



2015 ANNUAL REVIEW OF PRESCRIPTION MONITORING PROGRAMS

Research current through September 2015.

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PURPOSE AND STRUCTURE OF REVIEW

Prescription drug abuse continues to be a serious problem in America. As part of addressing this issue, 49 states and the District of Columbia have enacted prescription monitoring programs (PMPs) in an attempt to curb prescription drug abuse, misuse, and diversion. Each year brings multiple changes to prescription monitoring programs across the country. As part of our commitment to keeping stakeholders and other interested parties informed, NAMSDL has created this annual review (“Annual Review”) outlining those changes and compiling the relevant information into one comprehensive document.

The review includes relevant information on the changes made in the past year in certain areas related to PMPs, such as mandatory registration and access, types of authorized users, etc., and includes a map of the current status of states within that category.

TOPICS OF NOTE

Caselaw

Of particular interest to prescription monitoring programs is the *Oregon PDMP vs. DEA* case currently pending in the Ninth Circuit Court of Appeals. Initially filed by the Oregon PDMP in response to several subpoenas issued by the DEA for prescription monitoring information, several individuals and entities intervened in the case, including the Oregon chapter of the ACLU. The trial court ultimately decided that releasing prescription information pursuant to subpoenas violated the Fourth Amendment Constitutional rights of patients and law enforcement must, therefore, have a search warrant based on probable cause to obtain prescription monitoring information. The DEA appealed that ruling and, at the time of this Annual Review, the case is awaiting a decision in the Ninth Circuit.

Law Enforcement Access

As a result of the *Oregon PDMP vs. DEA* case, Utah amended its prescription monitoring program statutes to require that law enforcement obtain a search warrant prior to obtaining prescription monitoring information. Slightly more than half of the states require that law enforcement officials have an active investigation with a case number in order to receive prescription monitoring information, but that may change depending on the outcome of the *Oregon* case.

Mandatory Access Provisions

Twenty-nine (29) states now have mandatory access provisions where a state has – by statute, rule, or board policy – mandated that a prescriber or dispenser query the prescription monitoring program for information regarding a patient in certain circumstances. The circumstances vary from state to state and include, but are not limited to: 1) before initially prescribing a controlled substance to a patient in an opioid treatment program or pain management clinic; 2) in worker’s compensation cases; 3) prior to prescribing a hydrocodone only extended release medication in a non-abuse deterrent formula; and 4) prior to initially prescribing or dispensing an opioid analgesic or benzodiazepine.

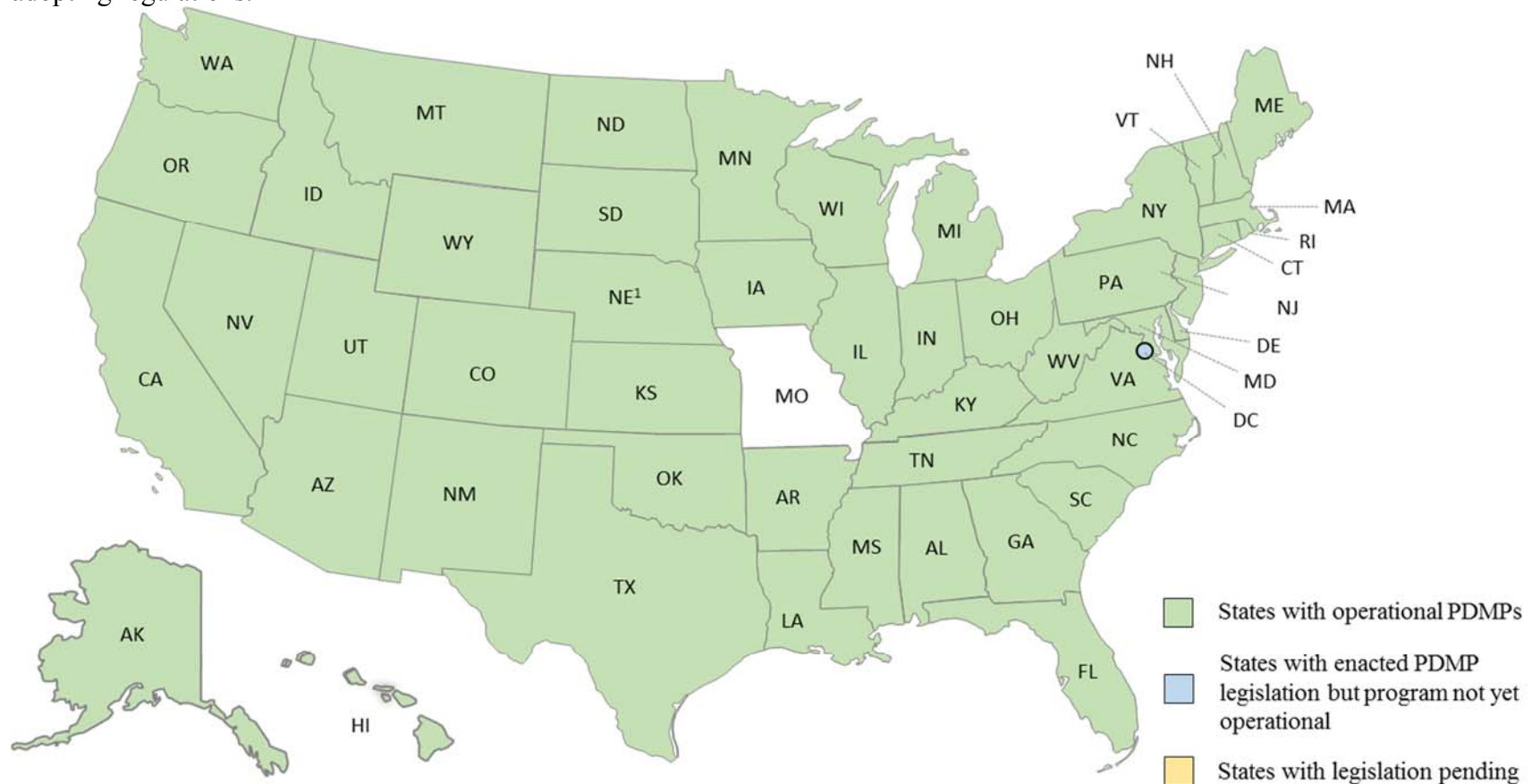
Things to Watch

One of the main areas that NAMSDL will be keeping an eye on in the future is how prescription monitoring programs go through the process of integrating their systems with electronic health records (EHR). As technology improves, it seems likely that many states will begin to integrate prescription records into EHR to streamline the process and make a patient’s prescription data readily and easily accessible to the health care practitioner through the patient’s electronic health records.



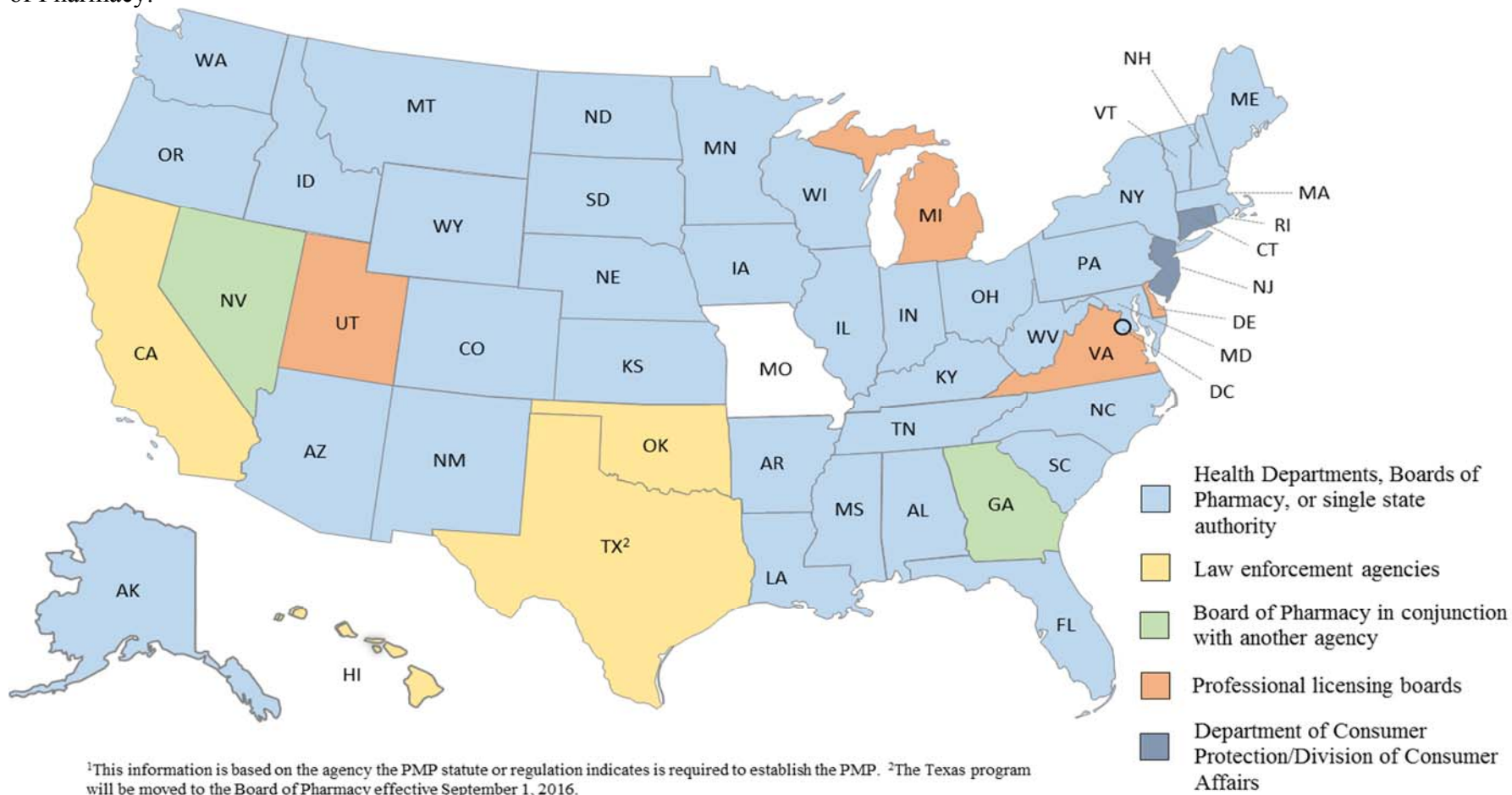
STATUS OF PRESCRIPTION MONITORING PROGRAMS

A prescription monitoring program is a statewide electronic database that collects designated data on controlled substances and, in several states, drugs of concern dispensed in the state. California is credited with operation of the first monitoring program in 1939. Seventy-six years later, 49 states and D.C. have passed statutes establishing a PMP. As of September 2015, 49 programs are collecting prescription data and providing authorized users access to that information. The District of Columbia is in the process of adopting regulations.



HOUSING ENTITIES¹

The PMP is housed within a specified statewide regulatory, administrative, or law enforcement agency. Forty-three (43) states and D.C. statutorily place the program in a health department, single state authority on drugs and alcohol, professional licensing department, or board of pharmacy. The housing agency distributes data from the PMP to individuals whom state law authorizes to receive the information for purposes of their profession. Effective September 1, 2016, the Texas program will move to the state Board of Pharmacy.



FUNDING OF PRESCRIPTION MONITORING PROGRAMS

Because of scarce state resources, PMP administrators and other officials use various mechanisms to fund the implementation, enhancement, and operation of the databases. These mechanisms include:

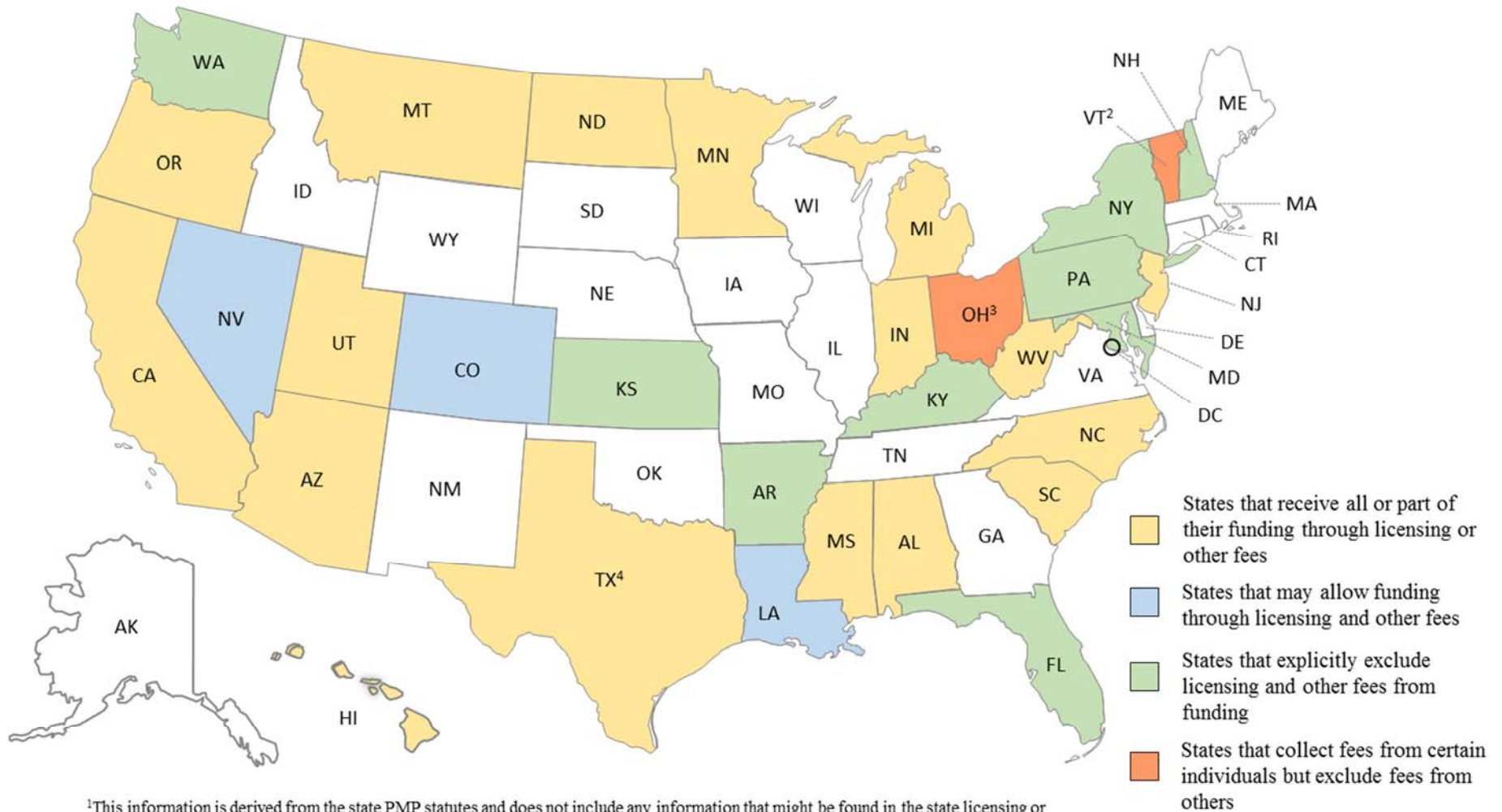
- Public or private grants
- State appropriations
- Licensing fees for prescribers, dispensers, or manufacturers
- State controlled substance registrations
- Direct support organizations

Currently, seventeen (17) states receive all or part of their monies through licensing and other fees. Texas will begin allowing the funding of the PMP through licensing fees on September 1, 2016. Vermont prohibits assessing a licensure fee against practitioners to fund the PMP, but does partially fund the PMP through fees assessed to pharmaceutical manufacturers. Ohio allows licensing and other fees from pharmacists, pharmacy interns, and certain distributors of dangerous drugs, but specifically prohibits the imposition of fees against prescribers. Three (3) additional states allow, but do not require, funding through controlled substance registration fees if no other resources are available. Nine (9) states explicitly prohibit the use of licensing and other fees to support PMP activities.

Florida passed legislation in 2015 appropriating funds for the operation of the PMP. Montana changed their funding provision to increase the fees allowed from \$15.00 to \$30.00. Texas added language to its statutes providing that the Board of Pharmacy can assess fees against individuals or entities authorized to prescribe or dispense controlled substances. The fees will be used to establish and maintain the PMP.

Information regarding the funding of programs is taken from the PMP statutes and regulations as well as from information received from PMP administrators. Note that there may be funding provisions in other statutes or regulations that are not included here, such as licensing fee statutes or regulations.

Funding Provisions of PMPs¹



¹This information is derived from the state PMP statutes and does not include any information that might be found in the state licensing or other statutes. ²Vermont specifically excludes licensing and other fees from practitioners, but does partially fund the PMP through fees assessed to pharmaceutical manufacturers. ³Ohio allows licensing and other fees from pharmacists, pharmacy interns, and certain distributors of dangerous drugs, but specifically prohibits the imposition of a fee on prescribers. ⁴The Texas provision becomes effective September 1, 2016.

TECHNOLOGY AND SOFTWARE

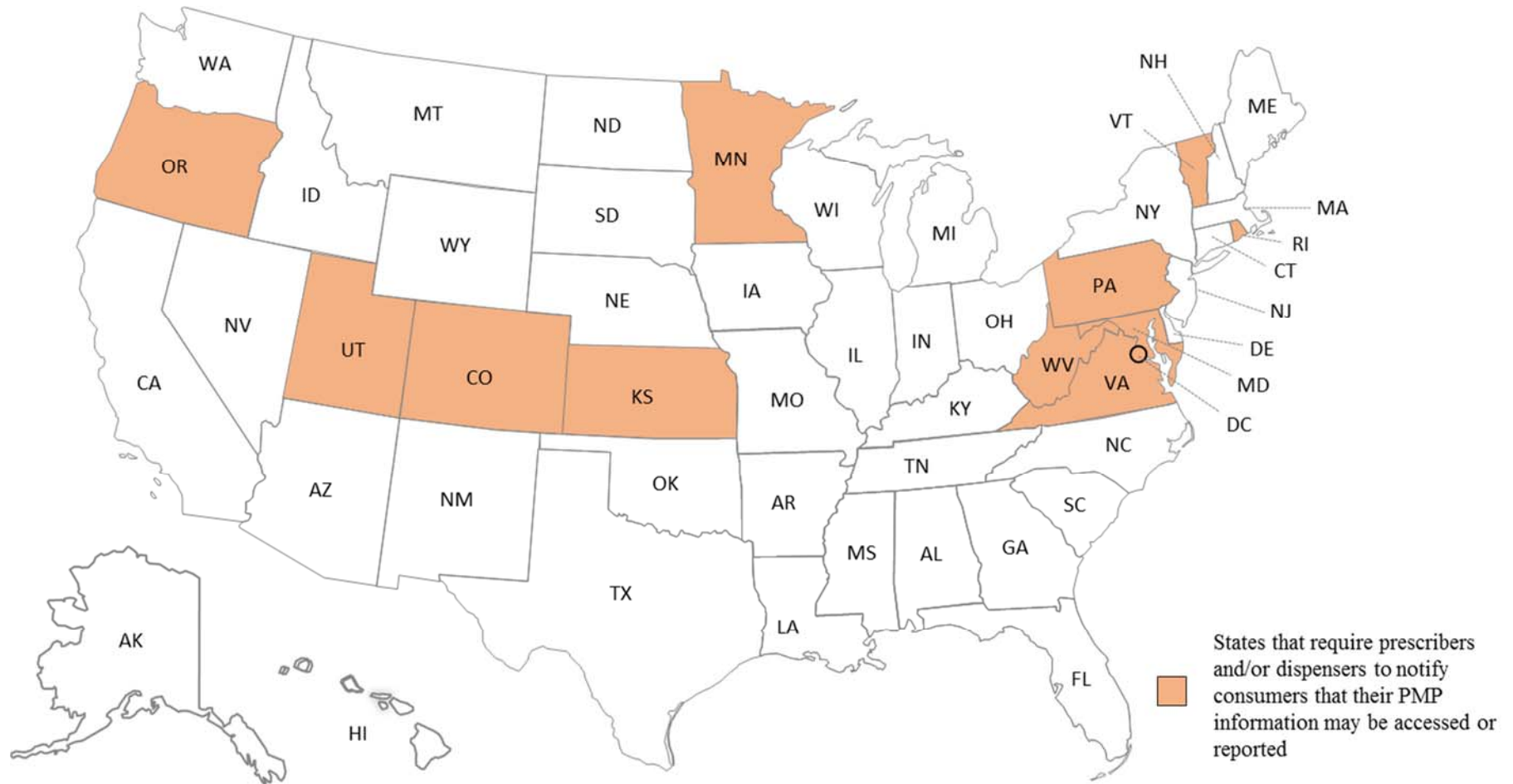
All housing agencies with operational PMPs use the PMP standards developed by the American Society of Automation in Pharmacy (ASAP) except Nebraska. For more information about ASAP, please visit their website at www.asapnet.org.

ASAP VERSION USED

Alabama	4.1	Kentucky	4.2	North Dakota	4.2
Alaska	4.1	Louisiana	4.2	Ohio	4.1
Arizona	4.2	Maine	4.2	Oklahoma	4.1
Arkansas	4.2	Maryland	4.2	Oregon	4.1
California	4.1	Massachusetts	4.1	Pennsylvania	4.2
Colorado	4.2	Michigan	4.1	Rhode Island	4.2
Connecticut	4.1	Minnesota	4.1	South Carolina	4.2
Delaware	4.2	Mississippi	3.0	South Dakota	4.1
D.C.	Unknown	Missouri	N/A	Tennessee	4.1
Florida	4.2	Montana	4.1	Texas	4.1
Georgia	4.2	Nebraska	HL-7 (non-ASAP)	Utah	95
Hawaii	4.1	Nevada	4.2	Vermont	3.0
Idaho	4.1	New Hampshire	4.2	Virginia	4.1
Illinois	4.1	New Jersey	4.2	Washington	4.2
Indiana	4.2	New Mexico	4.1	West Virginia	4.2
Iowa	4.1	New York	4.2	Wisconsin	4.2
Kansas	4.1	North Carolina	4.2	Wyoming	4.2

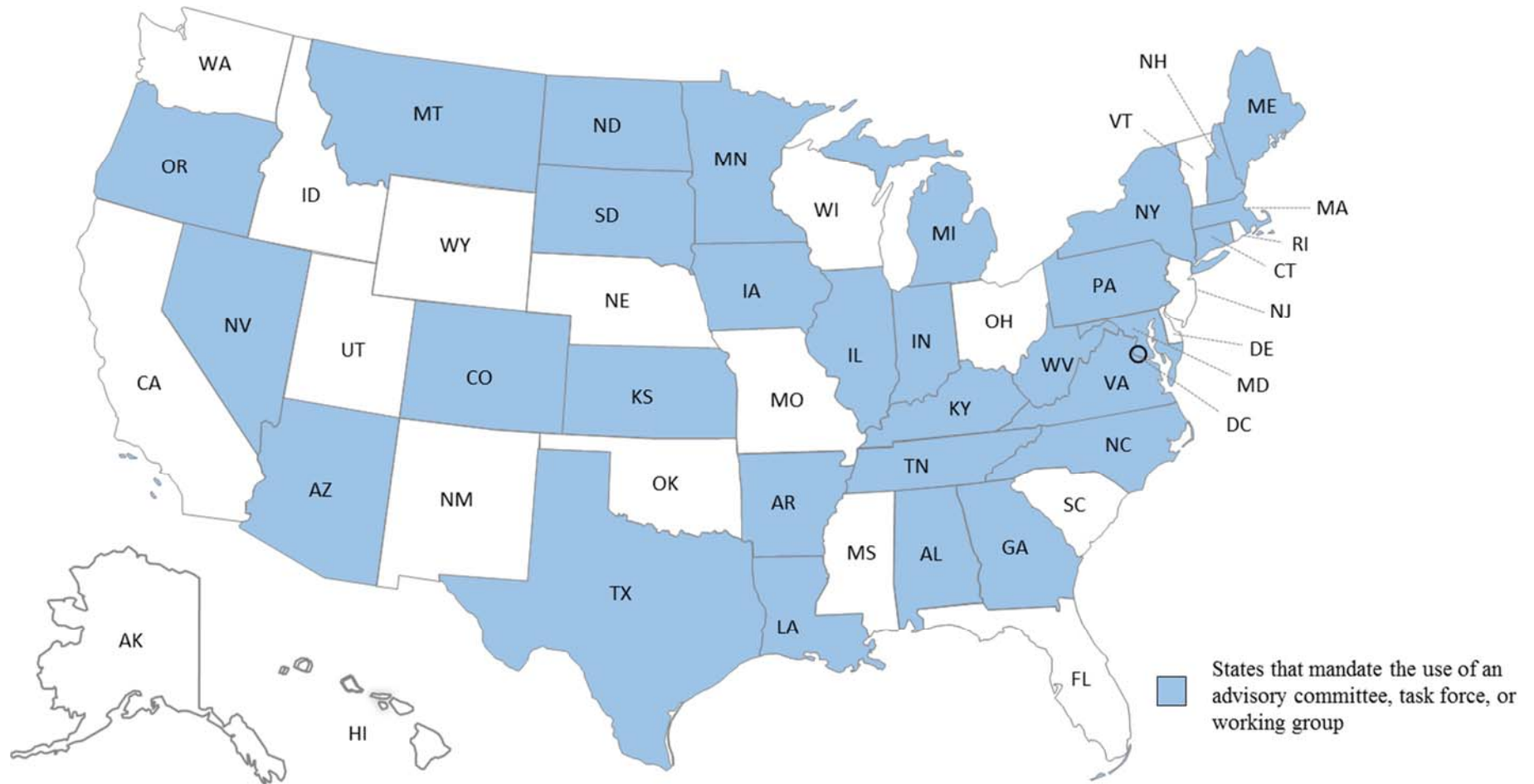
NOTICE TO CONSUMERS

Eleven (11) states and D.C. require prescribers, dispensers, or other entities to post or distribute written notice to consumers that their prescription information is being submitted to the prescription monitoring program and may be accessed by certain persons or entities. There was no change from 2014.



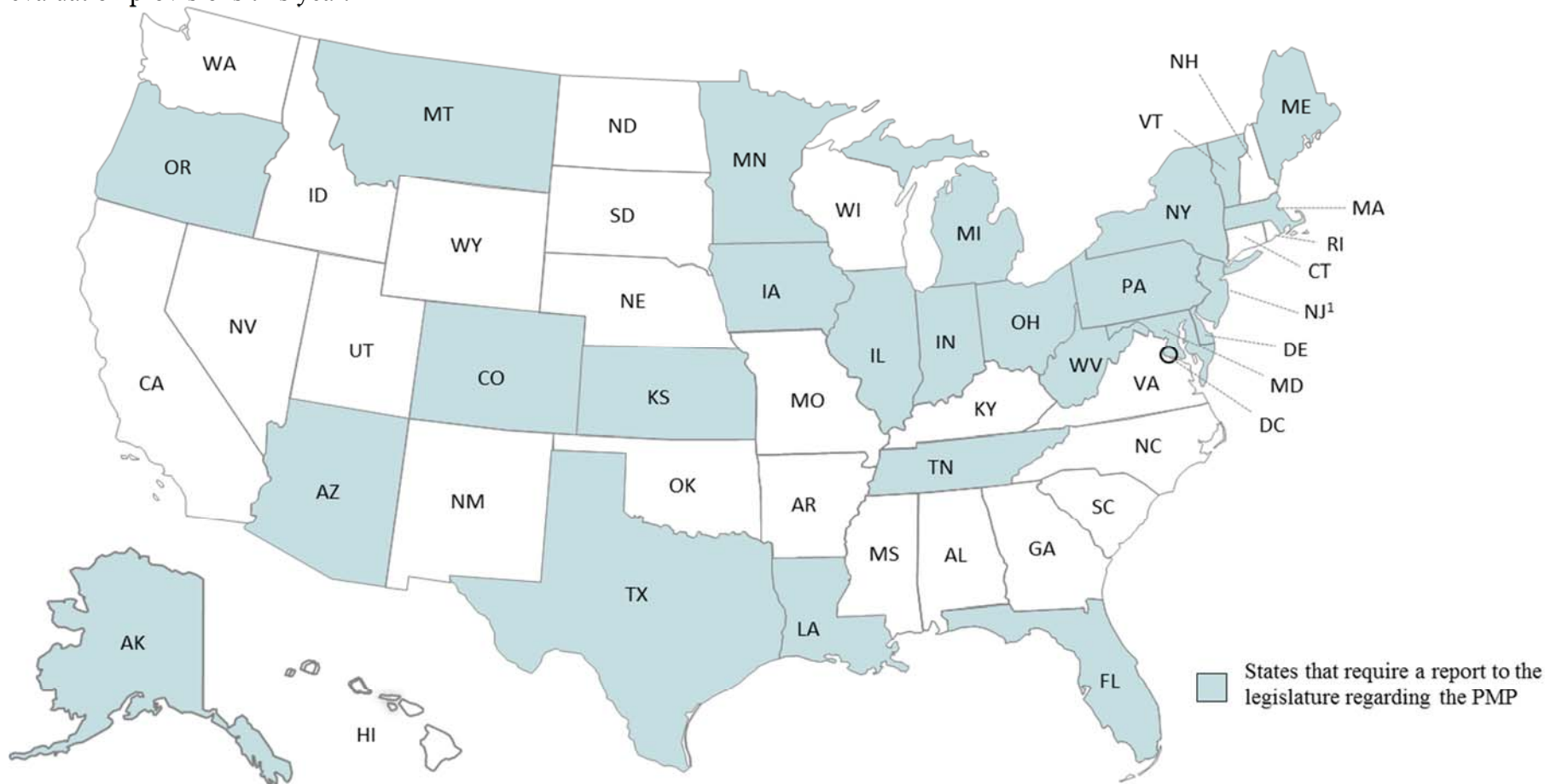
ADVISORY COMMITTEE, COUNCIL, TASK FORCE, OR WORKING GROUP

Thirty (30) states and D.C. have an advisory committee, council, task force, or working group that advises the housing entity on matters related to the PMP, including accessing data, submission of data, changes in technology, and effectiveness of the program. Illinois and Indiana added advisory committee provisions in 2015.



EVALUATION OF PRESCRIPTION MONITORING PROGRAM – REPORT TO LEGISLATURE

At this time, twenty-five (25) states require that the program provide a report to the state legislature regarding the effectiveness of the program and how the PMP has impacted the rate of prescription drug abuse within the state. Most of those states require the report to be made on at least an annual basis. The New Jersey provision goes into effect on November 1, 2015. Arizona and Illinois also added evaluation provisions this year.



¹The New Jersey provision goes into effect on November 1, 2015.

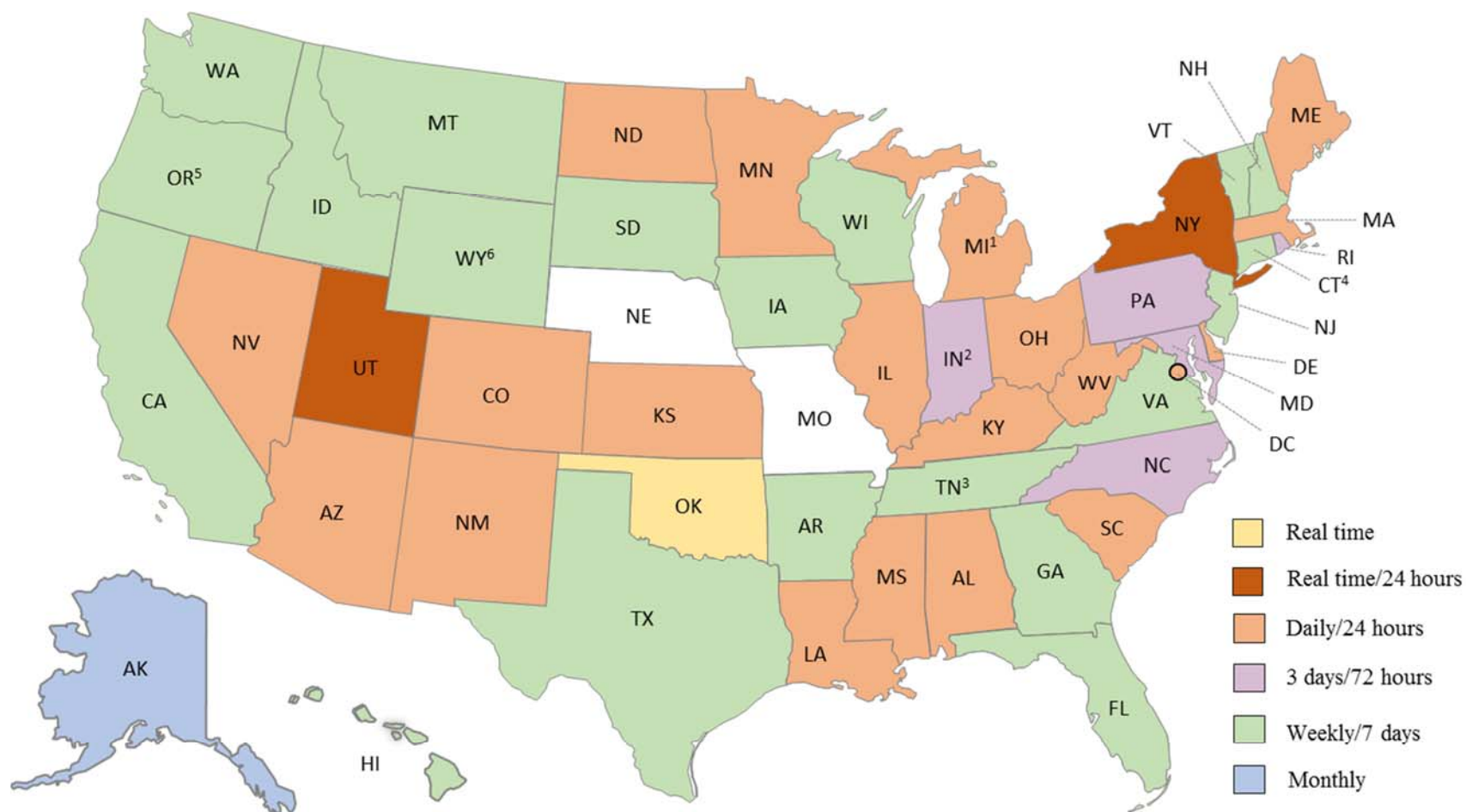
DATA COLLECTION INTERVAL

The data collection interval is the time within which a dispenser is required to submit dispensing information to the prescription monitoring program. This is the area where there has been the most change in the last year. Six (6) states went to daily reporting – Illinois, Maine, Massachusetts, Nevada, New Mexico, and Wyoming (effective January 1, 2016). Two states have implemented a real time or within 24 hours provision – Connecticut (effective July 1, 2016) and Utah. Finally, Oregon will begin requiring reporting within 72 hours on January 1, 2016. Indiana and Tennessee passed legislation in 2014 that will require dispensers to begin reporting dispensing information within 24 hours on January 1, 2016.

As of the time of this review, not including any changes that will go into effect in 2016, the following are the data collection interval totals:

- ◆ Real Time – 1 state
- ◆ Real Time/24 Hours – 2 states
- ◆ Daily – 19 states + D.C.
- ◆ 72 Hours – 5 states
- ◆ Weekly – 20 states
- ◆ Monthly – 1 state.

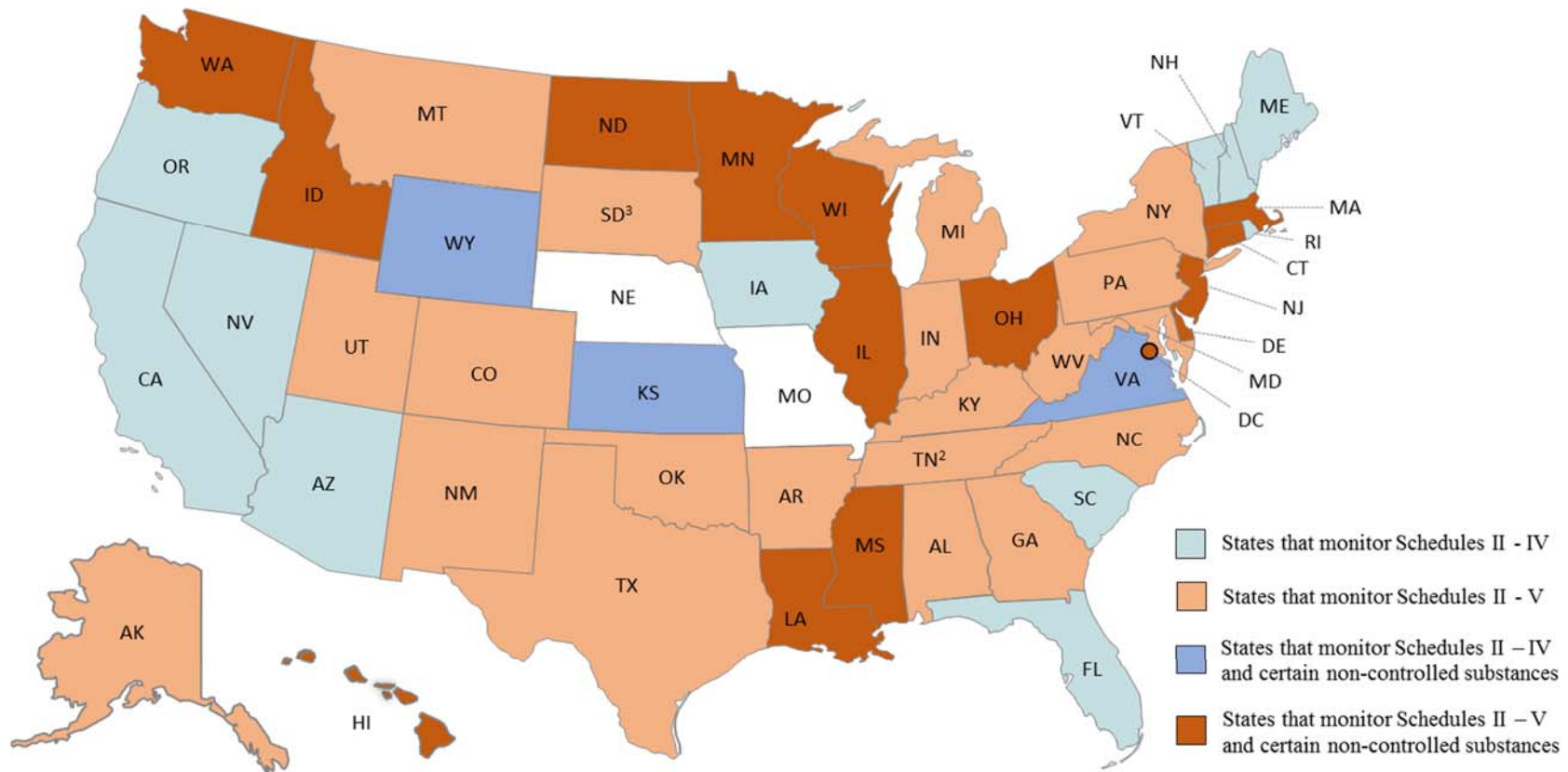




¹Michigan requires daily reporting for online reporting of dispensing information and weekly for mail-in submission of data. ²Indiana will begin requiring the submission of data within 24 hours by January 1, 2016. ³Tennessee will begin requiring daily submission on January 1, 2016. ⁴Connecticut will go to real time/24 hour reporting on July 1, 2016. It requires marijuana dispensaries to report marijuana dispensing to the PMP daily. ⁵Oregon goes to reporting within 72 hours on January 1, 2016. ⁶Wyoming goes to daily reporting on January 1, 2016.

SUBSTANCES MONITORED¹

Currently, all states with PMPs except Nebraska collect data on Schedule II – IV controlled substances. Nebraska’s PMP is voluntary; therefore, dispensers are not required to submit dispensing information on any particular controlled substance, or at all. At this time, thirty-four (34) states and D.C. also collect data on Schedule V substances. Another seventeen (17) states and D.C. collect data on certain non-controlled or non-scheduled substances, products containing butalbital, acetaminophen, and caffeine in combination, for example. There were no changes in 2015.

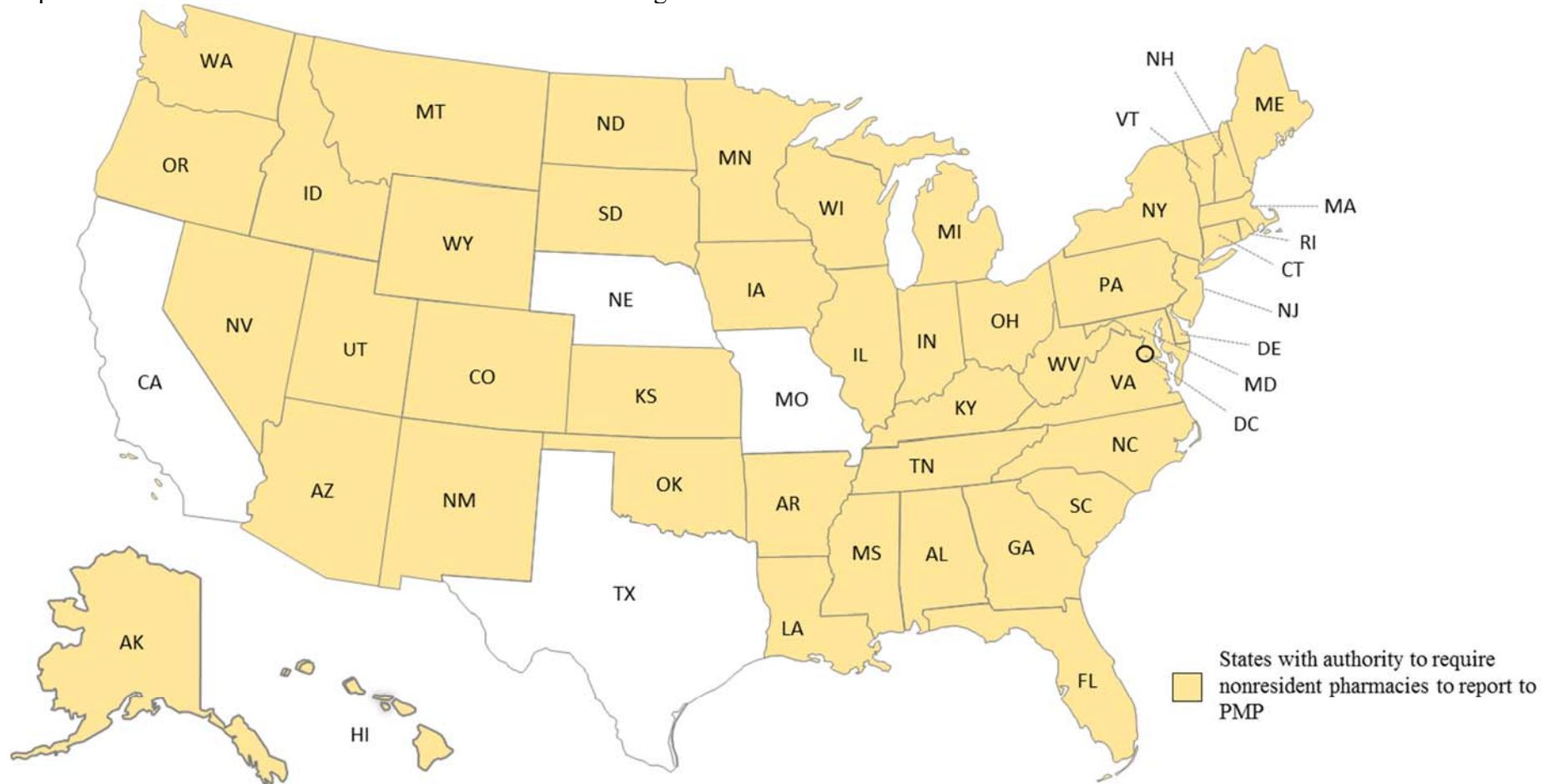


¹This map reflects those states with statutory authority to collect dispensing data on certain non-controlled substances and does not necessarily reflect those states with such authority who are actively collecting such data. ²Tennessee's law authorizes the monitoring of Schedule V substances that have been identified as demonstrating a potential for abuse. ³In South Dakota, all federal Schedule V substances are listed in Schedule IV, so they do monitor Schedule V controlled substances.

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NONRESIDENT PHARMACIES REQUIRED TO REPORT¹

Forty-six (46) states and D.C. currently have the authority to require nonresident pharmacies, that is, pharmacies whose physical location is outside the boundaries of that state, to report dispensing information to the state PMP if they dispense controlled substances to patients who are citizens of that state. There was no change from 2014.

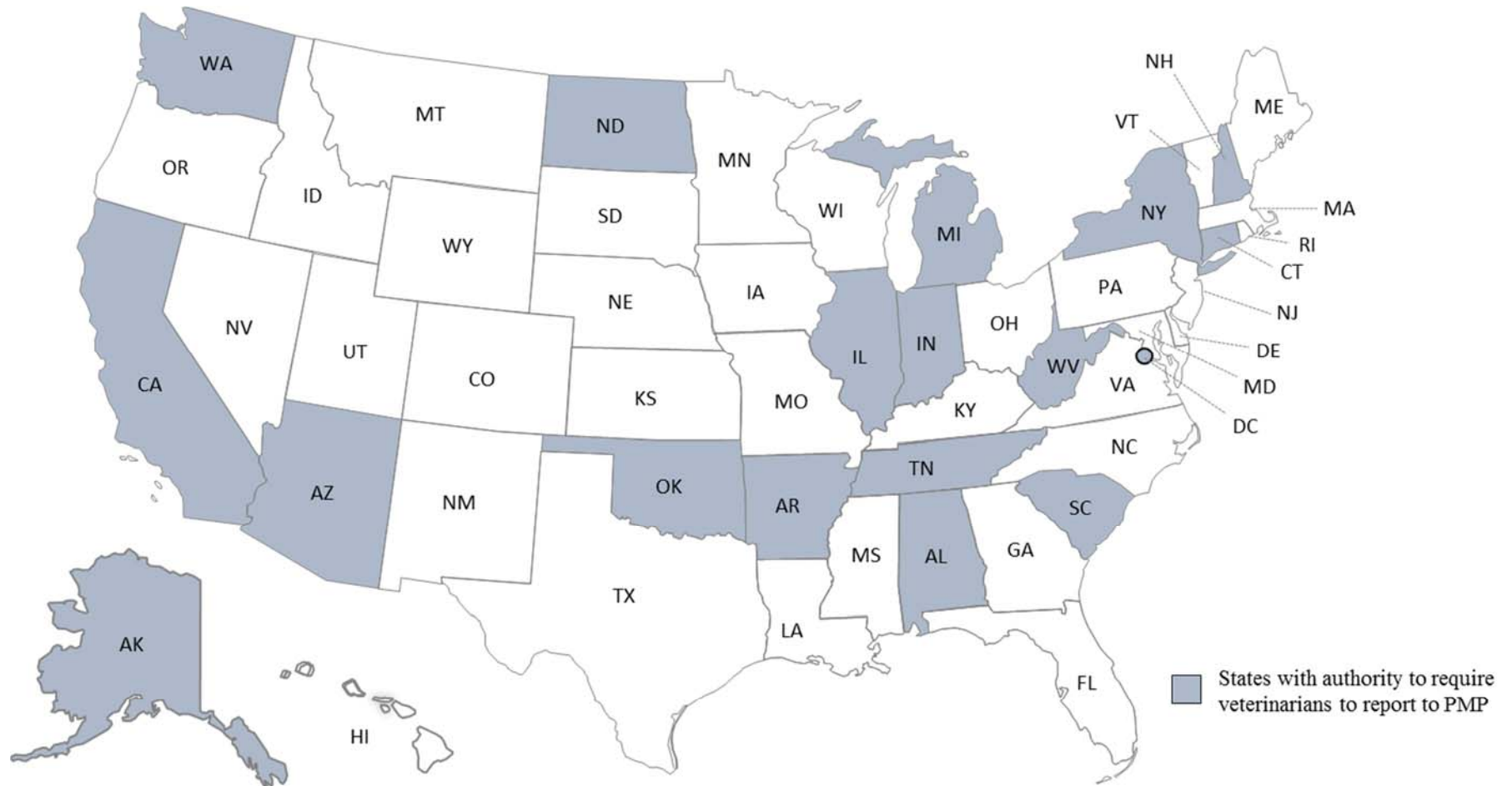


¹This map reflects those states with statutory authority to require nonresident pharmacies to report to the PMP and does not necessarily reflect those states with such authority who are actively collecting such data.

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VETERINARIAN REPORTING¹

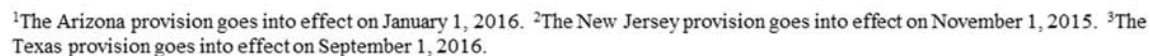
Seventeen (17) states and D.C. require veterinarians to report the dispensing of controlled substances to the PMP, in some cases on a less frequent basis than other dispensers. There was no change from 2014.



¹This map reflects those states with statutory authority to require veterinarians to report to the PMP and does not necessarily reflect those states with such authority who are actively collecting such data.

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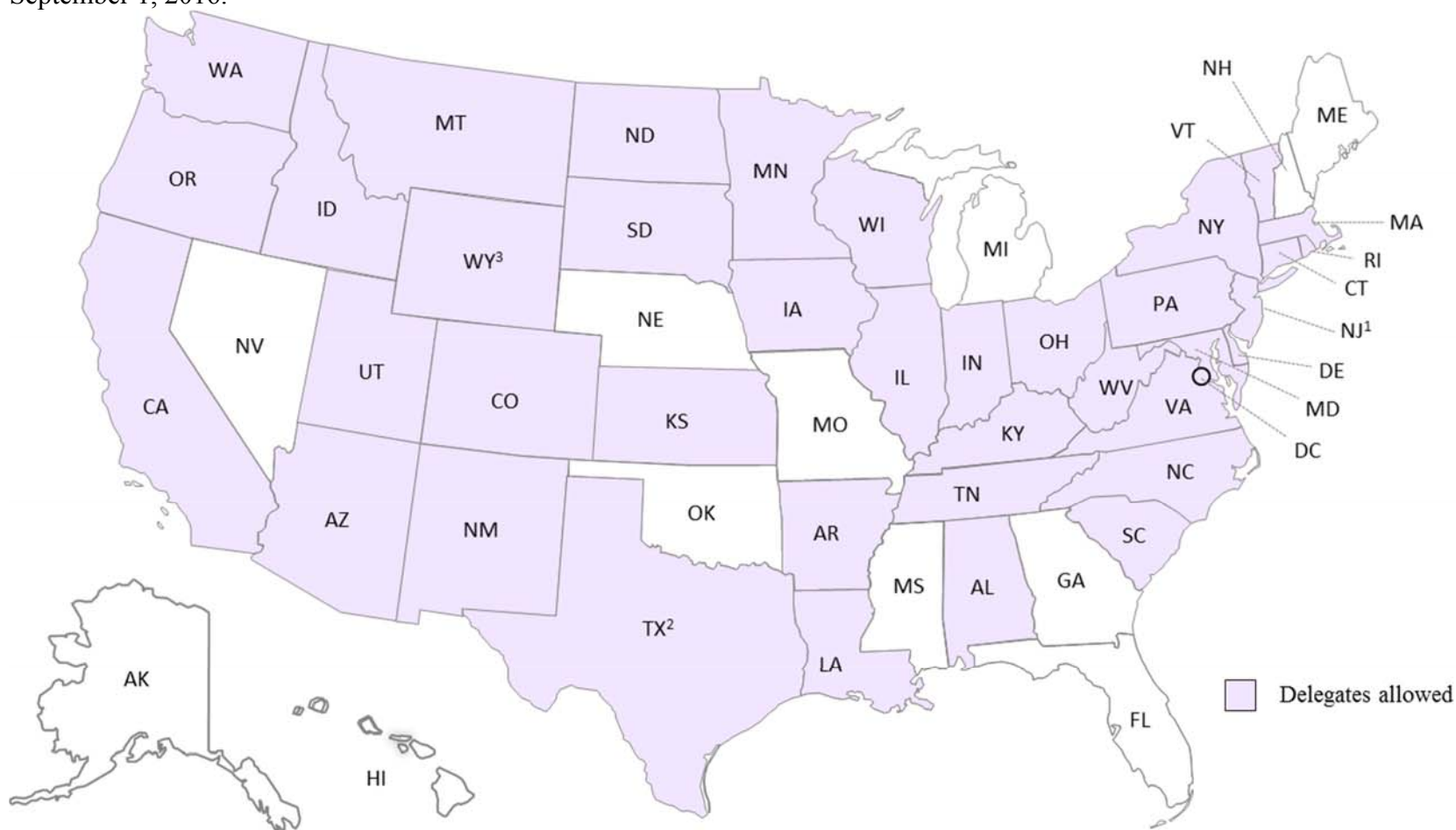
Twenty-six (26) states and D.C. allow receipt of PMP data by coroners, medical examiners, and/or state toxicologists to assist in determining the cause of death of a person. The Arizona provision will go into effect on January 1, 2016. The New Jersey provision goes into effect on November 1, 2015, and the Texas provision goes into effect on September 1, 2016.



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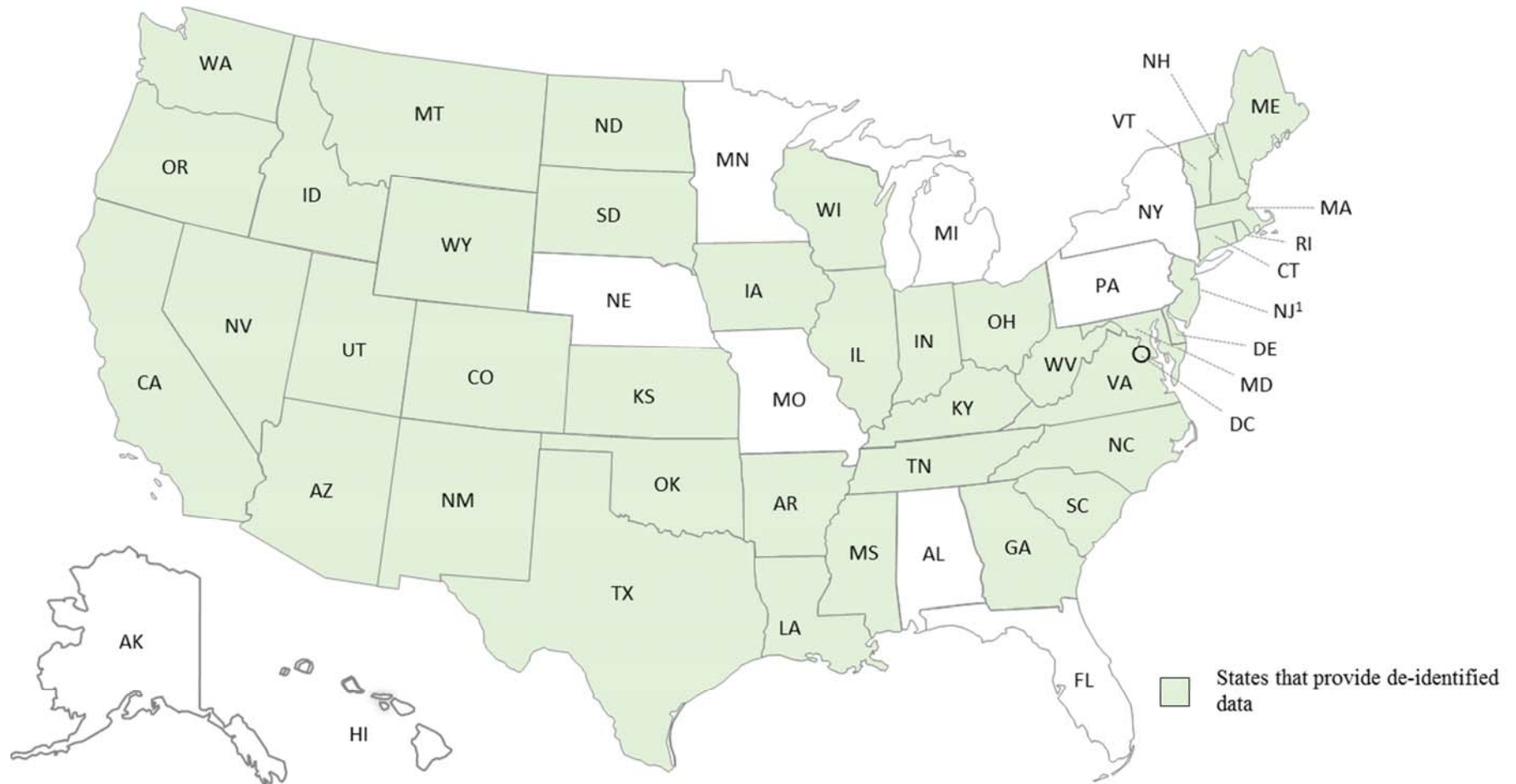
TYPES OF AUTHORIZED RECIPIENTS – AUTHORIZED DELEGATES

Thirty-eight (38) states and D.C. allow prescribers and/or dispensers to delegate access to the PMP to an authorized agent in their employ, whether a physician assistant, nurse practitioner, pharmacy technician, or, in some cases, authorized office staff. Five states added delegate provisions this year – Arkansas, Connecticut, Illinois, New Jersey, and Wyoming. The New Jersey provision goes into effect on November 1, 2015. The Wyoming provision goes into effect on January 1, 2016, and the Texas provision goes into effect on September 1, 2016.



TYPES OF AUTHORIZED RECIPIENTS – DE-IDENTIFIED DATA

New Jersey will become the fortieth state, plus D.C., to allow the provision of de-identified data for statistical, education, and research purposes on November 1, 2015.

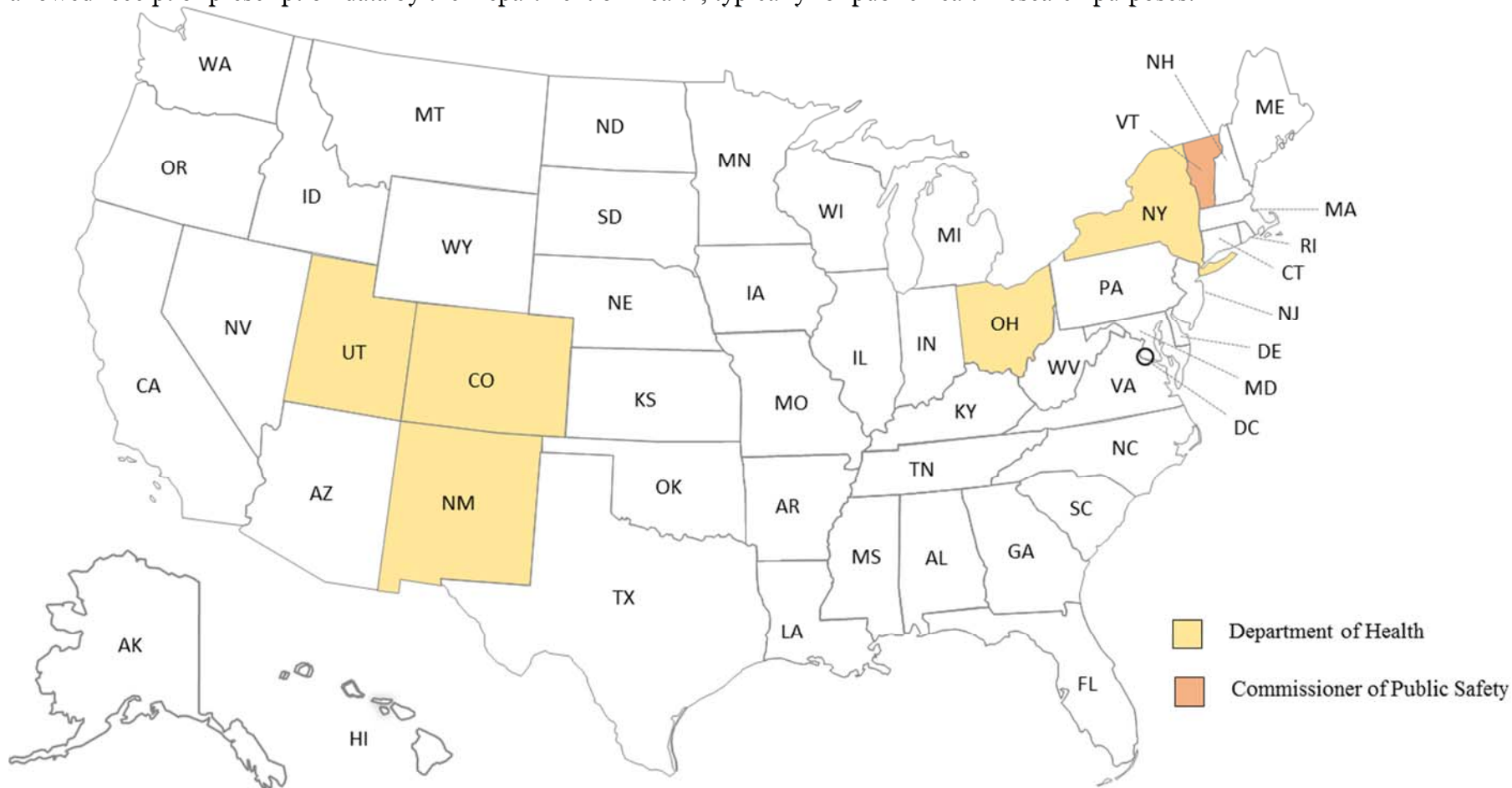


¹The New Jersey provision goes into effect on November 1, 2015.

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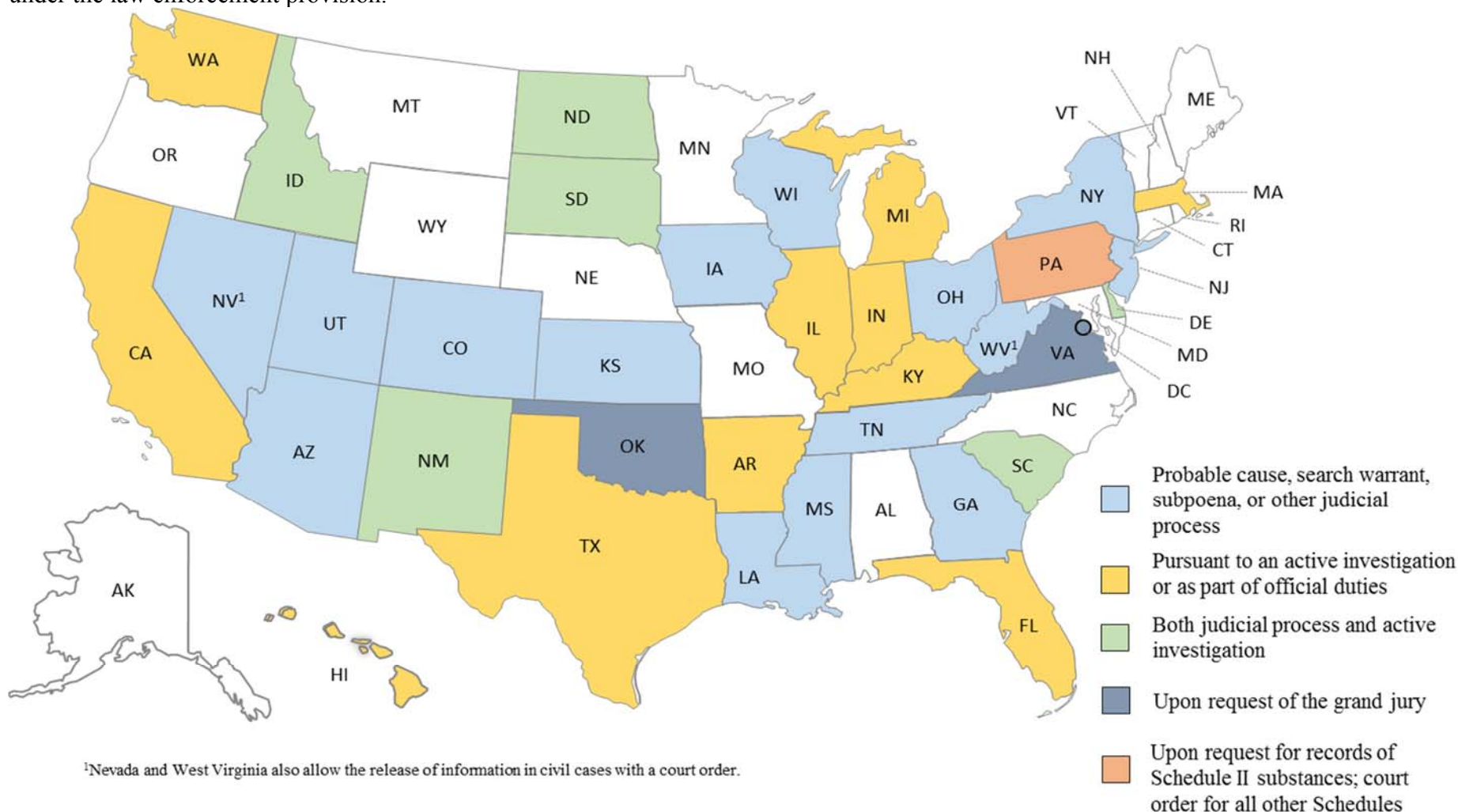
TYPES OF AUTHORIZED RECIPIENTS – DEPARTMENT OF HEALTH OR COMMISSIONER OF SAFETY

Ohio became the sixth state to allow the provision of PMP data to the state Department of Health or Commissioner of Safety. This category of authorized recipients does not include those states that provide data to the state Department of Health pursuant to the provision allowing receipt of data by licensing and regulatory boards or agencies generally, but only those states that have specifically allowed receipt of prescription data by the Department of Health, typically for public health research purposes.



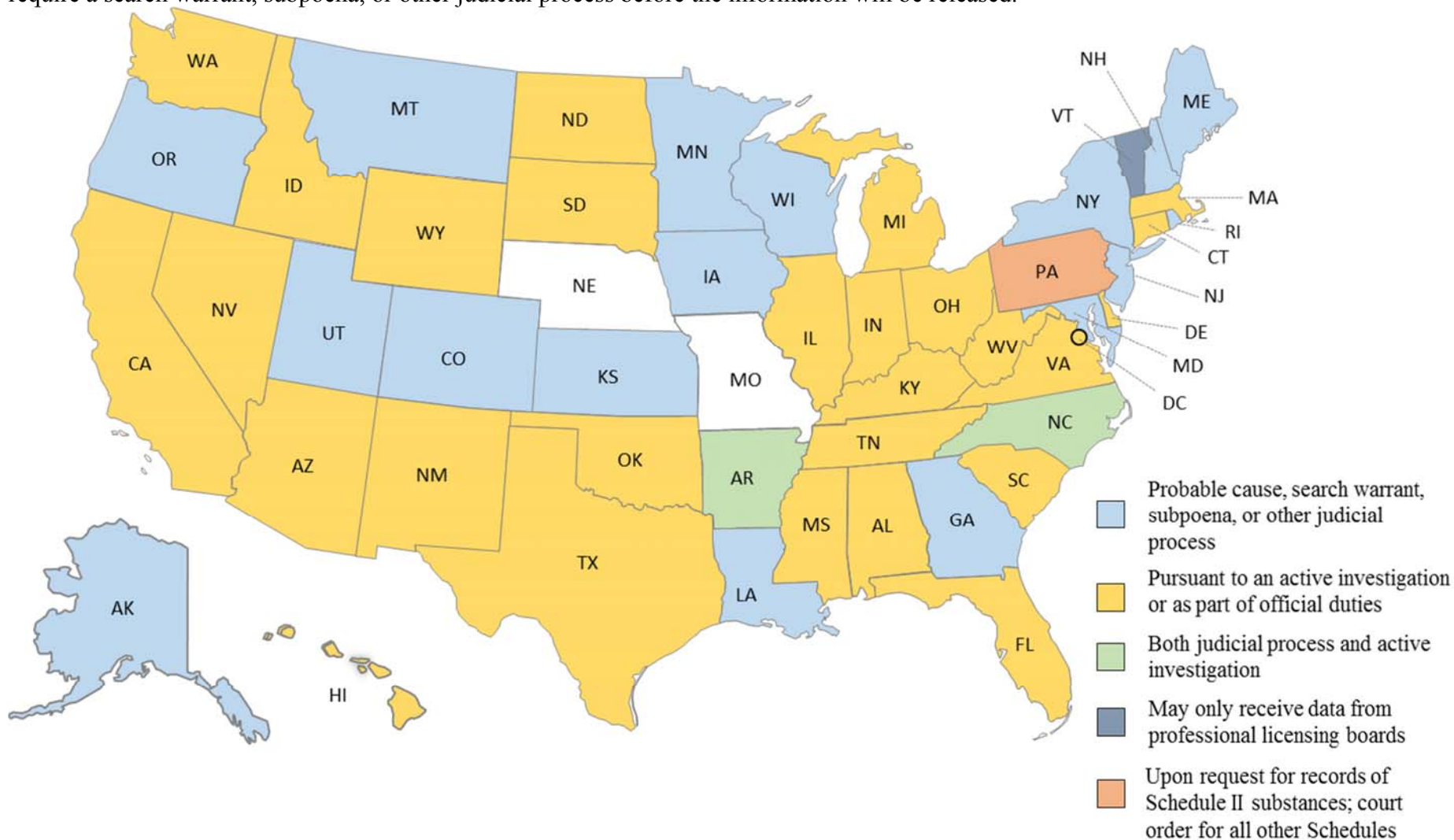
TYPES OF AUTHORIZED RECIPIENTS – JUDICIAL OFFICIALS

Thirty-five (35) states and D.C. specifically allow judicial officials, that is, prosecutors, judges, grand juries, or other officers of the court, to receive program data. In the states that do not have a specific provision in their state law, judicial officials may be covered under the law enforcement provision.



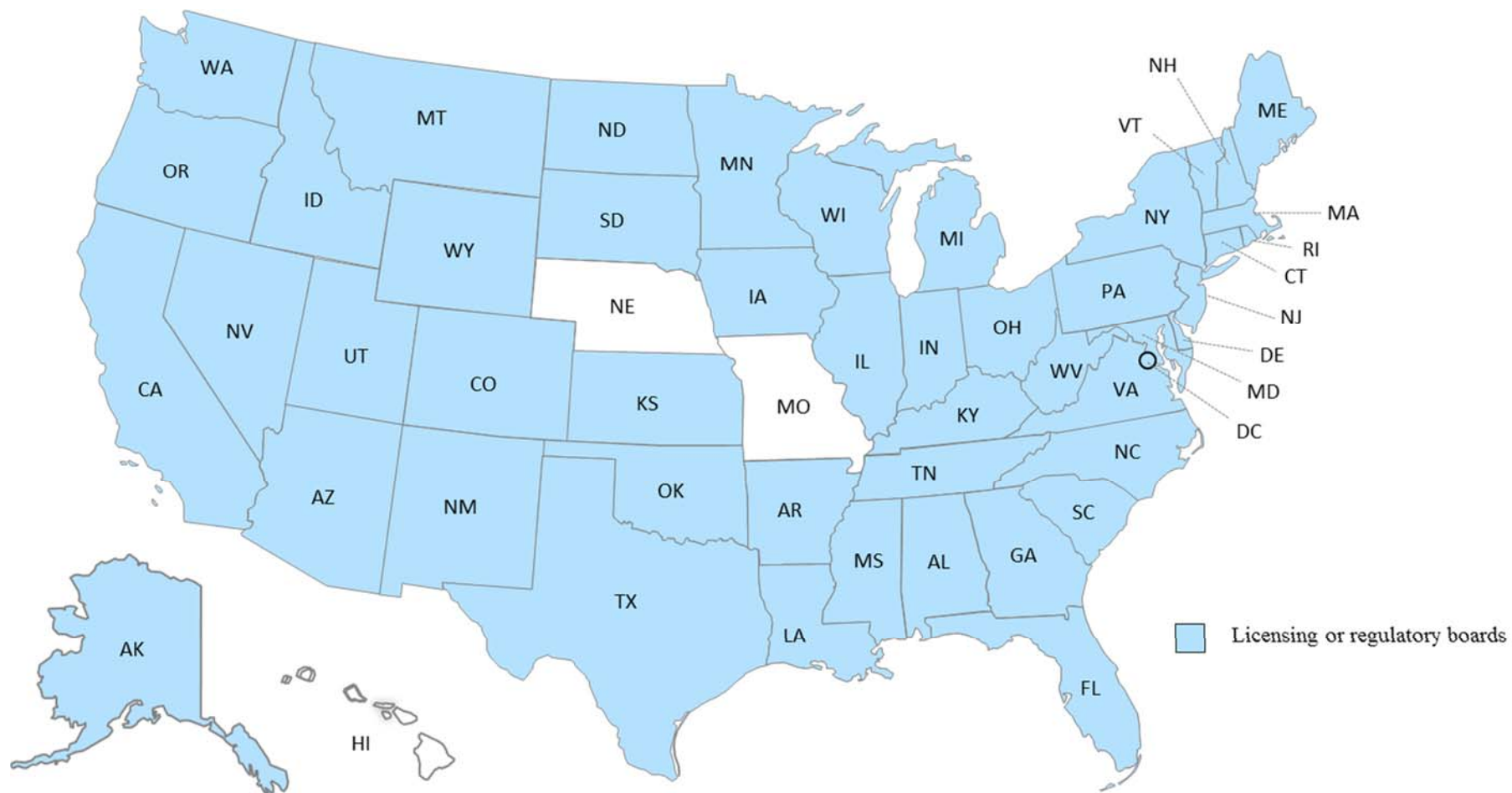
TYPES OF AUTHORIZED RECIPIENTS – LAW ENFORCEMENT OFFICIALS

Forty-eight (48) states and D.C. allow receipt of PMP information by law enforcement officials. Of those, seventeen (17) states require a search warrant, subpoena, or other judicial process before the information will be released.



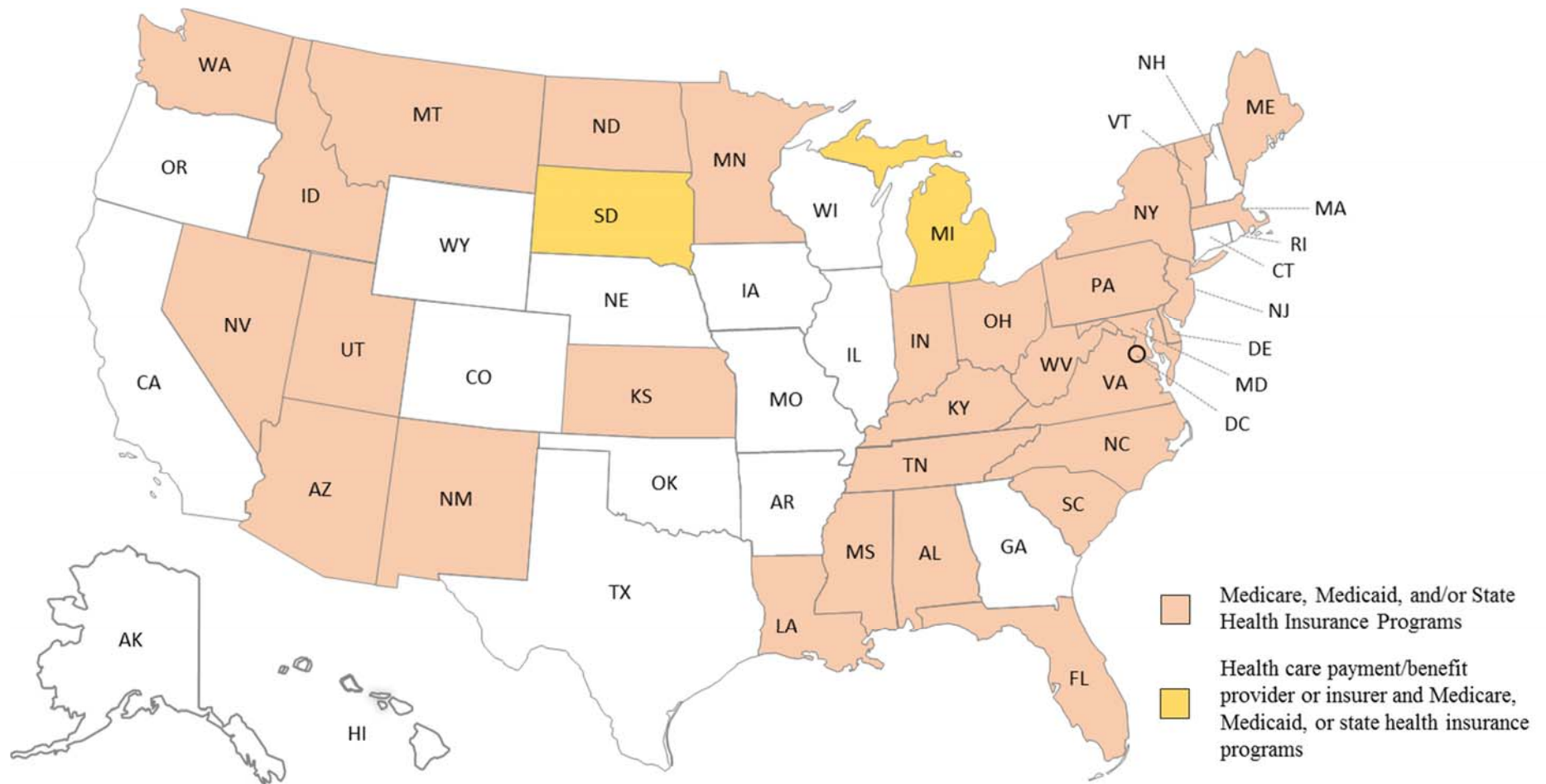
TYPES OF AUTHORIZED RECIPIENTS – LICENSING/REGULATORY BOARDS

At this time, forty-seven (47) states and D.C. allow receipt of PMP information by licensing/regulatory boards.



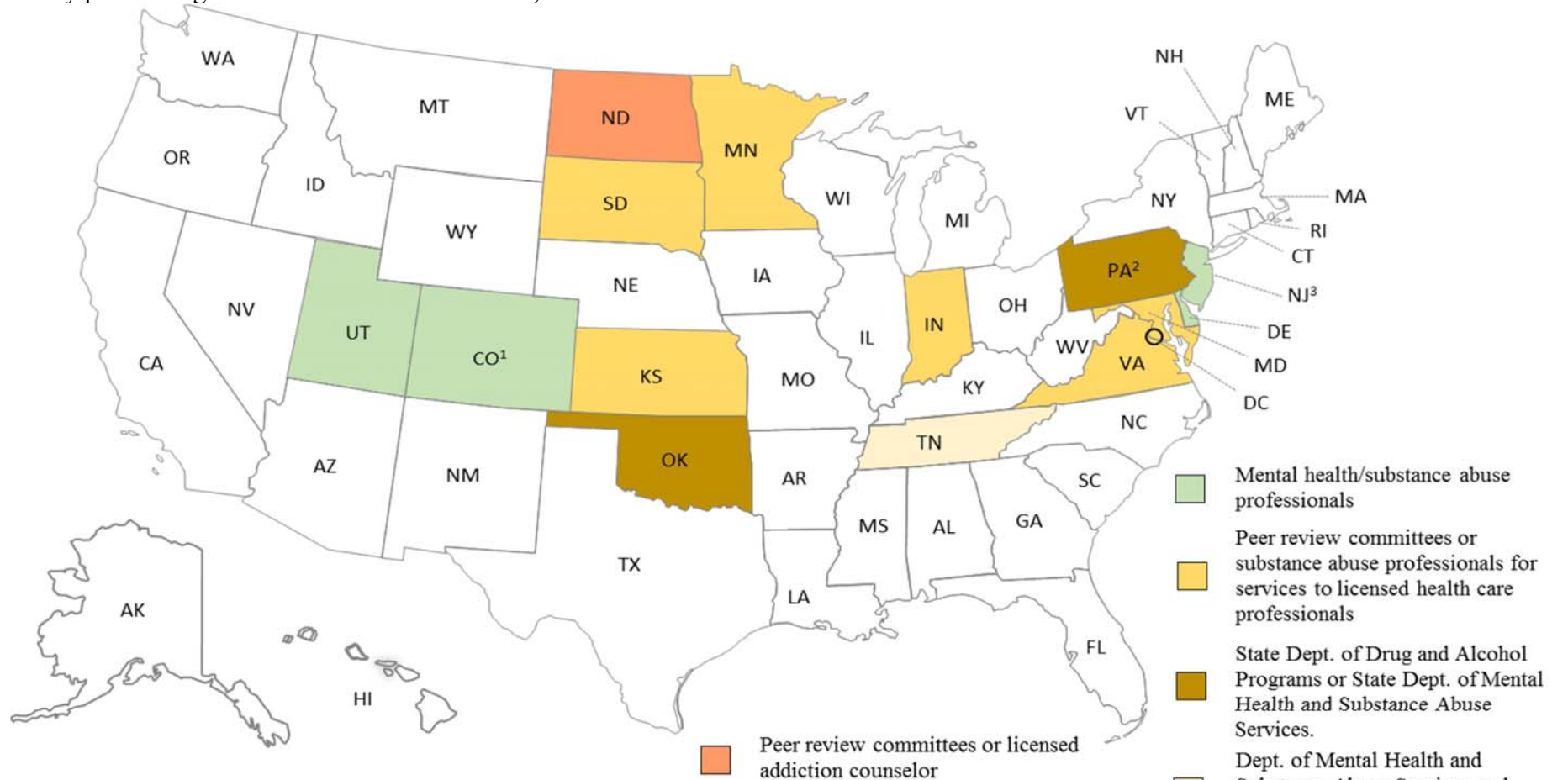
TYPES OF AUTHORIZED RECIPIENTS – MEDICARE, MEDICAID, STATE HEALTH INSURANCE PROGRAMS, AND/OR HEALTH CARE PAYMENT/BENEFIT PROVIDER OR INSURER

Thirty-two (32) states and D.C. allow receipt of program information by authorized representatives of Medicare, Medicaid, state health insurance programs, and/or health care payment/benefit providers or insurers, typically for the purpose of assisting in fraud investigations.



TYPES OF AUTHORIZED RECIPIENTS – MENTAL HEALTH/SUBSTANCE ABUSE PROFESSIONALS, PEER REVIEW COMMITTEES, OR QUALITY IMPROVEMENT COMMITTEE OF HOSPITAL

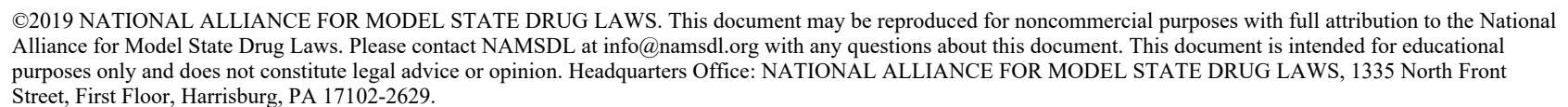
Currently, fourteen (14) states release information to certain professionals for use in the treatment of addicted individuals. The New Jersey provision goes into effect on November 1, 2015.



¹The Colorado PMP will release information to the medical director of a facility that treats addiction with controlled substances if the patient consents.

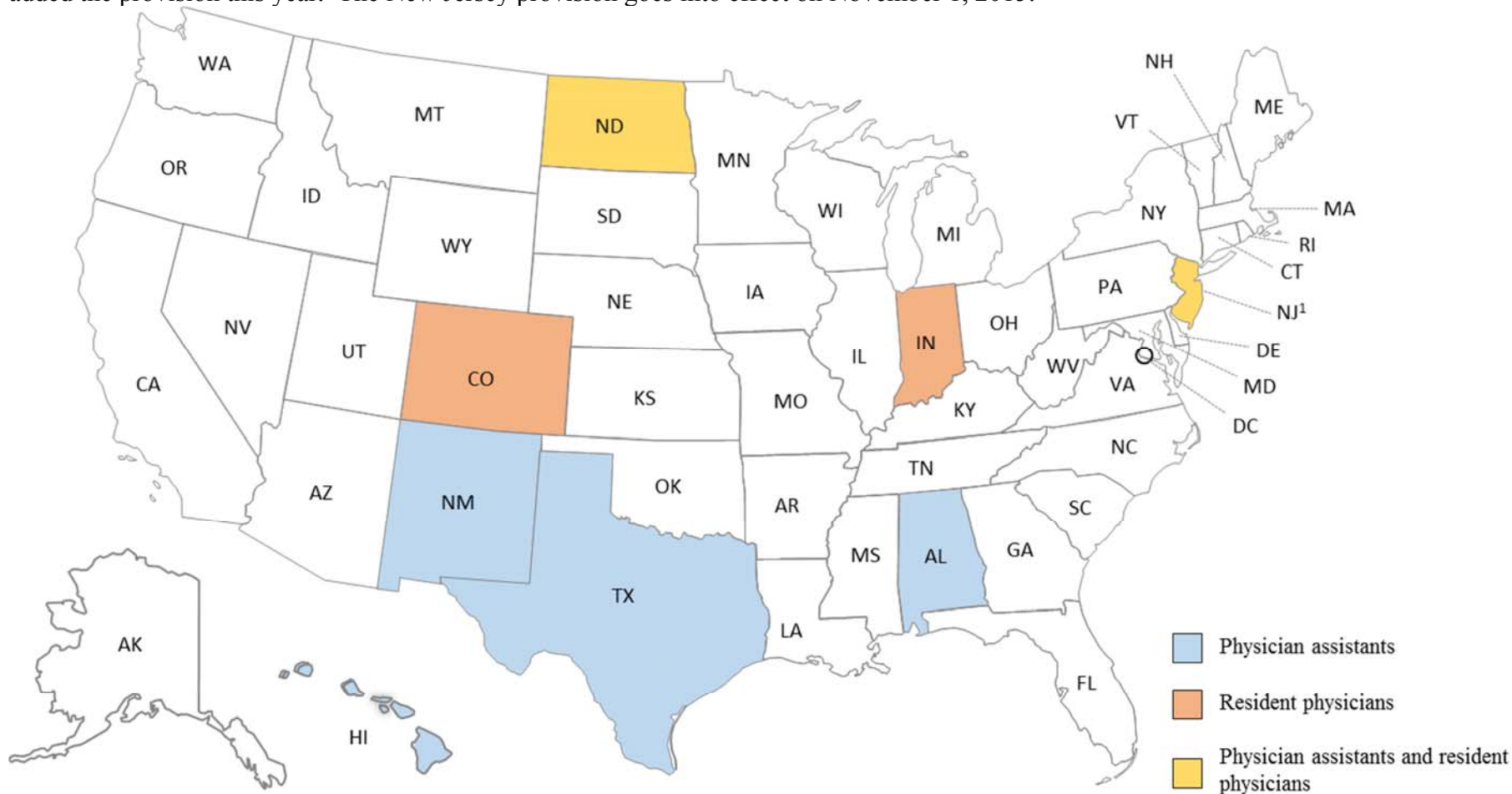
²In Pennsylvania, the release of information to the Department is limited to those individuals engaged in the administration of the Methadone Death and Incident Review Team. ³The New Jersey provision goes into effect on November 1, 2015.

Thirty-nine (39) states and D.C. allow patients or an individual on behalf of a patient to receive their dispensing data from the PMP.



TYPES OF AUTHORIZED RECIPIENTS – PHYSICIAN ASSISTANTS AND RESIDENT PHYSICIANS

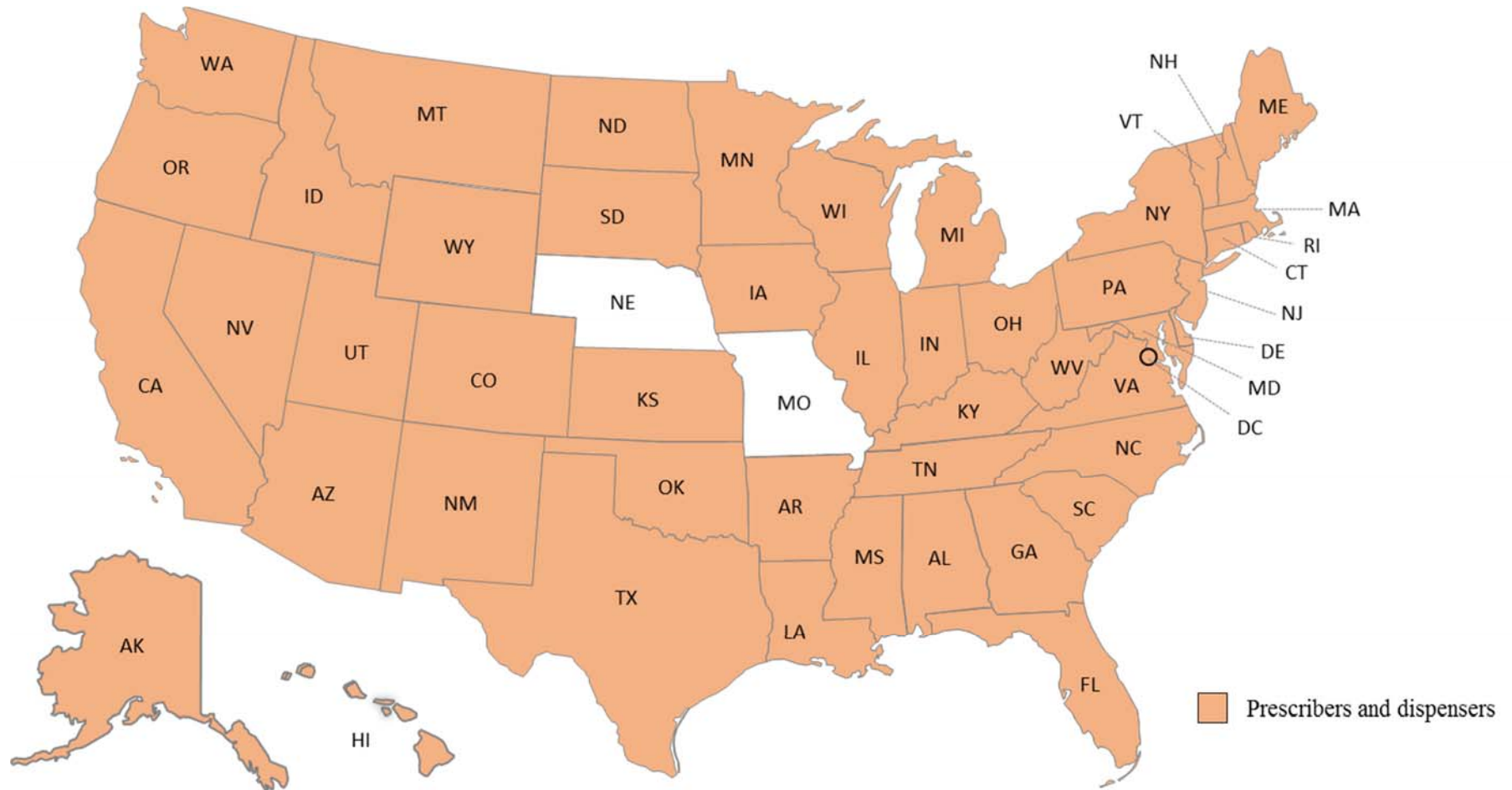
Eight (8) states specifically allow receipt of PMP information by physician assistants and/or resident physicians. This does not mean that those individuals cannot access the PMP in other states, rather that it is not specifically set out in statute. Indiana and New Jersey added the provision this year. The New Jersey provision goes into effect on November 1, 2015.



¹The New Jersey provision goes into effect on November 1, 2015.

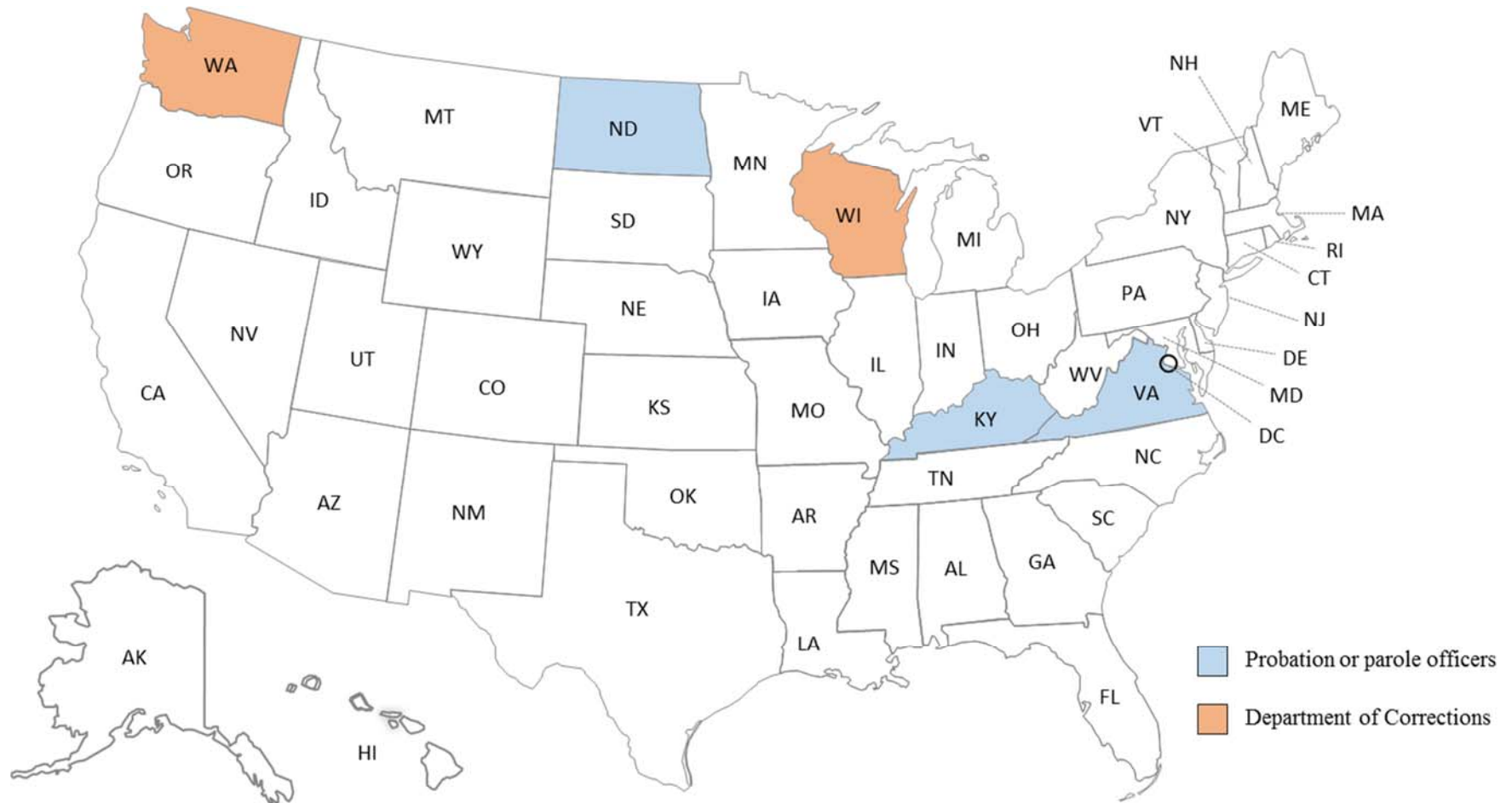
TYPES OF AUTHORIZED RECIPIENTS – PRESCRIBERS AND DISPENSERS

Forty-eight (48) states and D.C. allow receipt of PMP data by prescribers and dispensers.



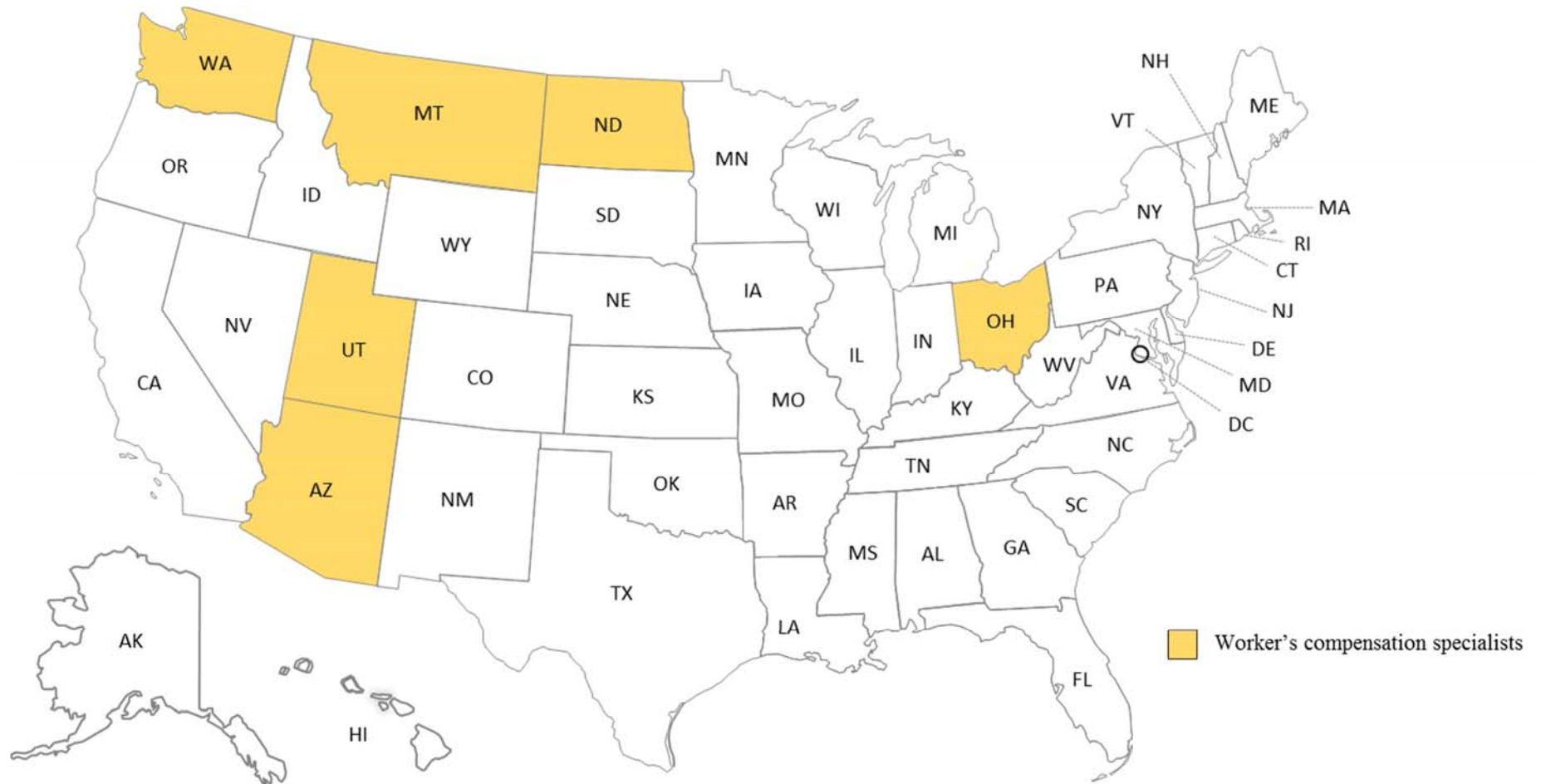
TYPES OF AUTHORIZED RECIPIENTS – PROBATION/PAROLE OFFICERS OR THE DEPARTMENT OF CORRECTIONS

At this time, five (5) states allow receipt of PMP information by probation/parole officers or authorized individuals with the Department of Corrections. Virginia became the fifth state in 2015.



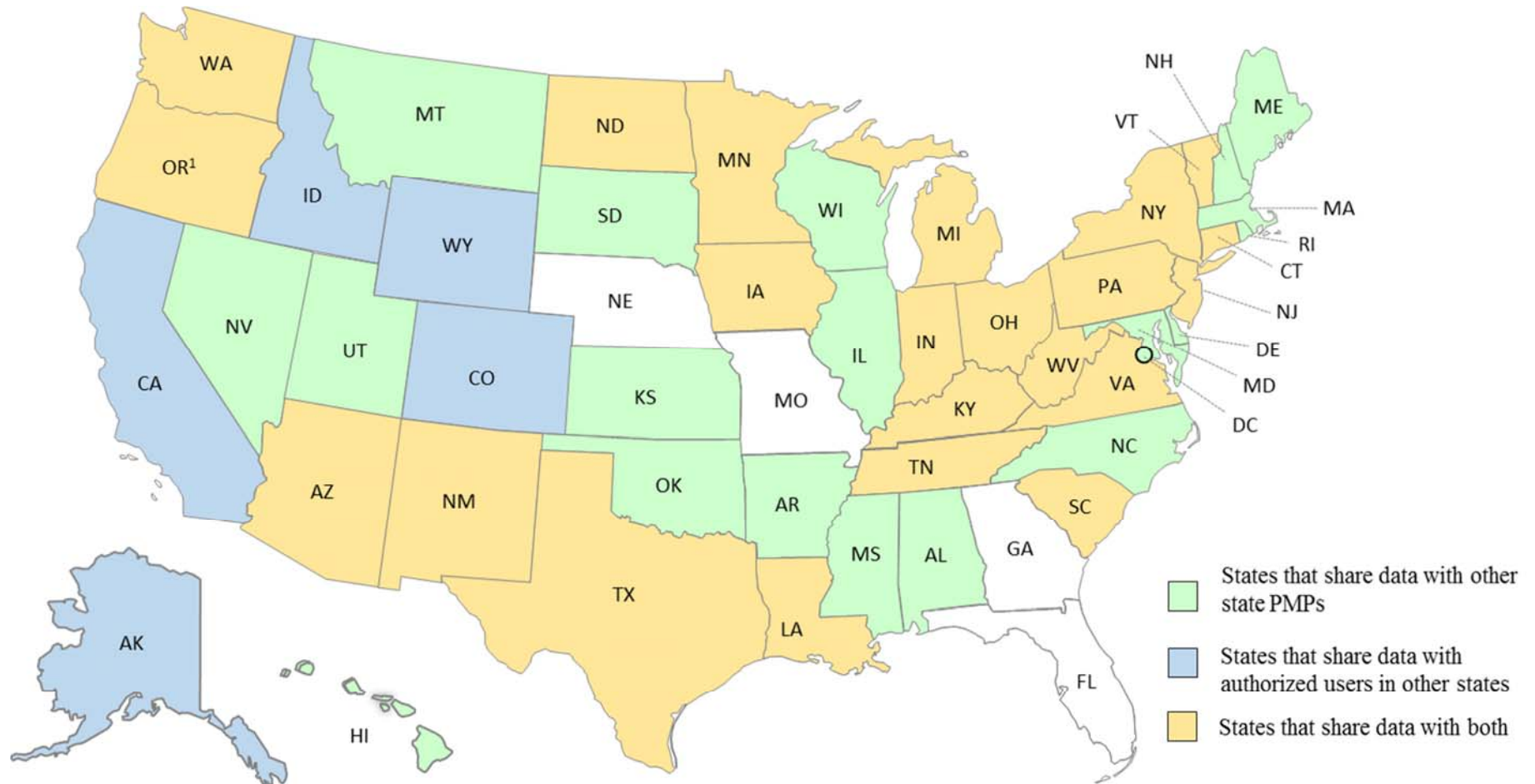
TYPES OF AUTHORIZED RECIPIENTS – WORKERS’ COMPENSATION SPECIALISTS

Six (6) states specifically authorize workers’ compensation specialists to receive patient information from the PMP. There was no change in 2015.



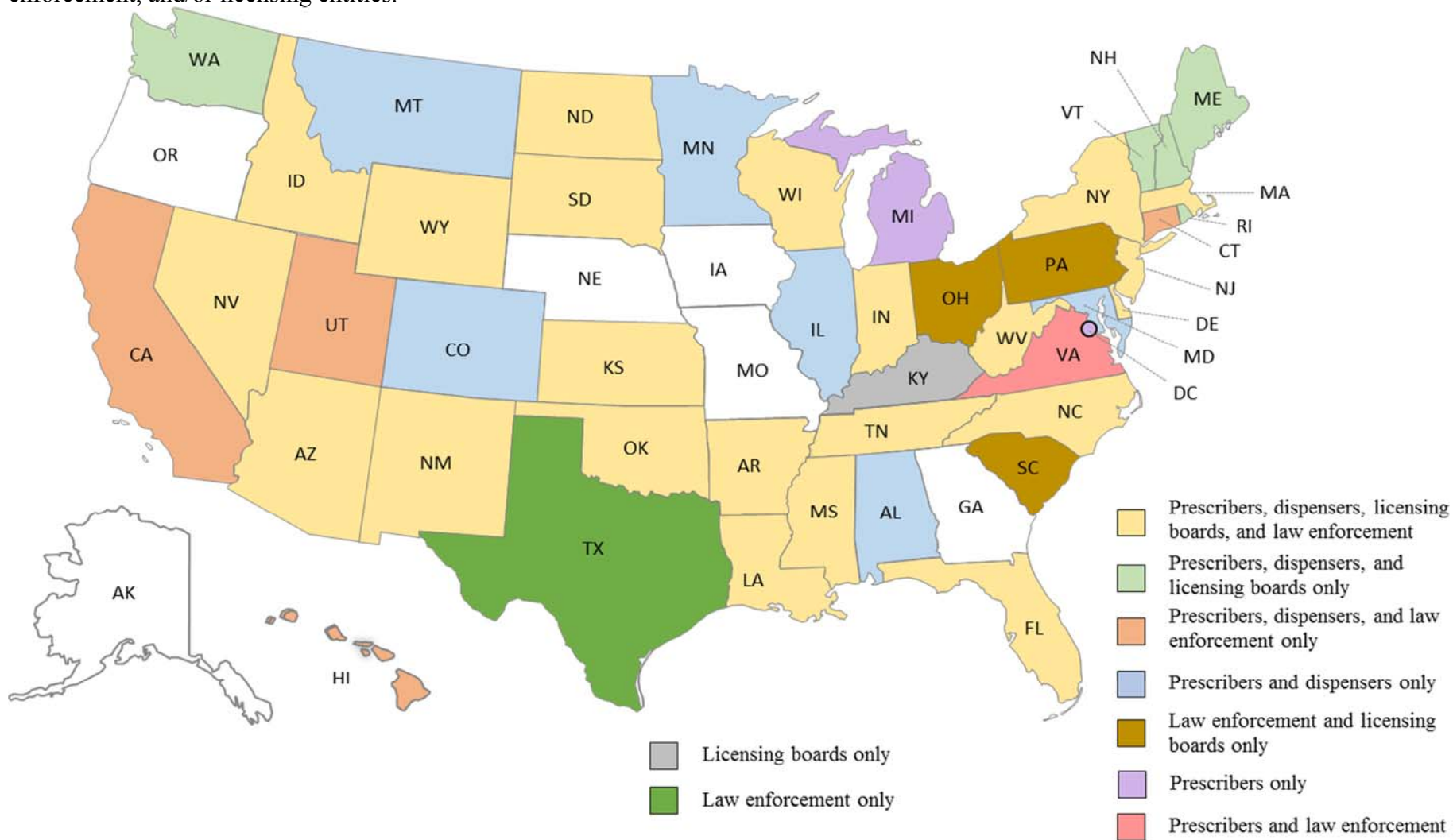
INTERSTATE SHARING OF PRESCRIPTION MONITORING PROGRAM DATA

Forty-six (46) states now allow interstate sharing of prescription monitoring program information. Texas previously only allowed authorized users in other states to access the PMP, but, beginning September 1, 2016, will also share data with other state PMPs.

¹Oregon will only allow direct access to practitioners in California, Idaho, and Washington.

UNSOLICITED REPORTS/ALERTS

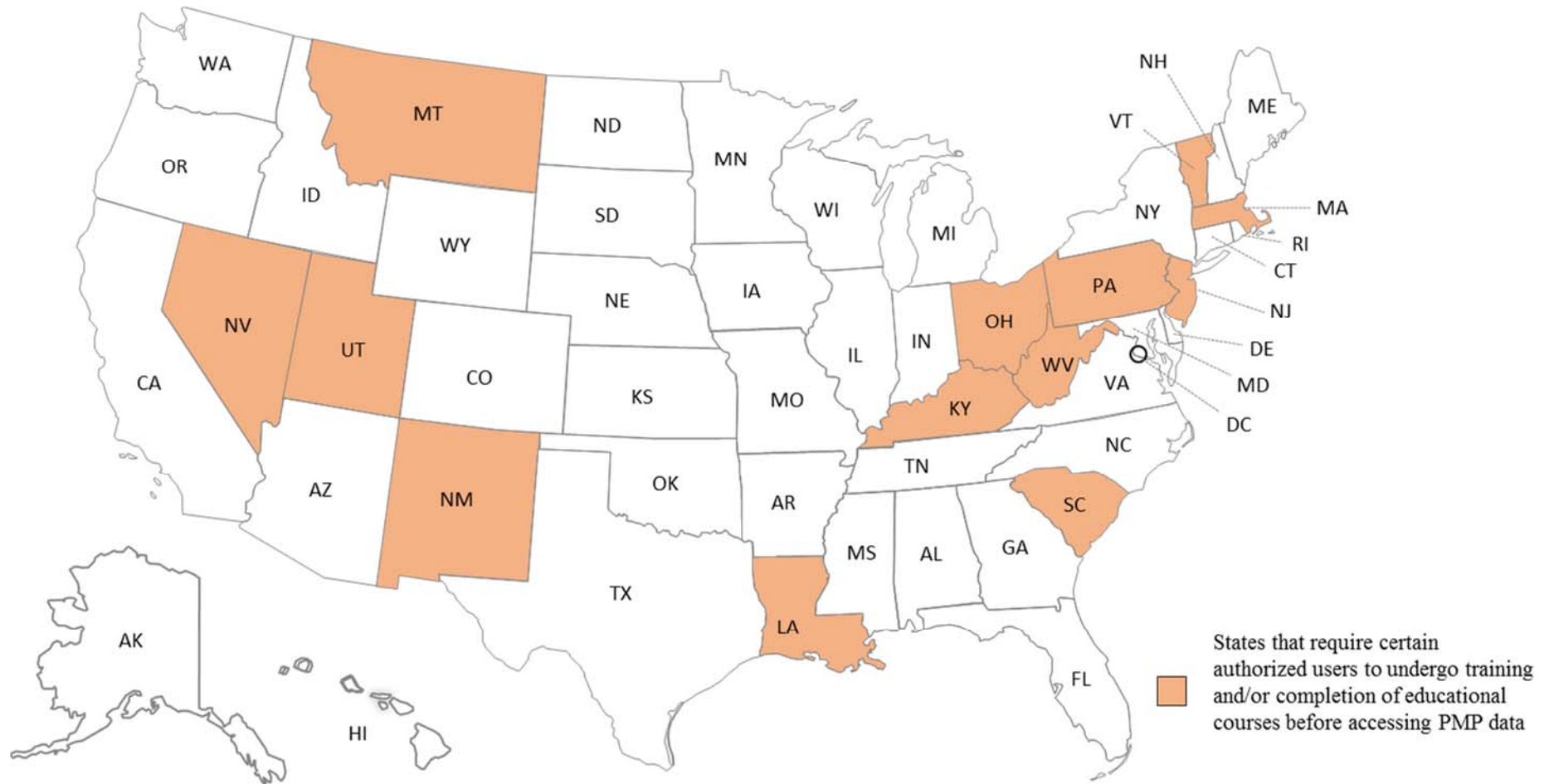
Currently, forty-four (44) states and D.C. have authority to send unsolicited reports or alerts to prescribers, dispensers, law enforcement, and/or licensing entities.



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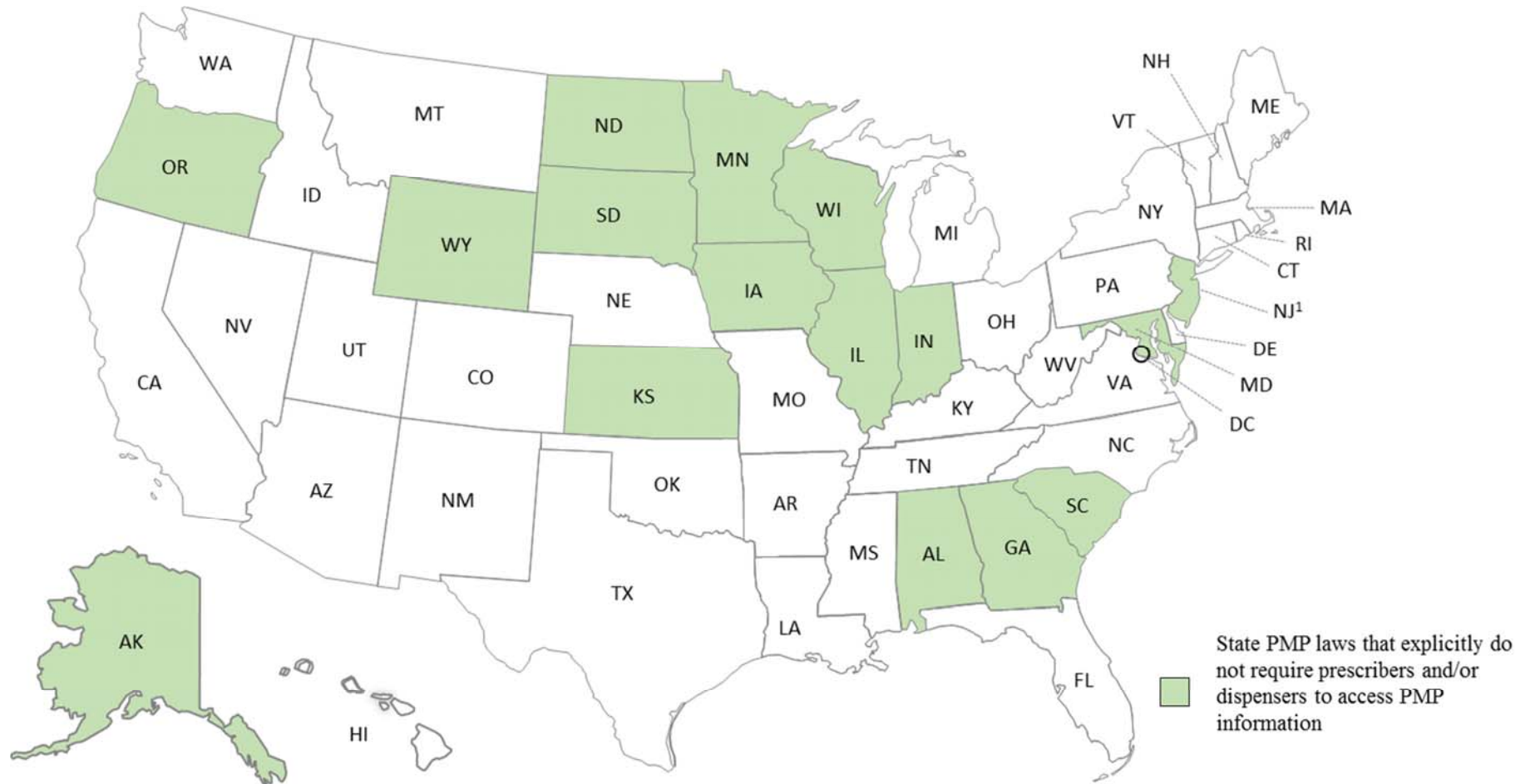
STATES THAT REQUIRE CERTAIN AUTHORIZED RECIPIENTS TO UNDERGO TRAINING FOR USE OF THE PMP

Thirteen (13) states require certain authorized users to receive training or take some educational course before using or receiving data from the PMP. Most states offer optional training in the use of the PMP, but these states have a mandatory training or education component.



STATES THAT SPECIFICALLY STATE THAT PRACTITIONERS HAVE NO OBLIGATION TO ACCESS PMP

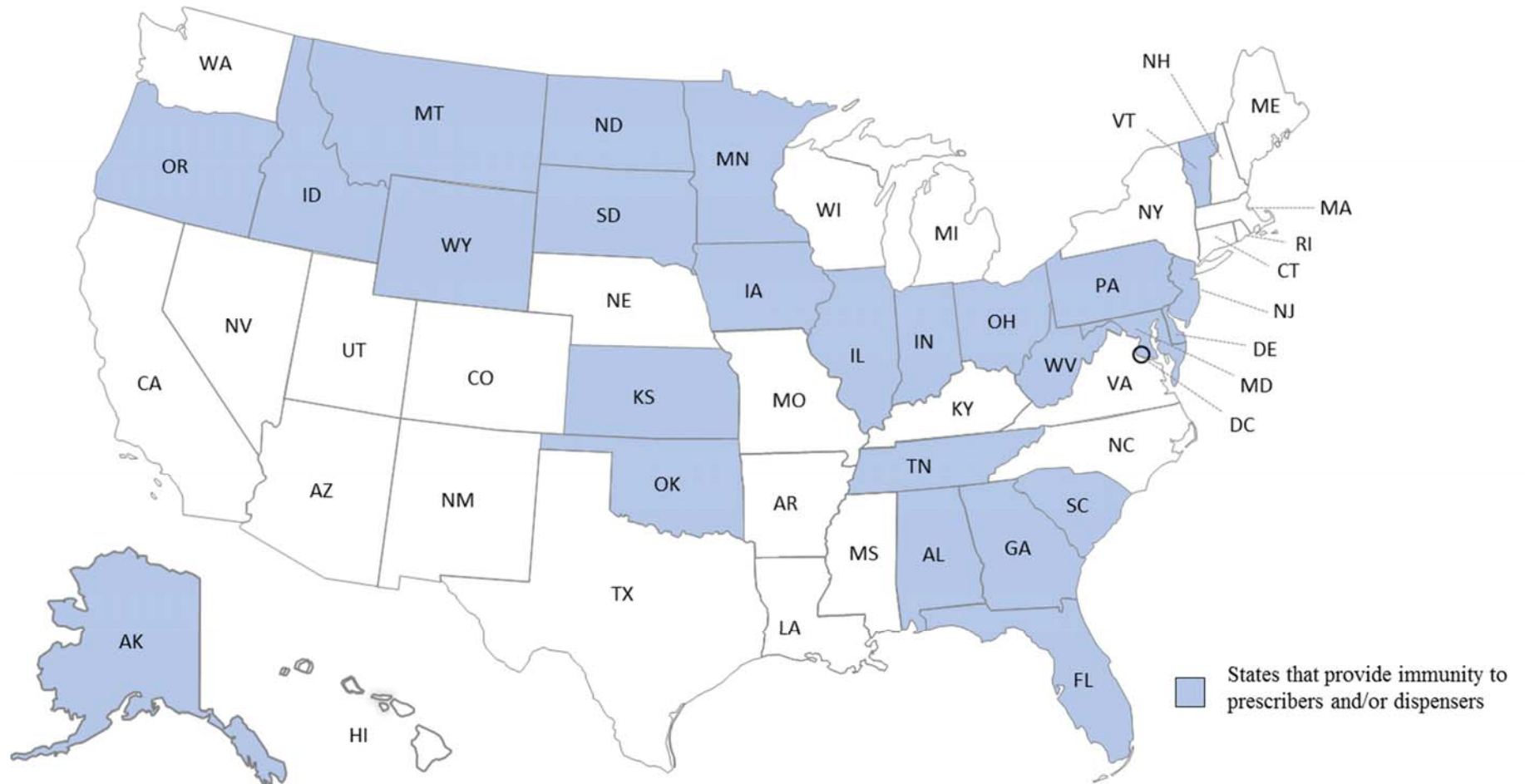
Sixteen (16) states provide by statute or regulation that practitioners have no obligation to access the PMP. New Jersey's provision is in effect until November 1, 2015.



¹The New Jersey provision is in effect until November 1, 2015.

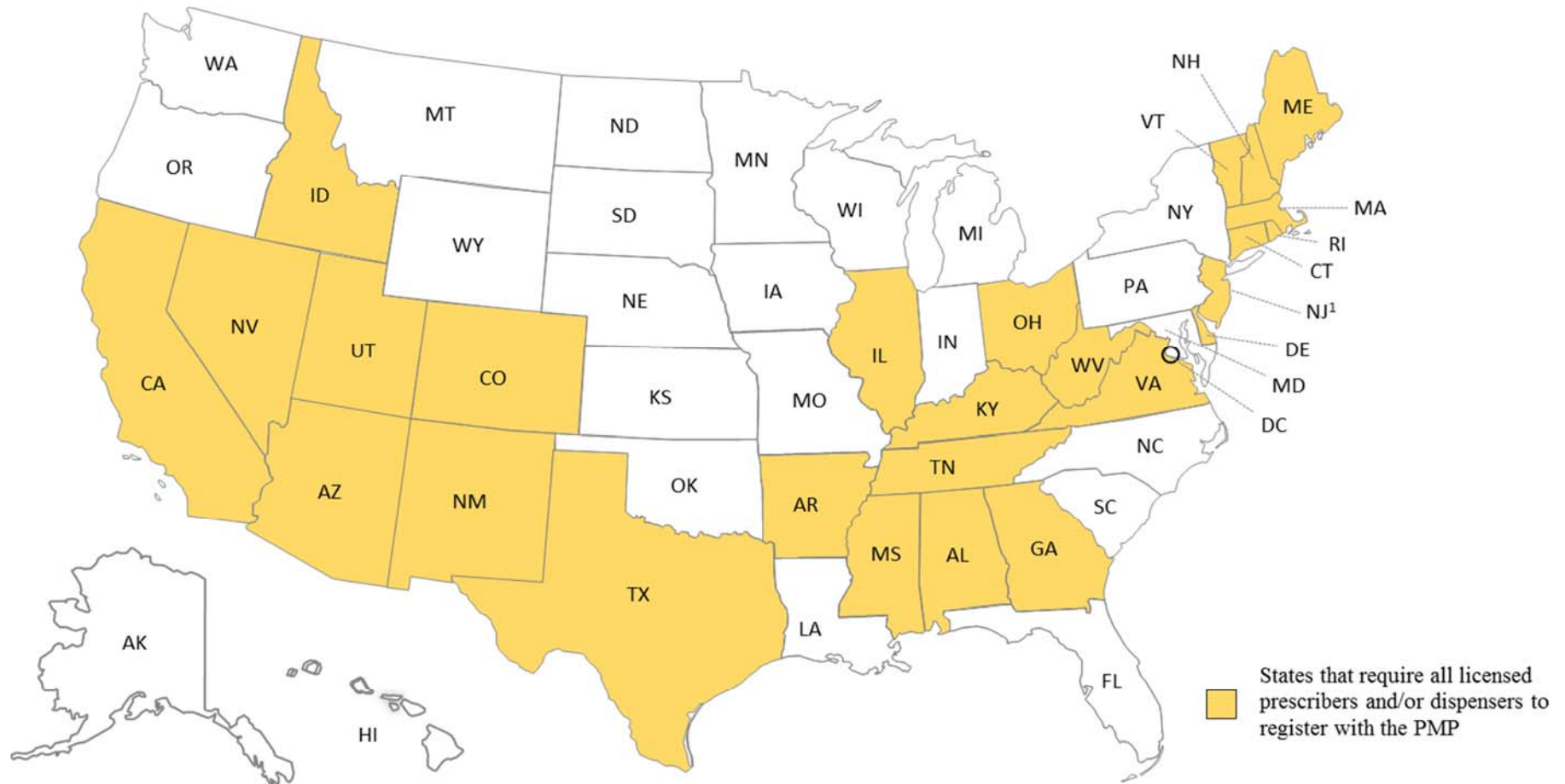
STATES THAT SPECIFICALLY PROVIDE IMMUNITY TO PRACTITIONERS

Twenty-five (25) states and D.C. specifically provide immunity from civil actions to practitioners for accessing or not accessing information in the database.



STATES THAT REQUIRE ALL PRESCRIBERS AND/OR DISPENSERS TO REGISTER WITH THE PMP

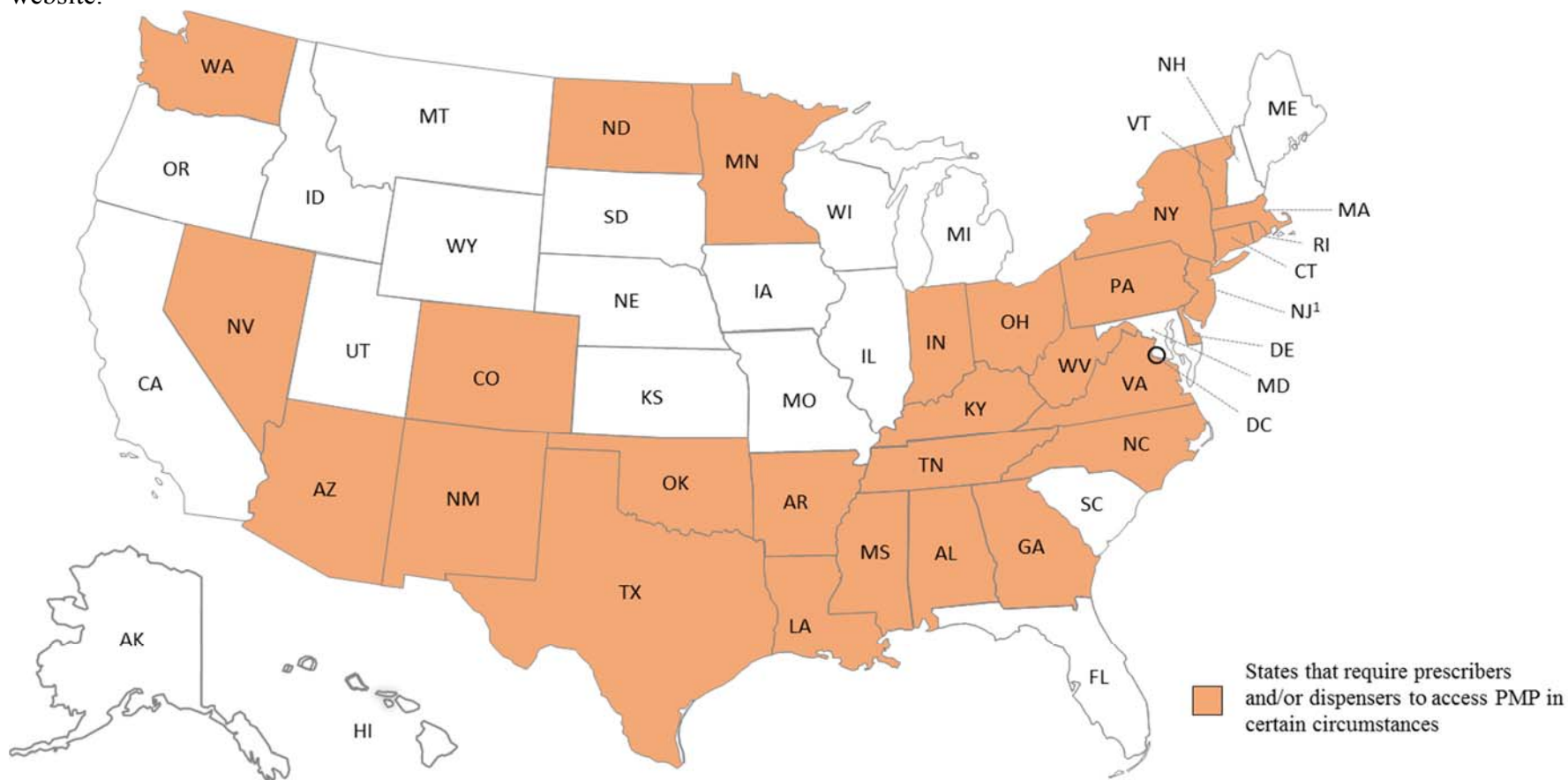
Twenty-six (26) states require that all prescribers and/or dispensers register to use the PMP in their state. Five states added the registration requirement this year – Arkansas, Illinois, Nevada, New Jersey, and Texas. The New Jersey provision goes into effect on November 1, 2015.



¹The New Jersey provision goes into effect on November 1, 2015.

STATES THAT REQUIRE PRESCRIBERS AND/OR DISPENSERS TO ACCESS THE PMP IN CERTAIN CIRCUMSTANCES

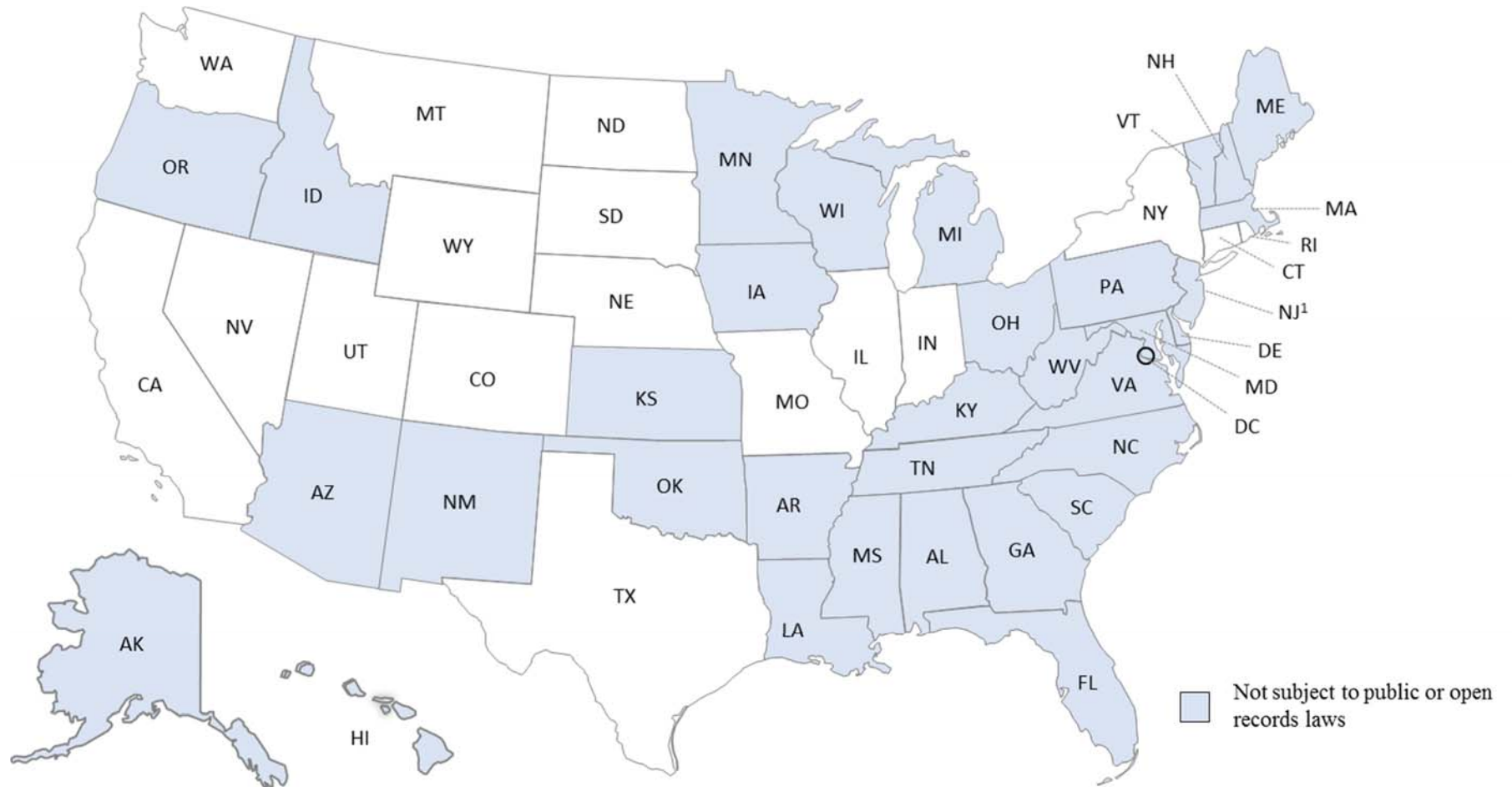
Twenty-nine (29) states require prescribers and/or dispensers to access the PMP in certain circumstances. Five states added the requirement this year – Alabama, Arkansas, Connecticut, New Jersey, and Texas. The New Jersey provision goes into effect on November 1, 2015. The specific circumstances under which a practitioner is required to access the PMP can be found on NAMSDL's website.



¹The New Jersey provision goes into effect on November 1, 2015.

DATA CONFIDENTIALITY – NOT SUBJECT TO PUBLIC OR OPEN RECORDS LAWS

While prescription monitoring program data is treated as confidential in every state, thirty-three (33) states and D.C. have specific language in their statutes that state that PMP data is confidential and not subject to public or open records laws.



DATA CONFIDENTIALITY – PENALTIES FOR WRONGLY DISCLOSING, USING, OR OBTAINING PMP DATA

Forty (40) states and D.C. specifically provide civil or criminal penalties for wrongly disclosing, using, or obtaining prescription monitoring program data.

