forgery, indiscriminate prescribing and "doctor shopping." Most programs provide patient specific drug information upon request of the patient's physician or pharmacist. Some state programs proactively notify physicians when their patients are seeing multiple prescribers for the same class of drugs. This assists healthcare professionals in managing patient care. It has been an extremely successful program to thwart diversion in a number of states.

### **What are the annual costs to operate a prescription drug monitoring program?**

The cost of implementing and operating a prescription drug monitoring program differs from state to state because of many variables that exist. The average cost to start a PDMP is approximately \$350,000. State annual operating costs for PDMPs range from \$100,000 to nearly \$1 million. Cost variations are affected by the frequency of data collection (daily, bi-weekly vs. monthly), the use of a third party vendor, the number of prescriptions written/filled in a state, the number of schedules (II-V) collected, and the use of official forms when required.

## The Bureau of Justice Assistance Prescription Drug Monitoring Program at a Glance

In the field, BJA's resources in the area of Prescription Drug Monitoring Programs (PDMPs) serve several critical functions:

- Provide resources for data collection and analysis systems at the state level;
- Provide enhancements funding for existing programs; and
- Facilitate the exchange of collected prescription data among state and local authorities (e.g. law enforcement, occupational licensing boards, certification and regulatory personnel, pharmacists, and physicians).

State	Agency Housing the PDMP	Schedules of Drugs Monitored	FY02	FY03	FY04	FY05	FY06	FY07	PDMP State and Local Contact
Alabama	Department of Public Health	II, III, IV, V		\$300,000	\$350,000	\$350,000	\$400,000	\$400,000	Patricia Stadlerberger, (334) 206-7981
Alaska	Division of Corporations, Business and Professional Licensing	**						\$49,436	Brian Howes, (907) 269-8109
Arizona	Board of Pharmacy	II, III, IV			\$50,000	\$50,000		\$50,000	Hal Wend, (623) 463-2727
California	Department of Justice, Bureau of Narcotic Enforcement	II, III, IV		\$387,745	\$350,000	\$350,000	\$400,000	\$400,000	Katherine Ellis, (916) 319-6863
Colorado	Department of Regulatory Agencies	II, III, IV, V			\$50,000	\$50,000			Wendy Anderson, (303) 894-7754
Connecticut	Department of Consumer Protection	II, III, IV, V		\$300,000	\$350,000	\$350,000	\$314,206		John Gadea, (860) 713-6065
Florida	Florida Office of Drug Control	**			\$349,530	\$349,954	\$400,000	\$400,000	Bill James, (850) 468-9557
Hawaii	Hawaii Department of Public Safety	II, III, IV		\$97,320			\$191,302		Glen Kimura, (808) 837-8481
Illinois	Board of Pharmacy	II, III, IV			\$349,994	\$349,994	\$400,000	\$400,000	Mark Johnston, (208) 334-2358
Indiana	Department of Health and Human Services	II, III, IV, V			\$281,876	\$216,796	\$373,659	\$389,312	Stanley Tymian, (317) 524-9074
Indiana	Indiana Professional Licensing Agency	II, III, IV, V			\$350,000	\$292,963			Marty Allain, (317) 234-2067
Iowa	Department of Public Health	II, III, IV			\$50,000				Terry Mikowski, (515) 281-5944
Kansas	Board of Pharmacy	**			\$50,000				Debra Billingsley, (785) 286-4056
Kansas	Cabinet for Health & Family Services, Office of the Inspector General	II, III, IV, V		\$240,000	\$350,000	\$350,000	\$400,000	\$400,000	Dave Hopkins, (502) 564-7985
Kentucky	Board of Pharmacy	Schedules monitored to be determined			\$50,000	\$50,000	\$400,000	\$400,000	Malcolm Broussard, (225) 925-6481
Louisiana	Office of Substance Abuse	II, III, IV		\$300,000	\$109,850	\$339,164	\$285,950		Daniel Echner, (207) 287-3363
Massachusetts	Massachusetts Department of Public Health	II		\$219,998	\$350,000	\$350,000	\$400,000	\$400,000	Grant Carrow, (617) 983-6701
Michigan	Bureau of Health Professions	II, III, IV, V			\$350,000	\$350,000			Michael Wisel, (517) 335-1768
Minnesota	Board of Pharmacy	II, III			\$349,915	\$350,000	\$400,000	\$400,000	Cody Wieberg, (651) 201-2825
Mississippi	Board of Pharmacy	II, III, IV, V			\$350,000	\$350,000			Mac McDuff, (601) 605-5388
Missouri	Department of Health and Senior Services	**			\$50,000	\$50,000			Susan McCann, (573) 751-6321
Montana	Montana Board of Crime Control	**			\$344,531	\$340,298	\$50,000	\$50,000	Lily Yamamoto, (406) 444-1610
Nevada	Board of Pharmacy	II, III, IV		\$515,267	\$344,531	\$340,298	\$400,000	\$400,000	Larry Pison, (775) 850-1440
New Hampshire	Department of Justice	**			\$350,000	\$49,836			Dave Strang, (603) 271-1248
New Jersey	Department of Law and Public Safety	**			\$350,000	\$350,000			Eric Rosen, (973) 504-6584
New Mexico	Board of Pharmacy	II, III, IV		\$245,650	\$350,000	\$350,000	\$400,000	\$400,000	Bill Harvey, (505) 222-9130
New York	New York Bureau of Narcotic Enforcement	II, III, IV, V		\$300,000	\$350,000	\$350,000	\$399,900	\$400,000	James Giglio, (518) 402-0707
North Carolina	Department of Health and Human Services	II, III, IV, V			\$50,000	\$50,000	\$399,900	\$399,900	John Womble, (919) 715-2771
North Dakota	Board of Pharmacy	Schedules monitored to be determined					\$372,315		Howard Anderson, (701) 328-9535
Ohio	Board of Pharmacy	II, III, IV, V		\$180,000	\$350,000	\$350,000	\$400,000	\$400,000	Danna Droz, (614) 486-4143
Oklahoma	Bureau of Narcotics and Dangerous Drugs	II, III, IV, V			\$350,000	\$350,000	\$259,820	\$400,000	John Duncan, (405) 521-2888
Oregon	Board of Pharmacy	**			\$350,000	\$350,000			Gary Schmale, (503) 731-4032
Pennsylvania	Office of Attorney General	II		\$180,000	\$350,000	\$350,000			Lawrence Cherba, (610) 791-6145
Rhode Island	Board of Pharmacy	II, III			\$350,000	\$350,000			Catherine Cordy, (401) 222-2837
South Carolina	Department of Health and Environmental Control	II, III, IV			\$350,000	\$350,000			Wilbur Harling, (803) 896-0636
Tennessee	Board of Pharmacy	II, III, IV, V			\$50,000	\$350,000	\$443,459	\$443,459	Kolleen Matthews, (615) 253-1305
Texas	Department of Public Safety	II, III, IV, V			\$349,010	\$375,427	\$349,010	\$375,427	Kelli Cox, (512) 424-2188
Texas	Department of Commerce, Division of Occupational & Provisional Licensing	II, III, IV, V		\$80,005					Marvin Sims, (801) 530-6232
Vermont	Department of Health	II, III, IV			\$350,000	\$350,000	\$398,388	\$398,388	Barbara Cimaglio, (802) 651-1550
Virginia	Board of Pharmacy	II, III, IV		\$180,000	\$82,300	\$350,000	\$400,000	\$400,000	Ralph Orr, (804) 662-9921
Washington	Disciplinary Board	Determined by disciplinary authority			\$50,000	\$50,000			Donald Williams, (360) 236-4829
West Virginia	Board of Pharmacy	II, III, IV	\$180,000		\$350,000	\$350,000			William Douglass, (304) 568-0558
Wyoming	Board of Pharmacy	II, III, IV	\$214,529		\$350,000	\$350,000			James Carder, (307) 234-0294

\*\*These states do not currently have legislation or regulation to establish a PDMP in place.

**PLEASE NOTE:** Washington currently has a duplicate prescription form program. The program applies to licensed practitioners and is used for disciplinary purposes or for disciplinary board supervision of a practitioner's practice.

A Prescription Drug Monitoring Program is defined as a program that is currently collecting prescription data and can respond to requests for those authorized to make these requests (*The National Alliance for Model State Drug Laws, 2007*).  
**Schedules of Drugs Monitored:** A list of controlled substances which identify how the substances on each list can be prescribed, dispensed or administered. A substance is placed on a particular schedule after consideration of several factors, including the substance's accepted medical usage in the United States and potential for causing psychological or physical dependence.  
 The information in this chart is current as of November 6, 2007.

Developed with the National Alliance for Model State Drug Laws under cooperative agreement 2005-PH-BX-K014 awarded by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.

## **Should there be a federal mandate for states to establish prescription monitoring programs or should states be encouraged to establish individual programs?**

In recognition of the proven effectiveness in curtailing the diversion and abuse of pharmaceutical controlled substances, the DEA has been a long time proponent of prescription drug monitoring programs (PDMPs). Further, it is DEA's intent to support the best available means to facilitate the establishment or enhancement of PDMPs to ensure prescription data is collected from the largest percentage of controlled substance dispensers in the most efficient, cost-effective manner.

Advantages of a national program may include an enhanced ability to identify and track prescription transactions across state lines. This is particularly important given the growing trend of filling prescriptions through mail order and Internet pharmacies. While several states declare their programs have the capability of generating reports on out-of-state prescribers or patients, they do not routinely disseminate this information to other states.

However, the size and cost of a national database may be prohibitive. The system would be required to annually collect data from over 673 million prescriptions from the nation's 65,000 DEA-registered pharmacies and respond to requests for information from more than 1.2 million DEA-registered practitioners. Additionally, the system would duplicate the efforts of state programs currently in operation. While only 38 states are currently operating prescription drug monitoring programs or have enacted legislation, these states, including those considering or in the process of proposing legislation, cumulatively account for 98 percent of the nation's DEA-registered pharmacies and 98 percent of all practitioners.

Conversely, because state databases are much smaller than that of a national program, state programs can more readily identify specific trends. In addition, state programs can identify patients who may need drug treatment due to abuse or addiction. State programs also have the ability to assist physicians whose patients may be receiving inadequate pain treatment causing the patient to see multiple physicians in order to obtain additional medication.

Efforts to implement state prescription drug monitoring programs tend to meet with opposition from a variety of groups including medical associations, pharmacy groups, pharmaceutical companies, patient advocacy groups, and civil liberty groups. The creation of a federal program would likely face opposition from those groups as well as from states' rights groups and from officials in states currently operating their own PDMP. The question arises as to whether a national program would be compatible with existing state programs. States currently operating programs may have to revise existing programs to accommodate a national program.

**What is NASPER?**

On August 11, 2005, President Bush signed into law the *National All Schedules Prescription Electronic Reporting Act of 2005* (NASPER). The act creates a grant program for states to create prescription drug monitoring databases and enhance existing ones, similar to the Harold Rogers Prescription Monitoring grant program. NASPER authorizes \$60 million for the program through fiscal 2010. While the Harold Rogers grant program is placed within the Department of Justice, the NASPER program is placed within the Department of Health and Human Services (HHS).

The NASPER grant program is authorized for \$60 million over five years, with \$15 million allocated for 2006 and 2007, and \$10 million for 2008, 2009, and 2010. However, HHS did not receive an appropriation in its FY2006, FY2007, or FY2008 budget for this program. Funding for NASPER in FY2009 has not yet been determined.

**What are the differences between the Harold Rogers Prescription Drug Monitoring grant program and NASPER?**

The Harold Rogers grant program, housed in the Department of Justice, allows states to establish their own requirements with regard to Schedules monitored, information sharing, and accessibility/availability to the program data. Harold Rogers **encourages** the sharing of information and prescription data among states. Harold Rogers **encourages** the submission of data for prescriptions in Schedules II, III, IV & V. Eligibility for Harold Rogers grant funds has a very simple requirement: States applying for grants must have in place an enabling statute or regulation *"that requires submission of controlled substance prescription data to a centralized database administered by an authorized state agency."*

The National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER), housed within the Department of Health and Human Services (HHS), requires states to meet requirements in order to receive grant funding. NASPER **requires** states to collect data for prescriptions in Schedules II, III, and IV. Additionally, NASPER **requires** states to be capable of sharing information and prescription data among states.

The following chart provides information on the 38 states with legislation enabling a prescription drug monitoring program including the type of program currently being operated, the schedules covered and the year the current version of the program was enacted.

	STATE	PROGRAM TYPE	SCHEDULES COVERED	YEAR ENACTED	DATA COLLECTION Started
1	AL	Electronic	C II-V	2004	April 2006
2	AK*	Electronic	C I-V	2008	

	STATE	PROGRAM TYPE	SCHEDULES COVERED	YEAR ENACTED	DATA COLLECTION Started
3	AZ	Electronic	C II-IV <i>2008</i>	2007	October 2008
4	CA	Single copy serialized, Electronic	C II-IV	2005	January 2007 (1939)
5	CO	Electronic	C II-V	2005	July 2007
6	CT	Electronic	C II-V <i>2008</i>	2007	July 2008
7	HI	Electronic	C II-V	2002	July 1999 (1992 –II only)
8	ID	Electronic	C II-V	2001	Oct 1997
9	IL	Electronic	C II-V	1999	April 2000/ Jan 2008
10	IN	Electronic	C II-V	2004	January 2005
11	IA*	Electronic	C II-IV <i>2008</i>	2006	
12	KY	Electronic	C II-V	1998	January 1999
13	KS*	Electronic	C II-IV	2008	
14	LA	Electronic	C II-V	2006	November 2008
15	ME	Electronic	C II-IV	2003	July 2004
16	MA	Electronic	C II	1992	April 2002
17	MI	Electronic	C II-V	2002	January 2003
18	MS	Electronic	C II-V	2005	May 2006
19	MN*	Electronic	C II-III <i>Jan 2009</i>	2007	
20	NV	Electronic	C II-V	1995	January 1997
21	NJ*	Electronic	C II-IV	2008	
22	NM	Electronic	C II-IV	2004	July 2005
23	NY	Single copy, serialized/ Electronic (state issued)	C II, Benzos	1998	July 1982
24	NC	Electronic	C II-V	2005	July 2007
25	ND	Electronic	C II-V	2005	September 2007
26	OH	Electronic	C II-V	2005	May 2006

	STATE	PROGRAM TYPE	SCHEDULES COVERED	YEAR ENACTED	DATA COLLECTION Started
27	OK	Electronic	C II-V	1990	July 2006
28	PA	Electronic	C II	1972	Late 2002
29	RI	Electronic	C II-III	1997	July 1997
30	SC	Electronic	C II-IV	2006	January 2008
31	TN	Electronic	C II-IV	2002	December 2006
32	TX	Single copy, serialized/ Electronic (state issued)	CII <i>II-V Sept 2008</i>	1997	July 1982
33	UT	Electronic	C II-V	1995	January 1997
34	VT*	Electronic	C II-IV Jan 2009	2006	
35	VA	Electronic	C II-IV	2002	June 2006
36	WA	Electronic	Limited Triplicate	1984	Limited program
38	WY	Electronic	C II-IV	2004	July 2004

\* Program is not currently operational – anticipated start date is listed.

## Conclusion

The goals of Prescription Drug Monitoring Programs are manifold, spanning education, prevention and law enforcement. The emerging challenge of prescription drug abuse and misuse is a complex issue that requires a concerted effort by all Floridians. Our state has become a source for illegally diverting medications for residents from Kentucky, Tennessee, Ohio, West Virginia, Massachusetts, New York, and other states. Florida is now the largest populated state without such a program. The resulting impact of reducing diversion of controlled substances will also assist law enforcement and benefit the state. In addition, it will provide valuable and much needed data to health care providers and enhance their ability to manage chronic pain. In all of its tremendous resources, Florida has a significant problem with the misuse and abuse of prescription drugs that can be addressed by the state legislature to effectively deal with the rising abuse of pharmaceuticals in Florida.

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