Alaska Prescription Drug Monitoring Program
Summary Prepared for the Board of Dental Examiners
Q1 2023

This report contains summary data from the Prescription Drug Monitoring Program (PDMP). Data is provided as a courtesy for the board and is intended to be used for informational purposes only.

News

- We have hired a Project Assistant to help with monitoring compliance.
- Statewide Gateway Integration is ongoing.
- Delegate Audit was completed in March.

Upcoming Activities

- McKinley Research Group Report (attached to this report) recommended the division form a workgroup to address the considerations of the report.
- Auto-approval coming soon!

Registration

Some licensed providers may be registered as an IHS, Military, or VA Prescriber and would not be counted in the number registered in AWARxE (PDMP).

Portal (Professional license system)

Number of licensed Dentists: 733
Number of Dentists with DEA registrations: 632
Number of PDMP Dental registrations: 584
Directly dispensing controlled substances: 26

AWARxE (PDMP)

Number registered with the PDMP: 571

Use – Review Compliance

Federally Scheduled II – III controlled substances, over a three-day supply (emergency, surgical and oncology specialties are omitted). The system does not capture treatment codes and is therefore not able to account for prescription(s) not reviewed due to some of the exemptions in AS 17.30.200(k)(4)(A).

Q4 2022: 5.54%
Q1 2023: 3.03%

Delinquent Reporters

We worked with the PDMP vendor to address reporting compliance and have a finalized tool. We are testing the tools available and creating a sustainable plan.

Recommendations

- Encourage increased reviewing. Mandatory review applies to non-refillable federally scheduled II – III controlled substances over a three-day supply (for further exemptions see AS 17.30.200(k)).
- Remind providers who are directly dispensing to report daily, including zero reports.
- Encourage the use of authorized delegates.
- Sign up for Statewide Gateway Integration!

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McKINLEY RESEARCH GROUP, LLC

Formerly McDowell Group

THE ALASKA PRESCRIPTION DRUG MONITORING PROGRAM

An Independent Analysis

FINAL REPORT

December 2022

PREPARED FOR:

Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development

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Executive Summary

Prescription Drug Monitoring Programs (PDMPs) are a tool to collect, analyze, and report information on the prescribing, dispensing, and use of federally classified schedule II, III, or IV controlled substances within a state. All 50 states have a PDMP, including Alaska.

The Alaska Legislature established the PDMP, an electronic controlled substance prescription database, in 2008 and it became operational in 2012. Mandates for prescribing practitioners and pharmacists to register, review prescriptions, and report using the PDMP database started in 2017. The PDMP is administered by the Board of Pharmacy under the Division of Corporations, Business and Professional Licensing (CBPL), Department of Commerce, Community, and Economic Development (DCCED).

DCCED contracted McKinley Research Group to independently and objectively explore the strengths and weakness of Alaska's PDMP, as well as capture recommendations for change at the statutory, regulatory, and process levels. These changes are necessary to keep up with the constantly evolving technology and policies supporting emergent best practices, data integration and compliance effectiveness.

The Board of Pharmacy's overarching goals of Alaska's PDMP include:

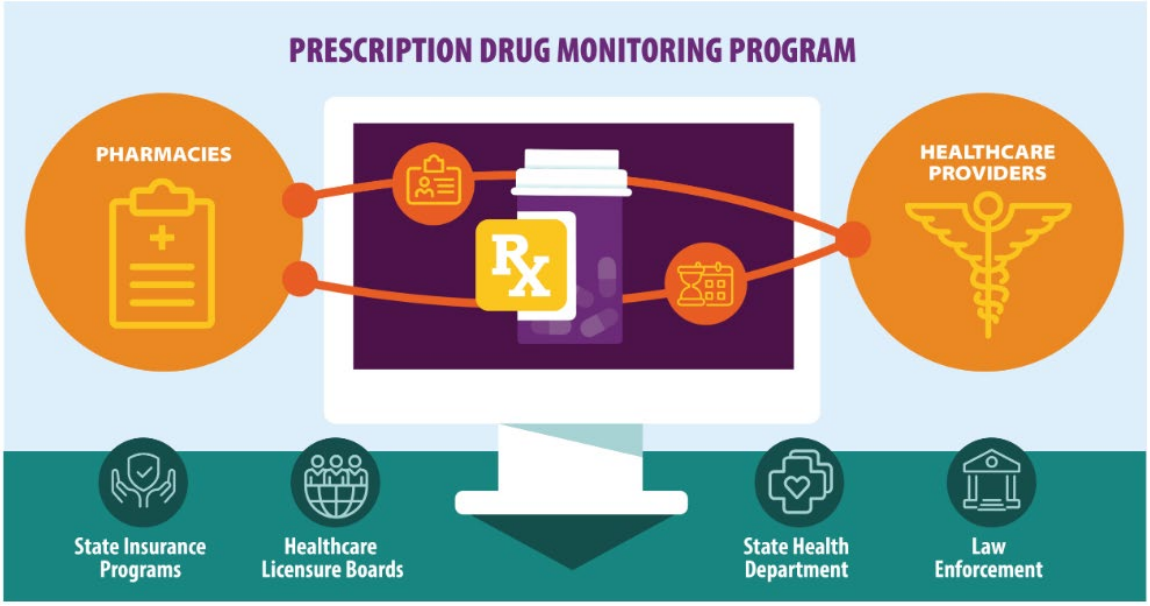
- **Monitoring and promoting judicious prescribing and dispensing practices**
- **Reducing inappropriate prescribing**
- **Identifying and preventing instances of misuse, abuse, and drug diversion**
- **Increasing provider communication across provider settings**

Determining the effectiveness of Alaska's PDMP is highly dependent upon numerous factors associated with Alaska's goals, supporting legislation, and program resources. These include the scope and breadth of use (i.e., mandated use, exemptions, compliance), implementation status and reach, ease of use and integration, data quality, data analysis and reporting capacities, and interagency data-sharing practices, among others.

Next Step Recommendation

It is recommended CBPL convene a PDMP working group to review the findings of this analysis and prioritize changes for improved effectiveness and impact through a multi-perspective lens. The nature of this optimization effort is beyond the scope or capacity of just the Board of Pharmacy itself and/or other healthcare licensure boards. Based on the Centers for Disease Control and Prevention (CDC) framework for PDMP Use and Effectiveness, it is recommended

that the working group be comprised of representatives from the PDMP program, state health department (i.e., Chief Medical Officer), state insurance programs (i.e., Medicaid Medical Director), healthcare licensure boards, and law enforcement.



Source: CDC

The working group can establish its own goals and objectives; however, this report offers several considerations for improvement. These considerations are based on a review of Alaska's PDMP current practices, a policy and process analysis of other state experiences and performances, and Alaska stakeholder perspectives. While the analysis provides more considerations for improvement, below are considerations that may require higher priority.

Considerations for Improvement

Governance

- **Evaluate the benefits and costs associated with shifting governance of the PDMP from the Board of Pharmacy to the Department of Health (DOH).** This shift would allow the PDMP to better meet its overarching goals of preventing drug misuse and diversion by improving data sharing with other public health datasets and enabling DOH analysts to identify trends and practices that can then be addressed by department policy leaders. Additionally, this transfer would streamline the use of federal dollars channeled through federal agencies to support PDMP enhancements, facilitate better interoperability across state lines, and maximize federal grant spending.

Management Capacity

- **Allocate a consistent level of appropriated state funding to support capacity and flexibility to implement program improvements,** such as data infrastructure and data sharing; these improvements may not be possible under restricted use of federal grants.
- **Address the Division of Legislative Audit 2021 recommendation to allocate sufficient resources for licensing examiner and investigator resources** to ensure PDMP requirements are enforced.[1]
- **Increase PDMP staff to include a data analyst** who can query the PDMP database and analyze output and outcome data to inform compliance and enforcement, evaluate controlled substance monitoring effectiveness, and advise policy decisions.

Mandated Use and Exemptions

- **Continue mandated PDMP use by all prescribing practitioners and pharmacists.** Removing prescribing practitioners from mandated reporting will erode efforts to meet the PMDP's goals to improve population health.
- **Implement best practices, as established by the PDMP Training and Technical Assistance Center, to better position and address the burden on veterinarians,** enabling full participation in the PDMP to meet its public health goals; best practices would include enhanced software compatibility and more educational outreach.
- **Assess all outpatient setting exemptions** that undermine prescribing practices and may potentially lead to overdoses and drug diversion, but also to better evaluate the outcomes of Alaska's PDMP with more complete and accurate data.

Delegates

- **Improve awareness of how many delegates can be assigned to license holders** and delegates' defined role and responsibilities.
- **Ensure the capacity for prescribers and dispensers to audit their delegate use.**
- **Consider legislative changes that would allow non-licensed certified medical assistants (CMAs) or dental assistants** access the PDMP as delegates of prescribing practitioners.

[1] Alaska State Legislature, Division of Legislative Audit. "A Sunset Review of the Department of Commerce, Community, and Economic Development (DCCED)," July 15, 2021.

Voluntary Users

- **Seek additional funding to further develop relationships with federal agencies and participation in Alaska's PDMP** and maximize compatibility of federal prescriber systems to Alaska PDMP.

Compliance Impacts

- **Identify clear priorities for PDPM investigations**, focusing on the program's intent to reduce overprescribing and overdoses, especially during the current backlog of investigations.
- **Hold licensing boards accountable to address compliance issues of their licensees and develop "standards of safe practice"** (if they have not already done so).

Data Sharing

- **Seek funding to enhance data infrastructure for effective data sharing.**
- **Examine the type, frequency, and form of data sharing with other practice boards and other public entities** (i.e., Department of Corrections, Department of Public Safety, DOH) to improve compliance and best practices.
- **Establish a framework for data integration and data sharing between state departments** (i.e., DOH, Department of Corrections, Department of Public Safety).
- **Allow and set guidelines for interstate health information exchanges** so state entities can share data under specific conditions.
- **Establish criteria for expanding or reducing the number of interstate data sharing agreements.**

Integration

- **Manage and communicate expectations of anticipated levels of statewide integration (PDMP/Heath information Exchange/Electronic Health Records) implementation,** particularly related to small practice settings and regions with poor broadband connectivity.
- **Seek sustainable funding (including general funds or grant funding) for integration** past FFY2024.
- **With increased integration, reevaluate PDMP capacity needs** to manage compliance, investigations, and data analysis.

Acronyms and Abbreviations

AHHA	Alaska Hospital & Healthcare Association
AK-ACEP	Alaska Chapter of the American College of Emergency Physicians
ASAP	American Society for Automation in Pharmacy
BJA	Bureau of Justice Assistance
CBPL	Division of Corporations, Business and Professional Licensing
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DEA	Drug Enforcement Administration
DCCED	Alaska Department of Commerce, Community, and Economic Development
DOH	Alaska Department of Health
DHA	Defense Health Agency
DOJ	U.S. Department of Justice
DPH	Division of Public Health
DUA	Data User Agreement
ED	Emergency Department
EHR	Electronic Health Record
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HSS	U.S. Department of Health and Human Services
ICD	International Classification of Diseases
IHS	Indian Health Service
IT	Information technology
MAT	Medication Assisted Treatment
MHS	Military Health System
MOU	Memorandum of Understanding
NABP	National Association of Boards of Pharmacy
OLE	Occupational Licensing Examiner
ONC	Office of the National Coordinator for Health Information Technology
ONDCP	Office of National Drug Control Policy
OSMAP	Office of Substance Misuse and Addiction Prevention
OUD	Opioid use disorder
PDMP	prescription drug monitoring program
PMS	Pharmacy Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
SOA	State of Alaska
SUD	Substance use disorder
VA	U.S. Department of Veteran Affairs
VHA	Veterans Health Administration

Introduction and Methods

Introduction

Prescription medications – particularly when misused or overprescribed – can contribute to dangerous drug interactions, substance use disorder, overdoses, and death.[2] According to the Alaska Opioid Data Dashboard, 170 opioid overdose deaths occurred in Alaska from June 2021 to May 2022.[3] To help ensure safe and appropriate prescriptions, the federal government has supported the use of prescription drug monitoring programs (PDMPs), electronic databases that track controlled substance prescriptions within a state. The 2020 National Drug Strategy states that expanding the use of PDMPs is a fundamental element of the nation's effort to reduce drug overdose deaths.[4] At present, all 50 states and four territories (Puerto Rico, District of Columbia, Northern Mariana Islands, and Guam) have a PDMP.

Alaska's PDMP was enacted through state legislation in 2008 and became operational in 2012, requiring prescribing practitioners and pharmacists to register, review prescriptions, and report using the PDMP database in 2017. The PDMP is administered by the Board of Pharmacy (the board) under the Department of Commerce, Community, and Economic Development (the department or DCCED), Division of Corporations, Business and Professional Licensing (the division or CBPL).

Purpose

In June 2022, the State of Alaska issued an Informal Request for Proposals to conduct an *Independent Analysis of the Alaska Prescription Drug Monitoring Program*. The described intent of the analysis was to explore the strengths and weakness of the current program, as well as capture recommendations for change at the statutory, regulatory, and process levels. McKinley Research Group (formerly McDowell Group), an Alaska-based research and consulting firm, was engaged to conduct this analysis, which began in July and extended through November 2022.

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[2] According to the Centers for Disease Control and Prevention (CDC), prescription drug misuse is when an individual uses a prescription drug in any way not directed by the prescriber. This includes using a prescription drug that was prescribed to another person (known as "diversion") or using it in an amount, frequency, duration, or any other way not directed by the prescriber.

[3] Alaska Opioid Data Dashboard, Alaska Department of Health, Division of Public Health, last modified September 21, 2022. https://health.alaska.gov/dph/Director/Pages/opioids/dashboard.aspx. (Accessed November 15, 2022.)

[4] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)

Methodology

McKinley Research Group used a mixed-methods approach, including collecting and analyzing primary and secondary data. The approach included a technical work session, Alaska PDMP data compilation and analysis, policy analysis, literature review, and stakeholder interviews. Where the policy and best practices review was supported by stakeholder perspectives, the study team prioritized the issue as an area for consideration.

Technical Work Session

Early in the research process, we convened a small group of PDMP policy and program leaders positioned to provide ready access to data and other documentation, recommend key stakeholders to interview, and discuss potential analytical issues. The 1.5-hour work session (held virtually) provided a contextual and technical grounding for the analysis with focused discussion on the PDMP's legislative and operational history, perceived challenges with current legislative and regulatory mandates, known shifts in expectations, perceived value, and intent of the PDMP, current PDMP capacity and consistency across health systems, and program sustainability.

Alaska PDMP Data Compilation and Analysis

PDMP reports submitted to the Alaska State Legislature, summary program data, and other data queried from the PDMP program, as available, were reviewed. This process informed the interview process and recommendations for policy and process improvements.

Policy Analysis and Literature Review

Critical to the analysis was a review of Alaska's current statutes and regulations pertaining to the PDMP and legislative reports and data. Additionally, McKinley Research Group conducted a peer-reviewed and white paper literature review of other states' and national PDMP policies, assessments, and outcomes. The review focused on best practices in PDMP legislation, regulation, policy, funding, staffing, data infrastructure, process systems, and emerging trends in PDMP expanded uses.

Stakeholder Perspectives

McKinley Research Group interviewed almost 50 professionals who work with the PDMP to better understand the program's effectiveness. Interviews were conducted by phone and video conference in September and October 2022. Stakeholders included various prescribing practitioners and pharmacists, drug misuse professionals, administrators, industry association leaders, investigators, licensing board members, and PDMP experts in other states. Stakeholders were asked about the PDMP's successes, challenges, clarity of legislation and regulations, system of governance, and ways to improve the program. (*A list of stakeholders interviewed is found in Appendix A.*)

Prescription Drug Monitoring Programs

Historical Context

PDMPs are designed to facilitate the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances within a state. Rising goals of PDMPs are to uphold state laws ensuring access to appropriate pharmaceutical care, deterring diversion of controlled substances, and using PDMP data to inform multi-sector population health and safety initiatives.

PDMPs are not a new concept. The earliest PDMP was established by New York State in 1918 to address concerns about the prescribing of drugs, such as heroin and cocaine; the law was rescinded three years later. The oldest continuously operated PDMP in the U.S. is in California, established in 1939. In the 1970s, Pennsylvania, New York, and Rhode Island added PDMPs, followed by Texas and Michigan in the 1980s. These PDMPs all had the same characteristics:

- Were tools for the enforcement of drug laws.
- Collected prescription information only on Schedule II controlled substances.
- Required multi-copy state-issued prescription forms to prescribe and dispense Schedule II medications.
- Required sending prescription information to the state within 30 days from the time the drug was dispensed. [5]

With electronic database and transmission technology emerging, 17 PDMPs were operational by 2000. In 2003, the U.S. Department of Justice (DOJ), through its Bureau of Justice Assistance (BJA) made federal grant funding available to states interested in establishing, implementing, and enhancing PDMPs. Initial research into the effectiveness of PDMPs showed they were a valuable tool for providing patient safety and identifying patients at risk for drug overdoses. By 2010, 27 more PDMPs were established (now totaling 44), with each state building on the experience and knowledge of earlier programs. The State of Alaska was no exception, with foundational legislation passed in 2008 and an operational PDMP in place by 2012. By 2022, all 50 states and four territories (Puerto Rico, District of Columbia, Northern Mariana Islands, and Guam) had a PDMP.

[5] PDMP TTAC. "Technical Assistance Guide: History of Prescription Drug Monitoring Programs," March 2018. https://www.pdmpassist.org/pdf/PDMP_admin/TAG_History_PDMPs_final_20180314.pdf. (Accessed October 18, 2022.)

Evolution of PDMPs

The earliest PDMPs were established primarily as enforcement and regulatory tools providing data to officials responsible for enforcing drug laws and overseeing the prescribing and dispensing of drugs. Consequently, state PDMP laws most frequently included law enforcement and regulatory goals, including reducing misuse and prescription drug diversion and aiding investigations. These types of legislative goals were much more common than health-focused goals, such as using the data to refer patients to treatment, reduce overdoses, or achieve public health goals. While this enforcement and regulatory role continues to be part of almost all current PDMPs, the focus of PDMPs is shifting to enhance patient care, assist in developing drug abuse prevention and treatment strategies, and inform state health policy development. In comparison to the early years of PDMPs, current-day PDMPs have become an important tool to address the drug abuse epidemic and inform public health and safety approaches.

States are continuously improving their programs to be more responsive to stakeholders with more timely and accurate information. All PDMPs allow access to their data by prescribing practitioners and pharmacists. Some PDMPs are now allowing access to data by nontraditional stakeholders, such as drug courts, medical examiners, and drug treatment programs. For example, Wisconsin and Utah collect data on individuals who have overdosed or been found guilty of drug violations and report this information to practitioners querying the PDMP. As recently as August 2020, revised 42 CFR Part 2 federal regulations went into effect, permitting certain federally assisted substance use disorder (SUD) treatment programs to report protected records (e.g., SUD medication prescribed or dispensed) to the applicable PDMP if required by state law and if the patient consents.[6] In response, some states are making PDMP legislative adjustments to reflect this change for enhanced health-focused uses.

Other improvements include interstate data sharing (now available in 47 states) and integration of PDMP data with health information exchanges (HIEs), electronic health records (EHRs), and pharmacy dispensing systems (PDS).[7]

Some examples of successful legislative changes to PDMPs and improved outcomes include:

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[6] PDMP TTAC. "42 CFR Part 2 and PDMPs Frequently Asked Questions," May 2021. https://www.pdmpassist.org/pdf/TTAC_42_CFR_Part_2_FAQs_final_20210528.pdf. (Accessed November 4, 2022.)
[7] PDMP TTAC. "Technical Assistance Guide: History of Prescription Drug Monitoring Programs," March 2018. https://www.pdmpassist.org/pdf/PDMP_admin/TAG_History_PDMPs_final_20180314.pdf. (Accessed October 18, 2022.)

- In 2010, Florida stopped health care providers from dispensing prescription opioid pain relievers from their offices and established a PDMP. By 2012, Florida experienced a 50% decrease in oxycodone overdose deaths.[8]
- In 2012, New York required prescribers to check the state's PDMP before prescribing opioids. By 2013, New York experienced a 75% drop in patients' seeing multiple prescribers for the same drugs (also referred to as "drug seeking").[9]
- In 2012, Tennessee required prescribers to check the state's PDMP before prescribing painkillers. By 2013, Tennessee experienced a 36% decline in patients' seeing multiple prescribers for the same drugs.[10]
- After creation of its PDMP, Pennsylvania experienced a 22% decrease in the overall quantity of opioid pills prescribed, a 9% decrease in partially filled prescriptions, and an 18% decrease in authorized refills between 2017 and 2020. Opioid prescriptions for greater than seven days of supply decreased by a larger amount than prescriptions for less than seven days of supply (43% vs. 27%). Similarly, prescriptions for more than 22 pills decreased more than prescriptions for less than 21 days (37% vs. 21%).[11]

Effectiveness of PDMPs

Determining state-level effectiveness of a PDMP is highly dependent upon numerous factors associated with each state's goals, supporting legislation, and program resources. These include the scope and breadth of use (i.e., mandated use, exemptions, compliance), implementation status and reach, ease of use and integration, data quality, data analysis and reporting capacities, and interagency data-sharing practices, among others.

However, evaluations of PDMPs in general have illustrated effective changes in prescribing behaviors, patients' use of multiple providers, and decreased substance abuse treatment admissions. PDMPs play an effective role in combating fraudulent prescription of drugs, monitoring controlled substance abuse, and reducing the erroneous prescription among practitioners. Prescribing practitioners and pharmacists are increasingly using available PDMP data as a patient education and clinical decision-making tool during a patient encounter. PDMP managers struggled for many years to expand the use of their data by prescribing practitioners and pharmacists. Mandatory registration and queries and one-click access have caused the use

[8] Johnson, Hall et al. "Decline in Drug Overdose Deaths After State Policy Changes – Florida 2010-2012", Morbidity and Mortality Weekly Report (2014): 569-574. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm. (Accessed October 18, 2022.)

[9] Arizona Department of Health Services. "50 State Review on Opioid Related Policy," 2017. https://www.azdhs.gov/documents/prevention/womens-childrens-health/injuryprevention/opioid-prevention/50-state-review-opioid-related-policy.pdf. (Accessed October 18, 2022.)

[10] Ibid.

[11] Miller C., Ilyas A.M. "Trends in Opioid Prescribing Following Pennsylvania Statewide Implementation of a Prescription Drug Monitoring Program." Cureus (August 11, 2022). https://pubmed.ncbi.nlm.nih.gov/36110459/. (Accessed September 22, 2022.)

of PDMP data to soar. More than half the states require prescribing practitioners and dispensers to check the PDMP data before prescribing or dispensing controlled substances, including opioids. Evidence indicates that mandated use is an effective tool to reduce the number of controlled substances dispensed, including opioids, benzodiazepines, and amphetamines.[12]

Research on PDMP's strengths concluded that the development of PDMP, supported by evolving state legislation and integrated data sharing, plays a crucial role in improving health outcomes and safety, identifying potential prescribing concerns, informing public health programs and policies, and driving third-party payer cost savings. PDMP implementation has mitigated opioid misuse and helped to reduce drug-poisoning deaths.[13] PDMPs have been shown to reduce incidences of doctor (or other prescribing practitioners, such as dentists or veterinarians) shopping. In addition, PDMPs play a role in increased transparency in reporting prescription drugs, especially controlled substances.[14] Some states proactively analyze the prescription data in search of patients, physicians, or pharmacies who exhibit an unusual order, use, or patterns for dispensing, which helps in the investigation of possible diversion or abuse.[15]

States, such as Maryland, Georgia, and Alabama, have effectively used aggregate PDMP data and other data sets to bolster public health policy and implement appropriate interventions among areas of targeted concern (i.e., critical differences in prescribing practices within the state, overdose rates with people receiving both opioids and benzodiazepines, nonfatal overdoses, and overdose fatality reviews).[16] Through its analysis of Medicaid prescription and hospital utilization data, Kentucky was able to reduce the opioid prescriptions, and opioid-related inpatient stay and emergency department rates, thereby resulting in significant savings in Medicaid spending.[17]

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[12] Manders L., and Abd-Elsayed A. "Mandatory Review of Prescription Drug Monitoring Program Before Issuance of a Controlled Substance Results in Overall Reduction of Prescriptions Including Opioids and Benzodiazepines." Pain Physician (June 23, 2020):299-304. https://pubmed.ncbi.nlm.nih.gov/32517396/. (Accessed October 25, 2022).

[13] Buchmueller, Thomas C., and Colleen Carey. "The effect of prescription drug monitoring programs on opioid utilization in Medicare." American Economic Journal: Economic Policy 10, no. 1 (2018): 77-112. https://www.aeaweb.org/articles?id=10.1257/pol.20160094. (Accessed October 24, 2022).

[14] Fahd Alogailia, Norjihan Abdul Ghania, Nordiana Ahmad Kharman Shah. "Prescription drug monitoring programs in the US: A systematic literature review on its strength and weakness." Journal of Infection and Public Health, Vol. 13, Issue 10 (October 2020): 1456-1461. https://www.sciencedirect.com/science/article/pii/S1876034120305657#!.#!. (Accessed Octo-ber 20, 2022.)

[15] Hawk, Kathryn, Gail D'Onofrio, David A. Fiellin, Marek C. Chawarski, Patrick G. O'Connor, Patricia H. Owens, Michael V. Pantalon, and Steven L. Bernstein. "Past-year prescription drug monitoring program opioid prescriptions and self-reported opioid use in an emergency department population with opioid use disorder." Academic Emergency Medicine 25, no. 5 (2018): 508-516. https://onlinelibrary.wiley.com/doi/full/10.1111/acem.13352. (Accessed October 23, 2022).

[16] The Pew Charitable Trusts. "Policy Changes Could Bolster Prescription Drug Monitoring Programs," 2020. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/policy-changes-could-bolster-prescription-drug-monitoring-programs. (Accessed October 31, 2022).

[17] Wen, Hefei, Jason M. Hockenberry, Philip J. Jeng, and Yuhua Bao. "Prescription Drug Monitoring Program Mandates: Impact on Opioid Prescribing and Related Hospital Use." Health Affairs, Volume 38, No. 9 (September 2019). https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00103. (Accessed October 11, 2022).

Features of Effectiveness

Universal Use

Policies that require providers to check a state PDMP prior to prescribing certain controlled substances have significant potential for ensuring that the utility and promise of PDMPs are maximized.

Ease of Use and Access

Promising practices integrate PDMPs into electronic health record (EHR) systems, permitting physicians to delegate PDMP access, and streamlining the process for providers to register with the PDMP.

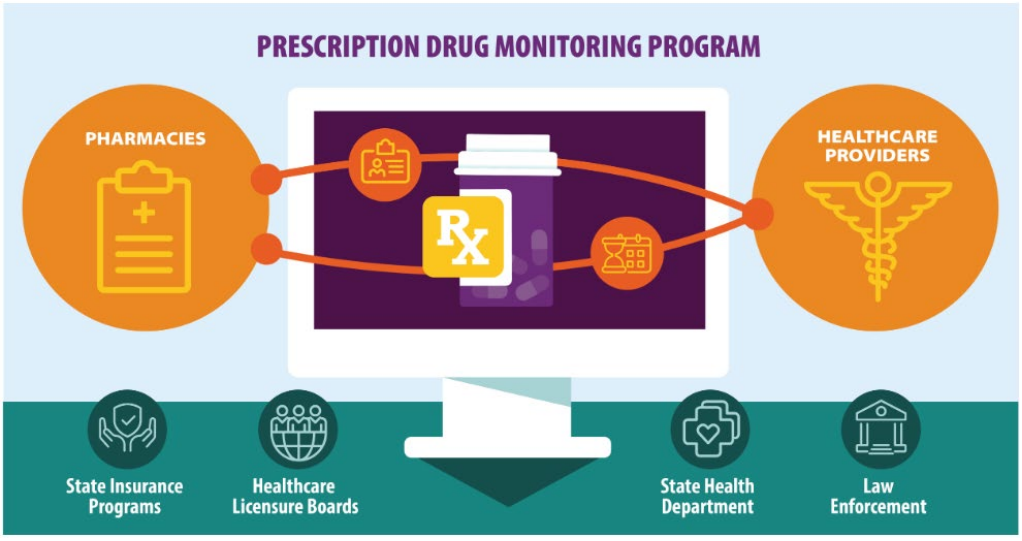
Real -Time Data

Timely PDMP data, as in a "real-time" i.e., under 5 minutes, maximizes the utility of the prescription history data, with significant implications for patient safety and public health.

Actively Managed

As a public health tool, PDMPs can be used by multiple state entities to understand the behavior of the epidemic and inform and evaluate interventions.[18]

Figure 1. PDMP Use and Optimal Effectiveness



Source: CDC

[18] Centers for Disease Control and Prevention. "Prescription Drug Monitoring Programs (PDMPs), 2022. https://www.cdc.gov/drugoverdose/prevention/index.html. (Accessed October 29, 2022).

The Role of Alaska's PDMP

In 2008, the Alaska Legislature passed Senate Bill (SB) 196, requiring the Board of Pharmacy to establish the Alaska PDMP – a federally funded electronic controlled substance prescription database. From 2009 to 2011, the State obtained startup federal grant funding and adopted PDMP regulations. On January 1, 2012, the Alaska PDMP became available for statewide use to licensees who registered. In response to the evolving opioid epidemic, the Alaska Opioid Policy Task Force, housed within the Alaska Department of Health and Social Services (now Department of Health [DOH]), conducted several community meetings to discuss potential opioid prescription guidelines and provide recommendations to the governor and Legislature in November 2016. In 2017, mandatory registering, reviewing, and reporting with the PDMP database were enacted under AS 17.30.200 for prescribing practitioners and pharmacists. (*Statutes and administrative codes relevant to Alaska PDMP can be found in Appendix B).* Bamboo Health, formerly Appriss Health, is the department's vendor, which provides the prescription drug monitoring interface, AWARxE.

The program is designed to improve patient care and to encourage cooperation and coordination among state, local, and federal agencies and other states to reduce the misuse, abuse, and diversion of Schedule II-IV controlled substances (hereon to be referred to as "controlled substances"). (*A list of these controlled substances can be found in Appendix C.*) The program's stated overarching goals include:

- Monitoring and promoting judicious prescribing and dispensing practices.
- Reducing inappropriate prescribing.
- Identifying and preventing instances of misuse, abuse, and drug diversion.
- Increasing provider communication across provider settings.[19]

[19] Alaska Department of Commerce, Community, and Economic Development. "Alaska Prescription Drug Monitoring Program Report to the 32nd Alaska State Legislature (2022)." https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2022_LegislativeReport.pdf. (Accessed October 19, 2022.)

Stakeholder Perspectives of the Role of Alaska's PDMP

Almost all stakeholders understood the PDMP's intent and goals, and about 90% of stakeholders reported they believe these goals are being met. Medical providers frequently described the PDMP as an effective tool that helps them do a better job prescribing.

Most in-state stakeholders (about 83%) believe the PDMP is a major factor in the decline of prescription drug misuse. "It's much more difficult for patients to hide that they're receiving multiple prescriptions. It's keeping people honest," one interviewee said.

> "My mother was addicted. No one thought an 86-year-old lady was a drug seeker. People didn't check the PDMP and see what her use was. That, ultimately, is what the PDMP is for."

Even among stakeholders who believe the PDMP is meeting goals, some said gaps in compliance remain due to inconsistent reporting and regulatory exemptions that allow opioids to still be easily obtained, such as the exemption to review the PDMP if prescribing within 48 hours of a procedure.

Most stakeholders who think the PDMP is not meeting its goals identified two main perceptions of failure to meet the program's intent: 1) investigations focus too much on technical compliance infractions instead of major prescribing violations that could lead to drug misuse and overdose, and 2) PDMP data are not being used sufficiently to address public health concerns.

> "The question for the Legislature is what's the purpose of the PDMP. Is it just to stop opioid use, or is it to punish doctors? A lot of our licensees wonder that."

> "Part of the problem is that the data are locked down in such a deep dark lockbox. Public health can't get access to the data."

Evaluation of Alaska's PDMP Components

This section describes the current construct of Alaska's PDMP, including governance, management capacity, mandated use and exemptions, delegates, voluntary users, patient matching, compliance impacts, data sharing, and integration. Stakeholders offered suggestions for each component, such as how to improve compliance, enhance ease of use, and better meet program goals. Policy research guides recommendations for alternative statutory, regulatory, and process considerations for each component.

Governance

Current Construct

Under Alaska Statute (AS) 17.30.200, the Alaska PDMP is housed under the Alaska Board of Pharmacy within the Division of Corporations, Business and Professional Licensing, DCCED. Under AS 08.80.030, the Board of Pharmacy was granted the powers necessary to establish and maintain a controlled substance prescription database as provided in AS 17.30.200. Bamboo Health is the State's current vendor providing prescription drug monitoring database services. The term PDMP may be used interchangeably with AWARxE, the prescription drug monitoring interface, as both terms refer to the database.

Policy and Process Review

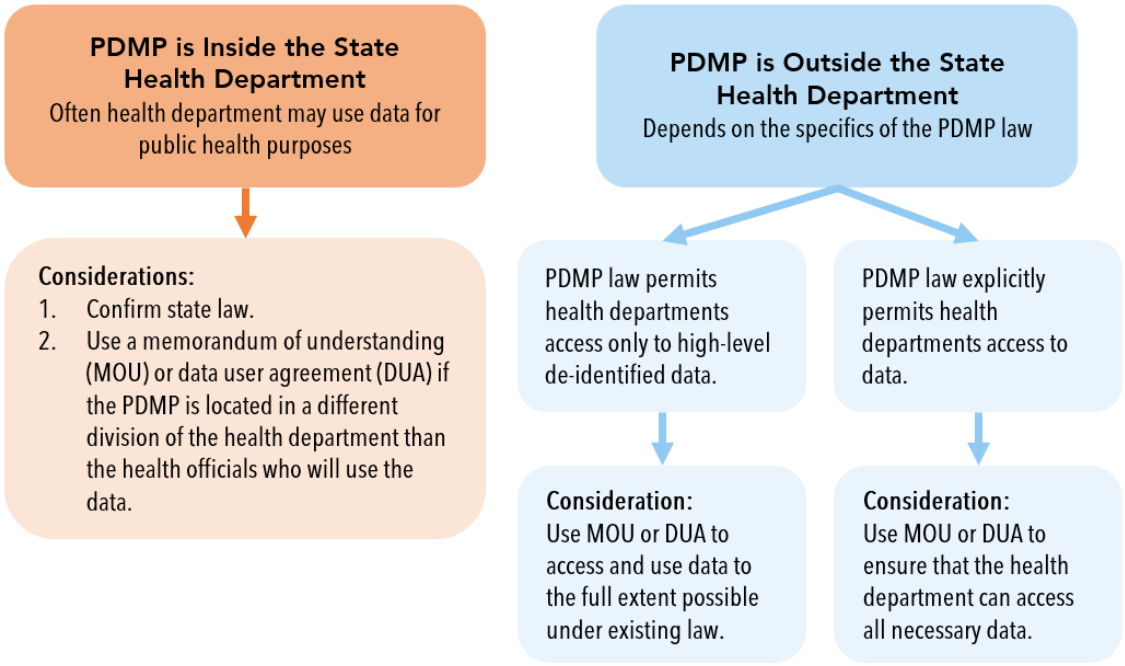
According to the PDMP Training and Technical Assistance Center, currently 17 of the 54 PDMPs across the nation are housed in a Board of Pharmacy (including Alaska), 17 in a state health department, and the rest are in consumer or professional licensing agencies. The advantage of housing a PDMP in a Board of Pharmacy is the ready access to pharmacy practices. However, the advantage to housing in a health department is the linkages with other databases and data analysis expertise, such as vital statistics, medical examiners, and other population health data sets.

Use of PDMPs as a public health tool has grown with the increase in prescription opioid overdoses, improvements in health IT, and an understanding that a robust public health response is necessary to address the opioid overdose epidemic. Health department staff are highly skilled in using data to address public health problems (for example, mandatory reporting of infectious diseases allows health departments to investigate reported cases, connect affected individuals with appropriate treatment, and implement focused preventive measures).

Increasing access to PDMP data can enable health departments to respond to and reduce opioid-related harms more effectively, coordinating with other agencies to ensure that patients are directed to appropriate clinicians when their prescribing practitioner stops prescribing opioids. Health departments also can link PDMP data with other datasets to improve surveillance, prevention, and response.[20]

The ease of sharing data with other public health data sets (i.e., Medicaid, vital statistics, medical examiners) is demonstrated in the figure below. While PDMP data can be assessed by public health officials outside of the state health department, the pathways are more streamlined if the PDMP is housed within a state health department.

Figure 2. Considerations for Accessing and Using PDMP Data Based on PDMP Location



Source: Centers for Disease Control and Prevention.

Additionally, when housed in the Board of Pharmacy, the Board of Pharmacy has increased compliance and data management responsibility to report to other practice boards. Yet, the Board of Pharmacy has no authority to make other board licensees compliant. (*For more details on compliance, see Compliance Impacts section.*)

[20] Centers for Disease Control and Prevention. "Leveraging Prescription Drug Monitoring Program (PDMP) Data in Overdose Prevention and Response," 2021. https://www.cdc.gov/drugoverdose/pdf/Leveraging-PDMPs-508.pdf. (Accessed September 28, 2022).

Stakeholder Perspectives

Stakeholders were divided as to whether the PDMP is effectively positioned under DCCED and the Board of Pharmacy. Most prescribers and dispensers interviewed said current DCCED oversight of the PDMP is working. However, public health officials, drug misuse specialists, and administrators more frequently advocated moving the PDMP to the DOH. Their reasons include:

> "I've always been very confused why is the PDMP not within state prevention work since it's a prevention tool."

- The PDMP's goals are better aligned with DOH's mission to protect public health.
- DOH could use PDMP data to offer prescribers more current information on opioid use, dangerous trends, pain management, and other issues.
- The Board of Pharmacy and other boards have limited ability to share PDMP data.
- Licensing boards are composed of volunteers, which limits their capacity in dealing with the PDMP and noncompliance.

> "They should separate the PDMP from Pharmacy partly because providers feel the Board of Pharmacy is policing their profession."

Some stakeholders expressed a sense that the Board of Pharmacy had been encumbered with a large responsibility overseeing the PDMP, without having the authority to enforce compliance. Creating a PDMP board outside the Board of Pharmacy and with members from various practice professions could provide more joint decision-making and oversight.

Some noted that even if the PDMP is moved to the DOH, licenses could still be used for enforcement, with a memorandum of agreement (MOU) established between departments so violations still affect practice licenses.

> "Just because it isn't housed there (in the Department of Commerce), doesn't mean it shouldn't have the teeth with licensing."

Stakeholders from other states noted moving the PDMP to another department sometimes creates difficulties. Disadvantages to moving the program include:

- Access to data – DOH in other states sometimes have been reluctant to share data with law enforcement and others outside of the department.
- Loss of data or interruption of data continuity – This may be caused by the transfer of data systems or a change in vendors.
- Cultural shifts – Departmental culture can impact approaches to compliance and enforcement.

Considerations for Improvement

- Evaluate the benefits and costs associated with shifting governance of the PDMP to DOH. This shift would allow for better data sharing with other public health datasets, provide better access to data analysts equipped to analyze and interpret the data, and

evaluate the effectiveness of the PDMP to meet its goals of identifying and preventing instances of misuse, abuse, and drug diversion.

- Transferring management to the DOH would streamline the use of federal dollars channeled through federal agencies to support PDMP enhancements and facilitate better interoperability across State lines.
- Any shift would require new legislation and regulations. It also would require a transfer of vendor management and staffing to ensure a smooth transition without loss of data and expertise.
- Regardless of where the PDMP is housed, further detailed examination of the type, frequency, and form of data sharing with other practice boards and other public entities (i.e., Department of Corrections, Department of Public Safety, DOH) needs to be addressed to improve compliance and best practices. (*See "Data Sharing" section below.)*

Management Capacity

Current Construct

FUNDING

The current annual operating budget for the Alaska PDMP is about $1 million. Federal and state grant funding pays for database vendor costs and all program staff. As the CBPL which includes the Alaska Board of Pharmacy does not have federal receipt authority, grant funding for the PDMP must be obtained through DOH, which has receipt authority. The DOH ultimately determines whether to pursue available PDMP funding opportunities. In the event DOH elects to proceed, the PDMP program manager writes the grant proposal(s). An overview of current funding is described below.

Table 1. Current Alaska PDMP Funding

Funding Source	Total Amount per Year	Funding Cycle Ends	Length of Funding Cycle
DOH - Bureau of Justice[a]	$337,000	September 2023	3 years
DOH -Division of Behavioral Health Statewide Opioid Response	$260,000	September 2025	2 years
DOH - CDC Overdose to Action[b]	$275,000-$300,000	September 2023	5 years
DOH - CDC – Statewide Gateway	$200,000	September 2023	-

Notes: [a]18% of the total $1.3 million BJA funding award goes to DOH to cover indirect costs as per federally approved negotiated rate. [b] Funding fluctuates per year based on availability of additional unused funds.

STAFFING

The Alaska PDMP is presently staffed with four full-time employees (FTEs). Current staff positions are identified below:

- PDMP Program Manager – oversees and manages all program components and activities and is responsible for securing operational funding through a recognized entity with receipt authority (typically the DOH).
- PDMP Occupational Licensing Examiner – a long-term nonpermanent role. The position aids with registration, database clean-up, and assists licensing boards with renewals. Other responsibilities include conducting registration audits, communicating with Indian Health Service (IHS) prescribers, and processing DEA status and name changes, as needed.
- PDMP Project Assistant – a long-term, nonpermanent role. The position is intended to assist in the creation of a sustainable plan to monitor compliance using vendor tools and analytics, providing education and outreach to dispensers, and assisting users with troubleshooting.
- PDMP Investigator – focuses on compliance and investigates issues of potential concern.

Policy and Process Review

FUNDING

When the Alaska PDMP was established, the intent was that the program would be funded through federal grants and state appropriations (AS 08.01.065). With the rising demands to address the opioid crisis, costs rose to implement the PDMP. Federal funding did not seem sufficient, so in 2018, the Division was granted regulatory authority to institute a $25 per biennium user fee to help offset administrative costs. However, fee collection was burdensome and inefficient. The Division then initiated a regulation change (12 AAC 02.107) to reduce the fee to $0. A combination of federal and state grants currently funds the program, with no fiscal support through state appropriation.

Program trajectory and priorities are dictated by grant availability and conditions, including evolving terms of agreement that some states are increasingly unwilling to accept. This results in ongoing funding uncertainty for a state-legislated mandate.

As potential uses of PDMP expansion emerge, multiple financial factors handicap the program's capacity to implement useful enhancements to PDMP's electronic database (i.e., integrated overdose data, a special module for opioid treatment programs to report per 42 CFR Part 2, expanded data analytics and reporting). These financial factors include lack of DCCED's direct receipt authority, funding uncertainties, and static funding levels within multi-year funding cycles. It is worth noting that some mandated users who oppose the Alaska PDMP recognize the ongoing fiscal uncertainty and are "holding out" to decide how compliant they will be.

The PDMP is an unfunded mandate (not aligned with legislative intent) and efforts for sustainable funding through licensee fees has not been successful, which is arguably not appropriate for a public health outcome. Additionally, federal grants received do not necessarily support evolving

program needs, leaving a lack of funding for data sharing or other initiatives to improve PMDP outcomes.

STAFFING

Across the country, the majority of PDMPs (35) operate with a staff of five FTEs or fewer. Program staff sizes range from 1 to 31 individuals functioning in a variety of capacities. On average, PDMPs have about 6.87 total employees with approximately 3.6 in operations, 1.0 in technical, 1.5 in analytical, and 0.8 in other job classifications.[21] In a 2021 legislative audit, the Alaska State Legislature recognized staffing is insufficient for investigation.[22] An investigator position was subsequently added, although investigators for the licensing boards also conduct PDMP investigations as part of their board's investigatory process.

The current staffing model for the Alaska PDMP reflects an emphasis on investigation and compliance. While these functions are necessary, the program's overall effectiveness in impacting and informing statewide public health and safety efforts (i.e., policies, programs, and initiatives) is currently limited.

Stakeholder Perspectives

Stakeholders consistently reported the PDMP staff has been very responsive in answering questions and providing needed resources, such as data and training. The PDMP manager received high ratings for communication, responsiveness, and active participation in board and other meetings. The PDMP staff was praised for tapping funding from multiple sources, maximizing federal funding, and minimizing user fees.

"Effective PDMPs invest in a trained data analyst who turns data into meaningful information necessary for better policies."

"Having one investigator is not enough if the Legislature wants all noncompliance issues to be looked into."

"If you want results, you are going to have to pay for it."

Despite giving the PDMP staff high marks, some stakeholders said they thought staffing levels are inadequate to deal with workloads and several noted Alaska's PDMP staff is smaller than its counterparts in other states. Some stakeholders particularly reported a need for more investigators, both within the PDMP staff and with the licensing boards. Although an investigator

[21] Bureau of Justice Assistance, U.S. Department of Justice. "PDMP Policies and Capabilities: Results From 2021 State Assessment." https://www.pdmpassist.org/pdf/PDMP%20Policies%20and%20Capabilities%202021%20Assessment%20Results_20210921.pdf. (Accessed October 26, 2022).

[22] Over 750 licensees were identified as potentially noncompliance with PDMP registration, review, and reporting requirements. Alaska State Legislature, Division of Legislative Audit. Alaska State Legislature, Division of Legislative Audit. "A Sunset Review of the Department of Commerce, Community, and Economic Development (DCCED)," July 15, 2021.

was added to the PDMP staff, stakeholders reported one position is not enough to handle the high volume of noncompliance cases.

Considerations for Improvement

FUNDING

- Alaska State Legislature should consider a consistent level of appropriated funding to support state initiatives for program improvements and flexibilities, such as data infrastructure, data sharing and analysis, and EHR statewide integration. Due to restricted use of federal grant funding, state appropriations can provide the capacity to maximize the PDMP's effectiveness.
- If the PDMP program continues to be housed within CBPL, consider approval of federal receipts authority to maximize the Division's federal grant dollars (rather than a percentage of overhead being retained by DOH).

STAFFING

- Regardless of whether the PDMP remains in the Board of Pharmacy or moves to the DOH, a data analyst who can query the database and analyze output and outcome data would offer considerably more information to inform compliance and enforcement, evaluate controlled substance monitoring effectiveness, and inform policy decisions.

Mandated Use and Exemptions

Current Construct

MANDATED USE

Under Alaska Statute (AS) 17.30.200, there is required PDMP registration and use for prescribing practitioners and pharmacists, along with a compliance process for mandatory review and reporting. Required users who are actively licensed to practice in Alaska include:

- Dentists, optometrists, physicians, and veterinarians who hold a DEA registration.
- Nurse practitioners who hold a DEA registration and state-level controlled substance prescriptive authority issued by the Alaska Board of Nursing.
- Physician Assistants who hold a DEA registration and an active collaborative practice agreement with prescribing physicians.
- Pharmacists who live and dispense controlled substances in Alaska.
- Pharmacies that dispense controlled substances in Alaska.

According to the PDMP's Report to the Alaska State Legislature (May 2022), total registered users in the PDMP is 9,527, a growth of 416% from the 1,847 users in 2017.

EXEMPTIONS

AS 17.30.200 also details exemptions for conducting a review of patient medical history and/or reporting prescription data in specific setting and situations. Exemptions for conducting a review of patient prescription history and/or reporting prescription data apply in the following cases:

- Dispensing to a patient for an outpatient supply of 24 hours or less at a hospital with an inpatient pharmacy for use after discharge (exempt by AS 17.30.200(t)(2)(A)).
- Dispensing to a patient for an outpatient supply of 24 hours or less at a hospital emergency department (exempt by AS 17.30.200(t)(2)(B)).
- Administering to an inpatient admitted to a healthcare facility (exempt by AS 17.30.200(k)).
- Administering at the scene of an emergency, in an ambulance, or in an emergency department (exempt by AS 17.30.200(k)(4)(A)(iii)).
- Dispensing, prescribing, or administering at a hospice or nursing home that has an inpatient pharmacy (AS 17.30.200(k)(4)(A)(iv)).
- Dispensing, prescribing, or administering immediately before, during, or within the first 48 hours after surgery or a medical procedure (exempt by AS 17.30.200(k)).
- Writing a nonrefillable prescription for a controlled substance in a quantity intended to last for no more than three days (exempt by AS 17.30.200(k)(4)(B)).[23]

Information on some medications dispensed from certain facilities cannot be submitted to Alaska's PDMPs without a patient's consent.[24]

Policy and Process Review

Most prescribing practitioners usually generate a report in case of the suspicion of drug abuse or practitioner shopping. However, if PDMP usage is not mandatory, not all prescribing practitioners are willing to go the extra mile and check the drug's overuse among their patients.[25] Prescriber-use mandates can rapidly increase PDMP utilization, which can have an immediate impact on prescriber behavior, helping to reduce inappropriate prescribing of opioids and benzodiazepines and also multiple-provider episodes (when patients visit numerous prescribers and/or pharmacies to obtain the same or similar drugs in a short time

[23] Alaska Department of Commerce, Community, and Economic Development. "Prescription Drug Monitoring Program Use & Exemptions." https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/PrescriptionDrugMonitoringProgram/UseExemptions.aspx. (Accessed October 11, 2022.)
[24] "Confidentiality of Substance Use Disorder Patient Records." *Code of Federal Regulations*, title 42, 2022, part 2.
[25] Patrick, Stephen W., Carrie E. Fry, Timothy F. Jones, and Melinda B. Buntin. "Implementation of prescription drug monitoring programs associated with reductions in opioid-related death rates." Health Affairs 35, no. 7 (2016): 1324-1332. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1496. (Accessed October 23, 2022).

span).[26] Consequently, research has supported the view that without a robust and mandatory PDMP, the incidence of drug abuse could not be reduced significantly when access is monitored.[27]

Some prescribing practitioners, such as veterinarians, have been resistant to mandated PDMP reporting.[28] However, there is growing recognition that if one prescribes a controlled substance, then that prescriber is a target for drug seekers.

For example, based on a survey of South Dakota licensed veterinarians who prescribe opioids in late 2018 and early 2019, veterinarians are largely aware of the increasing opioid problem, have modified their practices because of it, and are dedicated to finding a balance between treating their animal patients in the most effective way while also avoiding contributing to the opioid problem. Veterinarians are seeing an alarming trend of pet owners taking opioids intended for their pets to support their own addiction.[29] Additionally, about 14 states, including Alaska, do not have laws or regulations on mandatory reporting and immunity for inhumane treatment of animals.[30] In another study of Colorado veterinarians, 13% reported that they were aware of a person intentionally harming their pet, or making their pet seem harmed, to receive opioids for their own use. Further, 44% of veterinarians were aware of a veterinary staff member or client who abused or misused opioids. In this same study, 36% recommended improving the PDMP guidelines and tutorials to help improve access and utilization. The Colorado Consortium for Prescription Drug Abuse Prevention recommended devotion of time and resources to assess and interview on the issue of prescription opioid diversion in veterinary medicine for tracking and surveillance, requiring the same levels of compliance required of other prescribing practitioners for logging prescriptions of scheduled drugs into state PDMP systems. This should also include enhanced workplace policies, practices, procedures, training, and monitoring to mitigate the risks of diversion, misuse, and abuse by both clinic staff and clients.[31]

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[26] The Pew Charitable Trusts. "Prescription Drug Monitoring Programs: Evidence-based practices to optimize prescriber use," 2016. https://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs. (Accessed November 2, 2022.)

[27] Rasubala, Linda, Lavanya Pernapati, Ximena Velasquez, James Burk, and Yan-Fang Ren. "Impact of a mandatory prescription drug monitoring program on prescription of opioid analgesics by dentists." PLoS One 10, no. 8 (2015): e0135957. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0135957. (Accessed October 23, 2022).

[28] About 14 states exempt veterinarian from PDMP mandated reporting or specifically exclude veterinarians from the definition of "dispenser."

[29] Daly, Russ. "Another Piece of the Puzzle? Understanding South Dakota Veterinarians' Response to the Opioid Epidemic." South Dakota State University (April 2019). https://extension.sdstate.edu/sites/default/files/2019-04/P-00091.pdf. (Accessed September 22, 2022).

[30] Wisch, Rebecca. "Table of Veterinary Reporting Requirement and Immunity Laws," 2022. Michigan State University, Animal Legal & Historical Center. https://www.animallaw.info/topic/table-veterinary-reporting-requirement-and-immunity-laws. (Accessed November 16, 2022.)

[31] Mason, D. S., Tenney, L., Hellyer, P. W., & Newman, L. S. "Prescription opioid epidemic: Do veterinarians have a dog in the fight? American Journal of Public Health Perspectives, 108(9), (2018): 1162-1163. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6085026/. (Accessed September 22, 2022).

Stakeholder Perspectives

MANDATED USE

Some stakeholders recognized that PDMPs were an underused and ineffective resource prior to mandatory use requirements. Others, including individuals responsible for informing statewide substance misuse initiatives, equated mandated PDMP use with comprehensive data collection on all opioids prescribed or dispensed in Alaska.

> "Mandatory use was only enacted across the country because it wasn't being used."

> "Because of mandated use, I thought the PDMP database had comprehensive data on all opioid prescriptions."

EXEMPTIONS

A few stakeholders, including veterinarians, some dentists, and medical specialists, called for exemptions from PDMP requirements for their professions, saying the proportion of opioid prescriptions by practitioners in their field is so small as to be insignificant.

> "The drawback in removing exemptions is the political blowback. However, if the goal is to reduce overdose deaths, the exemptions are not helpful."

> "Dentists are one example – they will prescribe to the exemption, and they miss people who are drug seeking for criminal or fraudulent purposes."

However, other stakeholders argued that exemptions water down the intent of PDMP legislation to prevent drug misuse, diversion, and overdoses. One interviewee stated that if veterinarians are exempted from the PDMP, then dealing with prescription opioid abusers who target veterinarians falls back onto law enforcement.

> "Anything that can help law enforcement or prevent the problem is a good thing. [Veterinarians] need to be part of the solution. They can't ignore the problem."

Veterinarians who were interviewed advocated for a PDMP exemption, arguing that because they treat animals and operate under a different set of conditions than prescribers for humans, the PDMP is not appropriate for them. Other reasons include the following:

- The number of controlled substances veterinarians prescribe is miniscule. From 2016 to 2018, veterinarians prescribed 0.3% of the opioids prescribed in Alaska, according to the Board of Pharmacy.
- Some veterinarians believe they are expected to be applying Health Insurance Portability and Accountability Act (HIPAA) rules; however, the PDMP is not a HIPAA covered entity.
- While there may be options to allow for integration, veterinarians expressed their concerns their electronic reporting systems do not integrate with the PDMP easily.

- Identifying a certain human associated with an animal can be challenging, especially when animals are brought in by shelters, house sitters, or multiple people.

However, several stakeholders, including national PDMP experts and prescribers outside of veterinary medicine, stated that while they appreciate the differences between veterinarians and other practitioners, drug seekers have used pets to access medication. Removing veterinarians from mandated use would likely result in more drug seeking behavior impacting their practices. Also, veterinarians are increasingly prescribing drugs designed for humans (including muscle relaxants, antidepressants, anxiolytics, and opioids) for animals.

> "For veterinarians, the patients may be animals, but the animal didn't make the appointment, fill the prescription, abuse the drug, or are criminals….while DEA may track inventory, they don't know what the vet sent out to the patient unless they do an audit, which typically are acted on when there is a complaint…but if the vet writes a prescription that gets reported to the PDMP, it closes the distribution circle."

Considerations for Improvement

- Continue the mandated use by all prescribing practitioners and pharmacists. Removing prescribing practitioners from mandated reporting will erode efforts to meet the overarching goals of the PMDP itself and improve population health.
- Further assess all outpatient setting exemptions to not only improve prescribing practices, avoiding overdoses, and drug diversion, but also to better evaluate the outcomes of Alaska's PDMP with more complete and accurate data. Given the current extent of the exemptions, some program and data analyses are not currently possible.
- To better position and address the burden on veterinarians to fully participate in the PDMP and its public health goals, consider implementing the veterinarian best practices as established by the PDMP Training and Technical Assistance Center. Some of those best practices include:
    - Work with veterinary software vendors to update their software to incorporate the appropriate American Society for Automation in Pharmacy (ASAP) reporting format. Explore opportunities to incentivize the updates with federal (or state) grant funds.
    - Through educational outreach and improved access to published resources on the requirements for the PDMP, ensure the accurate capture of an animal owner's name, DOB, and gender and the ASAP format's species code. PDMPs may need to work with their PDMP vendors to ensure that veterinary medications are identified appropriately in the controlled-substance drug table and on PDMP reports.[32]

[32] PDMP TTAC. "Veterinary Best Practices," July 2020. https://mckinleycm.sharepoint.com/sites/PDMPEvaluation/Shared%20Documents/Legislation%20Review/TAG_Veterinary_Best_Practices_20200710.pdf?CT=1668637799739&OR=ItemsView. (Accessed September 20, 2022.)

Delegates

Current Construct

Delegates for the required users may access the PDMP only if licensed, registered, certified, or otherwise regulated by DCCED. That is, any professional who holds an active license under the DCCED's boards (as regulated under AS 08) can serve as a delegate. For example, the current legislation allows for a licensed hairdresser to be a delegate, but not a non-licensed medical assistant or dental assistant.

Policy and Process Review

A majority of PDMPs allow prescribers to authorize certain members of their health care teams to access the PDMP on their behalf. Such delegation is a widely adopted PDMP practice that supports, and potentially increases, prescriber use of the databases.[33] Health care staff with delegate accounts, also referred to as "subaccounts," can save time for prescribers, thereby supporting PDMP use. Such process improvements can facilitate two important prescriber clinical practices: consistent use of PDMP reports for most or all patients prescribed controlled substances, and pre-visit planning to ensure that PDMP information is readily available to the prescriber during a patient's visit.[34]

According to a national study, prescribing practitioners had generally positive views about the value of delegates (often nurses or medical assistants) using PDMPs. Some prescribing practitioners and pharmacists noted that the ability for delegates to access the PDMP was a significant time-saver for physicians in a busy practice. However, others expressed concern that allowing delegates to have access to the PDMP increased risks to patient privacy by increasing the number of people with access to sensitive patient information.[35] Some states, such as Alabama and Nevada limit the number of delegates per prescriber. Restricting subaccounts to licensed professionals may offer an additional layer of accountability, but at the expense of potentially lowering PDMP utilization. Some states hold prescribers accountable for their delegates' activity, including licensed and non-licensed delegates. For example, to assist prescriber oversight of delegates, Oregon and Maine allow prescribers to audit multiple delegates with a single query. This allows the prescriber to monitor for unauthorized use of the data.

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[33] Centers for Medicare & Medicaid Services. "Report to Congress: State Challenges and Best Practices Implementing PDMP Requirements Under Section 5042 of the Support Act," 2021. https://www.medicaid.gov/medicaid/data-and-systems/downloads/rtc-5042-state-challenges.pdf. (Accessed November 2, 2022.)

[34] The Pew Charitable Trusts. "Prescription Drug Monitoring Programs: Evidence-based practices to optimize prescriber use," 2016. https://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs. (Accessed November 2, 2022.)

[35] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)

Stakeholder Perspectives

> "We need more individuals to have access to PDMP on behalf of doctors. They need more delegates."

Many providers called for expanding the number and/or type of delegates (licensed and non-licensed) authorized to check the PDMP because of prescribing practitioners' heavy workloads. Several stakeholders mentioned anecdotally that some prescribers may be giving nondelegates their access codes because they don't have another licensed professional who can help in accessing PDMP data. Increasing delegates was the second most frequently mentioned way to increase PDMP usability, following PDMP integration into EHRs. Prescribers' recommendation was to allow ancillary staff without licenses to handle PDMP checks, while the State continues to hold licensed providers responsible for delegates' actions. While full integration into an EHR would reduce or eliminate the need for delegates in many situations, full integration is not realistic in many smaller practices.

Considerations for Improvement

- Improve awareness of how many delegates can be assigned to license holders and delegates' defined role and responsibilities and ensure the capacity for prescribers and dispensers to audit their delegate use.
- Consider legislative changes that would allow non-licensed certified medical assistants (CMAs) or dental assistants to access the PDMP as delegates of prescribing practitioners.

Voluntary Users

Current Construct

As stated in the Alaska PDMP's 2022 Legislative Report, 118 IHS pharmacists, 19 Veterans Affairs (VA) pharmacists, and 13 military pharmacists are registered with Alaska's PDMP. IHS had 534 prescribing practitioners, 74 VA prescribing practitioners, and 75 military prescribing practitioners who have voluntarily registered with Alaska's PDMP.

Since state laws and regulations governing access to these systems often apply only to prescribing practitioners licensed in the states in which the PDMP is located and many federal health care workers are not so licensed, many federal prescribing practitioners are not subject to these requirements. However, federal pharmacies have policies in place for these requirements.

In 2016, IHS implemented a policy change requiring all federal IHS pharmacies to report opioid prescribing information to state PDMPs.[36] In 2019, IHS released to all IHS federal facilities PDMP software that automatically reports controlled substance prescriptions to state-based PDMPs in near-real time. According to IHS officials, all IHS facilities now report information to their respective state PDMPs.[37] Additionally IHS has been in preliminary planning and design discussions to evaluate the feasibility of PDMP interoperability into the IHS EHR and advocating for PDMP standardization to facilitate information sharing.[38]

The Defense Health Agency (DHA) has its own PDMP to monitor opioid prescriptions for its beneficiaries and does not require that prescribing practitioners or pharmacists participate in state PDMPs.[39] In 2019, the Military Health System (MHS) entered an agreement with the National Association of Boards of Pharmacy (NABP) to establish a connection with their Prescription Monitoring Program (PMP) Interconnect System, which allows for the transfer of prescription data across state lines. The MHS PDMP is the first nonstate or territory PDMP permitted to become a part of NABP's Interconnect System.[40]

All Veterans Health Administration (VHA) pharmacies are required to participate in state PDMPs that are compatible with Veterans Affairs software. VHA pharmacies are required to enroll in the state program where the VA medical facility is geographically located and transmit data regarding Schedules II-V controlled substances daily. A separate VHA directive released in 2016 requires providers to query state PDMPs prior to initiating therapy with a controlled substance. Additionally, for each VHA patient, prescribing practitioners must query the state PDMPs at least once a year and document the results in the VA medical record.[41]

Policy and Process Review

Major federal agencies (such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of the National Coordinator for Health Information Technology (ONC), Office of National Drug Control Policy (ONDCP), VA, IHS) and others recognize the value of PDMPs and fully support their mission. Additionally, they have established policies and enacted laws and

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[36] According to Chapter 32 of the Indian Health Manual, all federal IHS pharmacy sites with an approved MOU between the IHS Area and the State in which the facility is located shall ensure that Schedule CII-CV dispensing data are reported at the frequency required by the State in which the facility is located.
[37] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)
[38] Ibid.
[39] Office of the Secretary of Defense, "Report to Congress On Prescription Drug Abuse," March 2016. file:///C:/Users/Dlogan/Downloads/Prescription%20Drug%20Abuse.pdf. (Accessed November 15, 2022.)
[40] Health.mil. "Military Health System Prescription Drug Monitoring Programs Procedures." https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/Prescription-Monitoring-Program/Prescription-Drug-Monitoring-Program-Procedures. (Accessed November 2, 2022).
[41] The Network for Public Health Law. "Indian Health Service and Military Medical Prescription Drug Monitoring Program Requirements Fact Sheet." https://www.commerce.alaska.gov/web/portals/5/pub/PHA_IHSdirectives_2018.06.pdf. (Accessed November 2, 2022).

regulations that allow participation into PDMPs and provide their own funding for the enhancement of existing PDMPs.

While Alaska cannot mandate federal government agencies' participation, particularly prescribing practitioners, there is growing recognition more integration between federal PDMPs and state PDMPs is needed for coordinated care of patients who access both federal and non-federal care systems, as well as to reduce the risk of opioid-related harm among these individuals.

Stakeholder Perspectives

Stakeholders observed Alaska has a large military, veteran, and IHS patient base that make these data part of Alaska PDMP "absolutely essential" because patients often receive care from military, VA or IHS prescribing practitioners as well as non-VA or IHS practitioners. This could lead to excessive prescriptions or potential harmful interactions between drugs. Amongst stakeholders, there was not a uniformed awareness of the level the PDMP was integrated into the Military Health System, VA, or IHS system.

Considerations for Improvement

- Seek additional funding to further develop relationships with federal agencies and participation in Alaska's PDMP and maximize compatibility of federal prescriber systems to Alaska PDMP.

Patient Matching

Current Construct

Prescribing practitioners and pharmacists find challenges matching PDMP records to the correct patient when searching the PDMP. Inaccurate patient matching can result in a PDMP search returning no records for a patient, returning records for the wrong patient, or returning multiple possible matches for a patient. These patient matching problems could happen due to clerical errors, patient name changes, patients having similar names and birthdates, or a patient using multiple names or having duplicate PDMP records. Such situations may result in a provider not having access to a patient's full medication history. Increased interstate data sharing often impacts the likelihood of patient matching difficulties. While proprietary algorithms may help alleviate these errors, their effectiveness has not been proven. Incorrect patient matching can lead to compliance issues and increase the number of compliance investigations.

Policy and Process Review

Office of the National Coordinator for Health Information Technology (ONC) officials stated that while the agency does not have authority over the operation of PDMPs, its broader efforts could

help address PDMP patient matching problems. In 2017, ONC published the Patient Demographic Data Quality Framework, a tool to help providers and other organizations assess their processes for managing data quality and improve the quality of the demographic data they use in matching. In 2019, ONC hosted a symposium on patient matching for PDMPs that brought together stakeholders, such as PDMP administrators and health IT developers, to discuss patient matching challenges faced by PDMPs. In addition, ONC officials described how they are obtaining private-sector input on technical solutions for patient matching and are working with health IT standards development organizations to better support patient matching. These efforts have the potential to improve patient matching for PDMPs.[42]

Stakeholder Perspectives

Several prescribing practitioners noted their struggles in accuracy when entering a patient's name. In some instances, the PDMP convention requests first and then last name, compared to a more common filing process of last and then first name. Additionally, inaccurate spelling and name variations, commonly used by drug seekers, further complicate patient matching.

> "Patient matching convention is one of the top issues all PDMP managers are trying to address."

Considerations for Improvement

- Review the naming convention to improve standardization with patient records.

Compliance Impacts

Current Construct

The Board of Pharmacy is required to ensure compliance with PDMP legislative mandates. However, the licensing boards are required to communicate with their licensees and enforce mandated use requirements stated within their respective chapters of AS 08. Licensing boards vary in the approaches to communicate PDMP information to their licensees. Half of the boards, including the State Medical Board, Board of Examiners in Optometry, and the Board of Veterinary Examiners, do not send out periodic notices to licensees. Board of Dental Examiners and Board of Nursing periodically communicate regarding PDMP registration. The Board of Pharmacy communicates routinely about registration and reporting.[43]

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[42] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)
[43] Alaska Department of Commerce, Community, and Economic Development. "Alaska Prescription Drug Monitoring Program Report to the 31st Alaska State Legislature (2018)." https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2020_LegislativeReport.pdf. (Accessed October 17, 2022).

As reported in the 2021 legislative audit of Alaska's Board of Pharmacy, each applicable practice board was at a different stage in implementing new controlled substance prescription database laws, and none of the boards, except the Board of Pharmacy, were fully monitoring or enforcing the PDMP requirements.[44] Potentially noncompliant licensees are referred to the Division's investigative section for further review. Legislation authorizes the Board of Pharmacy to provide unsolicited notifications to a pharmacist or prescribing practitioner if prescriptions for controlled substances are inconsistent with "standards of safe practice." However, "standards of safe practices" have only been defined by two other practice boards (State Medical Board and Board of Dental Examiners). Chairs from each of the relevant practice boards formed a PDMP Board Chair group in 2020 to coordinate compliance; however, biweekly meetings and participation were insufficient, and the process has subsequently been discontinued.

Beginning in the second quarter of calendar year (CY) 2020, mandatory use data reports were provided to prescribing boards quarterly. These reports provide de-identified data and general PDMP program information such as DEA licensure, PDMP registration, direct dispensers, use/compliance review findings, delinquent reports, recommendations, and statewide program updates. During a staffing crisis, the Governor issued an Administrative Order to mandate a focus on licensure and these reports were temporarily paused to allow staff time to assist where needed. The reports will resume in Q4 2022.

The Board of Pharmacy has annually prepared a PDMP report to the Alaska State Legislature; however, the reporting month has not been consistent.

Prescriber report cards are reflective of all opioids, anxiolytic, sedative, and hypnotic medications reported to the database and are unique to individual prescribers. AS 17.30.200(s) allowed the PDMP to generate and send these report cards to practitioners who hold a current DEA registration number, have registered with the PDMP, and have prescribed during the quarter on a quarterly basis. Since pharmacists and delegate are not prescribers, they do not receive a report card. Report cards were first issued in December 2017. The report cards were previously sent confidentially, on behalf of the PDMP, from Bamboo Health to the email address associated with the practitioner's account. Findings from the Alaska PDMP 2021 PDMP Awareness & Feedback Survey indicated that 78% of physicians received a prescriber report card. Most respondents were not surprised how they compared to other prescribers.[45] Only a few changed prescribing patterns based on the report card. Starting in the third quarter of calendar year 2021, the report cards were available within the PDMP and allow the user to interact with the metrics of each section of their report. Copies are no longer emailed to each

[44] Alaska State Legislature, Division of Legislative Audit. "A Sunset Review of the Department of Commerce, Community, and Economic Development (DCCED)," July 15, 2021.
[45] NPC Research. "Alaska's Prescription Drug Monitoring Program: Analysis of 2021 Awareness & Feedback Questionnaire," January 2022. https://www.commerce.alaska.gov/web/Portals/5/pub/PDMPNPCAnalysis_2021.pdf (Accessed October 29, 2022).

provider. Analysis of the Alaska 2021 PDMP Awareness & Feedback Survey results identified that only 11% of prescribers and 8% of pharmacists were aware of registration resources for unsolicited prescriber "report card."[46]

In 2014, the Board of Pharmacy established the current threshold for the multiple provider clinical alert or the "5-5-3 standard," which flags a patient who is doctor shopping if they see five or more prescribers or five pharmacies in three months.

Policy and Process Review

Noncompliance with PDMP registration, reporting, and review requirements, limits the effectiveness of the PDMP tool to reduce the misuse, abuse, and diversion of controlled substances. It also impacts ability to inform boards of potential disciplinary action needed for their licensees.

Stakeholder Perspectives

> "The goal is we need to help people not die, rather than penalize doctors and pharmacies (for technical errors)."

Prescribers reported two issues that put them at risk for noncompliance, even when they perceive they are using the system. The first is related the way the PDMP system records that a prescriber has checked PDMP information. With some nonintegrated EHR systems outside of a hospital emergency setting, PDMP information may automatically populate on the patient screen without the practitioner being technically logged into the PDMP. From a system perspective, the practitioner may appear to be noncompliant because there has not been an actual PDMP log-in. The second issue stems from complications in determining PDMP role assignment(s) for prescribing practitioners who may work in multiple settings (such as family practice clinic and an emergency department), which may result in unnecessary investigations.

> "We're going after the minor infractions instead of preventing overdoses and going after providers who are putting patients at risk."

Stakeholders also described the PDMP investigation environment as fraught with problems which may hinder the program's efforts to prevent excessive and harmful opioid prescriptions. Stakeholders reported PDMP investigations are bogged down too much on technical or compliance infractions (such as failing to pay registration fees or registering late) at the potential expense of serious violations (overprescribing, exceeding morphine milligram equivalents [MMEs], and combinations of harmful medications).

Stakeholders noted several challenges impacting the investigation process, including:

[46] Ibid.

1. Unclear priorities on which cases to pursue.
2. Too many decisionmakers so investigative priorities change and are overridden.
3. Inadequate staffing with high caseloads.
4. Lack of automation of basic tasks, such as sending out notification letters and registration reminders, so investigators can focus on pursuing over prescribers and violations that could lead to overdose or death.
5. Lack of integrated reporting systems, which would allow licensing examiners to track whether licensees registered with the PDMP; automatic PDMP activation when providers register for a license would also be useful (*note: the automatic PDMP activation is scheduled to be enabled in early 2023*).

Considerations for Improvement

- Address the Division of Legislative Audit recommendation to allocate sufficient resources to ensure PDMP requirements are enforced.[47]
- Identify clear priorities for PDPM investigations, focusing on the program's intent to reduce overprescribing and overdoses, especially during the current backlog of investigations.
- Hold licensing boards accountable to address compliance issues of their licensees and develop "standards of safe practice," if they haven't already done so.
- Produce legislative reports on a more consistent annual timeline, preferably in the fall to allow legislator review prior to the legislation session starting in January.

Data Sharing

Current Construct

To address public concerns about their patient information, AS 17.20.200 (and 12 AAC 52.880) authorizes the PDMP database and information contained within the database are confidential, are not public records, are not subject to public disclosure, and may not be shared with the federal government. The Board of Pharmacy shall undertake to ensure the security and confidentiality of the database and information contained within the database. Information contained within the database are not released to federal, state, or local law enforcement unless a court-ordered subpoena or search warrant is presented with the request. Deidentified data can be shared the DOH with "for the purpose of identifying and monitoring public health issues in the state."

[47] Alaska State Legislature, Division of Legislative Audit. "A Sunset Review of the Department of Commerce, Community, and Economic Development (DCCED)," July 15, 2021.

At present, the Alaska PDMP faces challenges sharing data with DOH and reporting on certain federally required performance measures due to the lack of necessary inter-agency data sharing agreements, audit capacities, and data quality concerns.[48] PDMP data are not effectively accessed by DOH for purposes of monitoring public health issues and/or informing public health and safety approaches.

The Alaska PDMP shares data with prescribers in 17 other states and the Military Health System through the National Association of Boards of Pharmacy's (NABP) PMP InterConnect program in conjunction with the AWAReX platform. AS 17.30.200(d)(3)(4) authorizes practitioners not licensed in Alaska to access patient prescription information from the Alaska PDMP, so long as the practitioner holds a license in another state. Practitioners licensed in these states do not have full access to the Alaska PDMP but may conduct a patient prescription history query to select states they are authorized to access. In return, practitioners licensed in Alaska may choose to include any or all seven states in a patient prescription history query.

As of October 1, 2022, Alaska Medicaid receives de-identified data reports on PDMP use and trends from the PDMP data base vendor, Bamboo Health. The Alaska PDMP does not capture payor status.

Policy and Process Review

Early in state PDMP development, PDMPs were conceived as regulatory and law enforcement tools.[49] As a result, most early state PDMP laws did not permit PDMP data to be provided to public health officials. However, PDMPs are now widely recognized for their value as public health tools. PDMP data can be used by prescribing practitioners and pharmacists to improve prescribing practices and reduce prescription opioid-related harms, while health departments across the country are using PDMP data to inform public health interventions.[50] PDMP utilization data are increasingly being used to identify fraud and abuse and informing healthcare policy around costs.

Federal agencies such as the CDC recognize the critical role PDMP data plays in prevention. The CDC's Overdose Data to Action (OD2A) funding initiative supports entities in getting high quality, complete, and timelier data on opioid prescribing and overdoses, and the use of those data to inform prevention and response. As reflected in the OD2A logic model, inclusion of more timely or real-time PDMP data, increased application of PDMP data prevention and response

[48] Alaska Department of Commerce, Community, and Economic Development. "Alaska Prescription Drug Monitoring Program Report to the 31st Alaska State Legislature (2018)." https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2020_LegislativeReport.pdf. (Accessed October 17, 2022).
[49] Initially, the development and operation of PDMPs were funded largely by the DEA. For this reason, most early PDMP laws did not permit identified PDMP data to be provided to public health officials.
[50] Centers for Disease Control and Prevention. "Leveraging Prescription Drug Monitoring Program (PDMP) Data in Overdose Prevention and Response," 2021. https://www.cdc.gov/drugoverdose/pdf/Leveraging-PDMPs-508.pdf. (Accessed September 28, 2022.)

activities, and increased access for state health departments are core overdose prevention strategies.[51] Alaska currently receives OD2A funding support for the PDMP (see funding section above).

If there are data deficiencies, the PDMP can be weakened.[52] Research has emphasized that to fully use PDMP, there was a need for data quality assurance and protection, enforcement and regulatory authority, and inter-agency collaboration.[53]

INTER-AGENCY SHARING

The Health Insurance Portability and Accountability Act (HIPAA), the federal law that governs access to and sharing of protected health information, does not generally limit the sharing of PDMP data for public health purposes.[54] While PDMPs do not themselves qualify as a covered entity, the entities that house such programs may be subject to the Privacy Rule. For example, some states house their PDMP within the state health department, which may qualify as a covered entity, while other states locate their PDMP within an agency that generally does not qualify as a covered entity, such as a law enforcement agency or a licensing agency that regulates health professionals.

To access PDMP data where PDMPs are not housed in health departments, the health department must rely on permissions granted under state law as well as agreements with the agency in which the PDMP is located. Some PDMP laws permit health departments to access only aggregate or de-identified data. In those states, MOUs or DUAs can be used to clarify the statute that governs the parties to whom PDMP data may be released and the purposes for which it may be used to permit health departments to access and use identified PDMP data. However, many states now recognize the value of PDMP data to inform public health actions and several

[51] CDC Overdose Data to Action (OD2A) Evaluation and Performance Measurement Plan Template.
[52] Lin, Dora H., Eleanor Lucas, Irene B. Murimi, Katherine Jackson, Michael Baier, Shannon Frattaroli, Andrea C. Gielen, Patience Moyo, Linda Simoni-Wastila, and G. Caleb Alexander. "Physician attitudes and experiences with Maryland's prescription drug monitoring program (PDMP)." Addiction 112, no. 2 (2017): 311-31 https://onlinelibrary.wiley.com/doi/abs/10.1111/add.13620. (Accessed October 23, 2022).
[53] Rutkow, Lainie, Katherine C. Smith, Alden Yuanhong Lai, Jon S. Vernick, Corey S. Davis, and G. Caleb Alexander. "Prescription drug monitoring program design and function: A qualitative analysis." Drug and alcohol dependence 180 (2017): 395-400. https://www.sciencedirect.com/science/article/abs/pii/S0376871617304817. (Accessed October 24, 2022).
[54] ChangeLab Solutions. "Leveraging Data Sharing for Overdose Prevention: Legal, Health, and Equity Considerations" (June 2020). https://www.changelabsolutions.org/sites/default/files/2020-07/LeveragingDataSharingforOverdose Prevention_accessible_FINAL_20200707.pdf. (Accessed November 16, 2022).

have changed their laws to explicitly permit health departments to access and use those data.[55] MOUs or DUAs are an appropriate mechanism to allow access.[56]

As of October 2021, under the SUPPORT Act, Medicaid providers are required to begin checking their state's PDMP before prescribing a controlled substance to a Medicaid beneficiary.[57] Currently, the act requires states to have PDMP data-sharing agreements with all contiguous states (while Alaska is not required to participate, it is considering the costs and funding potential of participation). In addition, certain Medicare providers also receive incentive payments based on criteria that include querying PDMPs. The Promoting Interoperability Programs (previously known as the Medicare and Medicaid EHR Incentive Programs) provides incentive payments to eligible professionals and hospitals for the adoption and meaningful use of certified EHR technology. Providers report on a set of required measures and receive points based on their performance on the measures. Medicare providers can receive bonus points for the optional measure of querying a PDMP.[58] Beginning in FFY 2023, states must annually report to the HSS Secretary on PDMP use and trends. Several PDMPS are sharing data with Medicaid for drug utilization review and to identify fraud and abuse. For drug utilization, 33 states currently have authority to share and 37 states are working with Medicaid fraud and abuse.

Patient privacy and confidentiality is extremely important for patient outcomes; they are also protected under the law. Federal and state privacy laws, including those applicable to PDMPs, provide protection for patients who seek or obtain medical care, and there are heightened legal protections for the privacy SUD treatment information. 42 CFR Part 2 (known as "Part 2") serves to protect patient records created by certain federally assisted programs for SUD treatment by certain federally assisted programs for SUD treatment by restricting the circumstances under which 42 CFR Part 2 Programs or other lawful holders can disclose such records. In July 2020, 42 CFR Part 2 regulations were revised to further facilitate better coordination of care in response to the opioid epidemic while maintaining confidentiality protections against unauthorized disclosure and use. The revised regulations went into effect in 2020. Revised 42 CFR Part 2 regulations now permit programs to report protected records (e.g., SUD medication

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[55] Centers for Disease Control and Prevention. "Leveraging Prescription Drug Monitoring Program (PDMP) Data in Overdose Prevention and Response," 2021. https://www.cdc.gov/drugoverdose/pdf/Leveraging-PDMPs-508.pdf. (Accessed September 28, 2022.)

[56] Using the example of the State of Utah (Utah Code Ann. §58-37f-301(2)(e)) where the PDMP is located outside its health department, legislative language to support data sharing includes: *"the division shall make information in the database and information obtained from other state or federal prescription monitoring programs by means of the database available only to the following individuals…(e) in accordance with a written agreement entered into with the department, employees of the Department of Health: (i) whom the director of the Department of Health assigns to conduct scientific studies regarding the use or abuse of controlled substances, if the identity of the individuals and pharmacies in the database are confidential and are not disclosed in any manner to any individual who is not directly involved in the scientific studies; (ii) when the information is requested by the Department of Health in relation to a person or provider whom the Department of Health suspects may be improperly obtaining or providing a controlled substance."*

[57] SUPPORT Act, H.R. 6, Section 5041-5042. U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division. https://www.deadiversion.usdoj.gov/schedules/. (Accessed October 11, 2022.)

[58] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)

prescribed or dispensed) to the applicable PDMP if required by state law, and if the patient consents. The Part 2 program or lawful holder must obtain patient consent to disclose records to a PDMP under § 2.31 prior to reporting of such information.[59, 60] Some of the revisions have direct impact on PDMP operations.

INTERSTATE DATA SHARING

Federal agencies, such as DOJ and HHS, have supported the establishment and enhancement of state PDMPs, including funding, technical guidance, and data-sharing resources. Federal agencies have taken steps to encourage and facilitate interstate data sharing of PDMP information. Federal grant funds may be used to facilitate the exchange of information and collection of prescriptions data and facilitate electronic information sharing among states. Since 2018, federal grant recipients must agree to ensure that their PDMP system has the capacity to exchange data with other PDMP systems via the RxCheck hub, a federal data exchange and EHR and health information exchange (HIE) integration platform.

Most states make their PDMP information available to other states – such as neighboring states or more broadly – so that providers can see information about prescriptions that patients may have obtained in other states. State PDMPs may share all the information in patients' PDMP reports with other states – so out-of-state providers can see the same information as in-state providers – or they may share a portion of the information. Most states use one or both of the following two data-sharing hubs to facilitate the sharing of PDMP information between states, allowing providers to query other states' PDMP information from within their own state PDMP:

- Prescription Monitoring Program (PMP) InterConnect: The National Association of Boards of Pharmacy created PMP InterConnect, in conjunction with a vendor. According to the National Association of Boards of Pharmacy, as of August 2020, PDMPs in 48 states, the District of Columbia, Puerto Rico, and the Defense Health Agency were active participants in PMP InterConnect.
- RxCheck: RxCheck is funded by DOJ's Bureau of Justice Assistance and is governed by the RxCheck Governance Board. As of August 2020, 32 states and the District of Columbia have operating connections to RxCheck.[61]

[59] "Confidentiality of Substance Use Disorder Patient Records." Code of Federal Regulations, title 42, 2022, §2.36.
[60] This requirement is commonly referred to as "Part 2" for the regulations in which it is codified (42 C.F.R. Part 2). Specifically, Part 2 applies to federally assisted individuals or entities including being a Medicaid/Medicare provider, being a nonprofit, receiving federal funds, or being licensed to prescribe or dispense methadone or buprenorphine. Not all providers that prescribe medication for opioid use disorder are Part 2 programs.
[61] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)

Stakeholder Perspectives

> "Data are the currency of health. If we don't have it and don't have reasonable interoperability, patients are harmed."

Stakeholders stressed the importance of improving PDMP data sharing among government agencies and medical providers and breaking down data silos that limit the program's impact on patient care. Nationally, states are increasing their data sharing and analysis capacity as people see the potential for integrated data to support prevention measures, health care policy, and patient outcomes, essentially using data to inform prevention and response. Recommendations for types of data to be shared include:

> "Having data silos between government entities entrusted with the health of Alaskans basically creates paralysis and goes against ethical responsibility."

- DOH data and vital statistics for fatal and nonfatal overdoses.
- Arrest records in which types of crimes are correlated with overdose frequency.
- DOH and epidemiology studies to assess and mitigate population risks.
- PDMP data between states, especially because of Alaska's seasonal workforce and visitor population.
- Medicaid data that can help identify fraud and abuse and affect claims authorization.
- PDMP trends and data provided to leaders of professional health care associations that provide education and outreach to medical providers.
- Data provided to hospitals on opioid use for certain diseases, conditions, and procedures to allow for better decision-making and training.
- PDMP data on over prescribers provided to Medicaid and hospitals.

> "If they can figure (real-time data sharing) out in the banking world, we can do so in the health information exchange world."

Some stakeholders reported a need for real-time data. PDMP entries may not show up for a day, allowing multiple prescriptions. "People can do a lot of doctor-shopping in one day."

Stakeholders also recommended expanding available drug data by including more types of prescriptions within the PDMP. The primary purpose is to prevent harmful drug combinations and potential overdoses. Recommended additions to the PDMP include:

- Monitoring all medications not just controlled substances.
- Prescriptions under Medicaid.
- Prescriptions on military bases.
- Methadone and other drugs used for addiction treatment.

Considerations for Improvement

- Seek funding to enhance data infrastructure for effective data sharing.

- Establish a framework for data integration and data sharing between state departments, i.e., DOH, Department of Corrections, Department of Public Safety.
- Allow and set guidelines for interstate health information exchanges so state entities can share data under specific conditions.
- Expand program capacity for customized queries.
- Establish criteria for expanding or reducing the number of interstate data sharing agreements.

Integration

Current Construct

AS 08.80.030 (2018) states the DOH shall establish and implement a statewide electronic health information exchange system and ensure the interoperability and compliance of the system with state and federal specifications and protocols for exchanging health records and data. DOH has issued a current request for proposals for statewide HIE services.[62] One implication for implementation of integration is broadband connectivity; 29% of physicians cited limitations with internet access as a barrier to using the PDMP.[63]

In 2021, 10 new PDMP integrations with health information systems occurred across Alaska. Alaska's current *Statewide Gateway Integration* program is a pilot program being offered to all end users to improve use of the PDMP. Gateway Integration provides a streamlined clinical workflow for providers by allowing users to query the PDMP database within an EHR/Pharmacy Management System (PMS). The integration eliminates the need for providers to navigate to the web portal, log in, and enter the patient's information. Instead, a button is added to the EHR/PMS to pull the patient's PDMP report while in the provider's clinical workflow. This program is available to any health care facility in the state (small clinics, major hospitals, dentist offices, etc.) to integrate the PDMP into their EHR or PMS. The system uses a provider authorization that verifies that the provider has an active PDMP registration and an active DEA registration. If they do not, they cannot use the system until they create an account. The funding for this was provided by the Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A) grant and will pay for integration services through September 2024. Funding for this program will continue based on availability of grant funding and increased utilization by providers in the state. A marketing approach is being developed and entities for potential

[62] DOH is scheduled to issue an intent to award notice around November 30 and a contract issued by mid-December.

[63] NPC Research. "Alaska's Prescription Drug Monitoring Program: Analysis of 2021 Awareness & Feedback Questionnaire," January 2022. https://www.commerce.alaska.gov/web/Portals/5/pub/PDMPNPCAnalysis_2021.pdf (Accessed October 29, 2022).

prioritization identified. It should be noted that integration efforts are complicated by the utilization of two data-sharing hubs, RxCheck and PMP InterConnect.

Although providers working in emergency settings are exempt from reviewing and reporting to the database, hospital providers in emergency departments review data contained within the PDMP because of collaboration among DCCED, the Alaska Hospital & Healthcare Association (AHHA), the Alaska Chapter of the American College of Emergency Physicians (AK-ACEP), Collective Medical Technologies, and the State of Alaska's health information exchange established in AS 18.23.300.16. Through an interface service provided by Collective Medical Technologies, patient-specific information is automatically pulled from the PDMP without the emergency department provider logging into the PDMP. Collective Medical Technologies and stakeholders are working with CBPL to see if some of the program's deficiencies can be overcome.

Policy and Process Review

In a federally funded hospital-based pilot project, the PDMP data requests increased 145-fold the year after integration, with a 22% decrease in hospital opioid prescriptions. During the same period, the PDMP data request rate increased by 28% statewide, with a 13% increase in hospital opioid prescriptions.[64]

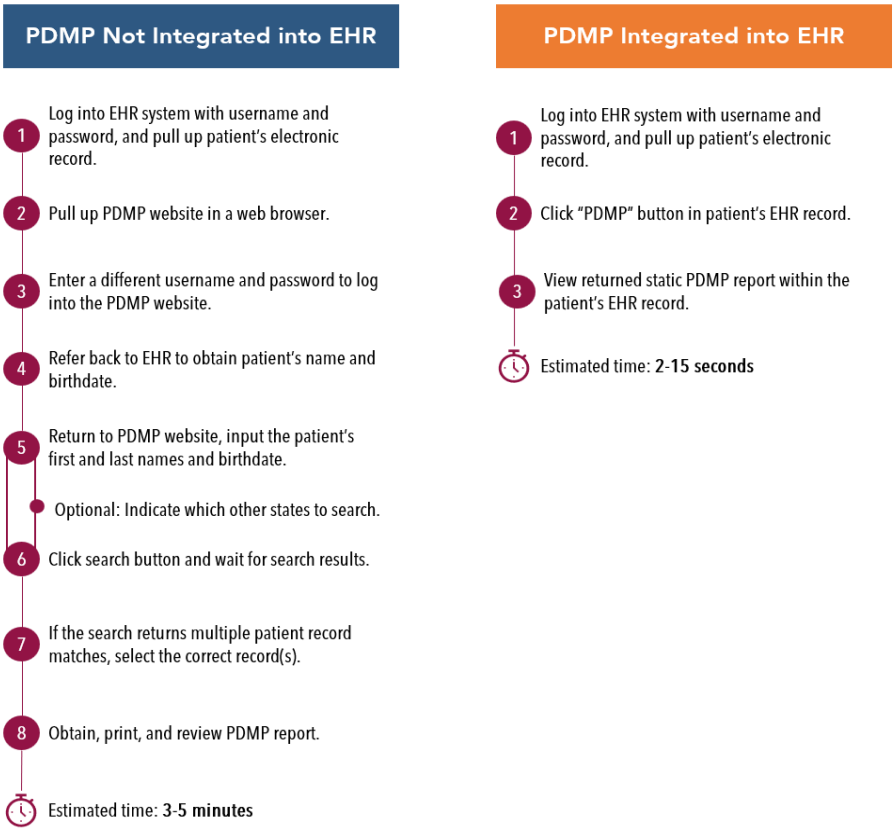
PDMP information can be integrated into different types of health IT systems, such as state or regional health information exchanges (HIE) and provider health IT systems such as EHRs and pharmacy dispensing systems.[65] In some states, governments are covering the costs related to state integration options for providers. However, achieving integration for all providers within their states is challenging particularly with smaller providers, those who lack health IT systems, or those with older health IT systems and outdated technology.

Qualitative research has identified some key factors influencing implementation of PDMPs such as linkage to electronic health records (EHR).[66] For example, physicians have identified lack of integration with EHR as a key challenge to most effectively using PDMPs when making patient care decisions. Without integration, physicians or their delegates must separately log into and search their state PDMP's website, which some physicians said could take several minutes per patient. This time can add up to a significant cumulative time burden for physicians who check

[64] Wang, Lucy Xiaolu, "The complementarity of drug monitoring programs and health IT for reducing opioid-related mortality and morbidity." Health Economics, Volume 30, Issue 9, (2021): 2026-2046. https://onlinelibrary.wiley.com/doi/full/10.1002/hec.4360#reference. (Accessed September 23, 2022).
[65] HIEs provide the technology and facilities needed to support the electronic sharing of data among hospitals, physicians, clinical laboratories, radiology centers, pharmacies, health plans (insurers), and public health departments.
[66] Finley, Erin P., Ashley Garcia, Kristen Rosen, Don McGeary, Mary Jo Pugh, and Jennifer Sharpe Potter. "Evaluating the impact of prescription drug monitoring program implementation: a scoping review." BMC health services research 17, no. 1 (2017): 1-8. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2354-5. (Accessed October 24, 2022).

the PDMP for many patients, those working in small practices with limited resources, or those in certain settings, such as an emergency department, in which time may be limited.[67] Integration is a "game changer" for ease of use and efficiency. The flow chart on the next page demonstrates how several steps (and time) can be eliminated with EHR integration.

Figure 3. PDMP EHR Integration



Source: Adapted from GAO analysis of interviews with physicians and PMDP officials (GAO-21-22).

From 2018 to 2022, ONC and the Centers for Disease Control and Prevention (CDC) collaborated on the Advancing PDMP and EHR Integration project. The purpose of this project was to advance and scale vendor PDMP integrations with health IT systems in a variety of hospital, primary care, and outpatient settings. Specific goals of the project included:

- Test and refine standards-based, nonproprietary approaches to enable effective integration of state PDMP data into healthcare system EHRs, including integration into clinical workflows.

[67] Government Accountability Office. "Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs," October 2020. https://www.gao.gov/assets/gao-21-22.pdf. (Accessed November 15, 2022.)

- Identify and advance promising vendor-agnostic approaches that support scalability and sustainability of PDMP – health IT integration.
- Explore emerging vendor-agnostic technical solutions to enhance access and use of PDMP data.
- Compile lessons learned and best practices that can be translated into vendor-agnostic, nonproprietary technical resources for states and health systems.

As an outcome of this effort, ONC and CDC produced an Integration Framework and an Integration Toolkit to serve as technical resources to other organizations interested in integrations. The Integration Framework provides guidance to healthcare systems and relevant stakeholders to support successful project execution, management and communications for Health IT integrations related to PDMPs and clinical decision support for opioid prescribing.[68]

Federal grant funders require recipient programs to use RxCheck for interstate data sharing and integration efforts. However, state PDMP managers appear to be favor PMP InterConnect. While it fills a similar function as RxCheck, PMP InterConnect offers a better interface with multiple system platforms with EHR and PMS and is more technologically advanced. Many state PDMP managers also have growing concerns about the potential reach of RxCheck for federally sharing data and conditions for funding.

The state is paying the licensing fee for the statewide integration program. This has the potential to lessen the integration burden for some prescribing practitioners.

Stakeholder Perspectives

"Integration takes user-friendliness from a 3 to a 10."

Effective integration into EHR systems is the key to PDMP usability, according to prescribers who were interviewed. Stakeholders indicated a strong correlation exists between PDMP integration and positive attitudes toward the PDMP. Prescribers in settings with seamless integration (such as hospitals) reported the PDMP is easy to use and is an effective tool. Those in settings with no or minimal integration (veterinarians, prescribers at small clinics and in specialty practices) said the PDMP is cumbersome and time-consuming, and they were more likely to call for exemptions for their field.

[68] Health IT.gov. "Prescription Drug Monitoring Programs." Last modified August 23, 2022. https://www.healthit.gov/topic/health-it-health-care-settings/prescription-drug-monitoring-programs. (Accessed October 24, 2022).

Considerations for Improvement

- Manage and communicate expectations of anticipated levels of statewide integration implementation, particularly related to small practice settings and regions with poor broadband connectivity.
- Seek sustainable funding (including general funds or grant funding) for integration past FFY2024.
- With increased integration, reevaluate capacity needs to manage compliance, investigations, and data analysis.

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Appendix A: List of Stakeholders Interviewed

Department of Commerce, Community, and Economic Development

Laura Carrillo, Executive Administrator, Board of Pharmacy, and former PDMP manager, DCCED
Greg Francois, Chief of Investigations, DCCED
Madeleine Henderson, Occupational Licensing Examiner, Board of Nursing, DCCED
Jason Kaeser, Occupational Licensing Examiner, Medical Board, DCCED
Sonia Lipker, Senior Investigator, DCCED
Natalie Norberg, Executive Administrator, Medical Board, DCCED
Erika Prieksat, Senior Investigator, DCCED
Lisa Sherrell, PDMP Manager, Acting Executive Administrator, Board of Pharmacy, DCCED
Tessa Walker-Linderman, RN, Executive Administrator, Board of Nursing, DCCED

Department of Health

Coleman Cutchins, Clinical Pharmacist, Alaska Department of Health
Jessica Filley, Epidemiology Specialist, Office of Substance Misuse and Addiction Prevention (OSMAP), Alaska Department of Health
Dr. Julius (Pepper) Goslin, Medicaid Medical Director, Alaska Department of Health
Deb Hull-Jilly, Program Manager and Injury Epidemiologist, Alaska Department of Health
Theresa Johnson, Program Manager, State Opioid Treatment Authority (SAMHSA), Alaska Department of Health
Erin Narus, Pharmacy Services Manager, Lead pharmacist (Medicaid), Alaska Department of Health
Charles Semling, Pharmacist, Alaska Medicaid Medication Review, Alaska Department of Health
Theresa Welton, Unit Manager for OSMAP, Alaska Department of Health
Dr. Anne Zink, Alaska Chief Medical Officer, Alaska Department of Health

Health Associations and Corporations

Michael Baldwin, Senior Evaluation and Planning Officer, Alaska Mental Health Trust Authority
Elizabeth King, Senior Director, Alaska Hospital and Healthcare Association
Dr. David Logan, Director, Alaska Dental Society
Dr. Nicholas Papacostas, Emergency Physician and President, Alaska Chapter of the American College of Emergency Physicians

Legislators

Rep. Ivy Spohnholz, Alaska State Legislature, Anchorage
Rep. Andi Story, Alaska State Legislature, Juneau

PDMP Board Chairs

Dr. Rachel Berngartt, Chair, Board of Veterinary Examiners
Dr. Brad Cross, Chair, Board of Examiners in Optometry
Dr. David Nielsen, Chair, Board of Dental Examiners
Dr. Justin Ruffridge, Chair, Board of Pharmacy
Danette Schloeder, Chair, Board of Nursing
Dr. Richard Wein, Chair, State Medical Board

Policy Experts and Out-of-State Authorities

Pat Knue, Director, Institute for Intergovernmental Research
Steven Schierholt, Executive Director, Ohio Board of Pharmacy
Don Vogt, Senior Project Coordinator, Institute for Intergovernmental Research
Darla Zarley, PDMP Administrator, Nevada Board of Pharmacy

Prevention Program Managers

Renee Rafferty, Director of Behavioral Services, Providence Alaska Health System
Kathleen Totemoff, Opioid Prevention and Treatment Advocate, Governor's Advisory Board on Alcoholism and Drug Abuse
Dr. Curt Wengel, Psychiatrist and Chief Medical Officer, Alaska Behavioral Health

Prescribing Practitioners and Pharmacists

Kari Bernard, Physician Assistant, Orion Behavioral Health Network
Dr. Corey Cox, Physician, Front Street Clinic
Dr. McKayla Dick, Veterinarian
Christopher Dietrich, Physician Assistant, Orion Behavioral Health Network
Claire Geldhof, RN, Public Health Nurse
Dr. Casey Gokey, Primary Care Physician and Assistant Chief Medical Officer, Anchorage Neighborhood Health Clinic
Dr. Lorelei Hass, Veterinarian, Ravenwood Veterinary Clinic
Ursula Iha, Pharmacist, Bartlett Regional Hospital

Dr. Dane Lenaker, Dentist and Consultant to the State on Dental Matters
Dr. Sheryl Lentfer, Optometrist
Dan Nelson, Pharmacist, Chief Andrew Isaac Health Center Pharmacy
Dr. Tracy Ward, Veterinarian

Appendix B: PDMP Alaska Statute and Administrative Code

Below are the most relevant current statutes and administrative codes for managing the Alaska PDMP.

Alaska Statutes

AK Stat § 08.01.065 (2020) Establishment of Fees

(a) Except for business licenses, the department shall adopt regulations that establish the amount and manner of payment of application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by this chapter.

(b) [Repealed, § 4 ch 34 SLA 1992.]

(c) Except as provided in (f) - (j) of this section, the department shall establish fee levels under (a) of this section so that the total amount of fees collected for an occupation approximately equals the actual regulatory costs for the occupation. The department shall annually review each fee level to determine whether the regulatory costs of each occupation are approximately equal to fee collections related to that occupation. If the review indicates that an occupation's fee collections and regulatory costs are not approximately equal, the department shall calculate fee adjustments and adopt regulations under (a) of this section to implement the adjustments. In January of each year, the department shall report on all fee levels and revisions for the previous year under this subsection to the office of management and budget. If a board regulates an occupation covered by this chapter, the department shall consider the board's recommendations concerning the occupation's fee levels and regulatory costs before revising fee schedules to comply with this subsection. In this subsection, "regulatory costs" means costs of the department that are attributable to regulation of an occupation plus

(1) all expenses of the board that regulates the occupation if the board regulates only one occupation;

(2) the expenses of a board that are attributable to the occupation if the board regulates more than one occupation.

(d) The license fee for a business license is set by AS 43.70.030(a). The department shall adopt regulations that establish the manner of payment of the license fee.

(e) [Repealed, § 28 ch 90 SLA 1991.]

(f) Notwithstanding (c) of this section, the department shall establish fee levels under (a) of this section so that the total amount of fees collected by the State Board of Registration for Architects, Engineers, and Land Surveyors approximately equals the total regulatory costs of the department and the board for all occupations regulated by the board. The department shall set the fee levels for the issuance and renewal of a certificate of registration issued under AS 08.48.211 so that the fee levels are the same for all occupations regulated by the board.

(g) Notwithstanding (c) of this section, the department shall establish fee levels under (a) of this section so that the total amount of fees collected by the department for all occupations regulated under AS 08.11 approximately equals the total regulatory costs of the department for all occupations regulated by the department under AS 08.11. The department shall set the fee levels for the issuance and renewal of licenses issued under AS 08.11 so that the fee levels are the same for all occupations regulated by the department under AS 08.11.

(h) Notwithstanding (c) of this section, the department shall establish fee levels under (a) of this section so that the total amount of fees collected by the Board of Barbers and Hairdressers approximately equals the total regulatory costs of the department, the board, and the Department of Environmental Conservation for all occupations regulated by the board. For purposes of this subsection, the regulatory costs of the Department of Environmental Conservation for the occupations regulated by the board include the cost of inspections under AS 08.13.210(b), the cost of developing and adopting regulations under AS 44.46.020 for barbershop, hairdressing, hair braiding, manicuring, esthetics, body piercing, ear piercing, tattooing , and permanent cosmetic coloring establishments, and the cost to the Department of Environmental Conservation of enforcing the regulations for body piercing, tattooing, and permanent cosmetic coloring establishments. The department shall set the fee levels for the issuance and renewal of a practitioner's license issued under AS 08.13.100 so that the license and license renewal fees are the same for all occupations regulated by the Board of Barbers and Hairdressers.

(i) Notwithstanding (c) of this section, the department shall establish fee levels under (a) of this section so that the total amount of fees collected by the Department of Commerce, Community, and Economic Development for specialty contractors, home inspectors, and associate home inspectors approximately equals the total regulatory costs of the department for those three registration categories. The department shall set the fee levels for the issuance and renewal of a certificate of registration issued under AS 08.18 so that the fee levels are the same for all three of these registration categories and so that the fee level for a home inspector with a joint registration is not different from the fee level for a home inspector who does not have a joint registration. In this subsection, "joint registration" has the meaning given in AS 08.18.171.

(j) The department shall establish for real estate appraisal management companies registered under AS 08.87 a registry fee in an amount that equals the amount determined by the federal

Appraisal Subcommittee established under 12 U.S.C. 3310 as a national registry fee for each real estate appraiser of the appraiser panel of a real estate appraisal management company under 12 U.S.C. 3338 (Title XI, Financial Institutions Reform, Recovery, and Enforcement Act of 1989), as amended by 12 U.S.C. 5301 - 5641 (Dodd-Frank Wall Street Reform and Consumer Protection Act); the department may annually remit fees paid under this subsection to the Appraisal Subcommittee for participation in the national registry for real estate appraisal management companies.

AK Stat § 08.80.030 (2018) Powers and Duties of The Board of Pharmacy

(a) The board is responsible for the control and regulation of the practice of pharmacy.

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) issue licenses to persons engaged in the manufacture and distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200;

(12) establish standards for the independent administration by a pharmacist of vaccines and related emergency medications under AS 08.80.168, including the completion of an immunization training program approved by the board;

(13) establish standards for the independent dispensing by a pharmacist of an opioid overdose drug under AS 17.20.085, including the completion of an opioid overdose training program approved by the board;

(14) require that a licensed pharmacist register with the controlled substance prescription database under AS 17.30.200(o);

(15) establish the qualifications and duties of the executive administrator and delegate authority to the executive administrator that is necessary to conduct board business;

(16) [Effective July 1, 2019.] license and inspect the facilities of wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159.

(c) The board shall post and maintain a link to the United States Food and Drug Administration's list of all currently approved interchangeable biological products on the board's Internet website.

(d) [Effective July 1, 2019.] The minimum specifications for facilities, equipment, personnel, and procedures for the compounding, storage, and dispensing of drugs established under (b)(7) of this section must be consistent with the requirements of secs. 201 – 208, P.L. 113-54 (Drug Supply Chain Security Act).

AK Stat § 18.23.300 (2018) Creation of Health Information Exchange System

(a) The department shall establish and implement a statewide electronic health information exchange system and ensure the interoperability and compliance of the system with state and federal specifications and protocols for exchanging health records and data.

(b) The system established under this section must

(1) include infrastructure planning that involves

(A) the designation by the commissioner of a qualified entity or combination of qualified entities in the state that

(i) has an advisory or governing body made up of health system stakeholders that include members identified under (d) of this section;

(ii) applies for available federal and state funding for planning and implementation of the system authorized by the commissioner;

(iii) submits an annual budget for approval of the commissioner;

(iv) complies with nondiscrimination and conflict of interest policies;

(v) meets and complies with federal and state health information policies and standards;

(vi) provides cost and cost saving data associated with the development and use of the system to the department;

(B) the development of statewide infrastructure to support the electronic health information exchange system established under this section and to connect electronic health records to the infrastructure;

(C) the development of a statewide technology plan, with the participation of identified stakeholders, to promote the implementation and sustained use by public and private health care payors and providers of electronic health records and the system established under this section in order to ensure interoperability among government-operated health information systems and other public and private health information and reporting systems;

(D) the development of policies and standards, consistent with federal and state law, to safeguard the privacy and security of health information;

(E) the development of a training and workforce development plan for implementing and serving the system;

(F) an estimate of costs of the hardware, software, services, and support needed to implement and maintain the technical infrastructure; and

(2) include implementation measures that

(A) provide for installation and training on the use of the system;

(B) set out a plan to encourage health care provider, payor, and patient use of electronic records over a sustained period of time;

(C) provide support to providers for workflow redesign, quality improvement, and care management services;

(D) provide for participation by all identified stakeholders in the planning and implementation of the system;

(E) comply with federal and state health information policies; and

(F) provide for periodic evaluation and improvement of the system.

(c) The department may enter into contracts, seek and accept available federal and private funds and equipment, and adopt regulations necessary to carry out the purposes of this section.

(d) The designee under (b)(1)(A) of this section may be a private for-profit or nonprofit entity or entities under contract with the state. The advisory or governing body of the designee must include

(1) the commissioner;

(2) eight other individuals, each of whom represents one of the following interests:

(A) hospitals and nursing home facilities;

(B) private medical care providers;

(C) community-based primary care providers;

(D) federal health care providers;

(E) Alaska tribal health organizations;

(F) health insurers;

(G) health care consumers;

(H) employers or businesses; and

(3) two nonvoting liaison members who shall serve to enhance communication and collaboration between the designee and both the Board of Regents of the University of Alaska and the commission established in the governor's office to review health care policy.

AK Stat § 17.30.200 (2017) Controlled Substance Prescription Database

(a) The controlled substance prescription database is established in the Board of Pharmacy. The purpose of the database is to contain data as described in this section regarding every prescription for a schedule II, III, or IV controlled substance under federal law dispensed in the state to a person other than under the circumstances described in (u) of this section.

(b) [See delayed amendment note.] The pharmacist-in-charge of each licensed or registered pharmacy, regarding each schedule II, III, or IV controlled substance under federal law

dispensed by a pharmacist under the supervision of the pharmacist-in-charge, and each practitioner who directly dispenses a schedule II, III, or IV controlled substance under federal law other than those dispensed or administered under the circumstances described in (u) of this section, shall submit to the board, by a procedure and in a format established by the board, the following information for inclusion in the database on at least a weekly basis:

(1) the name of the prescribing practitioner and the practitioner's federal Drug Enforcement Administration registration number or other appropriate identifier;

(2) the date of the prescription;

(3) the date the prescription was filled and the method of payment; this paragraph does not authorize the board to include individual credit card or other account numbers in the database;

(4) the name, address, and date of birth of the person for whom the prescription was written;

(5) the name and national drug code of the controlled substance;

(6) the quantity and strength of the controlled substance dispensed;

(7) the name of the drug outlet dispensing the controlled substance; and

(8) the name of the pharmacist or practitioner dispensing the controlled substance and other appropriate identifying information.

(c) The board shall maintain the database in an electronic file or by other means established by the board to facilitate use of the database for identification of

(1) prescribing practices and patterns of prescribing and dispensing controlled substances;

(2) practitioners who prescribe controlled substances in an unprofessional or unlawful manner;

(3) individuals who receive prescriptions for controlled substances from licensed practitioners and who subsequently obtain dispensed controlled substances from a drug outlet in quantities or with a frequency inconsistent with generally recognized standards of dosage for that controlled substance; and

(4) individuals who present forged or otherwise false or altered prescriptions for controlled substances to a pharmacy.

(d) The database and the information contained within the database are confidential, are not public records, are not subject to public disclosure, and may not be shared with the federal government. The board shall undertake to ensure the security and confidentiality of the database and the information contained within the database. The board may allow access to the

database only to the following persons, and in accordance with the limitations provided and regulations of the board:

(1) personnel of the board regarding inquiries concerning licensees or registrants of the board or personnel of another board or agency concerning a practitioner under a search warrant, subpoena, or order issued by an administrative law judge or a court;

(2) authorized board personnel or contractors as required for operational and review purposes;

(3) a licensed practitioner having authority to prescribe controlled substances or an agent or employee of the practitioner whom the practitioner has authorized to access the database on the practitioner's behalf, to the extent the information relates specifically to a current patient of the practitioner to whom the practitioner is prescribing or considering prescribing a controlled substance; the agent or employee must be licensed or registered under AS 08;

(4) a licensed or registered pharmacist having authority to dispense controlled substances or an agent or employee of the pharmacist whom the pharmacist has authorized to access the database on the pharmacist's behalf, to the extent the information relates specifically to a current patient to whom the pharmacist is dispensing or considering dispensing a controlled substance; the agent or employee must be licensed or registered under AS 08;

(5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database under a search warrant or order issued by a court establishing probable cause for the access and use of the information;

(6) an individual who is the recipient of a controlled substance prescription entered into the database may receive information contained in the database concerning the individual on providing evidence satisfactory to the board that the individual requesting the information is in fact the person about whom the data entry was made and on payment of a fee set by the board under AS 37.10.050 that does not exceed $10;

(7) a licensed pharmacist employed by the Department of Health and Social Services who is responsible for administering prescription drug coverage for the medical assistance program under AS 47.07, to the extent that the information relates specifically to prescription drug coverage under the program;

(8) a licensed pharmacist, licensed practitioner, or authorized employee of the Department of Health and Social Services responsible for utilization review of prescription drugs for the medical assistance program under AS 47.07, to the extent that the information relates specifically to utilization review of prescription drugs provided to recipients of medical assistance;

(9) the state medical examiner, to the extent that the information relates specifically to investigating the cause and manner of a person's death;

(10) an authorized employee of the Department of Health and Social Services may receive information from the database that does not disclose the identity of a patient, prescriber, dispenser, or dispenser location, for the purpose of identifying and monitoring public health issues in the state; however, the information provided under this paragraph may include the region of the state in which a patient, prescriber, and dispenser are located and the specialty of the prescriber; and

(11) a practitioner, pharmacist, or clinical staff employed by an Alaska tribal health organization, including commissioned corps officers of the United States Public Health Service employed under a memorandum of agreement; in this paragraph, "Alaska tribal health organization" has the meaning given to "tribal health program" in 25 U.S.C. 1603.

(e) The failure of a pharmacist-in-charge or a pharmacist to register or submit information to the database as required under this section is grounds for the board to take disciplinary action against the license or registration of the pharmacy or pharmacist. The failure of a practitioner to register or review the database as required under this section is grounds for the practitioner's licensing board to take disciplinary action against the practitioner.

(f) The board may enter into agreements with (1) dispensers in this state that are not regulated by the state to submit information to and access information in the database, and (2) practitioners in this state to access information in the database, subject to this section and the regulations of the board. The board shall prohibit a dispenser that is not regulated by the state from accessing the database if the dispenser has accessed information in the database contrary to the limitations of this section, discloses information in the database contrary to the limitations of this section, or allows unauthorized persons access to the database.

(g) The board shall promptly notify the president of the senate and the speaker of the house of representatives if, at any time after September 7, 2008, the federal government fails to pay all or part of the costs of the controlled substance prescription database.

(h) An individual who has submitted information to the database in accordance with this section may not be held civilly liable for having submitted the information. Dispensers or practitioners may not be held civilly liable for damages for accessing or failing to access the information in the database.

(i) A person who has reason to believe that prescription information from the database has been illegally or improperly accessed shall notify an appropriate law enforcement agency.

(j) The board shall notify any person whose prescription information from the database is illegally or improperly accessed.

(k) In the regulations adopted under this section, the board shall provide

(1) that prescription information in the database shall be purged from the database after two years have elapsed from the date the prescription was dispensed;

(2) a method for an individual to challenge information in the database about the individual that the person believes is incorrect or was incorrectly entered by a dispenser.

(3) a procedure and time frame for registration with the database;

(4) that a practitioner review the information in the database to check a patient's prescription records before dispensing, prescribing, or administering a schedule II or III controlled substance under federal law to the patient; the regulations must provide that a practitioner is not required to review the information in the database before dispensing, prescribing, or administering

(A) a controlled substance to a person who is receiving treatment

(i) in an inpatient setting;

(ii) at the scene of an emergency or in an ambulance; in this sub-subparagraph, "ambulance" has the meaning given in AS 18.08.200;

(iii) in an emergency room;

(iv) immediately before, during, or within the first 48 hours after surgery or a medical procedure;

(v) in a hospice or nursing home that has an in-house pharmacy; or

(B) a nonrefillable prescription of a controlled substance in a quantity intended to last for not more than three days.

(l) A person

(1) with authority to access the database under (d) of this section who knowingly

(A) accesses information in the database beyond the scope of the person's authority commits a class A misdemeanor;

(B) accesses information in the database and recklessly discloses that information to a person not entitled to access or to receive the information commits a class C felony;

(C) allows another person who is not authorized to access the database to access the database commits a class C felony;

(2) without authority to access the database under (d) of this section who knowingly accesses the database or knowingly receives information that the person is not authorized to receive under (d) of this section from another person commits a class C felony.

(m) To assist in fulfilling the program responsibilities, performance measures shall be reported to the legislature annually. Performance measures

(1) may include outcomes detailed in the federal prescription drug monitoring program grant regarding efforts to

(A) reduce the rate of inappropriate use of prescription drugs by reporting education efforts conducted by the Board of Pharmacy;

(B) reduce the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit;

(C) increase coordination among prescription drug monitoring program partners;

(D) involve stakeholders in the planning process;

(2) shall include information related to the

(A) security of the database; and

(B) reductions, if any, in the inappropriate use or prescription of controlled substances resulting from the use of the database.

(n) A pharmacist who dispenses or a practitioner who prescribes, administers, or directly dispenses a schedule II, III, or IV controlled substance under federal law shall register with the database by a procedure and in a format established by the board

(o) A pharmacist who dispenses or a practitioner who prescribes, administers, or directly dispenses a schedule II, III, or IV controlled substance under federal law shall register with the database by a procedure and in a format established by the board.

(p) The board shall promptly notify the State Medical Board, the Board of Nursing, the Board of Dental Examiners, the Board of Examiners in Optometry, and the Board of Veterinary Examiners when a practitioner registers with the database under (o) of this section.

(1) must be provided to the practitioner;

(2) is confidential;

(3) may not disclose information that is confidential under this section;

(4) may be in a summary form sufficient to provide notice of the basis for the unsolicited notification

(q) The board shall update the database on at least a daily basis with the information submitted to the board under (b) of this section.

(r) The Department of Commerce, Community, and Economic Development shall

(1) assist the board and provide necessary staff and equipment to implement this section; and

(2) establish fees for registration with the database by a pharmacist or practitioner required to register under (n) of this section so that the total amount of fees collected by the department equals the total operational costs of the database minus all federal funds acquired for the operational costs of the database; in setting the fee levels, the department shall

(A) set the fees for registration with the database so that the fees are the same for all practitioners and pharmacists required to register; and

(B) consult with the board to establish the fees under this paragraph.

(s) Notwithstanding (p) of this section, the board may issue to a practitioner periodic unsolicited reports that detail and compare the practitioner's opioid prescribing practice with other practitioners of the same occupation and similar specialty. A report issued under this subsection is confidential and the board shall issue the report only to a practitioner. The board may adopt regulations to implement this subsection. The regulations may address the types of controlled substances to be included in an unsolicited report, the quantities dispensed, the medication strength, and other factors determined by the board.

(t) A practitioner or a pharmacist is not required to comply with the requirements of (a) and (b) of this section if a controlled substance is

(1) administered to a patient at

(A) a health care facility; or

(B) a correctional facility;

(2) dispensed to a patient for an outpatient supply of 24 hours or less at a hospital

(A) inpatient pharmacy; or

(B) emergency department.

u) In this section,

(1) "board" means the Board of Pharmacy;

(2) "database" means the controlled substance prescription database established in this section;

(3) "knowingly" has the meaning given in AS 11.81.900;

(4) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140 and 11.71.160;

(5) "pharmacist-in-charge" has the meaning given in AS 08.80.480

Administrative Codes

12 AAC 02.107. Prescription Drug Monitoring Program Controlled Substance Prescription Database Registration

The following fees are established for registration as required under AS 17.30.200 with the prescription drug monitoring program (PDMP) controlled substance prescription database by a pharmacist who dispenses, or a practitioner who prescribes, administers, or directly dispenses a schedule II, III, or IV controlled substance under federal law: (1) initial registration fee, $0; (2) biennial registration renewal fee, $0. Authority: AS 08.01.065 AS 17.30.200

12 AAC 52.855. Registration with the Prescription Drug Monitoring Program Controlled Substance Prescription Database

(a) A prescriber shall register with the prescription drug monitoring program's controlled substance prescription database (PDMP) not later than 30 days initial licensure or the date of registration with the federal Drug Enforcement Administration (DEA), whichever is later.

(b) A licensed pharmacist practicing in this state shall register with the prescription drug monitoring program's controlled substance prescription database (PDMP). Registration must be completed not later than 30 days after initial licensure if the pharmacist's practice is expected to involve dispensing a schedule II, III or IV controlled substance under federal law. If not dispensing in this state, a pharmacist shall submit, a PDMP dispensation exemption form provided by the board, not later than 30 days after initial licensure, A pharmacist who submitted a dispensation exemption form shall register with the PDMP before dispensing a schedule II, III, or IV controlled substance under federal law in this state.

(c) Except as provided in (a) of this section, before dispensing, prescribing, or administering a schedule II, III, or IV controlled substance under federal law, a pharmacist or practitioner required to register with the PDMP must

(1) register online on the PDMP database by providing

A: an electronic mail address corresponding to an electronic mail account accessible to and utilized exclusively by the registering pharmacist or practitioners;

B: a password created by the Registrant at the time of registration just meets the minimum requirements set by the PDMP database;

C: a user role selected from the options provided by the PDMP database that meets closely corresponds to the registrant's professional role;

D: the registrant's healthcare specialty;

E: the DEA number issued to the registrants or, if a pharmacist, the employer's DEA number; and (2) pay the fee established in 12 AAC 02.107.

(d) After completing the registration requirements, a pharmacist or practitioner required to register with the PDMP will be issued a PDMP designation.

(e) A pharmacist or practitioner required to register with the PDMP must access information in the PDMP database using the credentials identified in (c)(1)(A) and (B) of this section.

(f) A pharmacist or practitioner required to register with the PDMP may access information in the PDMP using another registrant's credentials only as authorized by a contract executed by the department for the purposes of AS 47.05.270.

12 AAC 52.856. PDMP Designation Renewal

(a) A PDMP designation expires on the same date as the pharmacist's or practitioner's corresponding professional license.

(b) To renew a PDMP designation, a licensee must submit the fee established in 12 AAC 02.107 on or before the PDMP designation expiration date

12 AAC 52.857. Change In Dispensing or Distributing of Controlled Substances

(a) A pharmacist with a PDMP registration under 12 AAC 52.855 must notify the board on a form provided by the department when the pharmacist changes their PDMP status to no longer dispense controlled substances in this state not later than 10 days from the date of the change in dispensing status.

(b) A pharmacist who is not required to register with the PDMP and who has met the requirements in 12 AAC 52.855(b) must comply with the requirements in 12 AAC 52.855(c) not later than 10 days from the date of a change in practice that requires the pharmacist to register with the PDMP.

(c) A pharmacy required to report to the PDMP that no longer dispenses or distributes controlled substances in or to this state must notify the board on a form provided by the department not later than 10 days from the date of the change in dispensing or distributing status.

(d) A pharmacy that obtains a DEA registration after its license or registration is initially granted by the board must notify the board on a form provided by the department not later than 10 days from the date the DEA registration is issued to the pharmacy.

12 AAC 52.860. Access to and Conditions for Use of the Prescription Drug Monitoring Program Database

(a) Access to the PDMP is limited as described in AS 17.30.200(d).

(b) For the purposes in AS 17.30.200(d)(1) of an inquiry under a search warrant, subpoena, or order issued by an administrative law judge or a court,

(1) "personnel of the board" means employees of the Department of Commerce, Community, and Economic Development assigned to the Board of Pharmacy; and

(2) "personnel of another board or agency" mean an employee of this state who is assigned to a board or agency that requires a practitioner to register with the PDMP

(c) For the purposes of AS 17.30.200(d)(2), "authorized board personnel or contractors" means:

(1) employees of the Department of Commerce Community, and Economic Development assigned to the Board of Pharmacy and providing PDMP data storage as data management services; or

(2) employees of a contractor with this state who are providing PDMP data storage or data management services.

(d) For the purposes of AS 17.30.200(d)(3) and (4), a licensed practitioner or licensed or registered pharmacist authorizing an agent or employee access the PDMP is responsible for maintaining and terminating the agent or employee's access to the PDMP.

(e) For the purposes of AS 17.30.200(d)(8) and (10), "authorized employee of the Department of Health and Social Services" means an employee of the Department of Health and Social Services (DHSS) for whom that department's commissioner or commissioner's official designee has requested access in writing to the board before the release of information.

12 AAC 52.865. Reporting And Reviewing PDMP Information

(a) Unless excused from reporting under AS 17.30.200(t), a pharmacist must submit information required under AS 17.30.200(b), if the pharmacist-in-charge is not present.

(b) Unless excused from reporting under AS 17.30.200(t), a pharmacist or practitioner required to submit information under AS 17.30.200(b) must submit the information to the PDMP daily as of the previous submission date.

(c) The time computation under 12 AAC 02.920(b) applies to a submission of information under AS 17.30.200(b) and this section.

(d) For the purposes of AS 17.30.200(b)(1), "other appropriate identifier" and for the purposes of AS 17.30.200(b)(8), "other appropriate identifying information" mean the state-issued license number of the prescribing practitioner and state-issued license number of the dispensing pharmacist or practitioner.

(e) Not later than 72 hours after discovering an error in information submitted under AS 17.30.200(b), a pharmacist or practitioner required to submit the information under AS 17.30.200(b) must submit information correcting the error to the PDMP administrator. The time computation under 12 AAC 02.920(b) applies to a submission of information correcting an error in information submitted under AS 17.30.200(b).

(f) Unless excused from reporting under AS 17.30.200(t), or a waiver is granted under 12 AAC 52.870, a pharmacist or practitioner required to submit information under AS 17.30.200(b) must submit the information to the PDMP electronically through the website provided by the board.

(g) Unless excused from reviewing the PDMP under AS 17.30.200(k)(4)(A) – (B), a practitioner, but not a pharmacist, must review the information in the PDMP to check a patient's prescription records before dispensing, prescribing, or administering a schedule II or III controlled substance under federal law.

12 AAC 52.885. Purged Database Records

The following information will be purged from the PDMP database after two years have elapsed from the date the prescription was dispensed:

(1) the name of the prescribing practitioner and the practitioner's federal Drug Enforcement Administration registration number or other appropriate identifier;

(2) the date of the prescription;

(3) the date the prescription was filled and the method of payment;

(4) the name, address, and date of birth of the person for whom the prescription was written;

(5) the name and national drug code of the controlled substance;

(6) the quantity and strength of the controlled substance dispensed;

(7) the name of the drug outlet dispensing the controlled substance; and

(8) the name of the pharmacist or practitioner dispensing the controlled substance and other appropriate identifying information.

Appendix C: PDMP Reportable Controlled Substances Schedules

Definition of Controlled Substance Schedules

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules.[69] An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.

Schedules II-IV are considered reportable in the Alaska PDMP. Examples of these drugs in each schedule are listed below.

Schedule II/IIN Controlled Substances (2/2N)

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

Examples of Schedule II narcotics include hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include morphine, opium, codeine, and hydrocodone.

Examples of Schedule IIN stimulants include amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®).

Other Schedule II substances include amobarbital, glutethimide, and pentobarbital.

Schedule III/IIIN Controlled Substances (3/3N)

Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

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[69] U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division. https://www.deadiversion.usdoj.gov/schedules/. (Accessed October 11, 2022).

Examples of Schedule III narcotics include products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).

Examples of Schedule IIIN non-narcotics include benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.

Schedule IV Controlled Substances

Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

Examples of Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

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