

**PRESCRIPTION DRUG MONITORING:
STRATEGIES TO PROMOTE TREATMENT AND
DETER PRESCRIPTION DRUG ABUSE**

Statement of:

LAXMAIAH MANCHIKANTI, M.D.

**PRESIDENT AND EXECUTIVE DIRECTOR
AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS**

Before:

**Subcommittee on Health
House Energy and Commerce Committee**

March 4, 2004

Summary

Prescription Drug Monitoring: Strategies to Promote Treatment and Deter Prescription Drug Abuse

1. The management of pain is becoming a high priority in the USA
2. Controlled substance abuse and diversion is becoming a high priority
3. Drug abuse and diversion as a national problem
4. Management of abuse and diversion of controlled substance is a public health issue
5. Current state of affairs dictate the need for prescription monitoring programs
6. Problems facing physicians
7. Problems facing patients
8. The need for a comprehensive strategy to control drug abuse and diversion is increasing
9. Federal versus state control of controlled substances
10. A national program is feasible and cost-effective

The American Society of Interventional Pain Physicians is an organization representing interventional pain physicians and other health care professionals involved in interventional pain management. Our membership is 2,600 at the present time. It is estimated that there are 6,500 interventional pain physicians across the country practicing interventional pain management. Interventional pain management, as per NUCC, is defined as – “the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment.” As interventional pain physicians, our members are involved extensively in prescribing controlled substances, even though not to the same extent as non-interventional pain physicians whose mainstay of treatment of chronic pain is controlled substances.

1. The management of pain is becoming a high priority in the USA

- ◆ Chronic pain is prevalent in 15% to 30% of the population.
- ◆ In the last several years, health policy-makers, health professionals, regulators and the public have become increasingly interested in the provision of better pain therapies.

2. Controlled substance abuse and diversion is becoming a high priority

- ◆ Non-medical uses of psychotherapeutics as described in multiple surveys include non-medical use of any prescription type:
 - Pain relievers
 - Tranquilizers
 - Stimulants
 - Sedatives

This category does not include over-the-counter substances.

- ◆ This interest in managing chronic pain has led to the increased prescription of controlled substances, fueled by:
 - Pharmaceutical companies providing marketing and gifts.
 - Numerous organizations providing guidelines and standards.
 - Patient advocacy groups demanding opioids for benign pain.
 - Enactment of patient’s Bill of Rights in many states.
 - JCAHO regulations mandating monitoring and appropriate treatment of pain.
 - Patient’s right to pain relief.
- ◆ While the true extent of prescription drug abuse and diversion is unknown, estimates from a national survey indicate that the principle drug of abuse for nearly 10% of U.S. patients in treatment is a prescription drug.
- ◆ The most commonly abused drugs include oxycodone (Percodan, Percocet, Roxicet, Tylox, OxyContin), hydrocodone (Vicodin, Vicoprofen, Lorcet, Lortab), hydromorphone, morphine (Astramorph, Duramorph, MS Contin, Roxanol), codeine, clonazepam (Klonopin), alprazolam (Xanax), lorazepam (Ativan), diazepam (Valium) and carisoprodol (Soma).¹

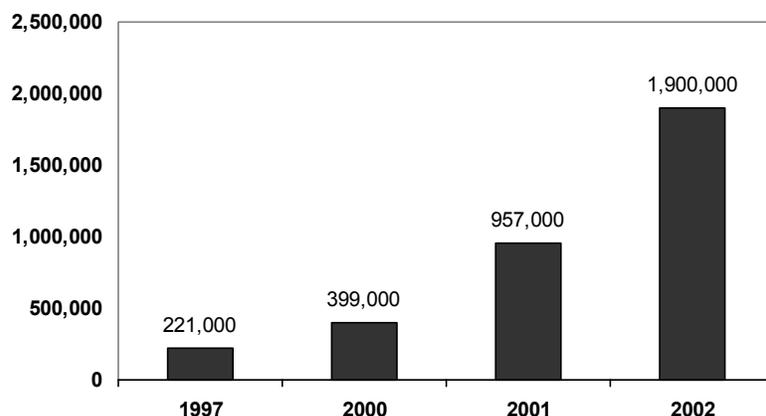
¹ 2002 National Survey on Drug Use and Health (NSDUH). Results from the 2002 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services.

- ◆ Prescription drug abuse ranks second behind marijuana.
- ◆ John Walters, Director of the White House Office of National Drug Control Policy, said “the non-medical use of prescription drugs has become an increasingly widespread and serious problem in this country, one that calls for immediate action”.
- ◆ Emergency room visits resulting from the abuse of narcotic pain relievers have jumped 163% since 1995.
- ◆ The proposed 2005 budget from the White House for prescription drug diversion control will increase by \$20 million to \$138 million. Most of the funds will be directed at reducing the non-medical use of prescription drugs, mainly opioids.

3. Drug abuse and diversion as a national problem

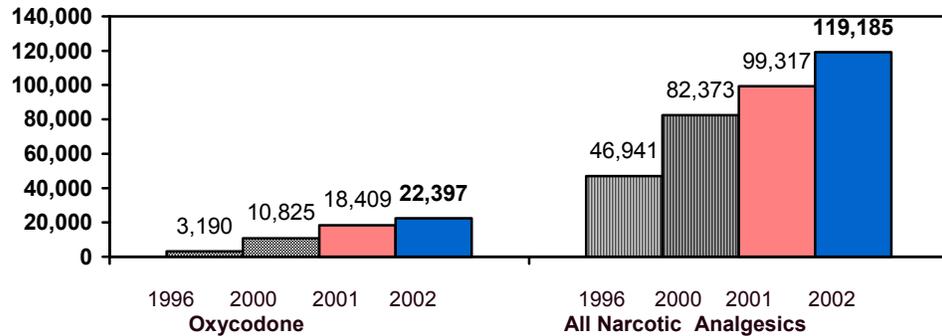
Results from the 2002 National Survey on Drug Use and Health showed the following:

- ◆ Non-medical pain reliever abuse prevalence among youths age 12 to 17 in increasing lifetime prevalence in 2002 was 11.2% from 9.6% in 2001.
- ◆ Among young adults aged 18 to 25, the lifetime non-medical pain reliever abuse rate increased from 19.4% in 2001 to 22.1% in 2002.
- ◆ The young adult rate had been 6.8% in 1992.
- ◆ Among the adult age group from 18 to 25 years, illicit drug use was as follows: marijuana - 17.3%, non-medical use of prescription drugs – 5.4%.
- ◆ Among 12 or 13-year olds, non-medical use of prescription drugs – 1.7%, marijuana – 1.4%, inhalants – 1.4%.
- ◆ In 2002, approximately 1.9 million persons age 12 or older had used OxyContin non-medically at least once in their lifetime.



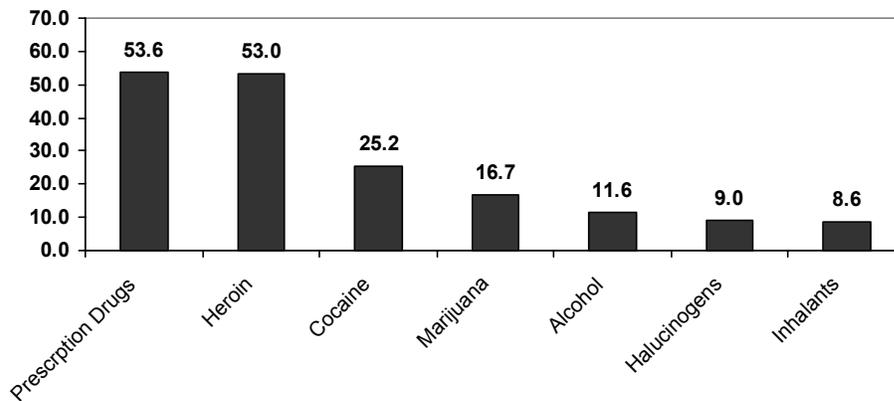
Non-Medical use of OxyContin

- ◆ Estimated number of emergency department mentions for total coterminous United States from 1996 to 2002 increased substantially.



Estimated number of Hydrocodone and Oxycodone Emergency Department (DAWN ED) mentions for total coterminous United States: 1996-2002

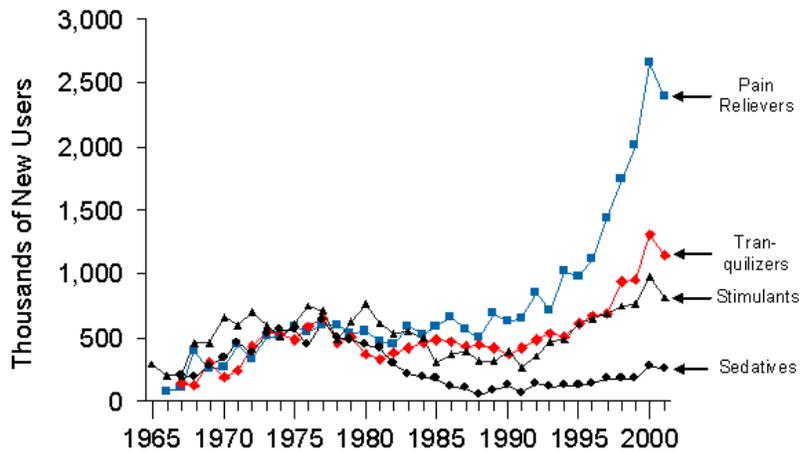
- ◆ Dependency or abuse of specific substances among past year users of substances is high for prescription drugs.



Percent of users with Dependence or Abuse of Specific Substances

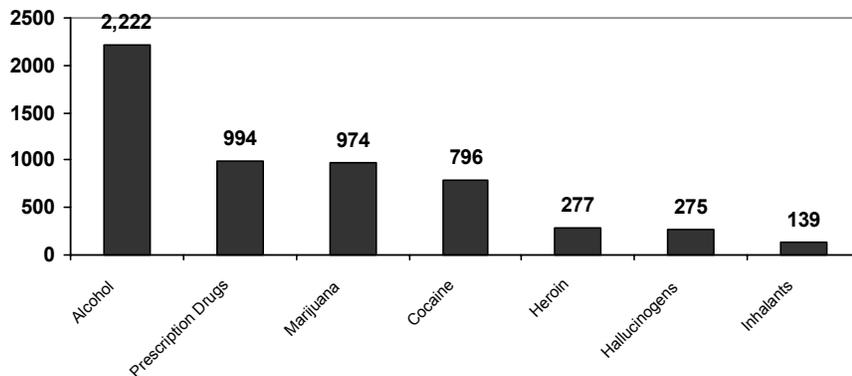
Source: 2002 National Survey on Drug Use and Health (NSDUH). Results from the 2002 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services

- ◆ *Drug abuse in chronic pain management is common.*
 - Substance abuse in chronic low back pain patients has shown to be 19%.
 - Substance abuse in interventional pain management settings has been shown to be 18% to 24%.
 - With prevalence of chronic pain ranging from 15% to 30% in the United States (25 to 45 million persons), the prescription drug abuse or misuse is seen in 18% to 24% (Approximately 5 million to 9 million persons).
 - *The illicit drug use among patients in chronic pain receiving controlled substances has been shown to be 14% to 32%.*
- ◆ New non-medical users of psychotherapeutics have been increasing steadily since 1965 to 2002.



Source: 2002 National Survey on Drug Use and Health (NSDUH). Results from the 2002 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services

- ◆ The following shows substances for which persons aged 12 or older received treatment in the past year based on 2002 survey.



Numbers (in Thousands) Receiving Treatment for Specific Substances

Source: 2002 National Survey on Drug Use and Health (NSDUH). Results from the 2002 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services

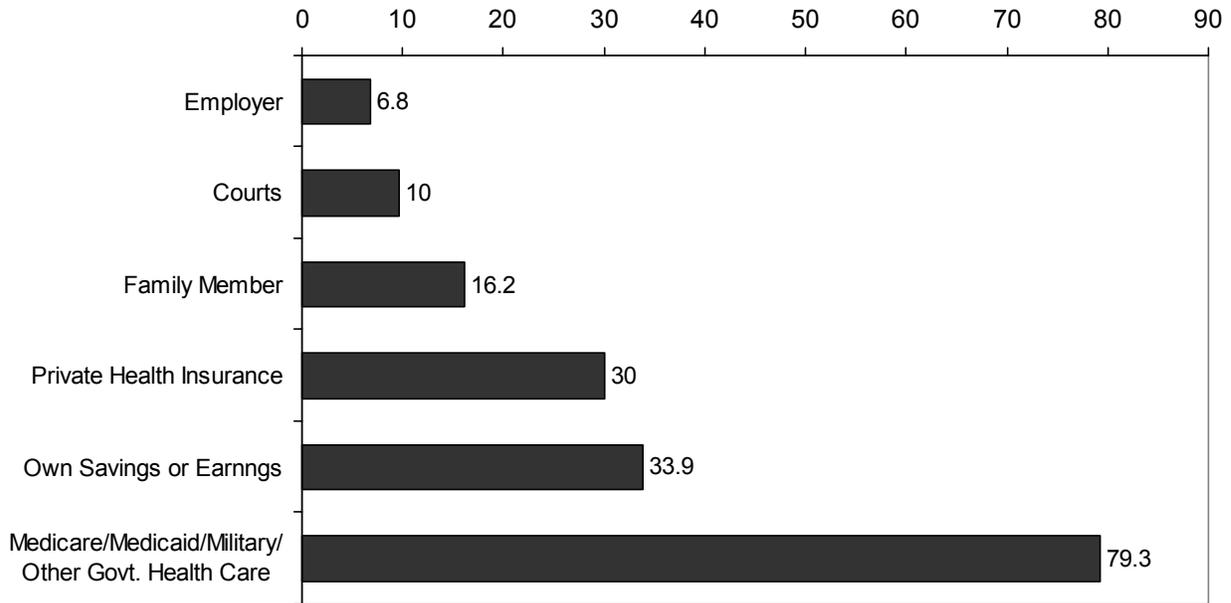
- ◆ Prevalence of mental illness is almost double in patients with drug abuse.

4. Management of abuse and diversion of controlled substance is a public health issue

- ◆ The diversion and abuse of prescription drugs are associated with incalculable costs to society in terms of addiction, overdose, death, and related criminal activities. The DEA has stated that the diversion and abuse of legitimately produced controlled pharmaceuticals constitute a multi-billion dollar illicit market nationwide². As of February 2002, OxyContin has been involved in 464 deaths from prescription drug abuse, as reported by DEA on the basis of medical examiners autopsy findings for 2000 and 2001 from 32 states.

² Drug Enforcement Administration and the National Alliance for Model State Drug Laws, *A closer Look at State Prescription Monitoring Programs* (<http://www.deadiversion.usdoj.gov/pubs/program/prescription-monitor/summary.htm>)

- ◆ Patients may be receiving Schedule II, III, and IV prescriptions from multiple practitioners who are unaware of the potential for drug interactions or of the potential for abuse, and diversion of certain medications.
- ◆ Drug spending is skyrocketing. Significant amounts of Medicaid funds are spent on abused drugs. Drug spending in some states has increased by 65% in 2003.
- ◆ Source of payment for specialty treatment or drug abuse and addiction treatment is highest for federal funds:



Percent Source of Payment for Treatment

(Note that the estimates of treatment by source of payment include persons reporting more than one source.)
 Source: 2002 National Survey on Drug Use and Health (NSDUH). Results from the 2002 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services

- ◆ Projected economic cost of drug abuse for 1998 through 2000 has been shown by Levin group as 143.4 billion for 1998, 152.5 billion for 1999, and 160.7 billion for 2000.

5. Current state of affairs dictate the need for prescription monitoring programs

- ◆ The increasing diversion of prescription drugs for illegal use is a disturbing trend in the nation’s battle against drug use and abuse.
- ◆ Prescription drug diversion is the channeling of pharmaceuticals for illegal purposes or abuse. It can involve activities such as “doctor shopping” by individuals who visit numerous physicians to obtain multiple prescriptions, illegal sales of prescription drugs by physicians or pharmacists, and prescription forgery.
- ◆ States have recognized the need for monitoring of controlled substances since 1940 with implementation in California followed by Hawaii in 1943 (**Table 1**).

Now, 15 states have such programs, which include California, Hawaii, Idaho, Illinois, Indiana, Kentucky, Massachusetts, Michigan, Nevada, New York, Oklahoma, Rhode Island, Texas, Utah, and Washington State.

- ◆ Florida and Virginia are actively pursuing such programs.
- ◆ GAO in its May 2002 report of state monitoring programs concluded that:
 - They indeed provide an efficient tool for stemming the growing problem of illegal diversion of prescription drugs.
 - They offer quick access to comprehensive information on drugs most likely to be abused and deter abusers from doctor shopping within the state.
 - Incidences of drug diversion, however, are on the rise in neighboring states, indicating the problem is proliferating or shifting to states without monitoring programs.
 - The programs have helped reduce availability of abused drugs in Kentucky, Nevada, and Utah.
- ◆ State prescription monitoring programs reduce expenses to healthcare officials, pharmacists, and law enforcement officials.
- ◆ State programs have helped shorten investigation time and reduce illegal drug diversion.

6. Problems facing physicians

- ◆ Every day a physician has to consider:
 - Litigation for failure to treat pain
 - Litigation for undertreatment
 - Criminal charges for abuse, addiction, or death
 - Numerous federal regulations
 - State Board of Medical Examiners
 - Drug Enforcement Agency
 - State Bureau of Narcotics
 - State Board of Pharmacy
- ◆ Case Study: Kentucky
 - Almost half a ton of prescription narcotics reached six counties in Eastern Kentucky from 1998-2001, equating to .75 pound for every adult in those counties.
 - On a per capita basis, Eastern Kentucky drugstores, hospitals, and legal outlets receive more prescription painkillers than anywhere else in the United States.
- ◆ The Escalating Problem: Hydrocodone

- Nationally, emergency room visits for hydrocodone overdoses increased 500 percent from 1990-2000
- Three Eastern Kentucky counties had enough Lortab, Lorcet, and Vicodin pills in 2001 to provide every adult in those countries with 156 pills
- OxyContin sells on the street for about \$40/pill; Lortab sells for \$20/pill and Lorcet for \$9/pill

◆ The Consequences

- From 1997-2001, Eastern Kentucky court cases involving possession and trafficking in controlled substances increased 348 percent.
- In 2000, three Eastern Kentucky counties had more DUIs related to drugs than to alcohol.
- One 21-bed substance-abuse residential house in eastern Kentucky recently reported that all of its beds were occupied by recovering prescription-drug addicts. The number of people in Eastern Kentucky seeking residential treatment for prescription drug addiction tripled from 1998-2001.

◆ Options for Physicians

- Referral to Pain Medicine Clinics
 - Clinics with mainstay treatment of opioids
 - Very limited resource
 - Rare option for Interventional Pain Specialists
- Refuse to Prescribe Controlled Substances
 - Not an option for many practices
 - Inadequate treatment of pain lawsuits
 - Litigation for addiction
 - Criminal charges of murder
- Surrender Schedule II DEA License
 - Lose many patients
 - Lose hospital privileges
 - Lose all insurance patients
 - Not an option for interventionalists

◆ Benefits for Physicians:

- NASPER could alert physicians about patients who are drug shopping.
- Physician can make more informed decisions on prescribing, leading to less risk for medical license.
- Decreased hassle factor with
 - DEA
 - Medical Board
 - US Attorneys

7. Problems facing patients

- ◆ Undertreatment of pain
- ◆ Suspicion may not be resolved
- ◆ KASPER
 - Information not available (of 1000 patients on controlled substances)

Total	26.6%
Kentucky residents	9.7%
Illinois residents	73.9%
Tennessee residents	80.4%
 - 2-4 weeks delay in reporting
- ◆ Patients who are drug shopping will benefit from physician intervention
- ◆ Patients who are not drug shopping will benefit from physician ability to feel more comfortable in prescribing medicines they need
- ◆ Benefits for Patients:
 - Improved access
 - Stable patient – physician relationship

“Honest patients receive appropriate treatment”

8. The need for a comprehensive strategy to control drug abuse and diversion is increasing

While state programs have been effective, the following deficiencies have been noted.

- ◆ From 1940 to 1999, states have been able to establish only 15 functioning programs. The number of states with prescription drug monitoring programs has grown only slightly over the past decade, from 10 in 1992 to 15 in 2002.
- ◆ The White House estimates to increase drug monitoring programs by 10 next year.
- ◆ The nationwide number of prescription drug monitoring programs has been changing. West Virginia terminated its program in 1998, but enacted legislation in 2002 to create a new program. New Mexico terminated its program in 2000 (Figure 1).
- ◆ Even though the 15 programs have a common goal of reducing prescription drug diversion and abuse, they vary in their objectives, design, and operation.
- ◆ The major purpose of the state programs is to help law enforcement identify and prevent prescription drug diversion.
- ◆ Education objectives to provide information to physicians, pharmacies, and the public is a secondary objective.
- ◆ Very few states are proactive to the extent that physicians can access the

information proactively to reduce or prevent abuse and diversion.

- ◆ Program design also varies across states, in terms of which drugs are covered, how prescription information is collected and which agency is given responsibility for the program.
- ◆ Methods for analyzing the data to detect potential diversion activity also differ among states.
- ◆ Only 4 of 15 states monitor Schedule IV drugs and only 5 of 15 monitor Schedule III drugs which are the subject of major controlled substance abuse.
- ◆ Challenges exist in establishing and expanding state programs, due to lack of awareness of the extent to which prescription drug abuse and diversion is a significant public health and law enforcement problem.
- ◆ Extent of diversion in abuse is not always recognized by the states.
- ◆ National efforts have focused only on providing guidance and technical assistance.
- ◆ **Incidents of drug diversion, however, are on the rise in neighboring states, indicating the problem is proliferating or shifting to states without monitoring programs.**

9. Federal versus state control of controlled substances

Federal

- ◆ Controlled Substances Act. The Controlled Substances Act established a classification structure for drugs and chemicals used in the manufacture of drugs that are designed as controlled substances.
- ◆ FDA regulations of prescription drugs. The FDA is responsible for ensuring that all new drugs are safe and effective.
- ◆ The DEA's regulation of controlled substances. The DEA is the primary federal agency responsible for enforcing the Controlled Substances Act. The DEA has the authority to regulate transactions involving the sale and distribution of controlled substances at the manufacturer and wholesale distributor levels.
- ◆ Guidelines for marketing drugs to healthcare professionals. In April 2003, HHS's Office of Inspector General issued voluntary guidelines for how drug

companies should market and promote their products to federal healthcare programs. Federal funds are spent through Medicare/Medicaid military health and other assistance programs spent by patients in acquiring drugs and also in drug treatment.

- ◆ Federal funds utilized for management diversion.

Thus, drugs are mostly controlled by federal agencies rather than state agencies.

State

- ◆ The state's regulation of practice of medicine and pharmacy and role in monitoring illegal use and diversion of prescription drugs. State laws govern the prescribing and dispensing of prescription drugs by licensed healthcare professionals.
- ◆ Multiple state agencies have responded to reports of drug abuse. However, complete information is not available from the directors of state Medicaid fraud control units in Kentucky, Maryland, Pennsylvania, Virginia, and West Virginia. They stated that drug abuse and diversion of OxyContin is a problem in these states.
- ◆ State Medical Licensure Boards have also responded to complaints about physicians who were suspected of abuse and diversion of controlled substances, but like the Medicaid Fraud Control Units, the Boards generally do not maintain data on the number of investigations that were involved.
 - Although Medical Boards may be tough, they can't always catch the bad apples
 - Kentucky's Board of Medical Licensure ranked fifth in the nation for disciplining physicians in 2001
 - Board reacts to complaints and can't statutorily look for problems on its own

In contrast, the DEA has statistics available on drug abuse and diversion.

Overall, federal control and responsibility outweighs states.

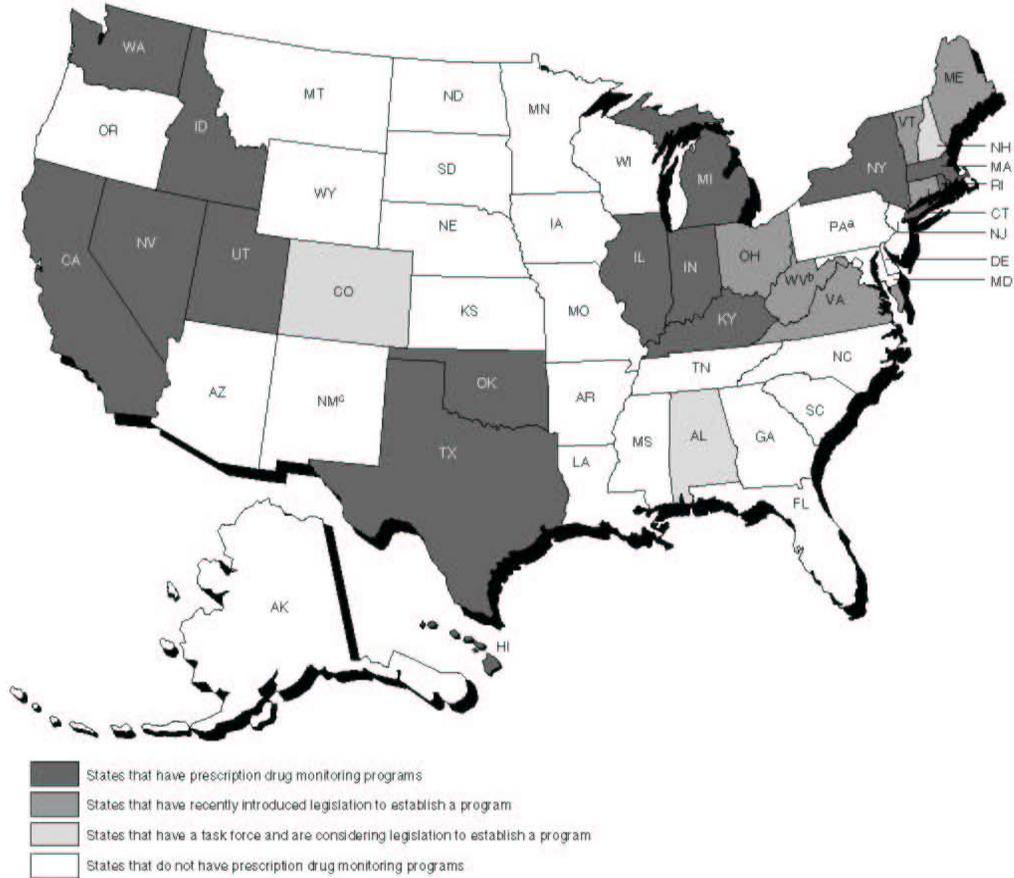
10. A national program is feasible and cost-effective

- ◆ The cost of the program in each state varies according to differences in their design and operational factors.
- ◆ Confidentiality appears to be a major concern. Both physicians who legitimately prescribe prescription drugs and patients who legitimately use them are concerned that the information collected, maintained, and monitored by state programs may be used inappropriately or compromised.
 - **All states, regardless of whether there is a state prescription monitoring program or not, have the authority under their laws to conduct investigations of the records of individuals**

alleged to be involved in prescription drug diversion and abuse, including the records of prescribing physicians and dispensing pharmacies.

- ◆ According to GAO, securing program funding is a critical challenge. The 2002 report states that according to officials from the National Alliance for Model State Drug Laws, the National Association of Drug Diversion investigators, and the DEA, securing program funding is a critical challenge faced by states that choose to develop, maintain, or expand a prescription drug monitoring program.
- ◆ A national or a regional comprehensive program with uniform data collection dispersion and ability for physicians to access the data will reduce drug abuse and diversion and at the same time, provide appropriate pain management. A national program has to capture data. There are approximately 60,000 pharmacies across the United States covering half a million prescriptions per year.
- ◆ A national program will be cost effective. However, a regional program with availability of data to all bordering states is feasible with data collection and in reducing drug diversion and abuse. However, the cost of such a program is not known. *Table 2* shows the contiguous states for each of the 50 states.
- ◆ As per the available data from the 2002 GAO report, describing key features of selected state prescription drug monitoring programs as shown in *Table 3*, the set of funding was \$415,000 in Kentucky, \$134,000 in Nevada, and \$50,000 in Utah. The annual operating costs consecutively for the 3 states was \$500,000, \$112,000 and \$150,000.

Figure 1: Status of Prescription Drug Monitoring Programs, by State, April 2002



^aPennsylvania does not have a PDMP, but requires pharmacies to submit data to the state attorney general's office.

^bWest Virginia terminated its PDMP in 1998 and has enacted legislation in 2002 to create a new program.

^cNew Mexico terminated its PDMP in 2000.

Source: National Alliance for State Model Drug Laws, 2002, and discussions with officials in New Mexico, Pennsylvania, and West Virginia.

Table 1. Characteristics of state prescription drug monitoring programs

State	Year Implemented	Controlled substance schedule(s) monitored	Type of monitoring system	Administrative Agency
California ^a	1940	II	Electronic and triplicate form ^b	Pharmacy and law enforcement
Hawaii	1943	II	Electronic	Law enforcement
Idaho	1967	II, III, and IV	Electronic	Pharmacy board
Illinois	1961	II	Electronic	Public health
Indiana	1995	II	Electronic	Law enforcement
Kentucky	1999	II, III, IV and V	Electronic	Public health
Massachusetts	1992	II	Electronic	Public health
Michigan ^c	1989	II	Single form	Commerce
Nevada	1997	II, III, and IV	Electronic	Pharmacy board and law enforcement
New York ^d	1977	II	Electronic	Public health
Oklahoma	1991	II	Electronic	Law enforcement
Rhode Island	1979	II, III	Electronic	Public health
Texas ^e	1982	II	Electronic	Law enforcement
Utah	1997	II, III, IV, and V	Electronic	Commerce's Licensing Division
Washington ^f	1987	Determined by disciplinary authority	Triplicate form ^b	Public health

^aCalifornia is currently testing an electronic monitoring program for Schedule II controlled substances. Until the pilot program is completed on July 1, 2003, pharmacies will also have to continue submitting copies of the triplicate forms to the state monitoring agency.

^bA triplicate prescription form is a paper prescription form issued by the state to prescribers, who must use it when writing prescriptions for covered controlled substances. The prescriber keeps one copy after writing the prescription, and the pharmacist keeps a copy when the prescription is filled and sends the third copy to the state PDMP.

^cIn 2001, Michigan enacted legislation to convert its PDMP to an electronic monitoring program. Until the new electronic system is implemented, the program will continue to require pharmacies to submit copies of state-issued official prescription forms for schedule II controlled substances.

^dAs of January 1, 2002, New York switched to an electronic monitoring system from a paper-based system using a triplicate form. The new electronic system is supplemented by a state-issued, single-copy prescription form that includes a number of security features to prevent counterfeits.

^eBeginning in September 1999, Texas permitted pharmacies to submit prescription data electronically rather than submitting paper copies of prescription forms. In March 2002, Texas switched from triplicate to single-copy forms with a number of security features to prevent counterfeits. The requirement to submit prescription forms to the state agency will continue until the electronic system is fully implemented.

The Washington program applies only to licensed practitioners whose prescribing practices require monitoring because of the past drug abuse or inappropriate prescribing. The drugs the program covers vary, depending on the prescriber, from one controlled substance to all prescriptions.

Source: National Alliance for Model State Drug Laws. Information is current through February 4, 2002.

Table 2. Shows the contiguous states for each of the 50 states

State	Surrounding States
Alabama	Florida, Georgia, Mississippi, Tennessee
Alaska	None
Arizona	California, Colorado, New Mexico, Nevada, Utah
Arkansas	Louisiana, Missouri, Mississippi, Oklahoma, Tennessee, Texas
California	Arizona, Nevada, Oregon
Colorado	Arizona, Kansas, Nebraska, New Mexico, Oklahoma, Utah, Wyoming
Connecticut	Massachusetts, New York, Rhode Island
Delaware	Maryland, New Jersey, Pennsylvania
Washington DC	Maryland, Virginia
Florida	Alabama, Georgia
Georgia	Alabama, Florida, North Carolina, South Carolina, Tennessee
Hawaii	None
Idaho	Montana, Nevada, Oregon, Utah, Washington, Wyoming
Illinois	Iowa, Indiana, Kentucky, Missouri, Wisconsin
Indiana	Illinois, Kentucky, Michigan, Ohio
Iowa	Illinois, Minnesota, Missouri, Nebraska, South Dakota, Wisconsin
Kansas	Colorado, Missouri, Nebraska, Oklahoma
Kentucky	Illinois, Indiana, Missouri, Ohio, Tennessee, Virginia, West Virginia
Louisiana	Arkansas, Mississippi, Texas
Maine	New Hampshire
Maryland	District Of Columbia, Delaware, Pennsylvania, Virginia, West Virginia
Massachusetts	Connecticut, New Hampshire, New York, Rhode Island, Vermont
Michigan	Indiana, Ohio, Wisconsin
Minnesota	Iowa, North Dakota, South Dakota, Wisconsin
Mississippi	Alabama, Arkansas, Louisiana, Tennessee
Missouri	Arkansas, Iowa, Illinois, Kansas, Kentucky, Nebraska, Oklahoma, Tennessee
Montana	Idaho, North Dakota, South Dakota, Wyoming
Nebraska	Colorado, Iowa, Kansas, Missouri, South Dakota, Wyoming
Nevada	Arizona, California, Idaho, Oregon, Utah
New Hampshire	Massachusetts, Maine, Vermont
New Jersey	Delaware, New York, Pennsylvania
New Mexico	Arizona, Colorado, Oklahoma, Texas, Utah
New York	Connecticut, Massachusetts, New Jersey, Pennsylvania, Vermont
North Carolina	Georgia, South Carolina, Tennessee, Virginia
North Dakota	Minnesota, Montana, South Dakota
Ohio	Indiana, Kentucky, Michigan, Pennsylvania, West Virginia
Oklahoma	Arkansas, Colorado, Kansas, Missouri, New Mexico, Texas

Oregon	California, Idaho, Nevada, Washington
Pennsylvania	Delaware, Maryland, New Jersey, New York, Ohio, West Virginia
Rhode Island	Connecticut, Massachusetts
South Carolina	Georgia, North Carolina
South Dakota	Iowa, Minnesota, Montana, North Dakota, Nebraska, Wyoming
Tennessee	Alabama, Arkansas, Georgia, Kentucky, Missouri, Mississippi, North Carolina, Virginia
Texas	Arkansas, Louisiana, New Mexico, Oklahoma
Utah	Arizona, Colorado, Idaho, New Mexico, Nevada, Wyoming
Vermont	Massachusetts, New Hampshire, New York
Virginia	District Of Columbia, Kentucky, Maryland, North Carolina, Tennessee, West Virginia
Washington	Idaho, Oregon
West Virginia	Kentucky, Maryland, Ohio, Pennsylvania, Virginia
Wisconsin	Iowa, Illinois, Michigan, Minnesota
Wyoming	Colorado, Idaho, Montana, Nebraska, South Dakota, Utah

Table 3. Key features of selected state prescription drug monitoring programs

Key features	Kentucky	Nevada	Utah
Census 2000 population	4.04 million	1.99 million	2.23 million
Year operational	1999	1997	1997
Start-up funding	\$415,000 in federal start-up grant funds	\$134,000 ^a in state funds	\$50,000 in one time state funds
Controlled substance schedules monitored	II, III, IV, V	II, III, IV	II, III, IV, V
Electronic data collection and reporting	Yes	Yes	Yes
Private contractor receives dispensing information and creates database	Yes	Yes	No
Annual operating costs (estimate)	\$500,000	\$112,000	\$150,000
Staff	4 full-time (1 licensed pharmacist investigator, 2 pharmacy technicians, 1 data entry operator) and 4 part-time	1 full-time with all administrative duties	3 full-time including manager and 2 support staff
Number of pharmacies reporting dispensing data (estimate)	1,300	387	375
Number of daily data requests received (estimate)	400	20	130 to 150
Report turnaround time to requestor (estimate)	4 hours	4 hours	3 hours
Penalty for unauthorized use or disclosure of PDMP data	Class D felony ^b	PDMP statute has no penalty	Third-degree felony ^c

^aNevada received \$265,000 for the first 2 years of its program's operations, including 2-year grants from two pharmaceutical companies and the state board of medical examiners.

^bKentucky law defines a class D felony as one carrying a sentence of at least 1 year, but not more than 5 years in prison.

^cUtah law defines a third-degree felony as one carrying a sentence of not more than 5 years in prison.

Source: GAO interviews with PDMP administrators.