

## **Diversion of Pharmaceutical Drugs**

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### **1. Basic Data**

*(Diversion of Licit Drugs)* "'Drug diversion' is best defined as the diversion of licit drugs for illicit purposes. It involves the diversion of drugs from legal and medically necessary uses towards uses that are illegal and typically not medically authorized or necessary."

Source:

"Drug Diversion in the Medicaid Program: State Strategies for Reducing Prescription Drug Diversion in Medicaid," Centers for Medicare & Medicaid Services (Baltimore, MD: January 2012), p. 1.

<https://www.cms.gov/MedicaidIntegrityProgram/Downloads/drugdiversion.pdf>

### **2.**

*(Nonmedical Use of Prescription Drugs)*

"□ The number and percentage of persons aged 12 or older who were current nonmedical users of psychotherapeutic drugs in

2011 (6.1 million or 2.4 percent) were lower than those in 2010 (7.0 million or 2.7 percent) and 2009 (7.0 million or 2.8 percent) (Figure 2.2).

"□ The number and percentage of persons aged 12 or older who were current nonmedical users of pain relievers in 2011 (4.5 million or 1.7 percent) were lower than those in 2010 (5.1 million or 2.0 percent) and 2009 (5.3 million or 2.1 percent) (Figure 2.3)."

Source:

Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012, p. 14.

<http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf>

3.

**(Nonmedical Use of Psychotherapeutics, 2011)** "In 2011, there were 2.3 million persons aged 12 or older who used psychotherapeutics nonmedically for the first time within the past year, which averages to around 6,400 initiates per day. The number of new nonmedical users of psychotherapeutics in 2011 was similar to the 2010 estimate (2.4 million), but was lower than the 2004 estimate (2.8 million). The number of new nonmedical users of pain relievers in 2011 (1.9 million) was lower than the numbers in 2002 through 2005 and in 2008 and 2009 (ranging from 2.2 million to 2.5 million). In 2011, the number of initiates was 1.2 million for tranquilizers, 670,000 for stimulants, and 159,000 for sedatives.

"• In 2011, the average age at first nonmedical use of any psychotherapeutics among recent initiates aged 12 to 49 was 22.4 years. More specifically, it was 21.8 years for pain relievers, 22.0 years for sedatives, 22.2 years for stimulants, and 24.6 years for tranquilizers. All of these estimates were similar to the corresponding estimates in 2010.

"• In 2011, the number of new nonmedical users of OxyContin® aged 12 or older was 483,000, which was similar to the 2010 estimate of 600,000. The average age at first use of OxyContin® among past year initiates aged 12 to 49 was the same in 2010 and 2011 (22.8 years)."

Source:

Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012, p. 58.

<http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf>

4.

**(Source of Psychotherapeutic Drugs Used Nonmedically)** "Past year nonmedical users of psychotherapeutic drugs are asked how they obtained the drugs they most recently used nonmedically. Rates averaged across 2010 and 2011 show that over one half of the nonmedical users of pain relievers, tranquilizers, stimulants, and sedatives aged 12 or older got the prescription

drugs they most recently used 'from a friend or relative for free.' About 4 in 5 of these nonmedical users who obtained prescription drugs from a friend or relative for free indicated that their friend or relative had obtained the drugs from one doctor."

Source:

Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012, p. 28.

<http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf>

5.

***(Source of Pain Relievers Used Nonmedically)***

"□ Among persons aged 12 or older in 2010-2011 who used pain relievers nonmedically in the past year, 54.2 percent got the pain relievers they most recently used from a friend or relative for free (Figure 2.14). Another 12.2 percent bought them from a friend or relative (which was higher than the 9.9 percent in 2008-2009). In addition, 4.4 percent of these nonmedical users in 2010-2011 took pain relievers from a friend or relative without asking. More than one in six (18.1 percent) indicated that they got the drugs they most recently used through a prescription from one doctor. Less than 1 in 20 users (3.9 percent) got pain relievers from a drug dealer or other stranger, 1.9 percent got pain relievers from more than one doctor, and 0.3 percent bought them on the Internet. These other percentages were similar to those reported in 2008-2009.

"□ Among persons aged 12 or older in 2010-2011 who used pain relievers nonmedically in the past year and indicated that they most recently obtained the drugs from a friend or relative for free in the past year, 81.6 percent of the friends or relatives obtained the drugs from just one doctor (Figure 2.14). About 1 in 20 of these past year nonmedical users of pain relievers (5.5 percent) reported that the friend or relative got the pain relievers from another friend or relative for free, 3.9 percent reported that the friend or relative bought the drugs from a friend or relative, 1.9 percent reported that the friend or relative bought the drugs from a drug dealer or other stranger, and 1.8 percent reported that the friend or relative took the drugs from another friend or relative without asking."

Source:

Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012, p. 28.

<http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf>

6.

***(Nonmedical Use of Psychotherapeutic Drugs by Type, 2004)*** "In 2004, 6.0 million persons were current users of psychotherapeutic drugs taken nonmedically (2.5 percent). These include 4.4 million who used pain relievers, 1.6 million who used tranquilizers, 1.2 million who used stimulants, and 0.3 million who used sedatives. These estimates are all similar to the

corresponding estimates for 2003.

"There were significant increases in the lifetime prevalence of use from 2003 to 2004 in several categories of pain relievers among those aged 18 to 25. Specific pain relievers with statistically significant increases in lifetime use were Vicodin®, Lortab®, or Lorcet® (from 15.0 to 16.5 percent); Percocet®, Percodan®, or Tylox® (from 7.8 to 8.7 percent); hydrocodone products (from 16.3 to 17.4 percent); OxyContin® (from 3.6 to 4.3 percent); and oxycodone products (from 8.9 to 10.1 percent)."

Source:

Substance Abuse and Mental Health Services Administration, Results from the 2004 National Survey on Drug Use and Health: National Findings (Rockville, MD: US Dept. of Health and Human Services, Office of Applied Studies, 2005), p. 1.

<http://www.oas.samhsa.gov/nsduh/2k4nsduh/2k4results/2k4results.pdf>

7.

**(Societal Impact of Diversion)** "The societal impact of CPD [controlled prescription drugs] diversion and abuse is considerable. Violent and property crime associated with CPD diversion and abuse has increased in all regions of the United States over the past 5 years, according to the National Drug Intelligence Center (NDIC) National Drug Threat Survey (NDTS). However, the association between crime and CPD diversion is reported much less frequently than the association between crime and illicit drugs. Increases in crime rates often result in higher budgetary expenditures for additional law enforcement resources. Moreover, the estimated cost of CPD diversion and abuse to public and private medical insurers is \$72.5 billion a year, <sup>3</sup> much of which is passed to consumers through higher health insurance premiums. Additionally, the abuse of prescription opioids is burdening the budgets of substance abuse treatment providers, particularly as prescription opioid abuse might be fueling heroin abuse rates in some areas of the United States."

Source:

National Drug Intelligence Center, Drug Enforcement Administration, "National Prescription Drug Threat Assessment," (Washington DC, April 2009), p. IV.

<http://www.justice.gov/archive/ndic/pubs33/33775/33775p.pdf>

8.

**(Inadequate Data)** The General Accounting Office reported in 2003 that "DEA officials told us that it is difficult to obtain reliable data on what controlled substances are being abused by individuals and diverted from pharmacies because available drug abuse and diversion tracking systems do not capture data on a specific brand-name product or indicate where a drug product is being abused and diverted on a state and local level. Because of the time lags in reporting information, the data reflect a delayed response to any emerging drug abuse and diversion problem."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), p. 32.

<http://www.gao.gov/new.items/d04110.pdf>

9.

**(OxyContin Availability)** "The large amount of OxyContin available in the marketplace may have increased opportunities for abuse and diversion. Both DEA and Purdue have stated that an increase in a drug's availability in the marketplace may be a factor that attracts interest by those who abuse and divert drugs."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), p. 30.

<http://www.gao.gov/new.items/d04110.pdf>

10.

**(Oxycontin)** "There are several factors that may have contributed to the abuse and diversion of OxyContin. OxyContin's formulation as a controlled-release opioid that is twice as potent as morphine may have made it an attractive target for abuse and diversion. In addition, the original label's safety warning advising patients not to crush the tablets because of the possible rapid release of a potentially toxic amount of oxycodone may have inadvertently alerted abusers to possible methods for misuse. Further, the rapid growth in OxyContin sales increased the drug's availability in the marketplace and may have contributed to opportunities to obtain the drug illicitly. The history of abuse and diversion of prescription drugs in some geographic areas, such as those within the Appalachian region, may have predisposed some states to problems with OxyContin. However, we could not assess the relationship between the growth in OxyContin prescriptions or increased availability with the drug's abuse and diversion because the data on abuse and diversion are not reliable, comprehensive, or timely."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), p. 29.

<http://www.gao.gov/new.items/d04110.pdf>

11.

**(Lack of OxyContin Data)** "At the state level, Medicaid fraud control units have investigated OxyContin abuse and

diversion; however, they do not maintain precise data on the number of investigations and enforcement actions completed. Similarly, state medical licensure boards have investigated complaints about physicians who were suspected of abuse and diversion of controlled substances, but they could not provide data on the number of investigations involving OxyContin."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), p. 6.

<http://www.gao.gov/new.items/d04110.pdf>

12.

**(Cost of Diversion)** "Moreover, the estimated cost of CPD diversion and abuse to public and private medical insurers is \$72.5 billion a year, <sup>3</sup> much of which is passed to consumers through higher health insurance premiums. Additionally, the abuse of prescription opioids is burdening the budgets of substance abuse treatment providers, particularly as prescription opioid abuse might be fueling heroin abuse rates in some areas of the United States."

Source:

National Drug Intelligence Center, Drug Enforcement Administration, "National Prescription Drug Threat Assessment," (Washington DC, April 2009), p. V.

<http://www.justice.gov/archive/ndic/pubs33/33775/33775p.pdf>

13.

**(Insurance Fraud )** "Insurance fraud is the main financier and enabler of drug diversion. Even so, few health insurers understand the pivotal role insurance fraud plays in a diversion epidemic that costs insurers up to \$72.5 billion a year.

"More specifically:

"□ Swindlers and drug abusers obtain the bulk of their illicit prescription narcotics through fraudulent insurance claims for bogus prescriptions, treating phantom injuries and other illegal deceptions;

"□ Drug diversion drains health insurers of up to \$72.5 billion a year, including up to \$24.9 billion annually for private insurers. The losses include insurance schemes, plus the larger hidden costs of treating patients who develop serious medical problems from abusing the addictive narcotics they obtained through the swindles;

"□ Insurers are potentially vulnerable to enormous liability lawsuits for failing to reasonably prevent fraud schemes that kill and injure people addicted by diversion schemes. Drug manufacturers and pharmacists already face such lawsuits."

Source:

The Mahon Consulting Group LLC for the Coalition Against Insurance Fraud, "Prescription for Peril: How Insurance Fraud Finances Theft and Abuse of Addictive Prescription Drugs," (Washington, DC: December, 2007), p. 4.

<http://www.insurancefraud.org/downloads/drugDiversion.pdf>

14.

*(Prescriptions for OxyContin and Other Opioids)* "According to IMS Health data, the annual number of OxyContin prescriptions for noncancer pain increased nearly tenfold, from about 670,000 in 1997 to about 6.2 million in 2002. In contrast, during the same 6 years, the annual number of OxyContin prescriptions for cancer pain increased about fourfold, from about 250,000 in 1997 to just over 1 million in 2002. The noncancer prescriptions therefore increased from about 73 percent of total OxyContin prescriptions to about 85 percent during that period, while the cancer prescriptions decreased from about 27 percent of the total to about 15 percent. IMS Health data indicated that prescriptions for other schedule II opioid drugs, such as Duragesic and morphine products, for noncancer pain also increased during this period. Duragesic prescriptions for noncancer pain were about 46 percent of its total prescriptions in 1997, and increased to about 72 percent of its total in 2002. Morphine products, including, for example, Purdue's MSContin, also experienced an increase in their noncancer prescriptions during the same period. Their noncancer prescriptions were about 42 percent of total prescriptions in 1997, and increased to about 65 percent in 2002."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), p. 18.

<http://www.gao.gov/new.items/d04110.pdf>

15.

*(Theft of Pharmaceuticals)* The *Journal of Pain and Symptom Management* published a research letter by scientists from the Pain & Policy Studies Group at the University of Wisconsin-Madison on drug crime as a source of diverted pharmaceuticals. The researchers examined data maintained by the US Drug Enforcement Administration on thefts and other incidents of loss of controlled substances by DEA registrants including pharmacists, manufacturers, and distributors. The data was complete for the years 2000-2003 for 22 Eastern states representing 53% of the US population. According to the researchers:

"A total of 12,894 theft/loss incidents were reported in these states between 2000 and 2003. Theft/losses were primarily from pharmacies (89.3%), with smaller portions from medical practitioners, manufacturers, distributors, and some addiction treatment programs that reported theft/losses of methadone.

"Over the 4-year period, almost 28 million dosage units of all controlled substances were diverted. The total number of dosage units for the six opioids is as follows: 4,434,731 for oxycodone; 1,026,184 for morphine; 454,503 for methadone; 325,921 for hydromorphone; 132,950 for meperidine; 81,371 for fentanyl."

Source:

Joranson, David E. MSSW & Aaron M. Gilson, PhD, Pain & Policy Studies Group, University of Wisconsin-Madison, "Drug Crime is a Source of Abuse Pain Medication in the United States," Letters, Journal of Pain & Symptom Management, Vol. 30, No. 4, Oct. 2005, p. 299.

<http://www.painpolicy.wisc.edu/publicat/05jpsm/05jpsm.pdf>

16.

**(Nonmedical Prescription Drug Use by Young People)** "NSDUH data showed a decline in past month nonmedical prescription drug use among youths between 2002 (4.0 percent) and 2008 (2.9 percent), with no significant change between 2008 and 2011 (2.8 percent). Among young adults aged 18 to 25, past month prevalence of nonmedical prescription drug use was 5.0 percent in 2011. This prevalence in 2011 was lower than the rates in other years since 2003, which varied between 5.9 and 6.5 percent. The most prevalent category of misused prescription drugs is pain relievers. Nonmedical pain reliever use in the past month among youths declined from 3.2 percent in 2002 to 2.3 percent in 2011, while the rate among young adults was lower in 2011 (3.6 percent) than in 2010 (4.4 percent) as well as in years from 2002 to 2009 (between 4.1 and 5.0 percent)."

Source:

Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012, p. 94.

<http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf>

17.

**(OxyContin Investigations, Arrests, and Seizures, 1996-2002)** "From fiscal year 1996 through fiscal year 2002, DEA initiated 313 investigations involving OxyContin, resulting in 401 arrests. Most of the investigations and arrests occurred after the initiation of the action plan. Since the plan was enacted, DEA initiated 257 investigations and made 302 arrests in fiscal years 2001 and 2002. Among those arrested were several physicians and pharmacists. Fifteen health care professionals either voluntarily surrendered their controlled substance registrations or were immediately suspended from registration by DEA. In addition, DEA reported that \$1,077,500 in fines was assessed and \$742,678 in cash was seized by law enforcement agencies in OxyContin-related cases in 2001 and 2002."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), p. 37.

<http://www.gao.gov/new.items/d04110.pdf>

18.

**(Illicit Sales of OxyContin, 2001)** "According to a 2001 HIDTA [High Intensity Drug Trafficking Area] report, the Appalachian region, which encompasses parts of Kentucky, Tennessee, Virginia, and West Virginia, has been severely affected by prescription drug abuse, particularly pain relievers, including oxycodone, for many years. Three of the four states -- Kentucky, Virginia, and West Virginia -- were among the initial states to report OxyContin abuse and diversion. Historically, oxycodone, manufactured under brand names such as Percocet, Percodan, and Tylox, was among the most diverted prescription drugs in Appalachia. According to the report, OxyContin has become the drug of choice of abusers in several areas within the region. The report indicates that many areas of the Appalachian region are rural and poverty-stricken, and the profit potential resulting from the illicit sale of OxyContin may have contributed to its diversion and abuse. In some parts of Kentucky, a 20-milligram OxyContin tablet, which can be purchased by legitimate patients for about \$2, can be sold illicitly for as much as \$25. The potential to supplement their incomes can lure legitimate patients into selling some of their OxyContin to street dealers, according to the HIDTA report."

Source:

General Accounting Office, "Prescription Drugs: Oxycontin Abuse and Diversion and Efforts to Address the Problem," GAO-04-110 (Washington, DC: Government Printing Office, December 2003), pp. 31-32.

<http://www.gao.gov/new.items/d04110.pdf>

19.

**(Overdose Deaths and Treatment Admissions)** "According to the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics, unintentional overdose deaths involving prescription opioids increased 114 percent from 2001 (3,994) to 2005 (8,541), the most recent nationwide data available. Further, the number of treatment admissions for prescription opioids as the primary drug of abuse increased 74 percent from 46,115 in 2002 to 80,131 in 2006, the most recent data available, according to the SAMHSA Treatment Episode Data Set (TEDS)."

Source:

National Drug Intelligence Center, Drug Enforcement Administration, "National Prescription Drug Threat Assessment," (Washington DC, April 2009), p. III.

<http://www.justice.gov/archive/ndic/pubs33/33775/33775p.pdf>

20.

**(Diversion and Fraud)** "According to law enforcement reporting, some individuals and criminal groups divert CPDs [controlled prescription drugs] through doctor-shopping and use insurance fraud to fund their schemes. In fact, Aetna, Inc. reports that nearly half of its 1,065 member fraud cases in 2006 (the latest year for which data are available) involved prescription benefits, and most were related to doctor-shopping, according to the Coalition Against Insurance Fraud (CAIF). CAIF further reports that diversion of CPDs collectively costs insurance companies up to \$72.5 billion annually, nearly two-thirds of which is paid by public insurers. Individual insurance plans lose an estimated \$9 million to \$850 million annually, depending on each plan's size; much of that cost is passed on to consumers through higher annual premiums."

Source:

National Drug Intelligence Center, Drug Enforcement Administration, "National Prescription Drug Threat Assessment," (Washington DC, April 2009), p. 20.

<http://www.justice.gov/archive/ndic/pubs33/33775/33775p.pdf>

21.

*(Pharmaceutical Drug Distribution in the US)* "Drugs in the United States generally do not travel straight from the line of production to the dispensing pharmacy. Rather, a serpentine maze provides a ripe environment for the infiltration of counterfeit, adulterated, and diverted drugs.<sup>15</sup>

"The distribution system is primarily tiered among manufacturers, the "Big 3" distributors/drug wholesalers, secondary wholesalers,<sup>16</sup> and repackagers. The FDA has identified three primary routes for drug sales in the United States, and each involves drugs passing through multiple hands, demonstrating the vulnerability of the distribution system to counterfeit, adulterated, and diverted products.<sup>17</sup> The "Big 3" wholesalers—Cardinal Health,<sup>18</sup> McKesson<sup>19</sup> and Amerisource Bergen,<sup>20</sup> which collectively account for nearly 90% of the primary wholesale market<sup>21</sup>—sell drugs into a distribution web containing large governmental agencies, secondary wholesalers, and criminal actors.<sup>22</sup> "Repackagers" of drugs further obscure the origin of a particular drug when they break wholesale drugs in bulk containers into smaller units for sale to pharmacies or, conversely, re-aggregate smaller units purchased as overstock from pharmacies into larger bundles for resale to wholesalers.<sup>23</sup> Because of the multiple distributors and the repackaging, the true origin of drugs in this net remains obscure.<sup>24</sup> "

Source:

Aleong, Stephanie Feldman, "Green Medicine: Using Lessons From Tort Law and Environmental Law to Hold Pharmaceutical Manufacturers and Authorized Distributors Liable for Injuries Caused by Counterfeit Drugs," University of Pittsburgh Law Review (Pittsburgh, PA: Winter 2007) Volume 69, Issue 2, p. 248-250.

<http://lawreview.law.pitt.edu/issues/69/69.2/Aleong.pdf>

## 22. Prescription Drug Monitoring Programs

*(State Prescription Drug Monitoring Programs, 2012)* "Prescription drug monitoring programs (PDMPs) are now authorized in 48 states and only two states (Missouri and New Hampshire) and the District of Columbia lack legislation

authorizing a PDMP. States such as Maryland, Georgia, and Arkansas recently passed legislation to establish PDMPs. In addition, states are beginning to share data across state lines. Ohio and Kentucky successfully shared data in a test pilot and many other states are expected to increase their data sharing capabilities over the next several months."

Source:

Office of National Drug Control Policy, "National Drug Control Strategy," (Washington, DC: Executive Office of the President, April 2012), p. 48.

[http://www.whitehouse.gov/sites/default/files/ondcp/2012\\_ndcs.pdf](http://www.whitehouse.gov/sites/default/files/ondcp/2012_ndcs.pdf)

23.

**(Effect of Implementation of PDMP)** "Our analysis showed that the implementation of a province-wide centralized prescription network was associated with large, immediate and sustained reductions in filled prescriptions for opioid analgesics and benzodiazepines deemed inappropriate by our definition. These findings provide empirical evidence that centralized prescription networks can reduce inappropriate prescribing and dispensing of prescriptions by offering health care professionals real-time access to prescription data. Physicians did not have access to PharmaNet when it was first introduced; consequently, the reductions observed in our study likely reflect the availability of real-time prescription information to front-line pharmacists."

Source:

Dormuth, Colin R., et al., "Effect of a centralized prescription network on inappropriate prescriptions for opioid analgesics and benzodiazepines," Canadian Medical Association Journal, November 6, 2012, vol. 184, no. 16, DOI:10.1503/cmaj.120465, p. 854.

<http://www.cmaj.ca/content/184/16/E852.abstract>

24.

**(PDMPs and Reduction of Diversion)** "States with PDMPs have realized benefits in their efforts to reduce drug diversion. These include improving the timeliness of law enforcement and regulatory investigations. For example, Kentucky's state drug control investigators took an average of 156 days to complete the investigation of an alleged doctor shopper prior to the implementation of the state's PDMP. The average investigation time dropped to 16 days after the program was established. In addition, law enforcement officials in Kentucky and other states view the programs as a deterrent to doctor shopping, because potential diverters are aware that any physician from whom they seek a prescription may first examine their prescription drug utilization history based on PDMP data."

Source:

General Accounting Office, "Prescription Drugs: State Monitoring Programs Provide Useful Tool to Reduce Diversion" (Washington, DC: Government Printing Office, May 2002), GAO-PO-634, p. 3.

<http://www.gao.gov/new.items/d02634.pdf>

25.

**(Physician Concerns Over PDMPs)** "Physicians are concerned that their prescribing decisions and patterns may be questioned and that they could be investigated without sufficient cause. Some physicians contend that patients may suffer because physicians will be reluctant to prescribe appropriate controlled substances to manage a patient's pain or treat their condition. Patients are concerned that their personal information may be used inappropriately by those with authorized access or shared with unauthorized entities. Pharmacists have also expressed concerns."

Source:

General Accounting Office, "Prescription Drugs: State Monitoring Programs Provide Useful Tool to Reduce Diversion" (Washington, DC: Government Printing Office, May 2002), GAO-PO-634, p. 18.

<http://www.gao.gov/new.items/d02634.pdf>

26.

**(Effects of PDMPs)** "Although several studies found implementation of prescription monitoring programs for Schedule II opioids associated with a decrease in prescription rates for Schedule II opioids and a shift towards increased rates of Schedule III, non-monitored opioid prescribing, the studies were not designed to determine whether the changes were due to a decrease in inappropriate or unnecessary Schedule II opioid use, or if these changes resulted in subsequent undertreatment of pain.<sup>317</sup>  
<sup>318</sup> No study has evaluated patient outcomes such as pain relief, functional status, ability to work, and abuse/addiction associated with implementation of a prescription monitoring program, formulary restriction, or other policies related to opioids prescribing. Claims of positive effects of prescription monitoring programs on reducing diversion are primarily based on anecdotal reports of impressions of efficacy from policymakers and law enforcement officials.<sup>316</sup> "

Source:

"Use of Chronic Opioid Therapy in Chronic Noncancer Pain: Evidence Review, " The American Pain Society in Conjunction with The American Academy of Pain Medicine (Glenview, IL: American Pain Society, February 2009), p.

[http://www.ampainsoc.org/library/pdf/Opioid\\_Final\\_Evidence\\_Report.pdf](http://www.ampainsoc.org/library/pdf/Opioid_Final_Evidence_Report.pdf)

27.

**(PDMP start-ups)** "Officials from DEA, the Alliance [National Alliance for Model State Drug Laws], and state PDMPs told us that states considering establishing a PDMP, or expanding an existing one, face several challenges. These include educating the public and policymakers about the extent of prescription drug diversion and abuse in their state and the benefits of a PDMP, responding to the concerns of physicians, patients, and pharmacists regarding the confidentiality of prescription

information, and funding the cost of program development and operations. Given a state's particular funding availability and budget priorities, program costs can be a major hurdle. The start-up costs for the three most recent PDMPs were \$415,000 for Kentucky, \$134,000 for Nevada, and \$50,000 for Utah. Estimated annual operating costs for these PDMPs varied from a high of about \$500,000 in Kentucky, to \$150,000 in Utah and \$112,000 in Nevada. Costs in these three states vary because of differences in the PDMP systems implemented, the number of pharmacies reporting drug dispensing data, and the number of practitioners and law enforcement agencies seeking information from the systems."

Source:

General Accounting Office, "Prescription Drugs: State Monitoring Programs Provide Useful Tool to Reduce Diversion" (Washington, DC: Government Printing Office, May 2002), GAO-PO-634, pp. 3-4.

<http://www.gao.gov/new.items/d02634.pdf>

28.

*(PDMPs and Neighboring States)* "The existence of a PDMP [prescription drug monitoring program] within a state, however, appears to increase drug diversion activities in contiguous non-PDMP states. When states begin to monitor drugs, drug diversion activities tend to spill across boundaries to non-PDMP states. One example is provided by Kentucky, which shares a boundary with seven states, only two of which have PDMPs—Indiana and Illinois. As drug diverters became aware of the Kentucky PDMP's ability to trace their drug histories, they tended to move their diversion activities to nearby nonmonitored states. OxyContin diversion problems have worsened in Tennessee, West Virginia, and Virginia—all contiguous non-PDMP states—because of the presence of Kentucky's PDMP, according to a joint federal, state, and local drug diversion report."

Source:

General Accounting Office, "Prescription Drugs: State Monitoring Programs Provide Useful Tool to Reduce Diversion" (Washington, DC: Government Printing Office, May 2002), GAO-PO-634, pp. 16-17.

<http://www.gao.gov/new.items/d02634.pdf>

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