STATE OF ALASKA

Department of Commerce, Community, and Economic Development
Professional Licensing

ALASKA BOARD OF PHARMACY

August 30 – 31, 2018

Board Meeting

Anchorage

Board Packet

PUBLIC COPY
(DAY 1)

2018 State Holiday Calendar

2

JANUARY

S	M	T	W	T	F	S
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State Holidays

Date	Holiday
01/01	New Year's Day
01/15	MLK Jr.'s Birthday
02/19	Presidents' Day
03/26	Seward's Day
05/28	Memorial Day
07/04	Independence Day

Holiday

State calendar maintained by the Division of Finance, Department of Administration
http://doa.alaska.gov/calendars.html
Rev. 07/10/2017

Biweekly employees please refer to appropriate collective bargaining unit agreement for more information regarding holidays.

State Holidays

Date	Holiday
09/03	Labor Day
10/18	Alaska Day
11/11	Veterans' Day (observed 11/12)
11/22	Thanksgiving Day
12/25	Christmas Day

Alaska Board of Pharmacy Roster

Board Member Name	Initial Appointment	Reappointed	Term End
Leif Holm, PharmD (Chair)	03/01/2015		03/01/2019
Richard Holt, PharmD, MBA (Vice Chair)	03/01/2016		03/01/2020
Sharon Long, Public Member	03/01/2018		03/01/2022
Lana Bell, RPh	05/31/2016	03/01/2018	03/01/2018
Phil Sanders, RPh	03/01/2016		03/01/2020
James Henderson, RPh	03/01/2017		03/01/2021
Tammy Lindemuth, Public Member	01/24/2018		03/01/2021

ALASKA BOARD OF PHARMACY MEETING

TENTATIVE AGENDA

AUGUST 30, 2018 (DAY 1)

Teleconference Line: 1-800-315-6338
Access Code: 52550

Board Members:

Richard Holt, *PharmD, MBA (Chair)*

Leif Holm, *PharmD (Vice Chair)*

James Henderson, *RPh*

Lana Bell, *RPh*

Phil Sanders, *RPh*

Tammy Lindemuth, *Public Member*

Sharon Long, *Public Member*

Upcoming Meetings:

TBD

Meeting Details

Meeting Name: Alaska Board of Pharmacy Meeting - Day 1

Meeting Start Time: 9:00 AM Alaskan Daylight Time

Meeting Start Date: 8/30/2018

Meeting End Time: 4:30 PM Alaskan Daylight Time

Meeting End Date: 8/30/2018

Meeting Location: Robert Atwood Building, 550 W 7th Ave, ACC 102

Agenda

I. Agenda Item #1 - 9:00 a.m. Roll Call/Call to Order

II. Agenda Item #2 - 9:05 a.m. Review/Approve Agenda

III. Agenda Item #3 - 9:10 a.m. Ethics Disclosures

IV. Agenda Item #4 - 9:15 a.m. Public Comment

V. Agenda Item #5 - 9:25 a.m. PDMP Update

   A. Board of Pharmacy Data Report

   B. PDMP Mandatory Registration - Quick Guide

   C. PDMP FAQs for Federal Employees

   D. PDMP Forms

Board Members:

Richard Holt, *PharmD, MBA (Chair)*

Leif Holm, *PharmD (Vice Chair)*

James Henderson, *RPh*

Lana Bell, *RPh*

Phil Sanders, *RPh*

Tammy Lindemuth, *Public Member*

Sharon Long, *Public Member*

Upcoming Meetings:

TBD

1. Initial Registration
2. Renewal Form
3. DHSS PDMP Access Form
4. DEA Change/Status Form
5. PDMP Access Form for Unlicensed Pharmacists (draft 07-18-18)
6. PDMP Dispensation Status Form (draft 05-11-18)

E. Awareness and Feedback Questionnaire Preliminary Results

F. PDMP InterConnect Steering Committee

G. CDC Data Driven Prevention Initiative (DDPI) Technical Review

H. PDMP Enhancements: NarxCare and Clinical Alerts

I. Statewide Opioid Action Planning Summit - Prescribing Practices Advisory Committee (Strategy Map)

J. PDMP Veterinary Requirements

K. Investigative Referral Guidelines

VI. Agenda Item #6 - 10:45 a.m. Investigative Report

VII. Agenda Item #7 - 11:00 a.m. Board Business (Part I)

A. Review Tabled/Outstanding Applications

1. Zachary Brown
2. Demetria Spencer
3. Fred Eaton
4. Thomas Humphreys

B. Discuss/Draft Regulations

1. 12 AAC 52.240 - Collaborative Practice Agreements (Old; Revisit)
   a. Collaborative Practice Approval Letter
2. Stale Applications (New)
3. Out-of-State Pharmacists (New)
4. 12 AAC 52.860(f) Interstate Data Sharing (New; codify law's opinion)
5. Photo Identification (Old; Revisit)
6. 12 AAC 52.490 - Prescriptions by Electronic Transmission (Suggestion to require through legislation)

VIII. Agenda Item #8 - 12:00 p.m. Lunch

Board Members:

Richard Holt, *PharmD, MBA (Chair)*

Leif Holm, *PharmD (Vice Chair)*

James Henderson, *RPh*

Lana Bell, *RPh*

Phil Sanders, *RPh*

Tammy Lindemuth, *Public Member*

Sharon Long, *Public Member*

Upcoming Meetings:

TBD

IX. Agenda Item #9 - 1:00 p.m. New EA Position Discussion with Sara Chambers (may go into executive session)

A. Suggested Timeline for SB 32 and SB 37 Regulations (further discussion on August 31)

B. Executive Administrator Position

X. Agenda Item #10 - 2:00 p.m. Conference and Meeting Updates

A. MPJE Exam Review - Rich Holt

B. Controlled Substance Advisory Committee - Lana Bell

XI. Agenda Item #11 - 2:30 p.m. Consent Agreements - Marilyn Zimmerman, Paralegal

XII. Agenda Item #12 - 3:00 p.m. Division Update/Budget Report - Melissa Dumas, Admin Officer

XIII. Agenda Item #13 - 3:15 p.m. Review Lost/Stolen Rx

XIV. Agenda Item #13 - 3:30 p.m. Correspondence

A. NABP - Performance Audits

B. NABP - Consumer Education Campaign

XV. Agenda Item #14 - 4:00 p.m. Administrative Business

A. Wall Certificates

B. Travel Receipts

C. Task List

1. Updated Self-Inspection Report Draft (08/29/18)

XVI. Agenda Item #15 - 4:15 p.m. Recess until August 31

CONFIDENTIAL

ETHICS SUPERVISOR DETERMINATION FORM

(Board or Commission Member)

Board or Commission: _____

Member Disclosing Potential Ethics Violation: _____

I have determined that the situation described on the attached ethics disclosure form

- ☐ does or would violate AS 39.52.110 - .190. Identify applicable statute below.
- ☐ does not or would not violate AS 39.52.110 - .190.

_____
Signature of Designated Ethics Supervisor (Chair)

_____
Printed Name of Designated Ethics Supervisor

Date: _____

COMMENTS (Please attach a separate sheet for additional space):

Note: Disclosure Form must be attached. Under AS 39.52.220, if the chair or a majority of the board or commission, not including the disclosing member, determines that a violation of AS 39.52.110-39.52.190 will exist if the member participates, the member shall refrain from voting, deliberating, or participating in the matter. A member will not be liable under the Ethics Act for action in accordance with such a determination so long as the member has fully disclosed all facts reasonably necessary to the determination and the attorney general has not advised the member, chair, or board or commission that the action is a violation. Forward disclosures with determinations to the State Ethics Attorney as part of your quarterly report. Quarterly reports are submitted to Litigation Assistant, Opinions, Appeals & Ethics, Department of Law, 1031 W. 4th Avenue, Suite 200, Anchorage, AK 99501.

Revised 2012

MEMORANDUM

State of Alaska
Department of Law

TO:

DATE:

FILE NO.:

TEL. NO.:

FROM: Angie White
Litigation Assistant
Department of Law
Opinions, Appeals, & Ethics Section

FAX:

SUBJECT: Executive Branch Ethics Act, AS 39.52 Quarterly Report
[INSERT QUARTERLY DATE RANGE]

******SAMPLE LANGUAGE – PLEASE COPY <u>ONLY</u> THE PARTS THAT APPLY ONTO YOUR BOARD OR COMMISSION'S LETTERHEAD ******

As designated ethics supervisor and chair [executive director] for the _____, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

OR

As designated ethics supervisor and chair [executive director] for the _____, I have received ___ notification(s) of a potential violation and ____ requests for ethics determinations under the Ethics Act (AS 39.52) I have attached a copy of the notices and requests along with my written determination(s) for review by the attorney general. I did [did not] receive an advisory opinion from the Attorney General.

<u>AND</u>

Except as addressed above, no other [board member] [commissioner] disclosed a potential conflict of interest at a recorded public meeting during this quarter.

OR

In addition to the above, at the [date] meeting, [Board member] [Commissioner] _____ disclosed a potential conflict with respect to _____[*insert brief description*]____. *Insert disposition*: [S/He refrained from participation.] *or* [I determined s/he could [could not] participate.] *or* [The Board [Commission] members voted to permit [not to permit] participation.]

State of Alaska
Department of Law
Who Is My Designated Ethics Supervisor?

Every state public officer, employee or board or commission member, has a designated ethics supervisor.

Executive Agencies

The ethics supervisor for each agency is the Commissioner or a senior manager to whom the Commissioner has delegated the function. The current ethics supervisor for each agency is listed below. The ethics supervisor for a Commissioner is Guy Bell, Director of Administrative Services in the Office of Governor, by delegation from the Governor.

Boards and Commissions

The Chair of each board and commission serves as the ethics supervisor for the other members and any executive director. The ethics supervisor for the Chair is Guy Bell, Director of Administrative Services in the Office of Governor, by delegation from the Governor. If a board or commission employs staff, the executive director serves as the ethics supervisor for these employees.

Public Corporations

The Chair of the board serves as the ethics supervisor for the other members of the board and any executive director. The executive director is the ethics supervisor for employees of the corporation.

Office of the Governor

The ethics supervisor for the Governor and Lieutenant Governor is the Attorney General. By delegation from the Governor, the ethics supervisor for the staff of the offices of the Governor and Lieutenant Governor is Guy Bell, Director of Administrative Services.

University of Alaska

By delegation of the University President, the ethics supervisor for university employees is Associate General Counsel Andy Harrington.

EXECUTIVE BRANCH AGENCIES

Administration: Leslie Ridle, Deputy Commissioner

Commerce, Community & Economic Development: Jon Bittner, Deputy Commissioner

Corrections: April Wilkerson, Director of Administrative Services

Education & Early Development: Les Morse, Deputy Commissioner

Environmental Conservation: Tom Cherian, Director of Administrative Services

Fish & Game: Kevin Brooks, Deputy Commissioner

Health & Social Services: Dallas Hargrave, Human Resource Manager

Labor & Workforce Development: Michael Monagle, Director, Division of Workers Compensation

Law: Jonathan Woodman, Assistant Attorney General

Military & Veterans Affairs: Marty Meyer, Special Assistant to Commissioner

Natural Resources: John Crowther, Inter-Governmental Coordinator

Public Safety: Terry Vrabec, Deputy Commissioner

Revenue: Dan DeBartolo, Administrative Services Director

Transportation & Public Facilities:

- Highways & Public Facilities: Steve Hatter, Deputy Commissioner
- Aviation: John Binder, Deputy Commissioner
- Central Region: Rob Campbell, Regional Director
- Northern Region: Rob Campbell, Acting Regional Director
- Southcoast Region: Acting Regional Director
- Alaska Marine Highway System: Michael Neussl, Deputy Commissioner
- Headquarters: Mary Siroky, Administrative Services Director

Updated April 2015

Department of Law attorney.general@alaska.gov P.O. Box 110300, Juneau, AK 99811-0300
Phone: 907-465-3600 Fax: 907-465-2075 TTY: 907-258-9161
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State of Alaska
Department of Law
Ethics Information for Members of Boards & Commissions (AS 39.52)

Introduction

This is an introduction to AS 39.52, the Alaska Executive Branch Ethics Act. This guide is not a substitute for reading the law and its regulations. State board and commission members who have further questions should contact their board chair or staff.

The Ethics Act applies to all current and former executive branch public employees and members of statutorily created boards and commissions.

Scope of Ethics Act (AS 39.52.110)

Service on a state board or commission is a public trust. The Ethics Act prohibits substantial and material conflicts of interest. Further, board or commission members, and their immediate family, may not improperly benefit, financially or personally, from their actions as board or commission members. The Act does not, however, discourage independent pursuits, and it recognizes that minor and inconsequential conflicts of interest are unavoidable.

Misuse of Official Position (AS 39.52.120)

Members of boards or commissions may not use their positions for personal gain or to give an unwarranted benefit or treatment to any person. For example, board members may not:

- use their official positions to secure employment or contracts;
- accept compensation from anyone other than the State for performing official duties;
- use State time, equipment, property or facilities for their own personal or financial benefit or for partisan political purposes;
- take or withhold official action on a matter in which they have a personal or financial interest; or
- coerce subordinates for their personal or financial benefit.
- attempt to influence outcome of an administrative hearing by privately contacting the hearing officer.

☹ Terry knew that a proposal that was before the board would harm Terry's business competitor. Instead of publicly disclosing the matter and requesting recusal, Terry voted on the proposal.

☹ Board member Mick has board staff employee Bob type an article for him that Mick hopes to sell to an Alaskan magazine. Bob types the article on State time.

Improper Gifts (AS 39.52.130)

A board member may not solicit or accept gifts if a person could reasonably infer from the circumstances that the gift is intended to influence the board member's action or judgment. "Gifts" include money, items of value, services, loans, travel, entertainment, hospitality, and employment. All gifts from registered lobbyists are presumed to be improper, unless the giver is immediate family of the person receiving the gift.

A gift worth more than $150 to a board member or the board member's immediate family must be reported within 30 days if:

- the board member can take official action that can affect the giver, or
- the gift is given to the board member because he or she is on a state board.

The receipt of a gift worth less than $150 may be prohibited if a person could reasonably infer from the circumstances that the gift is intended to influence the board member's action or judgment. Receipt of such a gift should be disclosed.

Any gift received from another government, regardless of value, must be reported; the board member will be advised as to the disposition of this gift.

A form for reporting gifts is available at www.law.alaska.gov/doclibrary/ethics or from the board or commission staff.

This restriction on gifts does not apply to lawful campaign contributions.

☹ The commission is reviewing Roy's proposal for an expansion of his business. Roy invites all the board members out to dinner at an expensive restaurant. He says it will be okay, since he isn't excluding any of the members.

☺ Jody receives a holiday gift every year from Sam. Jody was recently appointed to a state board, but Sam has no business that is before the board. Jody may accept the gift.

Improper Use or Disclosure of Information (AS 39.52.140)

No former or current member of a board may use or disclose any information acquired from participation on the board if that use or disclosure could result in a financial or personal benefit to the board member (or immediate family), unless that information has already been disseminated to the public. Board members are also prohibited from disclosing confidential information, unless authorized to do so.

☺ Sheila has been on the board for several years. She feels she has learned a great deal of general information about how to have a successful business venture. So she sets up her own business and does well.

☺ Delores has always advised and assisted the other doctors in her clinic on their continuing education requirements. After Delores is appointed to the medical board, she discloses this role to the board and continues to advise the doctors in her clinic.

☹ Jim reviews a confidential investigation report in a licensing matter. He discusses the practitioner's violation with a colleague who is not a board member.

Improper Influence in State Grants, Contracts, Leases or Loans (AS 39.52.150)

A board member, or immediate family, may not apply for, or have an interest in a State grant, contract, lease, or loan, if the board awards or takes action to administer the State grant, contract, lease, or loan.

A board member (or immediate family) may apply for or be a party to a competitively solicited State grant, contract or lease, if the board as a body does not award or administer the grant, contract, or lease and so long as the board member does not take official action regarding the grant, contract, or lease.

A board member (or immediate family) may apply for and receive a State loan that is generally available to the public and has fixed eligibility standards, so long as the board member does not take (or withhold) official action affecting the loan's award or administration.

Board members must report to the board chair any personal or financial interest (or that of immediate family) in a State grant, contract, lease or loan that is awarded or administered by the agency the board member serves. A form for this purpose is available at www.law.alaska.gov/doclibrary/ethics or from the board or commission staff.

☹ John sits on a board that awards state grants. John hasn't seen his daughter for nearly ten years so he figures that it doesn't matter when her grant application comes up before the board.

☹ The board wants to contract out for an analysis of the board's decisions over the last ten years. Board member Kim would like the contract since she has been on the board for ten years and feels she could do a good job.

Improper Representation (AS 39.52.160)

A board or commission member may not represent, advise, or assist a person in matters pending before the board or commission for compensation A nonsalaried board or commission member may represent, advise, or assist in matters in which the member has an interest that is regulated by the member's own board or commission, if the member acts in accordance with AS 39.52.220 by disclosing the involvement in writing and on the public record, and refraining from all participation and voting on the matter. This section does not allow a board member to engage in any conduct that would violate a different section of the Ethics Act.

☺ Susan sits on the licensing board for her own profession. She will represent herself and her business partner in a licensing matter. She discloses this situation to the board and refrains from participation in the board's discussions and determinations regarding the matter.

Restriction on Employment After Leaving State Service (AS 39.52.180)

For two years after leaving a board, a former board member may not provide advice or work for compensation on any matter in which the former member personally and substantially participated while serving on the board. This prohibition applies to cases, proceedings, applications, contracts, legislative bills, regulations, and similar matters. This section does not prohibit a State agency from contracting directly with a former board member.

With the approval of the Attorney General, the board chair may waive the above prohibition if a determination is made that the public interest is not jeopardized.

Former members of the governing boards of public corporations and former members of boards and commissions that have regulation-adoption authority, except those covered by the centralized licensing provisions of AS 08.01, may not lobby for pay for one year.

☹ The board has arranged for an extensive study of the effects of the Department's programs. Andy, a board member, did most of the liaison work with the contractor selected by the board, including some negotiations about the scope of the study. Andy quits the board and goes to work for the contractor, working on the study of the effects of the Department's programs.

☺ Andy takes the job, but specifies that he will have to work on another project.

Aiding a Violation Prohibited (AS 39.52.190)

Aiding another public officer to violate the Ethics Act is prohibited.

Agency Policies (AS 39.52.920)

Subject to the Attorney General's review, a board may adopt additional written policies further limiting personal or financial interests of board members.

Disclosure Procedures

DECLARATION OF POTENTIAL VIOLATIONS BY MEMBERS OF BOARDS OR COMMISSIONS (AS 39.52.220)

A board member whose interests or activities could result in a violation of the Ethics Act if the member participates in board action must disclose the matter on the public record and in writing to the board chair who determines whether a violation exists. A form for this purpose is available at www.law.alaska.gov/doclibrary/ethics or from the board or commission staff. If another board member objects to the chair's ruling or if the chair discloses a potential conflict, the board members at the meeting (excluding the involved member) vote on the matter. If the chair or the board determines a violation will occur, the member must refrain from deliberating, voting, or participating in the matter. For more information, see Ethics Act Procedures for Boards and Commissions available at the above noted web site.

When determining whether a board member's involvement in a matter may violate the Ethics Act, either the chair or the board or commission itself may request guidance from the Attorney General.

ATTORNEY GENERAL'S ADVICE (AS 39.52.240-250)

A board chair or a board itself may request a written advisory opinion from the Attorney General interpreting the Ethics Act. A former board member may also request a written advice from the Attorney General. These opinions are confidential. Versions of opinions without identifying information may be made available to the public.

REPORTS BY THIRD PARTIES (AS 39.52.230)

A third party may report a suspected violation of the Ethics Act by a board member in writing and under oath to the chair of a board or commission. The chair will give a copy to the board member and to the Attorney General and review the report to determine whether a violation may or does exist. If the chair determines a violation exists, the board member will be asked to refrain from deliberating, voting, or participating in the matter.

Complaints, Hearings, and Enforcement

COMPLAINTS (AS 39.52.310-330)

Any person may file a complaint with the Attorney General about the conduct of a current or former board member. Complaints must be written and signed under oath. The Attorney General may also initiate complaints based on information provided by a board. A copy of the complaint will be sent to the board member who is the subject of the complaint and to the Personnel Board.

All complaints are reviewed by the Attorney General. If the Attorney General determines that the complaint does not warrant investigation, the complainant and the board member will be notified of the dismissal. The Attorney General may refer a complaint to the board member's chair for resolution.

After investigation, the Attorney General may dismiss a complaint for lack of probable cause to believe a violation occurred or recommend corrective action. The complainant and board member will be promptly notified of this decision.

Alternatively, if probable cause exists, the Attorney General may initiate a formal proceeding by serving the board or commission member with an accusation alleging a violation of the Ethics Act. Complaints or accusations may also be resolved by settlement with the subject.

CONFIDENTIALITY (AS 39.52.340)

Complaints and investigations prior to formal proceedings are confidential. If the Attorney General finds evidence of probable criminal activity, the appropriate law enforcement agency shall be notified.

HEARINGS (AS 39.52.350-360)

An accusation by the Attorney General of an alleged violation may result in a hearing. An administrative law judge from the state's Office of Administrative Hearings serves as hearing officer and determines the time, place and other matters. The parties to the proceeding are the Attorney General, acting as prosecutor, and the accused public officer, who may be represented by an attorney. Within 30 days after the hearing, the hearing officer files a report with the Personnel Board and provides a copy to the parties.

PERSONNEL BOARD ACTION (AS 39.52.370)

The Personnel Board reviews the hearing officer's report and is responsible for determining whether a violation occurred and for imposing penalties. An appeal may be filed by the board member in the Superior Court.

PENALTIES (AS 39.52.410-460)

When the Personnel Board determines a board member has violated the Ethics Act, it will order the member to refrain from voting, deliberating, or participating in the matter. The Personnel Board may also order restitution and may recommend that the board member be removed from the board or commission. If a recommendation of removal is made, the appointing authority will immediately remove the member.

If the Personnel Board finds that a former board member violated the Ethics Act, it will issue a public statement about the case and will ask the Attorney General to pursue appropriate additional legal remedies.

State grants, contracts, and leases awarded in violation of the Ethics Act are voidable. Loans given in violation of the Ethics Act may be made immediately payable.

Fees, gifts, or compensation received in violation of the Ethics Act may be recovered by the Attorney General.

The Personnel Board may impose a fine of up to $5,000 for each violation of the Ethics Act. In addition, a board member may be required to pay up to twice the financial benefit received in violation of the Ethics Act.

Criminal penalties are in addition to the civil penalties listed above.

DEFINITIONS (AS 39.52.960)

Please keep the following definitions in mind:

Benefit - anything that is to a person's advantage regardless financial interest or from which a person hopes to gain in any way.

Board or Commission - a board, commission, authority, or board of directors of a public or quasi-public corporation, established by statute in the executive branch, including the Alaska Railroad Corporation.

Designated Ethics Supervisor - the chair or acting chair of the board or commission for all board or commission members and for executive directors; for staff members, the executive director is the designated ethics supervisor.

Financial Interest - any property, ownership, management, professional, or private interest from which a board or commission member or the board or commission member's immediate family receives or expects to receive a financial benefit. Holding a position in a business, such as officer, director, partner, or employee, also creates a financial interest in a business.

Immediate Family - spouse; another person cohabiting with the person in a conjugal relationship that is not a legal marriage; a child, including a stepchild and an adoptive child; a parent, sibling, grandparent, aunt, or uncle of the person; and a parent or sibling of the person's spouse.

Official Action - advice, participation, or assistance, including, for example, a recommendation, decision, approval, disapproval, vote, or other similar action, including inaction, by a public officer.

Personal Interest - the interest or involvement of a board or commission member (or immediate family) in any organization or political party from which a person or organization receives a benefit.

For further information and disclosure forms, visit our Executive Branch Ethics web site or please contact:

State Ethics Attorney
Alaska Department of Law
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501-5903
(907) 269-5100
attorney.general@alaska.gov

Revised 9/2013

Department of Law attorney.general@alaska.gov P.O. Box 110300, Juneau, AK 99811-0300
Phone: 907-465-3600 Fax: 907-465-2075 TTY: 907-258-9161
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State of Alaska
Department of Law
Executive Branch Ethics Act

Responsibilities of Designated Ethics Supervisors for Boards and Commissions

Boards and commissions subject to the Ethics Act have designated ethics supervisors. The chair serves as the designated ethics supervisor for board or commission members and the executive director. The executive director is the designated ethics supervisor for staff. The designated ethics supervisor for a chair is the governor, who has delegated this responsibility to Guy Bell, Administrative Director of the Office of the Governor.

Designated ethics supervisors should refer to the Manual for Designated Ethics Supervisors (April 2008), available from the state ethics attorney, regarding their responsibilities under the Ethics Act. Briefly, as designated ethics supervisor, you must --

1. Ensure that members and employees are provided copies of the guides, Ethics Information for Members of Boards and Commissions and Ethics Act Procedures for Boards and Commissions -- and keep a supply of disclosure forms.
    1. These guides, other educational materials, disclosure forms, statutes and regulations are available for review and copying on the Department of Law ethics web site. If access to this page is not available, please contact the Attorney General's office at 269-7195.
2. Review all disclosures, investigate potential ethics violations, make determinations regarding conduct, and take action.
3. Keep member or employee disclosure statements (of potential violations, receipt of gifts, and interests in grants/contracts/leases/loans) on file in your office. Disclosure of a gift received from another government must be forwarded to the Office of the Governor.
4. Submit an ethics report to the Department of Law in April, July, October and January for the preceding quarter. You will receive a reminder. There is a sample report on the ethics web page.
    1. Mail, email or fax to Kim Halstead, Litigation Assistant, Department of Law, Opinions, Appeals & Ethics Section, 1031 W. 4th Avenue, Suite 200, Anchorage, AK, 99501, ethicsreporting@alaska.gov, fax no. 907-279-2834.

You may request ethics advice from your agency's Assistant Attorney General or from the State Ethics Attorney, Jon Woodman, at 269-5100 or jonathan.woodman@alaska.gov. Please direct questions about reporting procedures to Kim Halstead at 269-7195 or kimberly.halstead@alaska.gov.

6/14

Department of Law attorney.general@alaska.gov P.O. Box 110300, Juneau, AK 99811-0300
Phone: 907-465-3600 Fax: 907-465-2075 TTY: 907-258-9161
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Intent:

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Overview:

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Delegate access is allowed so long as the delegate holds an active license, certification, or registration under AS 08. Delegate access can help relieve time-constraints as reviewing and reporting tasks can be distributed to qualified staff.

Updates and Imminent changes:

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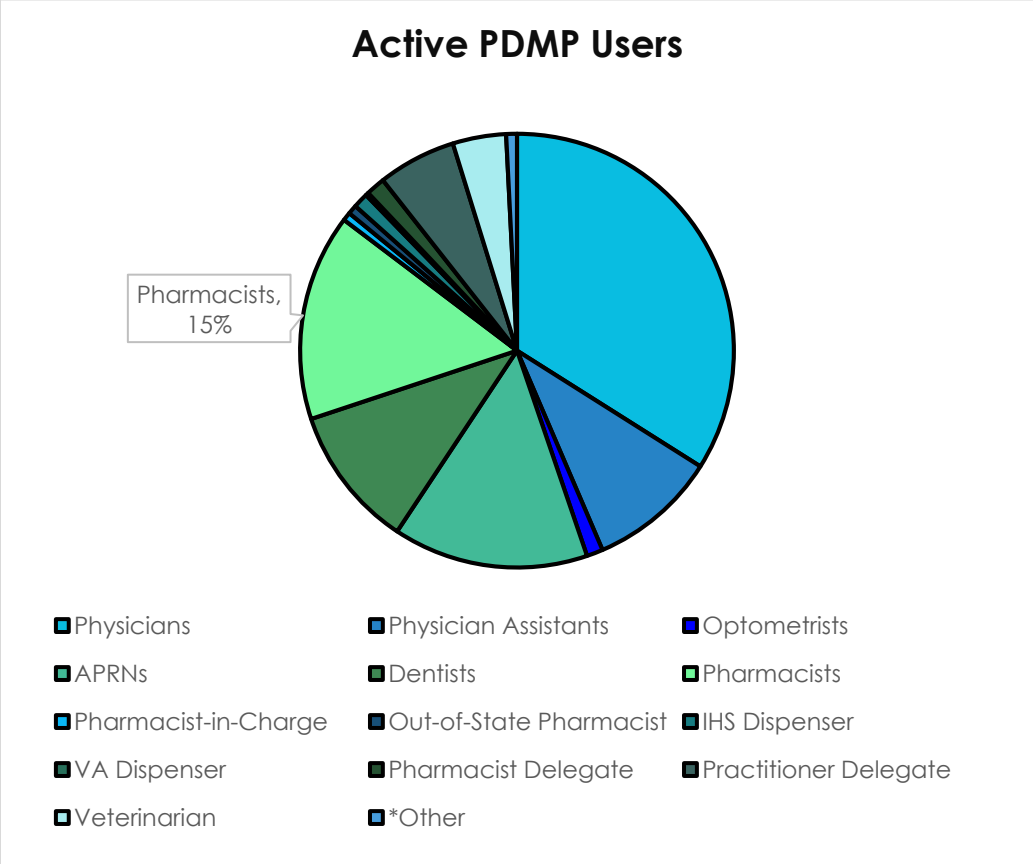
The Alaska State Board of Pharmacy regulates several license types, including pharmacists, pharmacy technicians, and pharmacy interns. All licensees required to register with the PDMP register using the user role 'Pharmacist', unless working for a federal employer (IHS, VA, military, etc.). Pharmacy technicians and interns may register as delegates for Pharmacist users.

Presently, there are a total of 6,293 registered users, 961 of which are registered using the 'Pharmacist' role (Figure 1). Pharmacists are among the top 3 professions of registered users and the majority of active licensed pharmacists are registered; the proportion of total licensed pharmacists to other professions with the PDMP is 15%, where pharmacists have reached 95% registration compliance (Figure 2).



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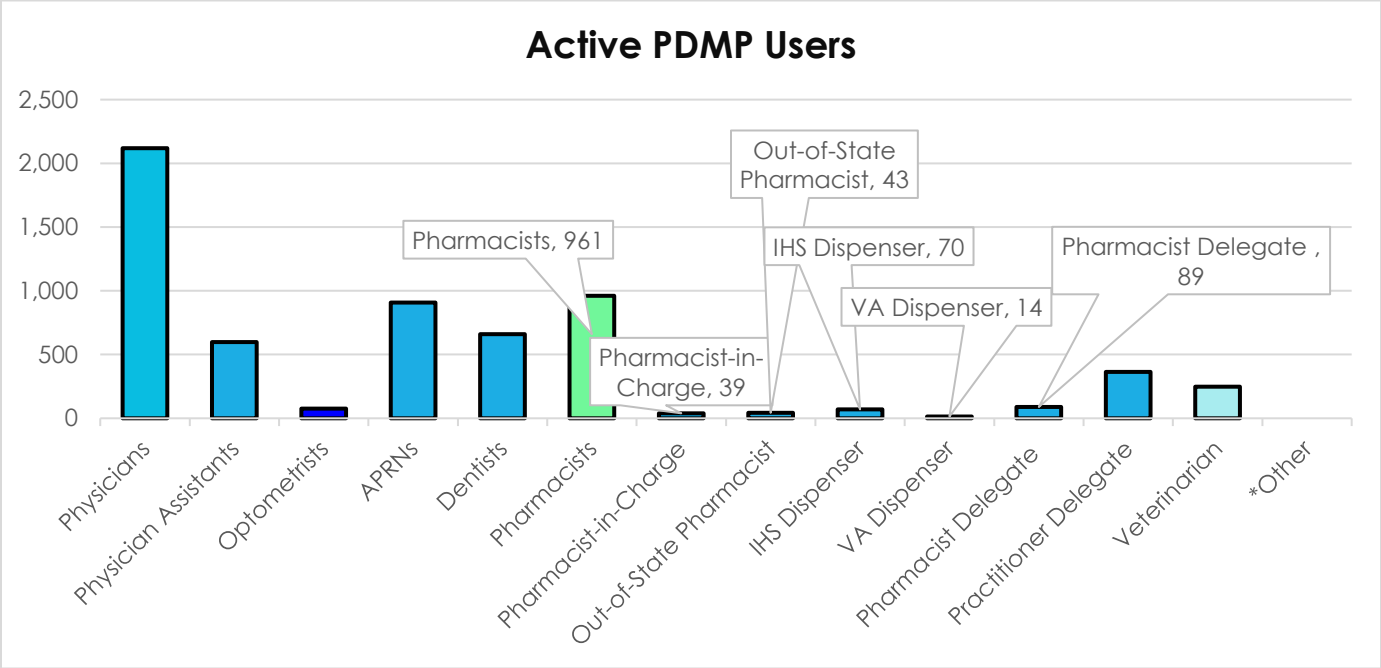

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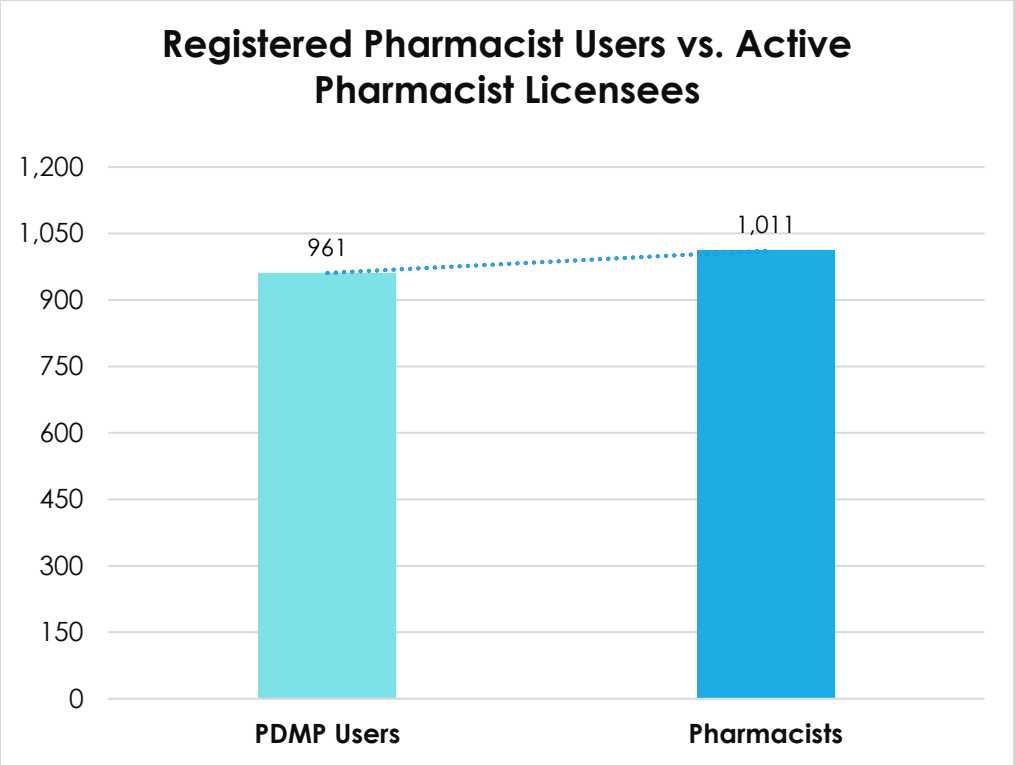

Figure 2. The proportion of licensed pharmacists to registered PDMP users. This represents a compliance rate of 95%, meaning only 5% of licensees potentially required to register are not yet registered. Registration exemptions are found here: https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/PrescriptionDrugMonitoringProgram/RegistrationandUseExemptions.aspx. When considering VA and IHS dispenser users, this compliance rate increases to 103% and may be inclusive of some IHS or VA pharmacists who also have an active Alaska pharmacist license.

The PDMP AWARxE platform includes capabilities to run threshold reports when a patient has met or exceeded an established threshold. The Alaska Board of Pharmacy established a 5-5-3 threshold during their January 29 – 31, 2014 board meeting (Figure 3).

Threshold Period	Criteria	# of Patients
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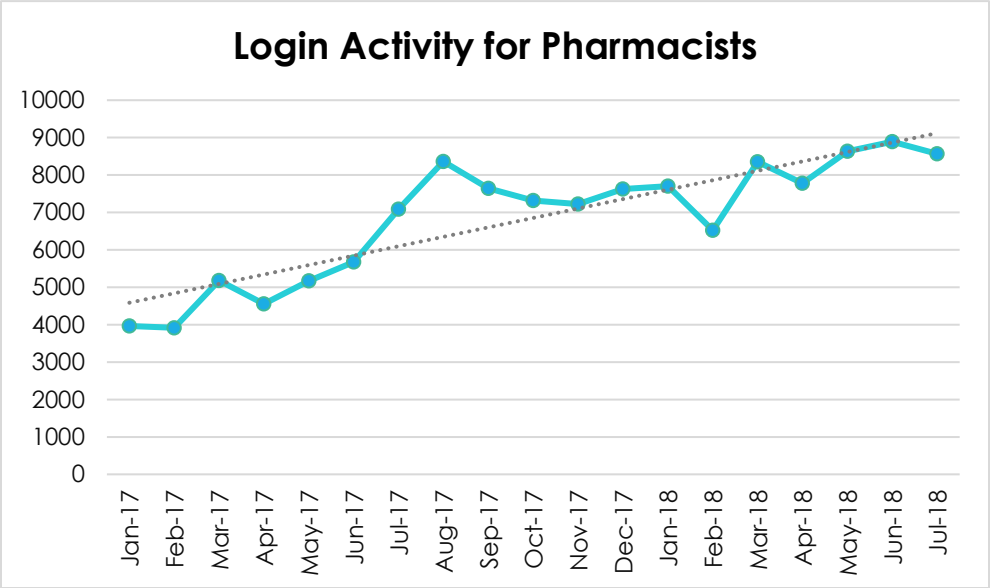

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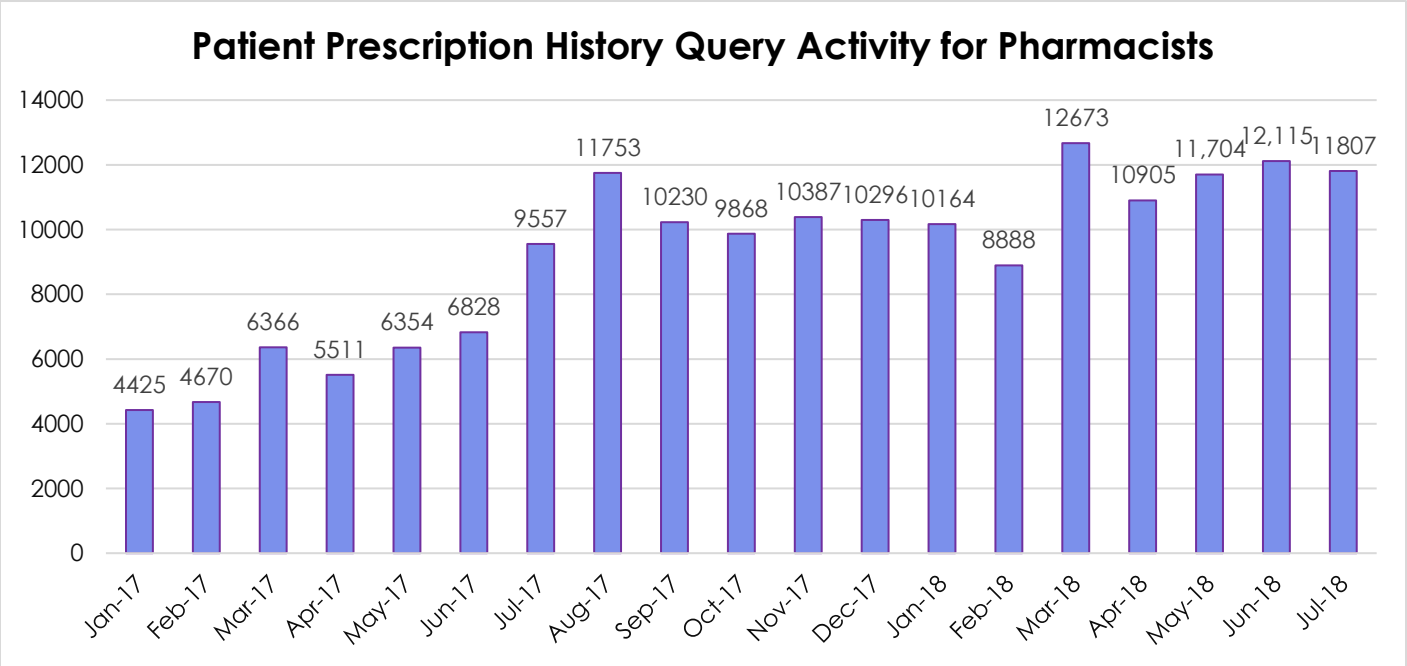

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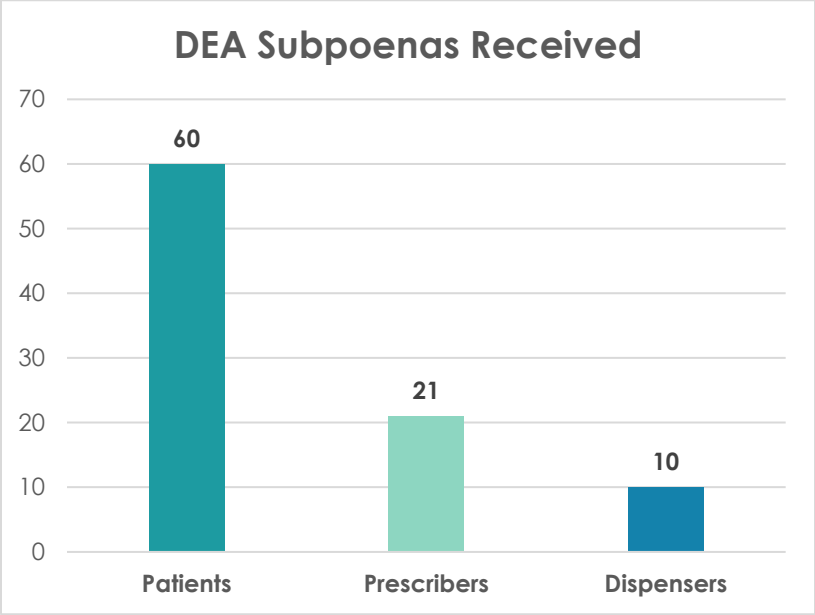
Under AS 17.30.200(d)(1) and 12 AAC 52.860(b), local, state, and federal law enforcement officials may receive information contained within the PDMP upon a search warrant, subpoena, or order issued by an administrative law judge or court. The number of subpoenas issued by the Drug Enforcement Administration are included in figure 6, below.



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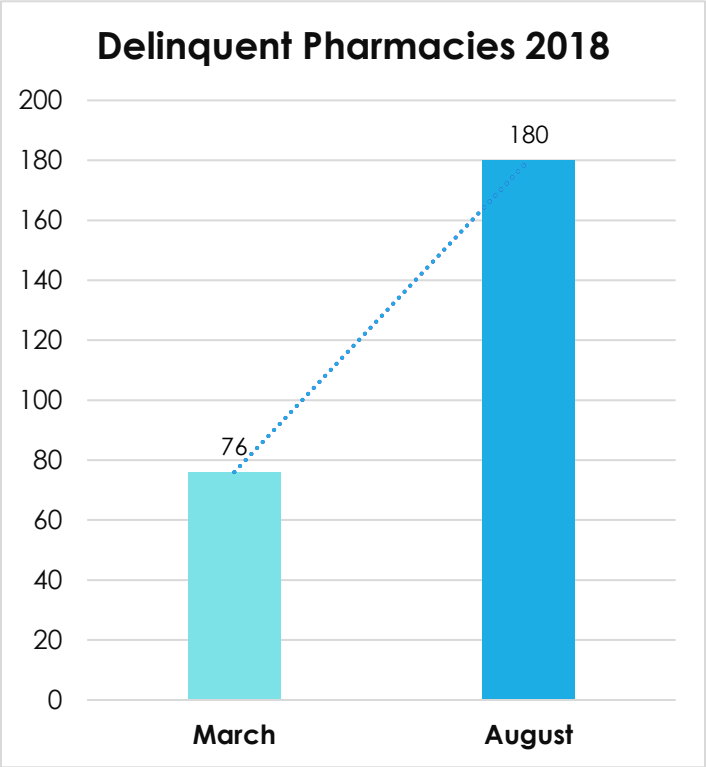

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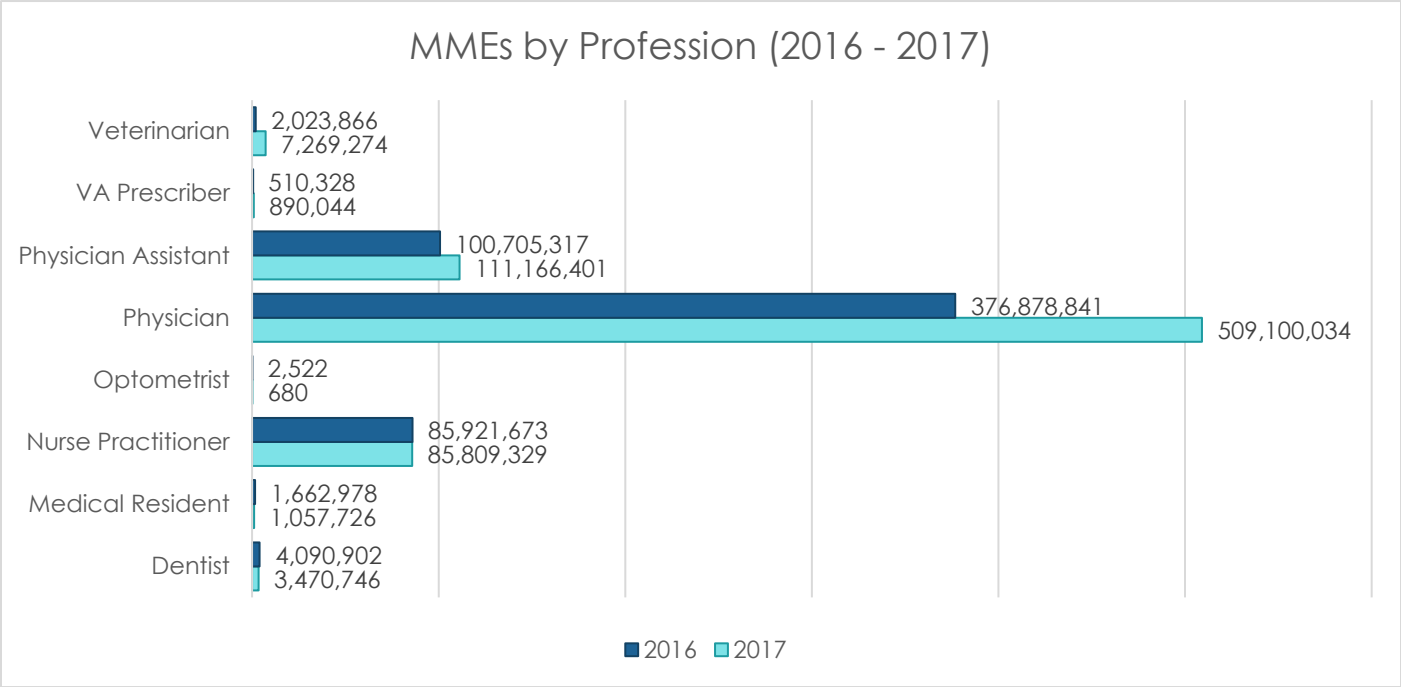

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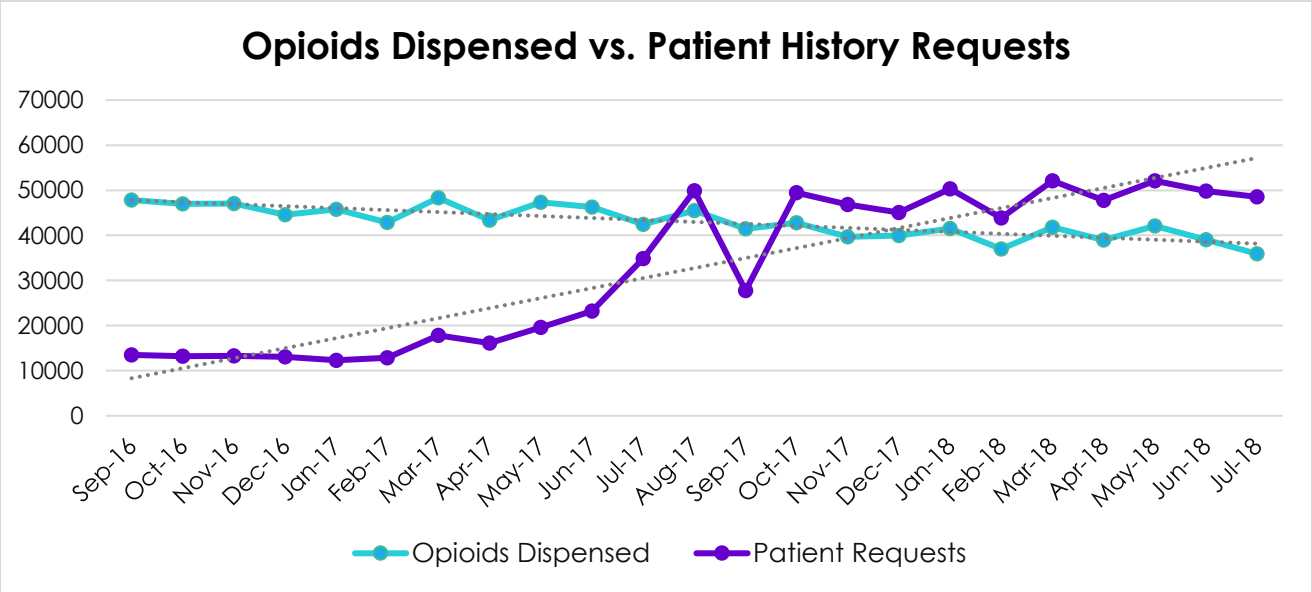

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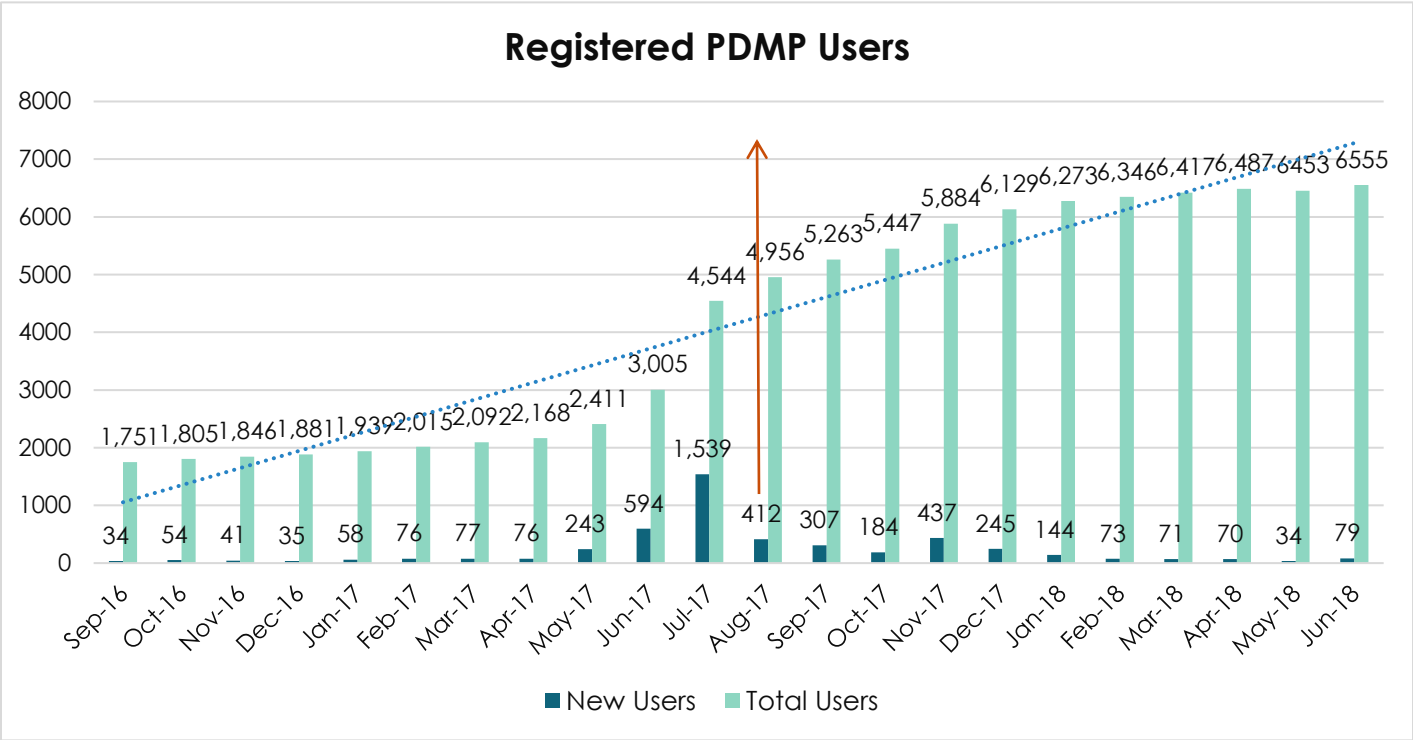

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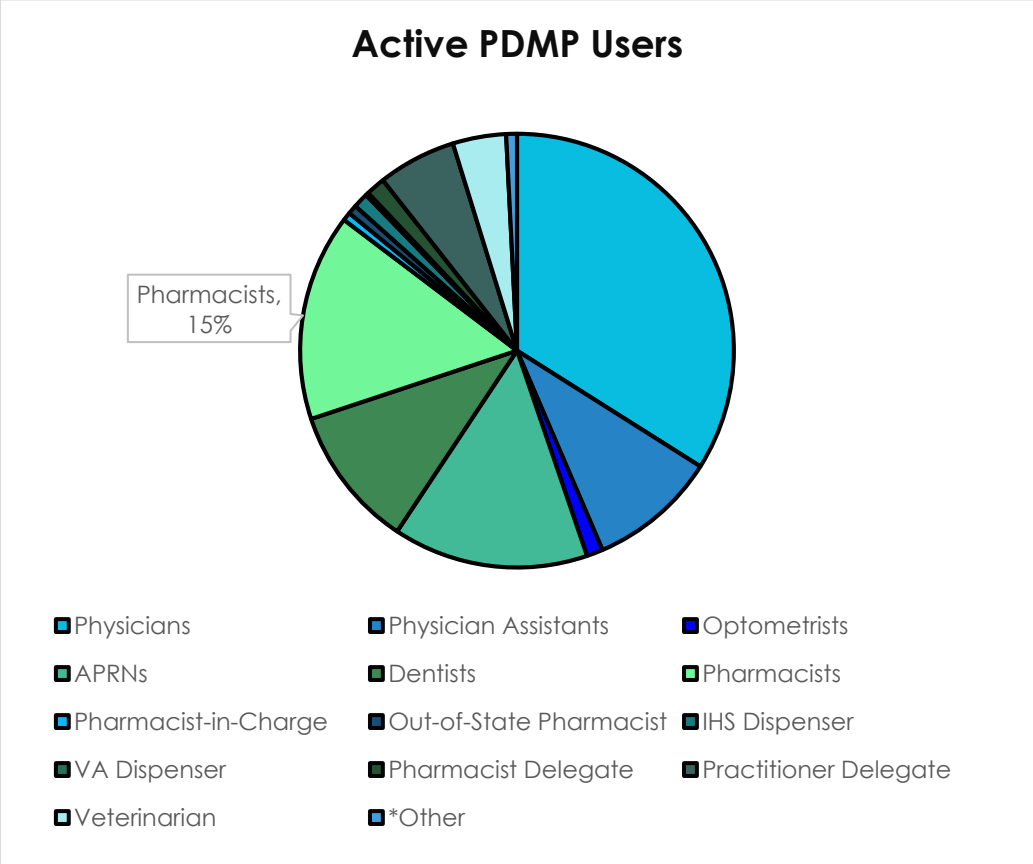

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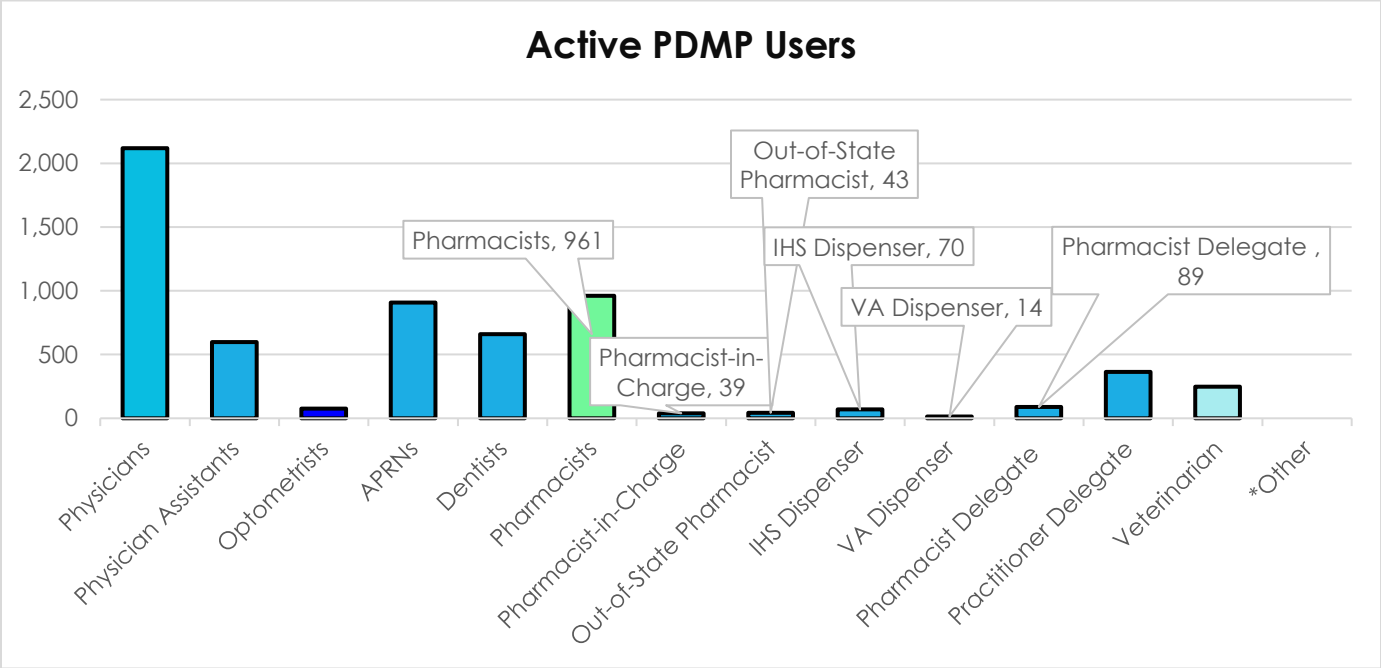

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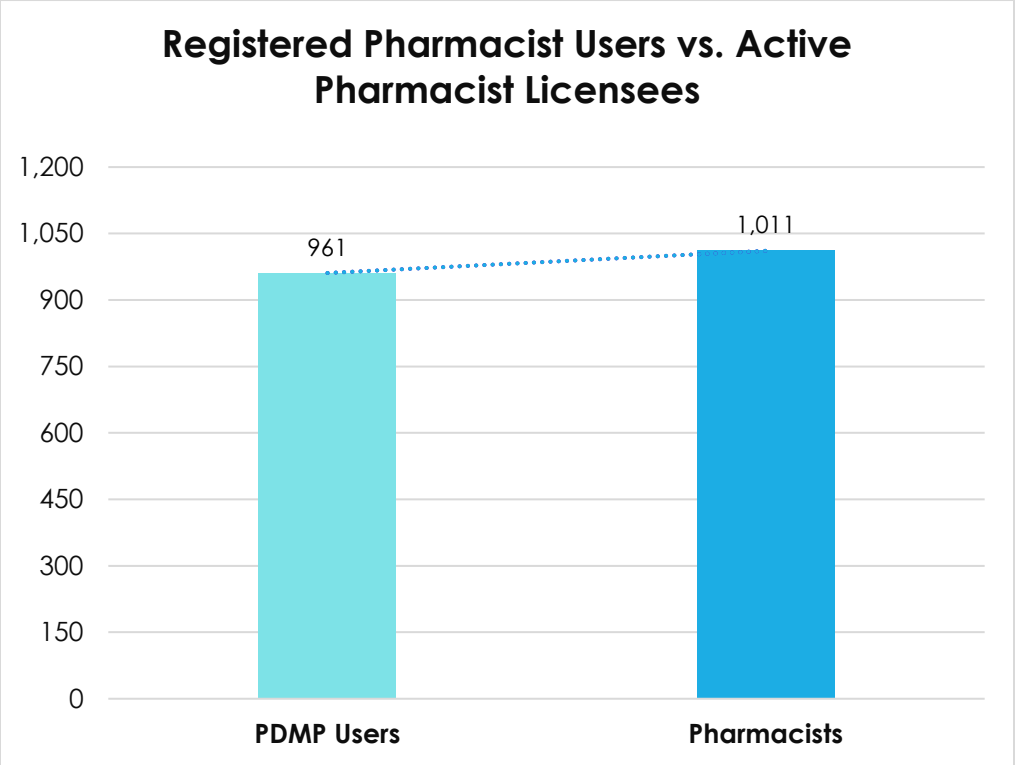

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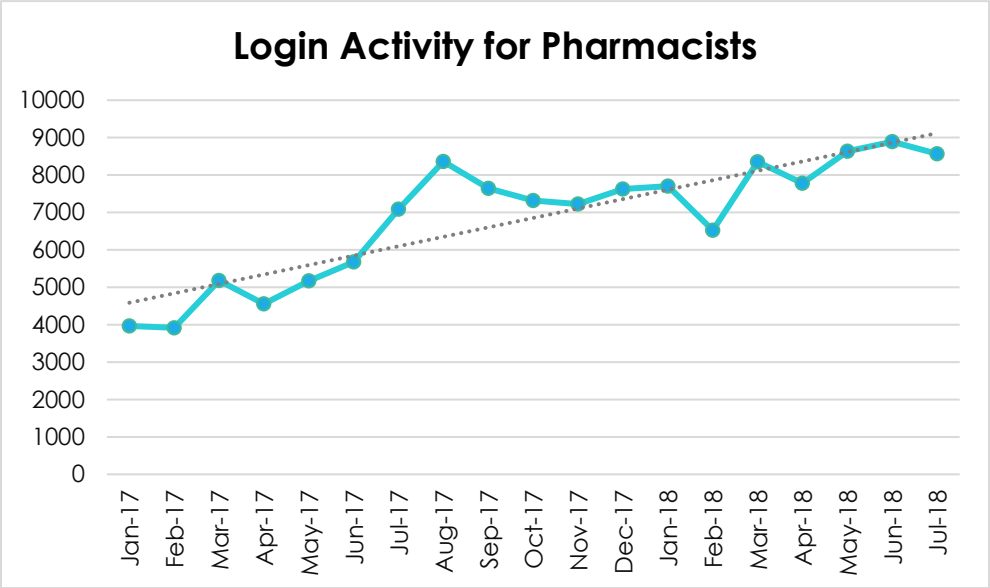

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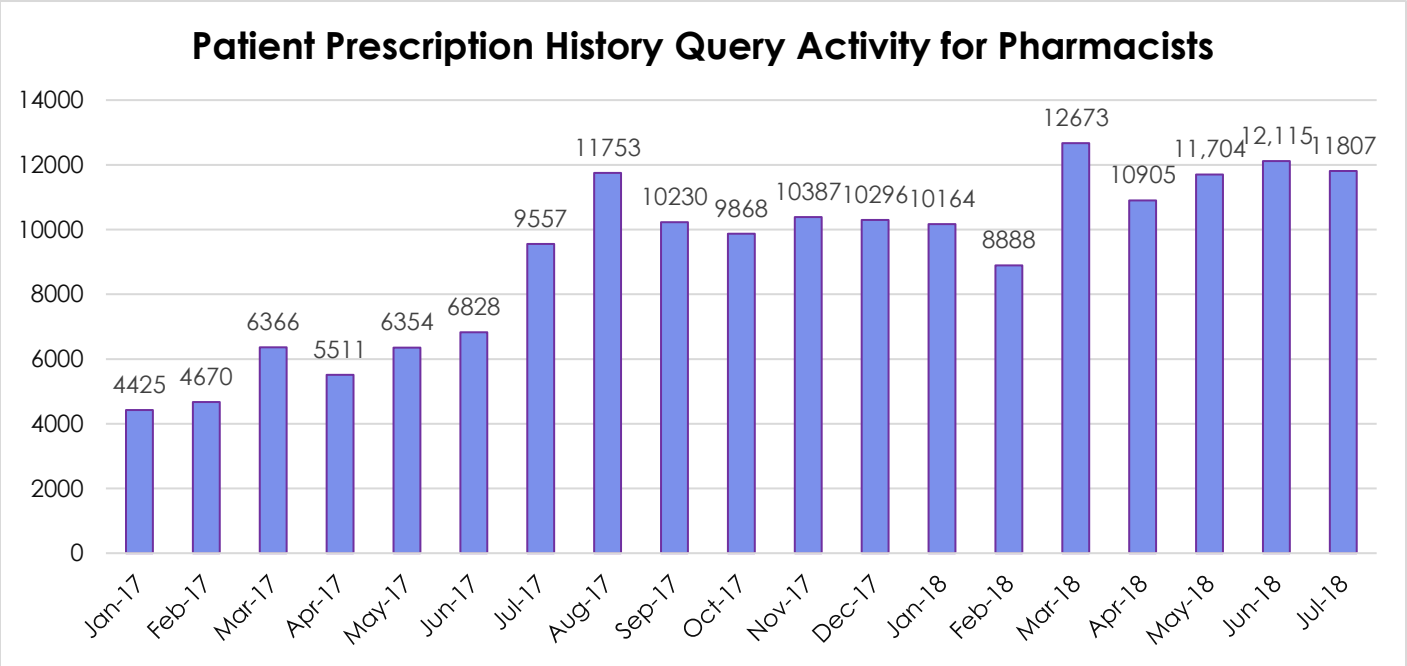

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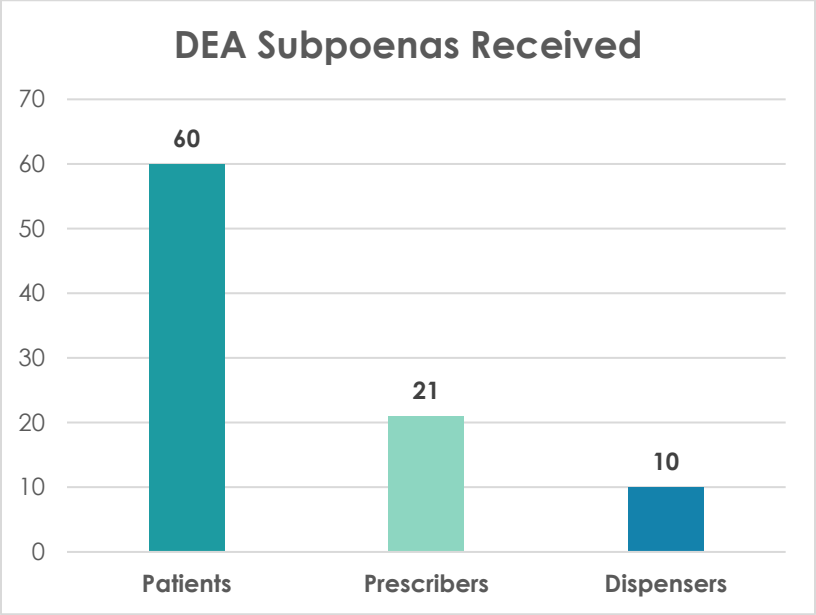

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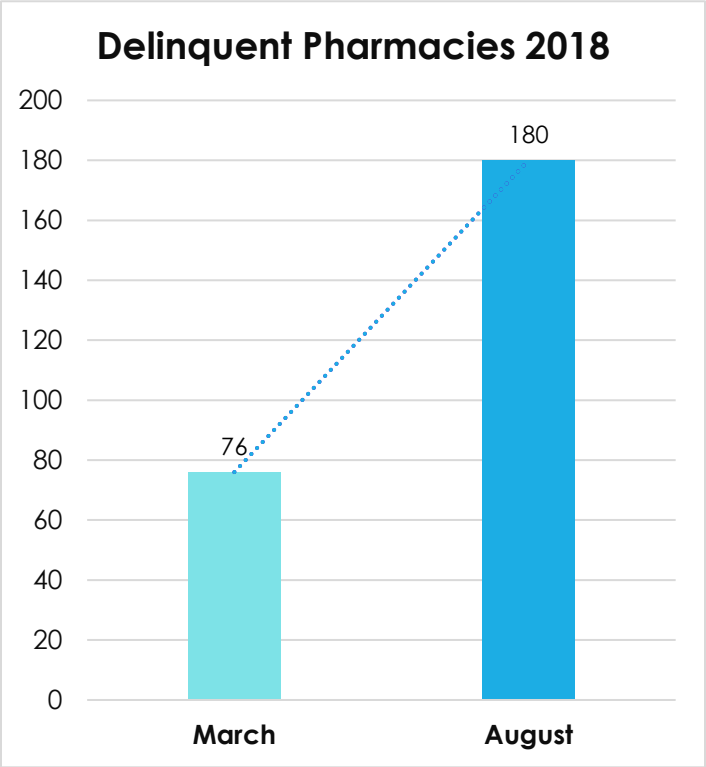

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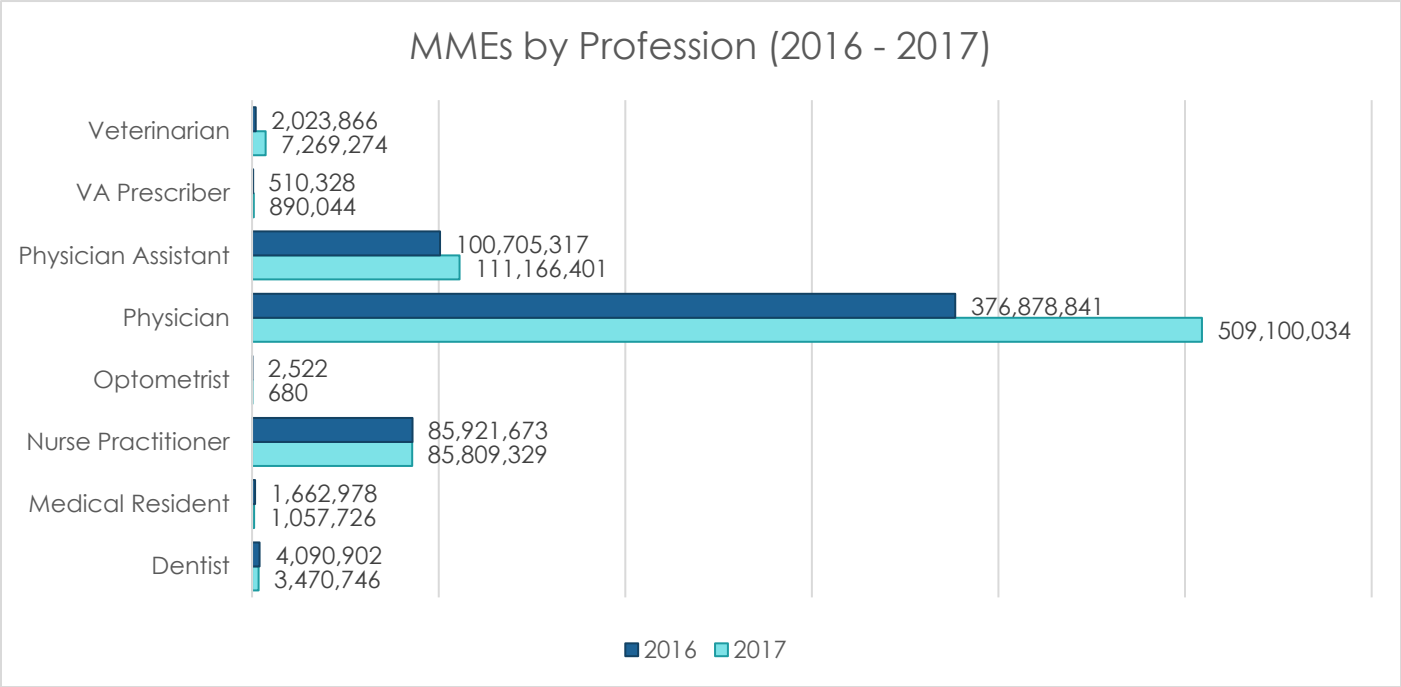

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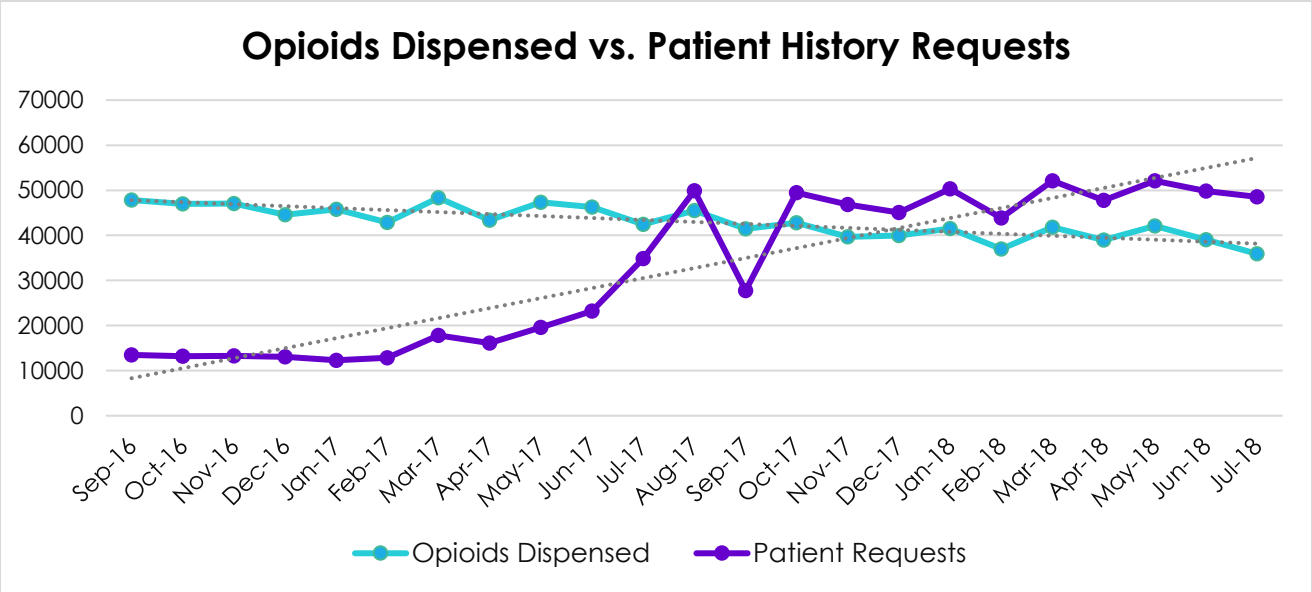

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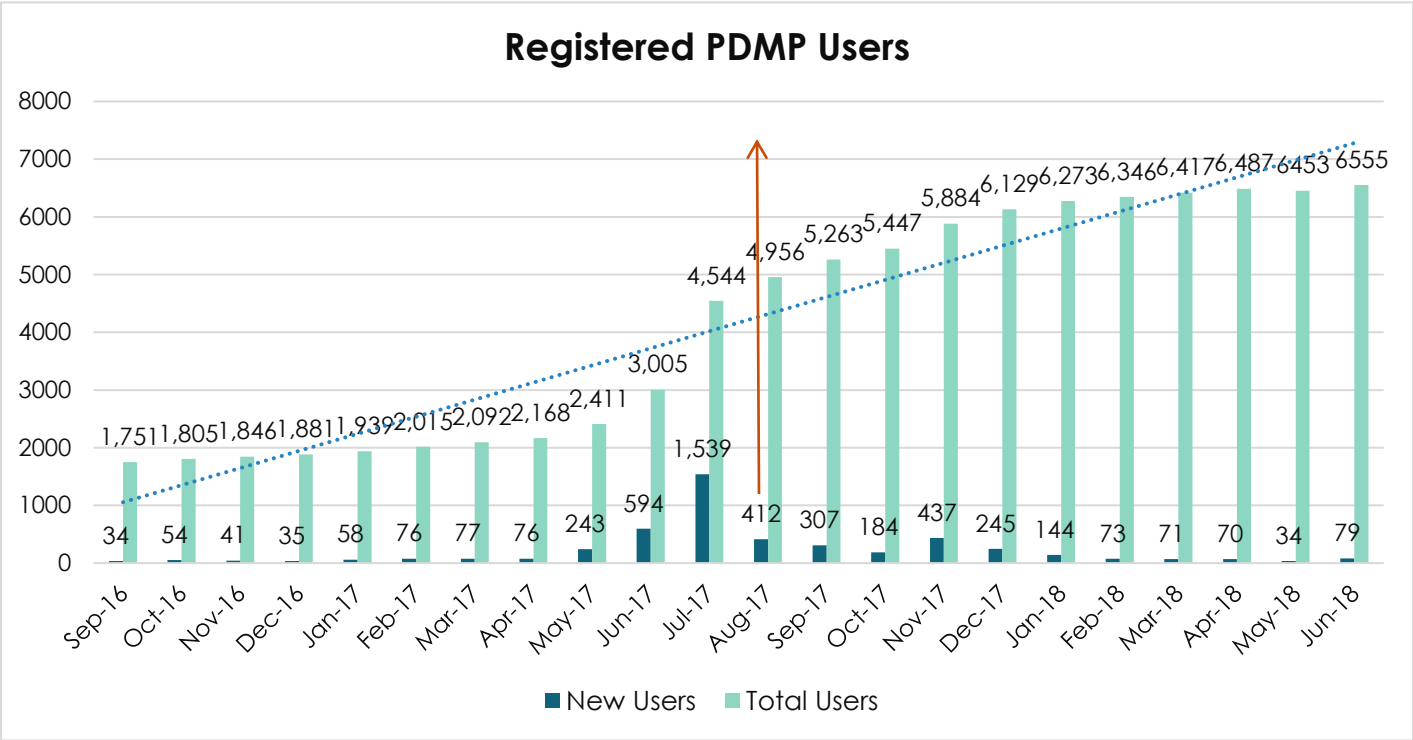

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General registration requirements apply to:

- Practitioners holding an active professional license, certification, registration, or permit under AS 08 and who hold an active registration from the Drug Enforcement Administration to prescribe controlled substances.
- Dispensers living in Alaska and dispensing federally scheduled II – IV controlled substances.

	Required to Register	**Required to Submit Registration Request through alaska.pmpaware.net**	**User Role Required**	**Required to Submit Fee**	**Required to Submit Paper Form(s)**
Federally-Employed Prescriber or Dispenser (IHS, VA, Military)	Not by AS 08 but may be required by an internal directive by federal employer	Yes, if choosing to or required to register by your federal employer	Yes; IHS, VA, or Military user roles only	No; do not submit form 08-4760 (initial form) or 08-4761 (renewal form)	No; do not submit form 08-4760 (initial form) or 08-4761 (renewal form)
Non-Federally-Employed Prescriber or Dispenser	Required to register by AS 08 and AS 17.30.200	Yes	Yes	Yes; submit form 08-4760 (for first time registrants) and form 08-4761 to renew your PDMP registration at the time coinciding with your professional license renewal date	Yes; submit form 08-4760 (for first time registrants) and form 08-4761 to renew your PDMP registration at the time coinciding with your professional license renewal date
Both Federally-Employed and Non-Federally-Employed	- See above requirement -	Yes, create separate accounts. Use the email account issued by your federal employer for your IHS, VA, or military account, and use your non-federal employer email or secure personal email for your other (required registration) account.	For your federal account, use the appropriate IHS, VA, or Military User Role. Use the appropriate user role for your profession for the required registration account.	- See above requirement -	- See above requirement -

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)
FREQUENTLY ASKED QUESTIONS FOR FEDERAL EMPLOYEES

(VA, IHS, Military, and Other Federal Employment)

View the Registration Requirement Quick Guide HERE.

1.) I work exclusively in an organization under the Indian Health Service as a prescriber. I'm told by my employer that I must register with the PDMP, but am contrarily told by the state PDMP office that I am not required to register. Which is correct?

> The state PDMP office has no jurisdiction over federal employees and therefore cannot *require* they be registered with the controlled substance prescription database. Alaska Statute AS 08.The Registration and Use Exemptions page located on pdmp.alaska.gov acknowledges that there may be a directive from the federal employer requiring PDMP registration; follow the directive of your employer and when submitting a registration request through alaska.pmpaware.net, select the user role, "IHS Prescriber". The same is true for pharmacists; use the user role, "IHS Dispenser". The same is true for Veterans Administration employees; use the user role "VA Prescriber" or "VA Dispenser".

2.) As an IHS, VA, military, or other federal prescriber or dispenser working exclusively in this sovereign capacity, am I required to submit the PDMP fee for initial access (form #08-4760) and renewal of my registration (form #08-4761)?

> No, you are not required by AS 08 to submit any fee or form; however, in the future, these forms may include a checkbox profession type for IHS, VA, military, or other federal prescribers or dispensers.

3.) I do not work exclusively for a federal employer; I work both with the IHS, VA, military, or other federal employer and with a non-federal employer. Am I required to register?

> The state PDMP office has no jurisdiction over federal employees and therefore cannot *require* they be registered with the controlled substance prescription database. If you do hold an active professional license under AS 08.08, have a DEA registration to prescribe controlled substances, and are working outside of federal employment, you are required to be registered with the PDMP and pay the initial and renewal fees. Please see form #s 08-4760 and 08-4761.

4.) Since I work as a federal prescriber or dispenser and also as a non-federal prescriber or dispenser, am I permitted to have more than one account? (Also see FAQ #5)

> Yes, if you are working in two different capacities, you can have two different accounts. 12 AAC 52.855 refers to login credentials to access the PDMP and applies to licensed practitioners or pharmacists required to register with the database (excludes federal employees); however, because AS 17.30.200(d)(11) allows access to IHS prescribers or dispensers, these individuals can have a separate account from or in addition to their required account. The same is true for VA, military or other federal employees. For the non-federal account, the initial (#08-4760) and renewal (#08-4761) forms and fee are required. Only submit these via hardcopy mail or fax.

5.) How do I register with two different accounts?

Your account is tied to the email address used to login to the PDMP. Use the email associated with your federal employer for one account and be sure to select the appropriate user role, e.g.: IHS Prescriber. For the other account, use the other email supplied by your non-federal employer or a secure personal email account. Select the appropriate role category, e.g.: Physician (MD, DO).

For non-federal employees registering for the first time:

Step 1.) Initiate the online request at alaska.pmpaware.net
Step 2.) Verify your email by clicking on the link sent from an automated email
Step 3.) Fill out form #08-4760 and submit the PDMP payment
Step 4.) Wait for administrative approval

6.) What if I no longer work with a federal employer due to moving out of state or because my employment is now exclusively with a non-federal employer—what should I do with my IHS, VA, military, or other federal PDMP account?

Please contact the PDMP office at akpdmp@alaska.gov if your employment status changes. If you no longer work with a federal employer, your PDMP account associated with this employer will be deactivated. If you will still be working in a non-federal capacity with a professional license issued by AS 08 and have a DEA registration (if a prescriber) or dispense federally scheduled II – IV controlled substances (if a dispenser), you will be required to comply with all registration and/or reporting requirements.

PDMP

FOR DIVISION USE ONLY

THE STATE of ALASKA

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

Prescription Drug Monitoring Program
State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550 • Fax: (907) 465-2974
Email: *akpdmp@alaska.gov*
Website: *PDMP.Alaska.Gov*

Prescription Drug Monitoring Program (PDMP)

Initial Payment Form

Actively licensed practitioners in Alaska with DEA registrations who prescribe, administer, or directly dispense federally scheduled II–IV controlled substances and all pharmacists who dispense federally scheduled II-IV controlled substances are required to register with the database and pay this fee.

1. **Are you already registered with the PDMP?**
   If yes, do NOT use this form. You must submit Form 08-4761
2. **Have you already submitted a PDMP registration request through alaska.pdmpaware.net?**
   If no, do NOT fill out this form yet. You must first initiate the registration request online.
3. **Do you work for an Indian health service, the Veterans Administration, or other federal employer?***If yes, do NOT use this form or pay the fee. You can still submit a registration request through alaska.pdmpaware.net using the proper user role, for example, "IHS Prescriber".*

Required Fee:	☐ Initial PDMP Registration Fee	**$25.00**

Practitioner Type:

☐ Dentist ☐ Pharmacist ☐ Optometrist
☐ Physician Assistant ☐ Physician (MD, DO) ☐ Veterinarian
☐ Advanced Nurse Practitioner (NP, NM, CNS, CRNA) ☐ Podiatrist

AK Professional License Number:	DEA Registration Number(s):	Initial Issue Date(s):

Complete Name:	First Name:	Middle Name:	Last Name:	
Full Address:	Address:	City:	State:	ZIP Code:
Contact Phone:	(☐☐☐) ☐☐☐ – ☐☐☐☐			
PDMP Email:				

Signature: _____ **Date:** _____

THE STATE of ALASKA

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

FOR DIVISION USE ONLY

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
333 Willoughby Avenue, 9th Floor, Juneau, AK 99801
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

CREDIT CARD PAYMENT

For security purposes, do not email credit card information. Mail this credit card payment form to the division. Completion of this form is not proof of payment until the division processes the information. If any information on this form is illegible, the form will be rejected.

Name of Applicant or Licensee: _____

License Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:
  - 1. _____ _____
  - 2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: _____

08-4438 Rev 05/01/18 Credit Card Payment Form

VISA or Mastercard Number: _____ **Expiration Date:** _____

Billing ZIP Code: _____ **3-Digit Security Code:** _____

This section below the dotted line will be destroyed upon processing of the payment.

Confidential

PDMP

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THE STATE of ALASKA

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

Prescription Drug Monitoring Program (PDMP)
State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 269-8404 • Fax: (907) 465-2974
Email: *akpdmp@alaska.gov*
Website: *PDMP.Alaska.Gov*

PDMP Registration Renewal

DO NOT USE THIS FORM IF:

- You are NOT already registered with the PDMP — Use the INITIAL form (*08-4760*)
- Your Alaska professional license is more than three months from being due for renewal
- You work for an Indian health service, the Veterans Administration, or other federal employer

A $25.00 renewal payment is required for the PDMP controlled substance prescription database for continued registration and access. The due date for the renewal fee coincides with your license renewal end date. If a pharmacist, provide your employing pharmacy's DEA registration.

Required Fee:	☐ PDMP Registration Renewal Fee	**$25.00**

Practitioner Type:

☐ Dentist ☐ Physician (MD, DO) ☐ Optometrist
☐ Podiatrist ☐ Medical Resident ☐ Veterinarian
☐ Pharmacist ☐ Physician Assistant
☐ Advanced Nurse Practitioner (NP, NM, CNS, CRNA)

AK Professional License Number:	DEA Registration Number(s):	Initial Issue Date(s):

Complete Name:	First Name:	Middle Name:	Last Name:	
Full Address:	Address:	City:	State:	ZIP Code:
Contact Phone:	(☐☐☐) ☐☐☐ – ☐☐☐☐			
PDMP Email:				

All actively licensed practitioners with Drug Enforcement Agency registrations to write prescriptions are required to review a patient's prescription history before prescribing, administering, or directly dispensing a federally scheduled II – IV controlled substance unless otherwise exempt under AS 17.30.200(k) or (u). By paying this fee and providing your signature below, you acknowledge continuous compliance with PDMP use and confidentiality requirements set out in AS 17.30.200(d).

Signature: _____ **Date:** _____

THE STATE of ALASKA

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333 Willoughby Avenue, 9th Floor, Juneau, AK 99801
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550 • Fax: (907) 465-2974

CREDIT CARD PAYMENT

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Name of Applicant or Licensee: _____

License Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

☐ Application Fee: _____ _____

☐ License or Renewal Fee: _____ _____

☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:

1. _____ _____
2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: _____

08-4438 Rev 05/01/18 Credit Card Payment Form

Confidential

VISA or Mastercard Number: _____ **Expiration Date:** _____

Billing ZIP Code: _____ **3-Digit Security Code:** _____

This section below the dotted line will be destroyed upon processing of the payment.

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State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
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Email: *akpdmp@alaska.gov*
Website: *PDMP.Alaska.Gov*

Prescription Drug Monitoring Program

Data Access for the Alaska Department of Health and Social Services

By authority of AS 17.30.200(d)(10) and 12 AAC 52.860, the Alaska Department of Health and Social Services (DHSS) may receive data contained in the Alaska Prescription Drug Monitoring Program (PDMP), the state's controlled substance prescription database. Authorized access will only be granted to DHSS's commissioner or commissioner's official designee upon a request in writing to access data contained in the PDMP. Use this form to submit the written request.

- AS 17.30.200(d)(10) **DOES NOT** allow disclosure of data to DHSS that identifies a patient, prescriber, dispenser, or dispenser location.
- AS 17.30.200(d)(10) **DOES** allow disclosure of regional identification in which a patient, prescriber, or dispenser is located as well as disclosure of the health care specialty of the prescriber.

Requestor:

☐ I am the DHSS Commissioner.
☐ I am the DHSS Commissioner's delegate. I have attached my delegation authority.

I AM REQUESTING THE FOLLOWING DATA *(check all that apply):*

☐ **Drug Name(s):** *(refer to list on page 3)*

Generic name(s) of the federally scheduled II-IV controlled substance(s):

_____

☐ **Timeframe**

Provide the prescription or dispensation timeframe *(prescription data is purged from the database after two years have elapsed from the date the prescription was dispensed per AS 17.30.200(k)(1))*:

Data Begin Date: _____ Data End Date: _____

☐ **Region(s):** *(refer to key on next page)*

☐ All Regions ☐ Interior ☐ Far North
☐ Southwest ☐ Southcentral ☐ Southeast

☐ **Measures**

- ☐ Population size of patients receiving prescriptions for the controlled substance(s).
- ☐ Profession or role type prescribing the controlled substance(s):
  - ☐ Dentist
  - ☐ Podiatrist
  - ☐ Optometrist
  - ☐ Physician Assistant
  - ☐ Physician (MD, DO)
  - ☐ Veterinarian
  - ☐ APRN (NP, NM, CNS, CRNA)
- ☐ Health care specialty: _____

  (see next pages for list of health care specialties)
- ☐ Number of pharmacies dispensing the federally scheduled II-IV controlled substance(s) by region.

☐ **QUICK DATA**

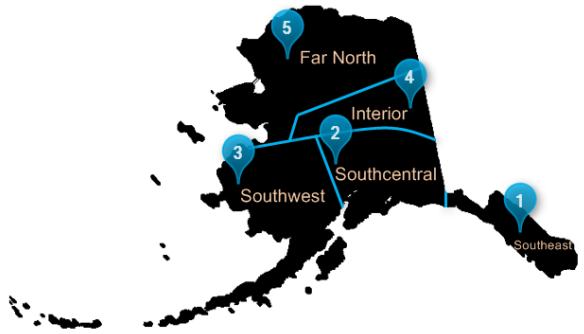
- ☐ Top 10 Counties by Prescription Count (Year-to-Date)
- ☐ Top 10 Drug Classes by Prescription Count (Year-to-Date)
- ☐ Prescription Percent by Drug Schedule (Year-to-Date)
- ☐ Number of Prescriptions by Age Distribution (Calendar Year, Year-to-Date)

Printed Name: _____ **Title:** _____

Signature: _____ **Date:** _____

IMPORTANT:

If a requested search criteria has the potential to identify a patient, prescriber, or dispenser, (such as a practitioner with the only specialty in a certain region), the request may not be fulfilled in order to protect the identity of the individual.



1 — Southeast Region

- Haines Borough
- Juneau Borough
- Ketchikan Gateway Borough
- Petersburg Census Area
- Prince of Wales-Hyder Census Area
- Sitka Borough
- Skagway Municipality
- Wrangell City and Borough

2 — Southcentral Region

- Anchorage Borough
- Kenai Peninsula Borough
- Matanuska-Susitna Borough
- Valdez-Cordova Census Area

3 — Southwest Region

- Bethel Census Area
- Dillingham Census Area
- Kodiak Island Borough

4 — Interior Region

- Fairbanks North Star Borough
- Southeast Fairbanks Census Area

5 — Far North Region

- Nome Census Area
- Northwest Arctic Borough

GENERIC NAMES OF FEDERALLY SCHEDULED II-IV CONTROLLED SUBSTANCES

- ☐ **00** SELECT ALL
- ☐ **01** Acetaminophen with Codeine Phosphate
- ☐ **02** Alprazolam
- ☐ **03** Amphetamine
- ☐ **04** Aspirin/Caffeine/Dihydrocodeine Bitartrate
- ☐ **05** Buprenorphine
- ☐ **06** Buprenorphine HCL
- ☐ **07** Buprenorphine HCL/Naloxone HCL
- ☐ **08** Butalbital/Acetaminophen/Caffeine/Codeine Phosphate
- ☐ **09** Butorphanol Tartrate
- ☐ **10** Carisoprodol
- ☐ **11** Carisoprodol/Aspirin/Codeine Phosphate
- ☐ **12** Chlordiazepoxide HCL
- ☐ **13** Clobazam
- ☐ **14** Clonazepam
- ☐ **15** Clorazepate Dipotassium
- ☐ **16** Codeine Phosphate/Butalbital/Aspirin/Caffeine
- ☐ **17** Codeine Sulfate
- ☐ **18** Dexmethylphenidate HCL
- ☐ **19** Dextroamphetamine Sulf-Saccharate/Amphetamine Sulf-Aspartate
- ☐ **20** Diazepam
- ☐ **21** Estazolam
- ☐ **22** Fentanyl
- ☐ **23** Fentanyl Citrate
- ☐ **24** Flurazepam HCL
- ☐ **25** Hydrocodone Bitartrate
- ☐ **26** Hydrocodone Bitartrate/Acetaminophen
- ☐ **27** Hydrocodone/Ibuprofen
- ☐ **28** Hydromorphone HCL
- ☐ **29** Ibuprofen/Oxycodone HCL
- ☐ **30** Levorphanol Tartrate
- ☐ **31** Lisdexamfetamine Dimesylate
- ☐ **32** Lorazepam
- ☐ **33** Meperidine HCL
- ☐ **34** Methadone HCL
- ☐ **35** Methylphenidate
- ☐ **36** Methylphenidate HCL
- ☐ **37** Morphine Sulfate
- ☐ **38** Morphine Sulfate/Naltrexone HCL
- ☐ **39** Opium/Belladonna Alkaloids
- ☐ **40** Oxazepam
- ☐ **41** Oxycodone HCL
- ☐ **42** Oxycodone HCL/Acetaminophen
- ☐ **43** Oxycodone HCL/Aspirin
- ☐ **44** Oxycodone Myristate
- ☐ **45** Oxymorphone HCL
- ☐ **46** Pentazocine HCL/Naloxone HCL
- ☐ **47** Quazepam
- ☐ **48** Tapentadol HCL
- ☐ **49** Temazepam
- ☐ **50** Tramadol HCL
- ☐ **51** Tramadol HCL/Acetaminophen
- ☐ **52** Triazolam
- ☐ **53** Zolpidem Tartrate

Health Care Specialties

- **Allopathic & Osteopathic Physicians**
  - Allergy & Immunology
  - Allergy & Immunology - Allergy
  - Allergy & Immunology - Clinical & Laboratory Immunology
  - Anesthesiology
  - Anesthesiology - Addiction Medicine
  - Anesthesiology - Critical Care Medicine
  - Anesthesiology - Hospice and Palliative Medicine
  - Anesthesiology - Pain Medicine
  - Anesthesiology - Pediatric Anesthesiology
  - Clinical Pharmacology
  - Colon & Rectal Surgery
  - Dermatology
  - Dermatology - Clinical & Laboratory Dermatological Immunology
  - Dermatology - Dermatopathology
  - Dermatology - MOHS-Micrographic Surgery
  - Dermatology - Pediatric Dermatology
  - Dermatology - Procedural Dermatology
  - Electrodiagnostic Medicine
  - Emergency Medicine
  - Emergency Medicine - Emergency Medical Services
  - Emergency Medicine - Hospice and Palliative Medicine
  - Emergency Medicine - Medical Toxicology
  - Emergency Medicine - Pediatric Emergency Medicine
  - Emergency Medicine - Sports Medicine
  - Emergency Medicine - Undersea and Hyperbaric Medicine
  - Family Medicine
  - Family Medicine - Addiction Medicine
  - Family Medicine - Adolescent Medicine
  - Family Medicine - Adult Medicine
  - Family Medicine - Geriatric Medicine
  - Family Medicine - Hospice and Palliative Medicine
  - Family Medicine - Obesity Medicine
  - Family Medicine - Sleep Medicine
  - Family Medicine - Sports Medicine
  - General Practice
  - Hospitalist
  - Independent Medical Examiner
  - Internal Medicine
  - Internal Medicine - Addiction Medicine
  - Internal Medicine - Adolescent Medicine
  - Internal Medicine - Advanced Heart Failure and Transplant Cardiology
  - Internal Medicine - Allergy & Immunology
  - Internal Medicine - Cardiovascular Disease
  - Internal Medicine - Clinical Cardiac Electrophysiology
  - Internal Medicine - Clinical & Laboratory Immunology
  - Internal Medicine - Critical Care Medicine
  - Internal Medicine - Endocrinology, Diabetes & Metabolism
  - Internal Medicine - Gastroenterology
  - Internal Medicine - Geriatric Medicine
  - Internal Medicine - Hematology
  - Internal Medicine - Hematology & Oncology
  - Internal Medicine - Hepatology
  - Internal Medicine - Hospice and Palliative Medicine
  - Internal Medicine - Hypertension Specialist
  - Internal Medicine - Infectious Disease
  - Internal Medicine - Interventional Cardiology
  - Internal Medicine - Magnetic Resonance Imaging (MRI)
  - Internal Medicine - Medical Oncology
  - Internal Medicine - Nephrology
  - Internal Medicine - Obesity Medicine
  - Internal Medicine - Pulmonary Disease
  - Internal Medicine - Rheumatology
  - Internal Medicine - Sleep Medicine
  - Internal Medicine - Sports Medicine
  - Internal Medicine - Transplant Hepatology
  - Legal Medicine
  - Medical Genetics - Clinical Biochemical Genetics
  - Medical Genetics - Clinical Cytogenetic
  - Medical Genetics - Clinical Genetics (M.D.)
  - Medical Genetics - Clinical Molecular Genetics
  - Medical Genetics - Molecular Genetic Pathology
  - Medical Genetics - Ph.D. Medical Genetics
  - Neurological Surgery
  - Neuromusculoskeletal Medicine & OMM
  - Neuromusculoskeletal Medicine, Sports Medicine
  - Nuclear Medicine
  - Nuclear Medicine - In Vivo & In Vitro Nuclear Medicine
  - Nuclear Medicine - Nuclear Cardiology
  - Nuclear Medicine - Nuclear Imaging & Therapy
  - Obstetrics & Gynecology
  - Obstetrics & Gynecology - Critical Care Medicine
  - Obstetrics & Gynecology - Female Pelvic Medicine and Reconstructive Surgery
  - Obstetrics & Gynecology - Gynecologic Oncology
  - Obstetrics & Gynecology - Gynecology
  - Obstetrics & Gynecology - Hospice and Palliative Medicine
  - Obstetrics & Gynecology - Maternal & Fetal Medicine
  - Obstetrics & Gynecology - Obesity Medicine
  - Obstetrics & Gynecology - Obstetrics
  - Obstetrics & Gynecology - Reproductive Endocrinology
  - Ophthalmology
  - Ophthalmology - Ophthalmic Plastic and Reconstructive Surgery
  - Oral & Maxillofacial Surgery

- Orthopaedic Surgery
- Orthopaedic Surgery - Adult Reconstructive Orthopaedic Surgery
- Orthopaedic Surgery - Foot and Ankle Surgery
- Orthopaedic Surgery - Hand Surgery
- Orthopaedic Surgery - Orthopaedic Surgery of the Spine
- Orthopaedic Surgery - Orthopaedic Trauma
- Orthopaedic Surgery - Pediatric Orthopaedic Surgery
- Orthopaedic Surgery - Sports Medicine
- Otolaryngology
- Otolaryngology - Facial Plastic Surgery
- Otolaryngology - Otolaryngic Allergy
- Otolaryngology - Otolaryngology/Facial Plastic Surgery
- Otolaryngology - Otology & Neurotology
- Otolaryngology - Pediatric Otolaryngology
- Otolaryngology - Plastic Surgery within the Head & Neck
- Otolaryngology - Sleep Medicine
- Pain Medicine - Interventional Pain Medicine
- Pain Medicine - Pain Medicine
- Pathology - Anatomic Pathology
- Pathology - Anatomic Pathology & Clinical Pathology
- Pathology - Blood Banking & Transfusion Medicine
- Pathology - Chemical Pathology
- Pathology - Clinical Informatics
- Pathology - Clinical Pathology
- Pathology - Clinical Pathology/Laboratory Medicine
- Pathology - Cytopathology
- Pathology - Dermatopathology
- Pathology - Forensic Pathology
- Pathology - Hematology
- Pathology - Immunopathology
- Pathology - Medical Microbiology
- Pathology - Molecular Genetic Pathology
- Pathology - Neuropathology
- Pathology - Pediatric Pathology
- Pediatrics
- Pediatrics - Adolescent Medicine
- Pediatrics - Child Abuse Pediatrics
- Pediatrics - Clinical & Laboratory Immunology
- Pediatrics - Developmental – Behavioral Pediatrics
- Pediatrics - Hospice and Palliative Medicine
- Pediatrics - Medical Toxicology
- Pediatrics - Neonatal-Perinatal Medicine
- Pediatrics - Neurodevelopmental Disabilities
- Pediatrics - Obesity Medicine
- Pediatrics - Pediatric Allergy/Immunology
- Pediatrics - Pediatric Cardiology
- Pediatrics - Pediatric Critical Care Medicine
- Pediatrics - Pediatric Emergency Medicine
- Pediatrics - Pediatric Endocrinology
- Pediatrics - Pediatric Gastroenterology
- Pediatrics - Pediatric Hematology-Oncology
- Pediatrics - Pediatric Infectious Diseases
- Pediatrics - Pediatric Nephrology
- Pediatrics - Pediatric Pulmonology
- Pediatrics - Pediatric Rheumatology
- Pediatrics - Pediatric Transplant Hepatology
- Pediatrics - Sleep Medicine
- Pediatrics - Sports Medicine
- Phlebology
- Physical Medicine & Rehabilitation
- Physical Medicine & Rehabilitation - Brain Injury Medicine
- Physical Medicine & Rehabilitation - Hospice and Palliative Medicine
- Physical Medicine & Rehabilitation - Neuromuscular Medicine
- Physical Medicine & Rehabilitation - Pain Medicine
- Physical Medicine & Rehabilitation - Pediatric Rehabilitation Medicine
- Physical Medicine & Rehabilitation - Spinal Cord Injury Medicine
- Physical Medicine & Rehabilitation - Sports Medicine
- Plastic Surgery
- Plastic Surgery - Plastic Surgery Within the Head and Neck
- Plastic Surgery - Surgery of the Hand
- Preventive Medicine - Aerospace Medicine
- Preventive Medicine - Clinical Informatics
- Preventive Medicine - Medical Toxicology
- Preventive Medicine - Obesity Medicine
- Preventive Medicine - Occupational Medicine
- Preventive Medicine - Preventive Medicine/Occupational Environmental Medicine
- Preventive Medicine - Public Health & General Preventive Medicine
- Preventive Medicine - Sports Medicine
- Preventive Medicine - Undersea and Hyperbaric Medicine
- Psychiatry & Neurology - Addiction Medicine
- Psychiatry & Neurology - Addiction Psychiatry
- Psychiatry & Neurology - Behavioral Neurology & Neuropsychiatry
- Psychiatry & Neurology - Brain Injury Medicine
- Psychiatry & Neurology - Child & Adolescent Psychiatry
- Psychiatry & Neurology - Clinical Neurophysiology
- Psychiatry & Neurology - Diagnostic Neuroimaging
- Psychiatry & Neurology - Forensic Psychiatry
- Psychiatry & Neurology - Geriatric Psychiatry
- Psychiatry & Neurology - Hospice and Palliative Medicine
- Psychiatry & Neurology - Neurodevelopmental Disabilities
- Psychiatry & Neurology - Neurology
- Psychiatry & Neurology - Neurology with Special Qualifications in Child Neurology
- Psychiatry & Neurology - Neuromuscular Medicine
- Psychiatry & Neurology - Obesity Medicine
- Psychiatry & Neurology - Pain Medicine
- Psychiatry & Neurology - Psychiatry (General Practice)
- Psychiatry & Neurology - Psychosomatic Medicine
- Psychiatry & Neurology - Sleep Medicine
- Psychiatry & Neurology - Sports Medicine
- Psychiatry & Neurology - Vascular Neurology

- Radiology - Body Imaging
- Radiology - Diagnostic Neuroimaging
- Radiology - Diagnostic Radiology
- Radiology - Diagnostic Ultrasound
- Radiology - Hospice and Palliative Medicine
- Radiology - Neuroradiology
- Radiology - Nuclear Radiology
- Radiology - Pediatric Radiology
- Radiology - Radiation Oncology
- Radiology - Radiological Physics
- Radiology - Therapeutic Radiology
- Radiology - Vascular & Interventional Radiology
- Surgery
- Surgery - Hospice and Palliative Medicine
- Surgery - Pediatric Surgery
- Surgery - Plastic and Reconstructive Surgery
- Surgery - Surgery of the Hand
- Surgery - Surgical Critical Care
- Surgery - Surgical Oncology
- Surgery - Trauma Surgery
- Surgery - Vascular Surgery
- Thoracic Surgery (Cardiothoracic Vascular Surgery)
- Transplant Surgery
- Urology
- Urology - Female Pelvic Medicine and Reconstructive Surgery
- Urology - Pediatric Urology

- **Dental Providers**
  - Dental Therapist
  - Dentist
  - Dentist - Dental Public Health
  - Dentist - Dentist Anesthesiologist
  - Dentist - Endodontics
  - Dentist - General Practice
  - Dentist - Oral and Maxillofacial Pathology
  - Dentist - Oral and Maxillofacial Radiology
  - Dentist - Oral and Maxillofacial Surgery
  - Dentist - Orthodontics and Dentofacial Orthopedics
  - Dentist - Pediatric Dentistry
  - Dentist - Periodontics
  - Dentist - Prosthodontics
  - Denturist
  - Oral Medicinist

- **Eye and Vision Services Providers**
  - Optometrist
  - Optometrist - Corneal and Contact Management
  - Optometrist - Low Vision Rehabilitation
  - Optometrist - Occupational Vision
  - Optometrist - Pediatrics
  - Optometrist - Sports Vision
  - Optometrist - Vision Therapy

- **Veterinarian**

- **Pharmacy Service Providers**
  - Pharmacist
  - Pharmacist - Ambulatory Care
  - Pharmacist - Critical Care
  - Pharmacist - General Practice
  - Pharmacist - Geriatric
  - Pharmacist - Nuclear
  - Pharmacist - Nutrition Support
  - Pharmacist - Oncology
  - Pharmacist - Pediatrics
  - Pharmacist - Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist
  - Pharmacist - Pharmacotherapy
  - Pharmacist - Psychiatric

- **Physician Assistants & Advanced Practice Nursing Providers**
  - Advanced Practice Midwife
  - Anesthesiologist Assistant
  - Clinical Nurse Specialist
  - Clinical Nurse Specialist - Acute Care
  - Clinical Nurse Specialist - Adult Health
  - Clinical Nurse Specialist - Chronic Care
  - Clinical Nurse Specialist - Community Health/Public Health
  - Clinical Nurse Specialist - Critical Care Medicine
  - Clinical Nurse Specialist - Emergency
  - Clinical Nurse Specialist - Ethics
  - Clinical Nurse Specialist - Family Health
  - Clinical Nurse Specialist - Gerontology
  - Clinical Nurse Specialist - Holistic
  - Clinical Nurse Specialist - Home Health
  - Clinical Nurse Specialist - Informatics
  - Clinical Nurse Specialist - Long-Term Care
  - Clinical Nurse Specialist - Medical-Surgical
  - Clinical Nurse Specialist - Neonatal

- Clinical Nurse Specialist - Neuroscience
- Clinical Nurse Specialist - Occupational Health
- Clinical Nurse Specialist - Oncology
- Clinical Nurse Specialist - Oncology, Pediatrics
- Clinical Nurse Specialist - Pediatrics
- Clinical Nurse Specialist - Perinatal
- Clinical Nurse Specialist - Perioperative
- Clinical Nurse Specialist - Psychiatric/Mental Health
- Clinical Nurse Specialist - Psychiatric/Mental Health, Adult
- Clinical Nurse Specialist - Psychiatric/Mental Health, Child & Adolescent
- Clinical Nurse Specialist - Psychiatric/Mental Health, Child & Family
- Clinical Nurse Specialist - Psychiatric/Mental Health, Chronically Ill
- Clinical Nurse Specialist - Psychiatric/Mental Health, Community
- Clinical Nurse Specialist - Psychiatric/Mental Health, Geropsychiatric
- Clinical Nurse Specialist - Rehabilitation
- Clinical Nurse Specialist - School
- Clinical Nurse Specialist - Transplantation
- Clinical Nurse Specialist - Women's Health
- Nurse Anesthetist, Certified Registered
- Nurse Practitioner
- Nurse Practitioner - Acute Care
- Nurse Practitioner - Adult Health
- Nurse Practitioner - Community Health
- Nurse Practitioner - Critical Care Medicine
- Nurse Practitioner - Family
- Nurse Practitioner - Gerontology
- Nurse Practitioner - Hospice and Palliative Medicine
- Nurse Practitioner - Neonatal
- Nurse Practitioner - Neonatal, Critical Care
- Nurse Practitioner - Obstetrics & Gynecology
- Nurse Practitioner - Occupational Health
- Nurse Practitioner - Pain Medicine
- Nurse Practitioner - Pediatrics
- Nurse Practitioner - Pediatrics, Critical Care
- Nurse Practitioner - Perinatal
- Nurse Practitioner - Primary Care
- Nurse Practitioner - Psychiatric/Mental Health
- Nurse Practitioner - School
- Nurse Practitioner - Women's Health
- Physician Assistant
- Physician Assistant - Medical
- Physician Assistant - Surgical

- **Podiatric Medicine & Surgery Service Providers**
  - Assistant, Podiatric
  - Podiatrist
  - Podiatrist - Foot & Ankle Surgery
  - Podiatrist - Foot Surgery
  - Podiatrist - General Practice
  - Podiatrist - Primary Podiatric Medicine
  - Podiatrist - Public Medicine
  - Podiatrist - Radiology
  - Podiatrist - Sports Medicine

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THE STATE of ALASKA

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

Board of Pharmacy
State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550
Email: *BoardOfPharmacy@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfPharmacy*

DEA Registration Status Change Notification

Under AS 17.30.200, all actively licensed practitioners who also hold a registration with the Drug Enforcement Agency (DEA) must register with the Alaska Prescription Drug Monitoring Program (PDMP). If you hold an active professional license but have had a change of status in your DEA registration, submit this form so your PDMP registration file can be updated accordingly. In addition, all newly licensed in-state pharmacies and out-of-state registered pharmacies must provide a DEA registration to record data compliance only if the pharmacy dispenses or distributes federally scheduled II-IV controlled substances in or into the state.

Full Name:		**License #:**	

Practice Type:	☐ Dentist	☐ Optometrist	☐ Pharmacy (in-state)
	☐ Podiatrist	☐ Physician (MD, DO)	☐ Pharmacy (out-of-state)
	☐ Veterinarian	☐ Physician Assistant	☐ APRN (NP, NM, CNS, CRNA)

Provide employing pharmacy's DEA registration, if applicable:	

My DEA Registration is . . .

- ☐ New or First-Issue
- ☐ Lapsed
- ☐ Expired
- ☐ Current

DEA Registration Number: _____

Issue Date: _____

Expiry Date: _____

Additional DEA Registrations and Expiration Dates:	

All actively licensed practitioners with DEA registrations to write prescriptions and all pharmacists who dispense are required to review a patient's prescription history before prescribing, administering, or directly dispensing a federally scheduled II-IV controlled substance unless otherwise exempt under AS 17.30.200(k) or (u). If you otherwise meet the criteria to register with the PDMP, you acknowledge your obligation to comply with reviewing and/or reporting requirements by providing your signature below. If PDMP requirements do not apply because you no longer hold an active DEA registration, also provide your signature below indicating you acknowledge that should your DEA status change to active, a new DEA Status form must be submitted to the department and a registration must be completed at: *alaskapmpaware.net*

Signature: _____ **Date:** _____

Alaska Prescription Drug Monitoring Program

PDMP Access Agreement for Pharmacists not Licensed in Alaska

Alaska Statute (AS) 17.30.200(f)(1) allows pharmacists not licensed in Alaska to submit prescription information to the Alaska PDMP on behalf of an out-of-state pharmacy that ships, mails, or delivers prescription drugs into the state more than twice a year, however, the out-of-state pharmacy must possess a valid Alaska registration as required by AS 08.80.458 and 12 AAC 52.130(c). The unlicensed Alaska pharmacist must hold a valid license in another state as required by AS 17.30.200(d)(4) and may be permitted to access the Alaska PDMP. **You must first initiate the registration request online at alaska.pmpaware.net. Forms submitted before a request is submitted may not be processed.**

Before filling out this form, did you initiate a registration request using the PDMP user role, 'Out of State Pharmacist'? Yes No

I. Applicant Information

Name of Pharmacist: _____ Licensed in State: _____

License Number: _____ Expiration: _____

Address: _____

Phone: _____ Email: _____

II. Pharmacy Information

Name of Pharmacy: _____

Alaska Registration Number: _____ Reporting to the PDMP Daily? Yes No

Drug Enforcement Agency Number: _____

III. Agreement

By providing my signature below, I agree to only interact with the Alaska Prescription Drug Monitoring Program's controlled substance database only to report prescription information to Alaska on behalf of the out-of-state registered pharmacy above or to access information contained within the database. I further agree not to allow any unauthorized person to access the database on my behalf and will not disclose confidential information to an unauthorized person. I acknowledge that this agreement is only valid under the conditions that I hold a valid license in another state and am employed by a pharmacy currently registered to ship, mail, or deliver prescription drugs to Alaska.

Signature: _____ Date: _____

PDMP

FOR DIVISION USE ONLY

THE STATE of ALASKA

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

Prescription Drug Monitoring Program
State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550 • Fax: (907) 465-2974
Email: *akpdmp@alaska.gov*
Website: *PDMP.Alaska.Gov*

PDMP Account Status Change Form

- This form is for practitioners and pharmacists who have or had an account in AWARxE only. Individuals registering for the first time must first initiate a registration in AWARxE and fill out form 08-4760.
- Fill out this form if you are no longer required to be registered with the Prescription Drug Monitoring Program (PDMP) or if your account has already been deactivated and you are again required to register. Practitioners requiring to register again with the PDMP do not need to submit another registration to PDMP AWARxE but are required to pay the $25.00 initial registration fee per 12 AAC 02.107. In accordance with AS 17.30.200, PDMP registration requirements only apply to practitioners actively licensed in Alaska who hold a Drug Enforcement Agency registration and pharmacists who dispense federally scheduled II – IV controlled substances in Alaska.

☐ **Activate Registration**
You must activate your registration by paying the renewal fee if your license was previously in lapsed or retired status and you have renewed or reinstated your license and also hold an active DEA registration. This also applies if you have held an active license but recently obtained a new or renewed DEA registration. **$25.00**

☐ **Deactivate Registration**
You must deactivate your account if you no longer hold an active Alaska professional license or hold a DEA registration. This also applies if you are a pharmacist no longer dispensing controlled substances in Alaska due to the duties of your job position or due to living in another state, territory, or country. **no fee**

Complete Name:	First Name:	Middle Name:	Last Name:
Phone Number:	(☐☐☐) ☐☐☐ – ☐☐☐☐		
Email Address:			
Alaska Professional License Number or Alaska PDMP Registration Number:			

Practitioner Type:

☐ Dentist ☐ Pharmacist ☐ Optometrist
☐ Physician Assistant ☐ Physician (MD, DO) ☐ Veterinarian
☐ APRN (NP, NM, CNS, CRNA) ☐ Podiatrist

Signature: _____ **Date:** _____

ADM

FOR DIVISION USE ONLY

THE STATE of ALASKA

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

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
333 Willoughby Avenue, 9th Floor, Juneau, AK 99801
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

CREDIT CARD PAYMENT

For security purposes, do not email credit card information. Mail this credit card payment form to the division. Do not email or fax. Completion of this form is not proof of payment until the division processes the information. If any information on this form is illegible, the form will be rejected.

Name of Applicant or Licensee: _____

License Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:
  - 1. _____ _____
  - 2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: _____

08-4438 Rev 05/01/18 Credit Card Payment Form

VISA or Mastercard Number: _____ **Expiration Date:** _____

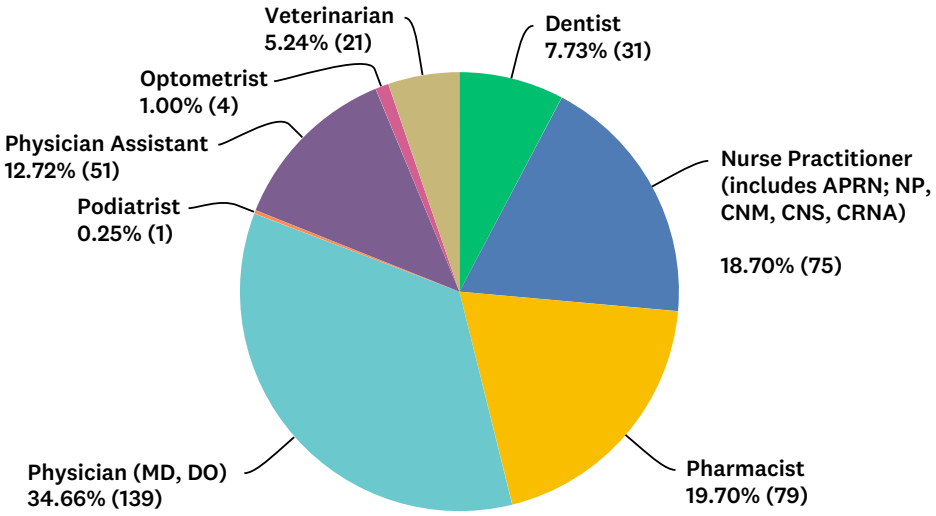
Billing ZIP Code: _____ **3-Digit Security Code:** _____

This section below the dotted line will be destroyed upon processing of the payment.

Confidential

Q1 Please specify your user role (should match the user role used to register with the PDMP).

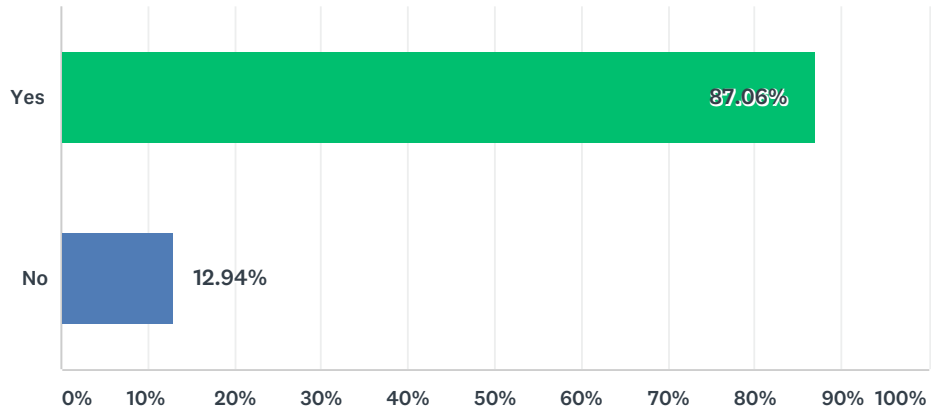
Answered: 401 Skipped: 1



ANSWER CHOICES	RESPONSES	
Dentist	7.73%	31
Nurse Practitioner (includes APRN; NP, CNM, CNS, CRNA)	18.70%	75
Pharmacist	19.70%	79
Physician (MD, DO)	34.66%	139
Podiatrist	0.25%	1
Physician Assistant	12.72%	51
Optometrist	1.00%	4
Veterinarian	5.24%	21
TOTAL		401

Q2 Are you aware that a State of Alaska PDMP website is available to all practitioners and pharmacists required to register with the PDMP and can be accessed at pdmp.alaska.gov? This website is separate from the PDMP platform, AWARxE.

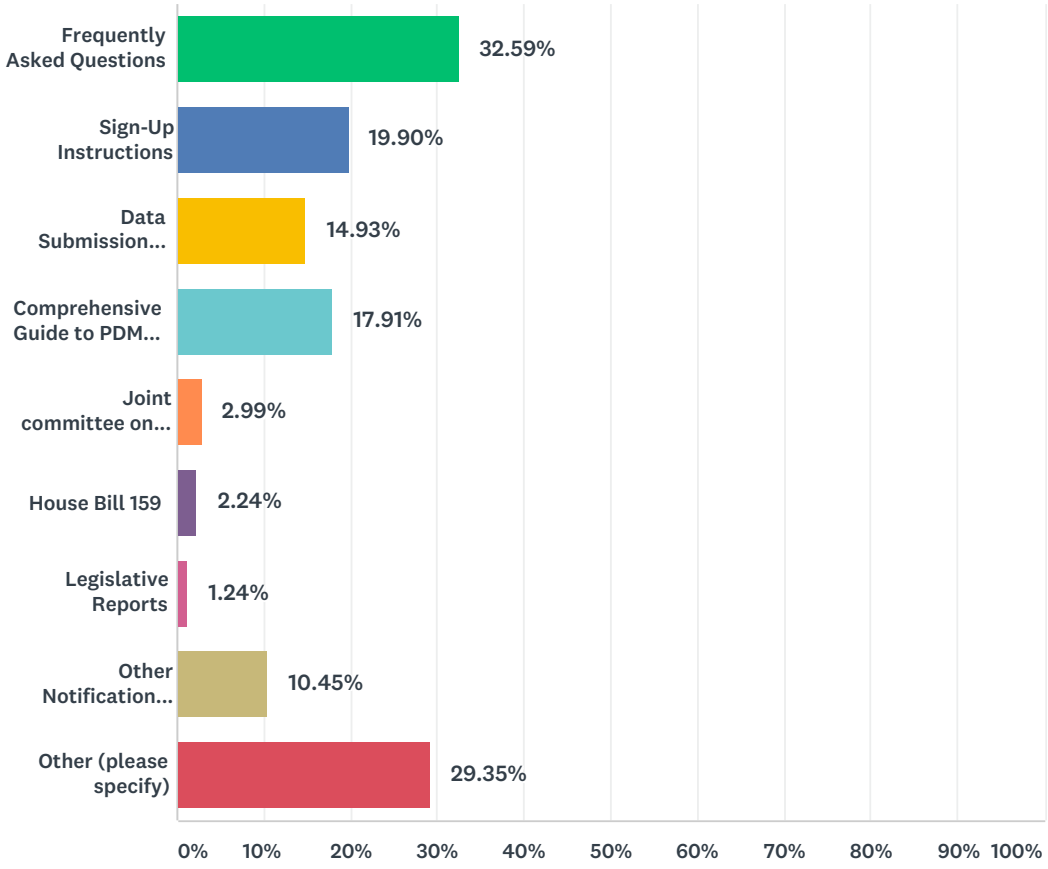
Answered: 402 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	87.06%	350
No	12.94%	52
TOTAL		402

Q3 What source(s) of information do you find most helpful when navigating the State of Alaska PDMP website (pdmp.alaska.gov)?

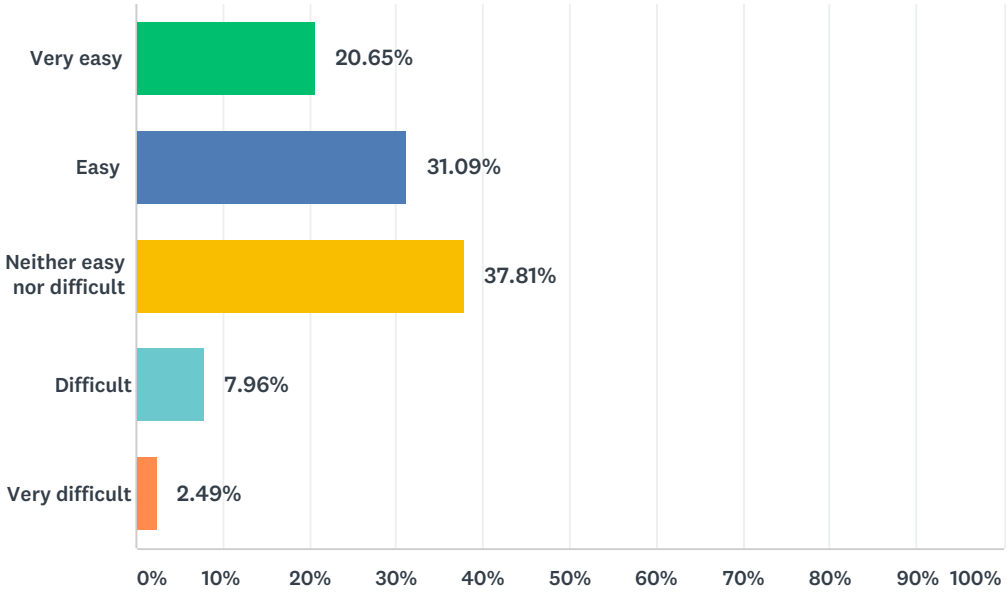
Answered: 402 Skipped: 0



ANSWER CHOICES	RESPONSES	
Frequently Asked Questions	32.59%	131
Sign-Up Instructions	19.90%	80
Data Submission Dispenser Guide	14.93%	60
Comprehensive Guide to PDMP Requirements and Effective Dates	17.91%	72
Joint committee on Prescriptive Guidelines Report to Alaska State Legislature	2.99%	12
House Bill 159	2.24%	9
Legislative Reports	1.24%	5
Other Notifications Embedded into Website	10.45%	42
Other (please specify)	29.35%	118
Total Respondents: 402		

Q4 Rate the accessibility of the State of Alaska PDMP website (pdmp.alaska.gov).

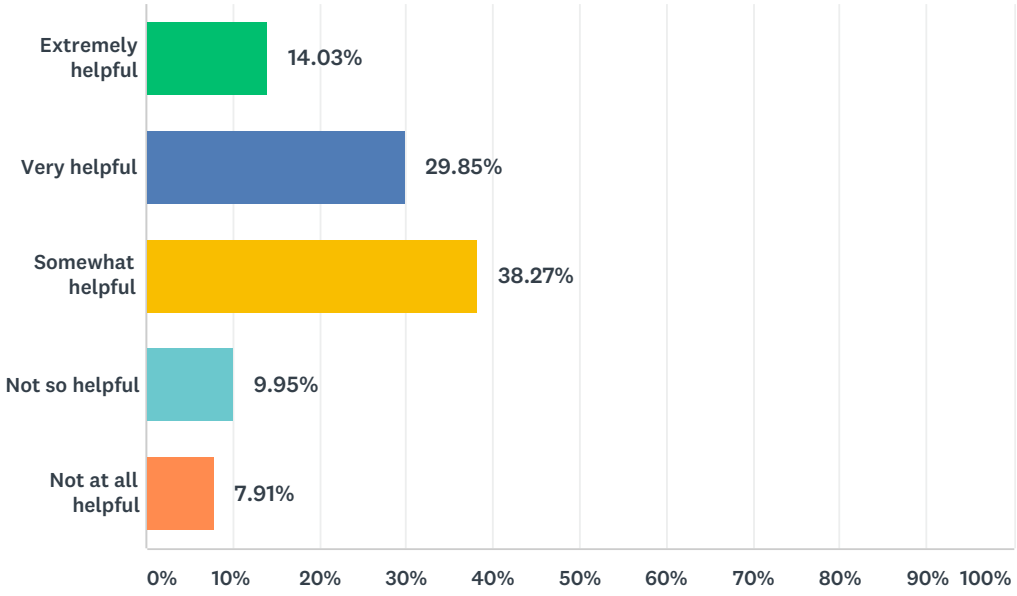
Answered: 402 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very easy	20.65%	83
Easy	31.09%	125
Neither easy nor difficult	37.81%	152
Difficult	7.96%	32
Very difficult	2.49%	10
TOTAL		402

Q5 Rate the helpfulness of the State of Alaska PDMP website (pdmp.alaska.gov).

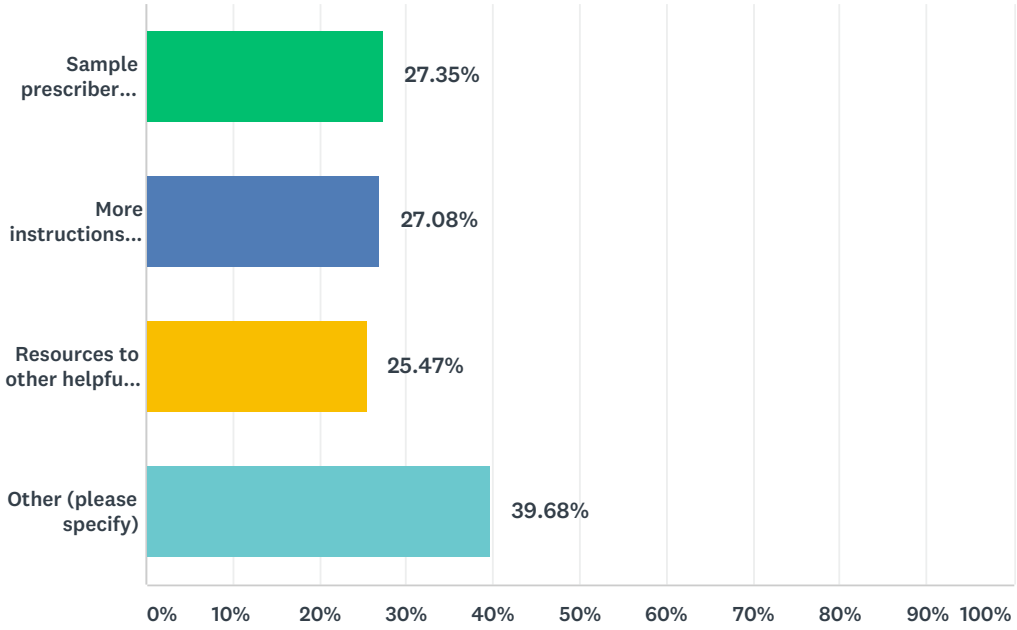
Answered: 392 Skipped: 10



ANSWER CHOICES	RESPONSES	
Extremely helpful	14.03%	55
Very helpful	29.85%	117
Somewhat helpful	38.27%	150
Not so helpful	9.95%	39
Not at all helpful	7.91%	31
TOTAL		392

Q6 What could be added to improve the quality of the PDMP state website (pdmp.alaska.gov)?

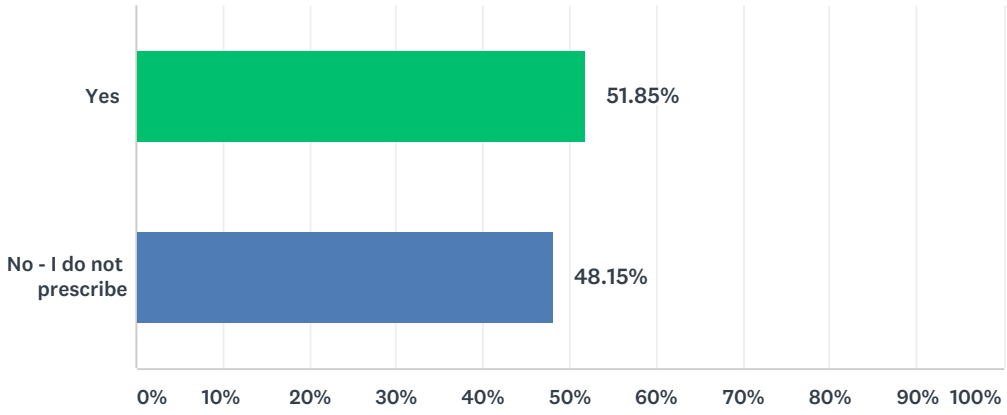
Answered: 373 Skipped: 29



ANSWER CHOICES	RESPONSES	
Sample prescriber report "report card"	27.35%	102
More instructions on how to use the the PDMP database, AWARxE	27.08%	101
Resources to other helpful links or relevant organizations, e.g.: Alaska Department of Health and Social Services or Centers for Disease Control and Prevention	25.47%	95
Other (please specify)	39.68%	148
Total Respondents: 373		

Q7 Do you regularly receive a prescriber report card?

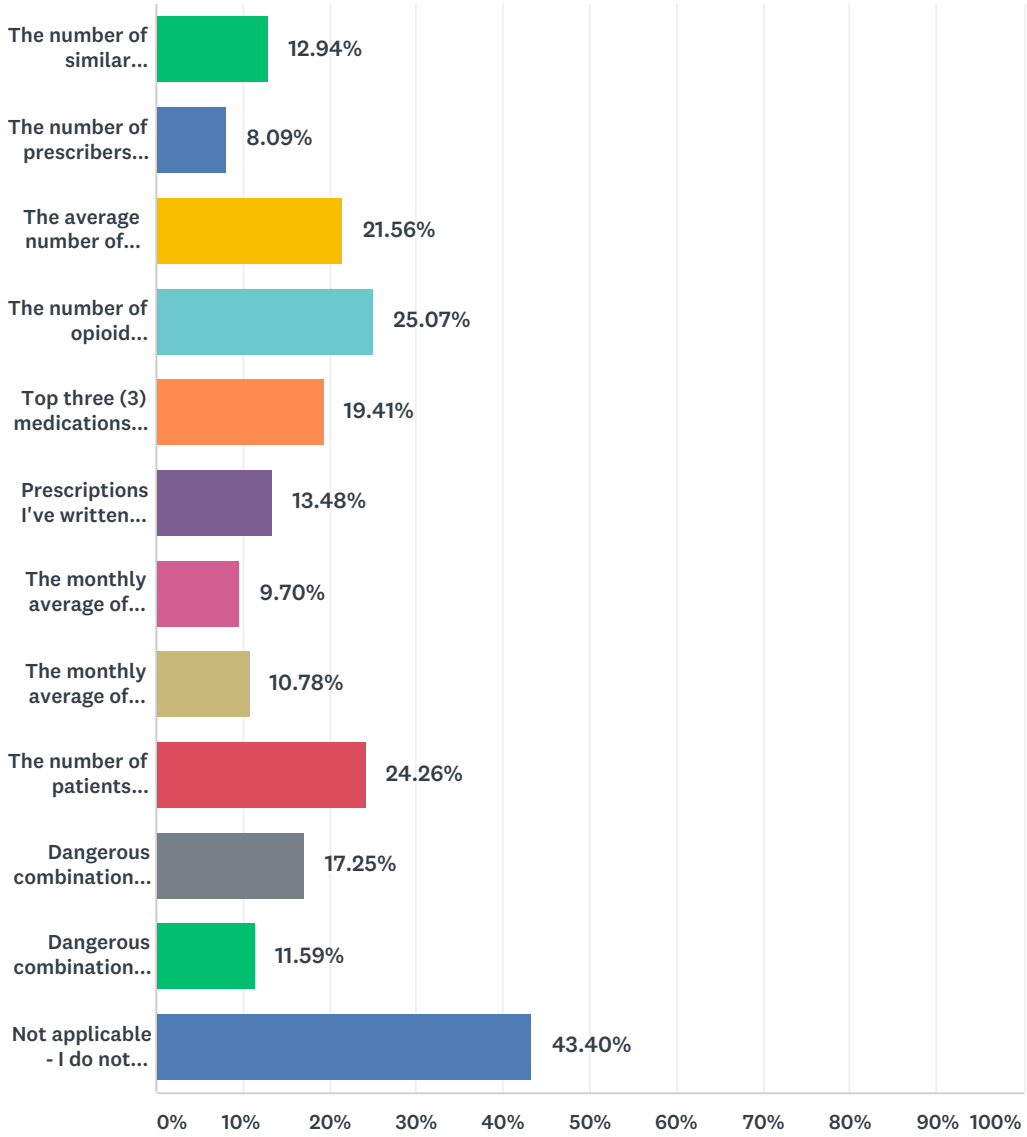
Answered: 378 Skipped: 24



ANSWER CHOICES	RESPONSES	
Yes	51.85%	196
No - I do not prescribe	48.15%	182
TOTAL		378

Q8 What specific metrics of the report card do you find most informative? (Check all that apply).

Answered: 371 Skipped: 31

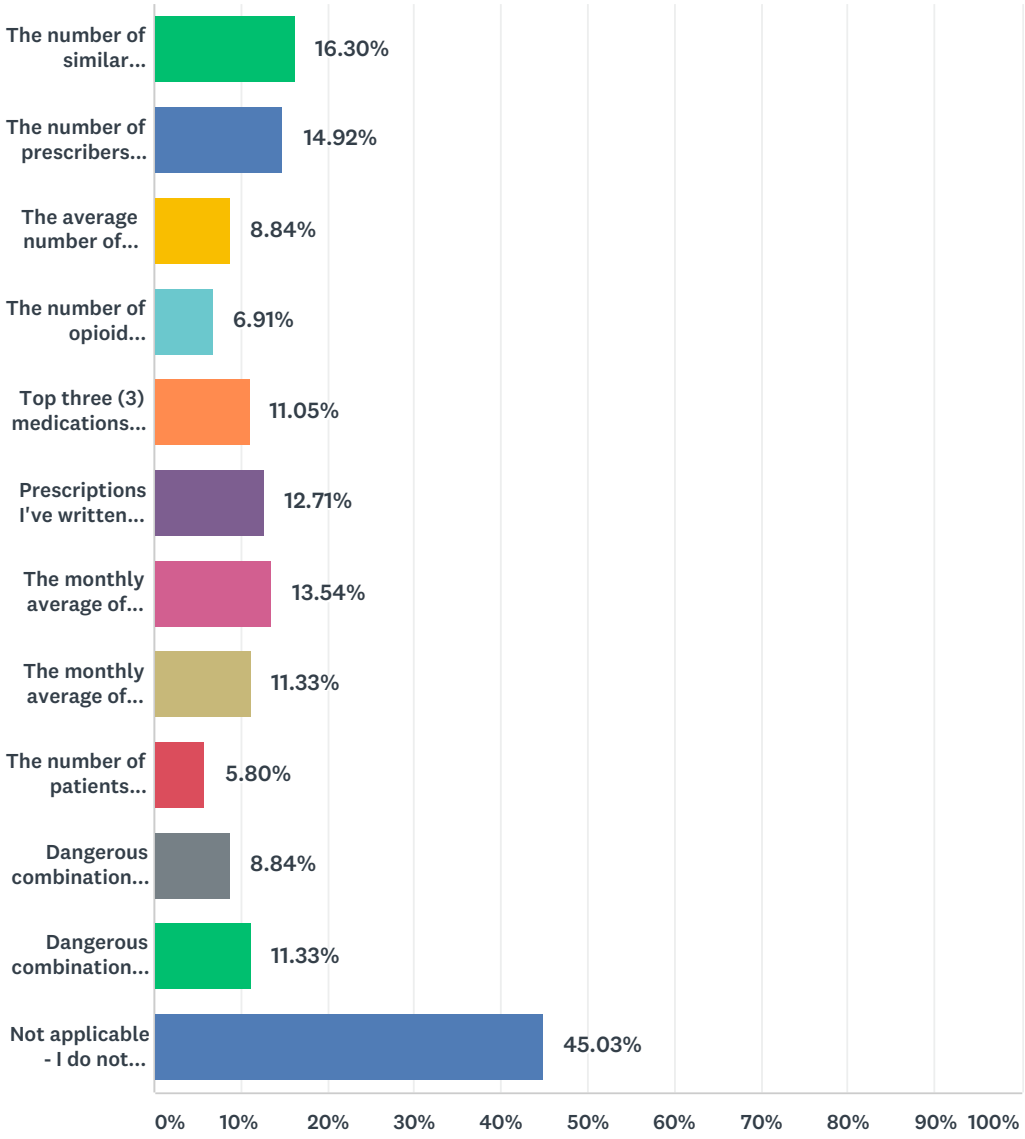


ANSWER CHOICES	RESPONSES	
The number of similar prescribers working within my profession	12.94%	48
The number of prescribers working in the same specialty	8.09%	30
The average number of patients receiving opioids compared to similar prescribers and prescribers in the same specialty	21.56%	80
The number of opioid prescriptions I've written compared to similar prescribers and prescribers in the same specialty	25.07%	93
Top three (3) medications I've prescribed	19.41%	72
Prescriptions I've written by Morphine Milligram Equivalent (MME)	13.48%	50
The monthly average of prescription volumes in MME written	9.70%	36

The monthly average of anxiolytic, sedative, and hypnotic prescriptions	10.78%	40
The number of patients exceeding multiple provider thresholds	24.26%	90
Dangerous combination therapies (prescriptions for opioids + benzodiazepines) I've written compared to other prescribers	17.25%	64
Dangerous combination therapies (prescriptions for opioids + benzodiazepines + carisoprodol) I've written compared to other prescribers	11.59%	43
Not applicable - I do not prescribe	43.40%	161
Total Respondents: 371		

Q9 What specific metrics of the report card do you find least informative? (Check all that apply).

Answered: 362 Skipped: 40

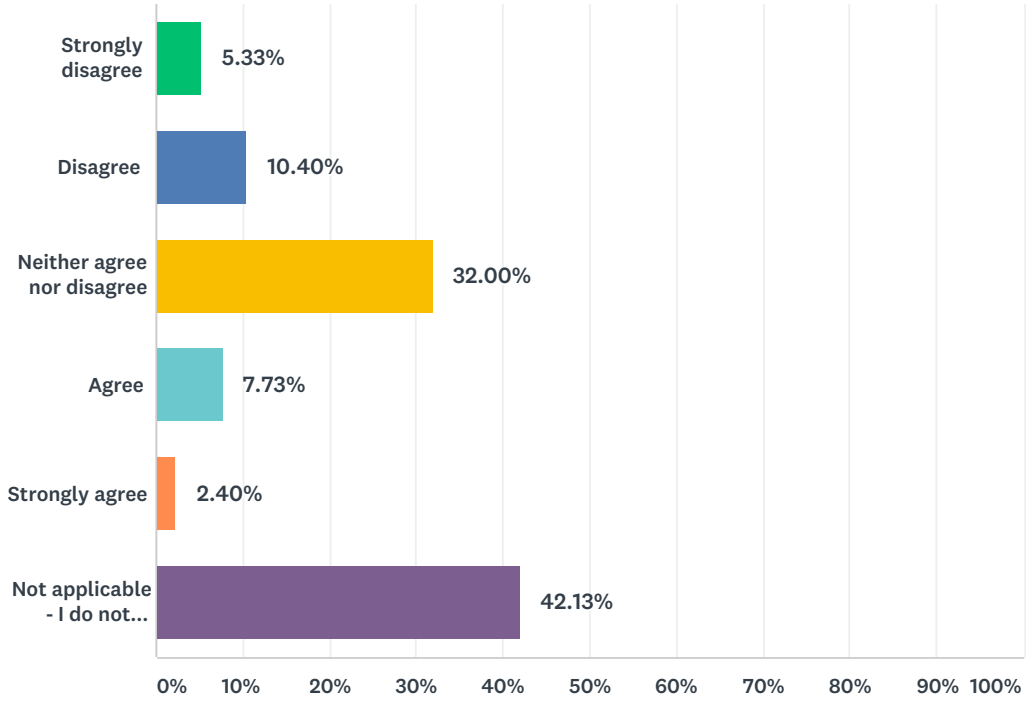


ANSWER CHOICES	RESPONSES	
The number of similar prescribers working within my profession	16.30%	59
The number of prescribers working in the same specialty	14.92%	54
The average number of patients receiving opioids compared to similar prescribers and prescribers in the same specialty	8.84%	32
The number of opioid prescriptions I've written compared to similar prescribers and prescribers in the same specialty	6.91%	25
Top three (3) medications I've prescribed	11.05%	40
Prescriptions I've written by Morphine Milligram Equivalent (MME)	12.71%	46
The monthly average of prescription volumes in MME written	13.54%	49

The monthly average of anxiolytic, sedative, and hypnotic prescriptions	11.33%	41
The number of patients exceeding multiple provider thresholds	5.80%	21
Dangerous combination therapies (prescriptions for opioids + benzodiazepines) I've written compared to other prescribers	8.84%	32
Dangerous combination therapies (prescriptions for opioids + benzodiazepines + carisoprodol) I've written compared to other prescribers	11.33%	41
Not applicable - I do not prescribe	45.03%	163
Total Respondents: 362		

Q10 In looking at my report card, I was surprised by how I compare to other prescribers within the same specialty.

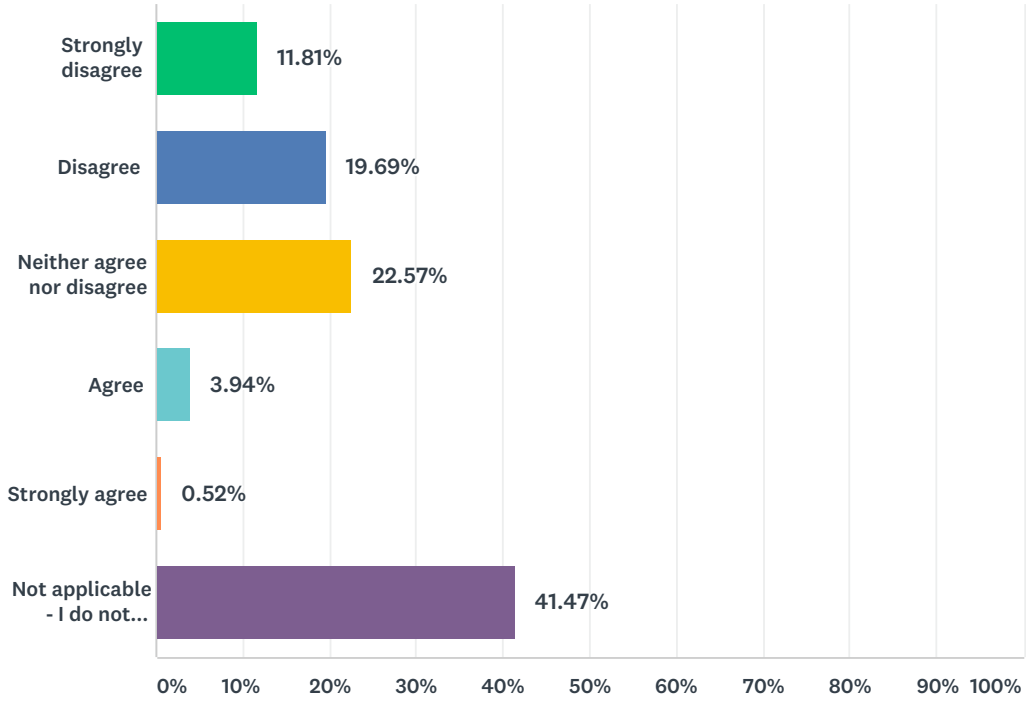
Answered: 375 Skipped: 27



ANSWER CHOICES	RESPONSES	
Strongly disagree	5.33%	20
Disagree	10.40%	39
Neither agree nor disagree	32.00%	120
Agree	7.73%	29
Strongly agree	2.40%	9
Not applicable - I do not prescribe	42.13%	158
TOTAL		375

Q11 I changed my prescribing patterns as a result of looking at my report card.

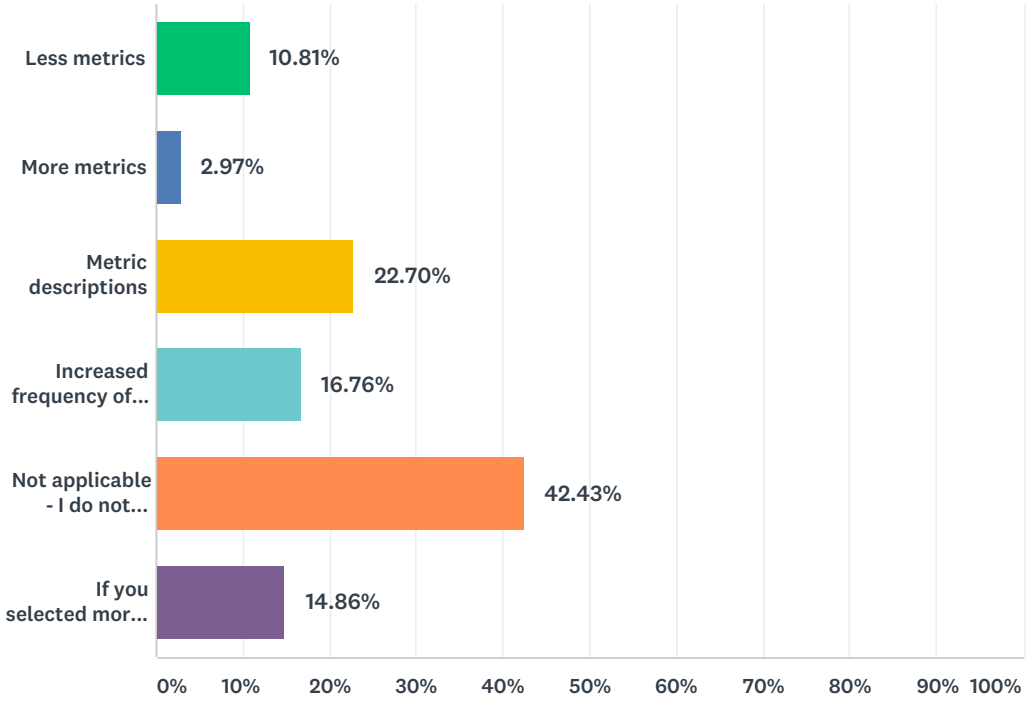
Answered: 381 Skipped: 21



ANSWER CHOICES	RESPONSES	
Strongly disagree	11.81%	45
Disagree	19.69%	75
Neither agree nor disagree	22.57%	86
Agree	3.94%	15
Strongly agree	0.52%	2
Not applicable - I do not prescribe	41.47%	158
TOTAL		381

Q12 What could be changed about the report card to improve them? (Check all that apply).

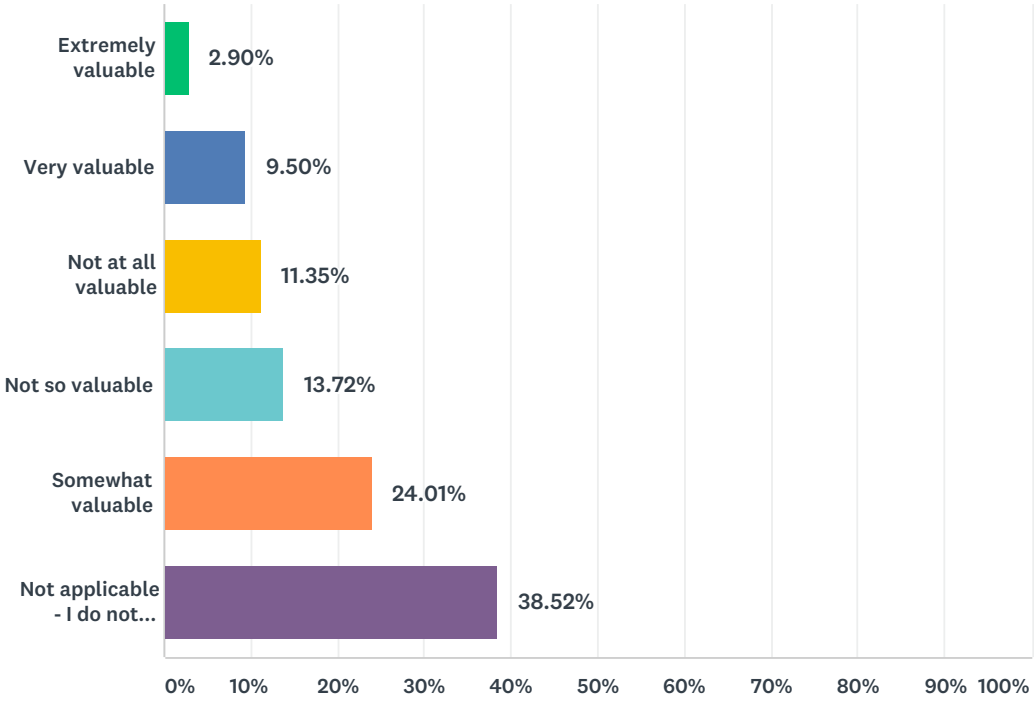
Answered: 370 Skipped: 32



ANSWER CHOICES	RESPONSES	
Less metrics	10.81%	40
More metrics	2.97%	11
Metric descriptions	22.70%	84
Increased frequency of receiving report cards	16.76%	62
Not applicable - I do not prescribe	42.43%	157
If you selected more metrics, please describe.	14.86%	55
Total Respondents: 370		

Q13 Rate the overall value of report cards as a tool to assist in clinical decision making.

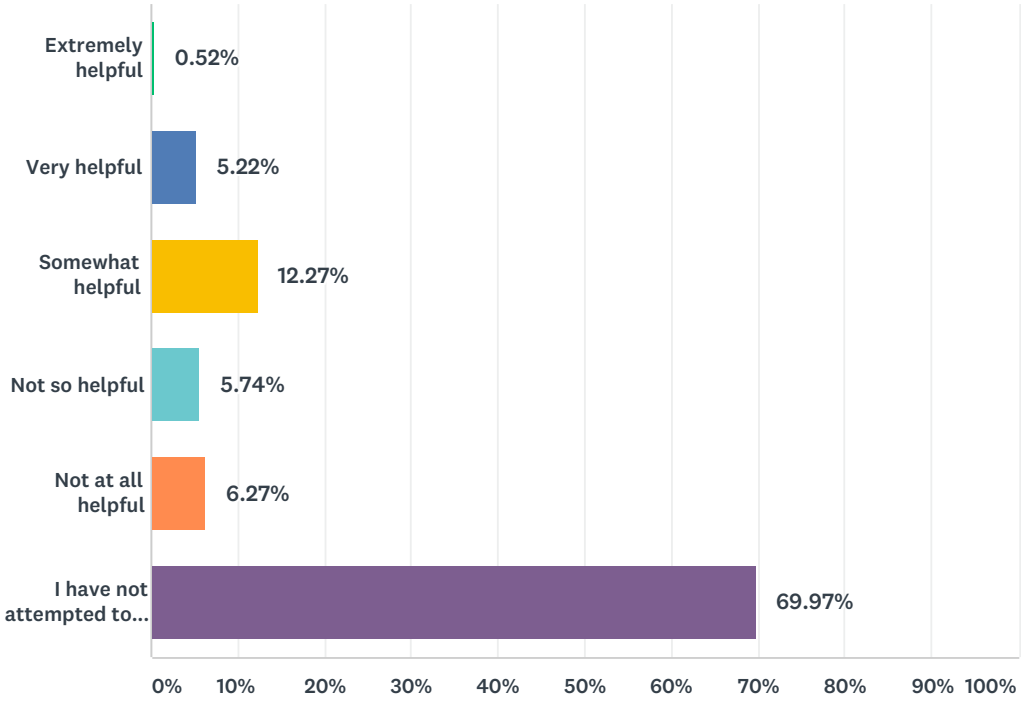
Answered: 379 Skipped: 23



ANSWER CHOICES	RESPONSES	
Extremely valuable	2.90%	11
Very valuable	9.50%	36
Not at all valuable	11.35%	43
Not so valuable	13.72%	52
Somewhat valuable	24.01%	91
Not applicable - I do not prescribe	38.52%	146
TOTAL		379

Q14 Rate the helpfulness of Appriss Support in assisting with account issues.

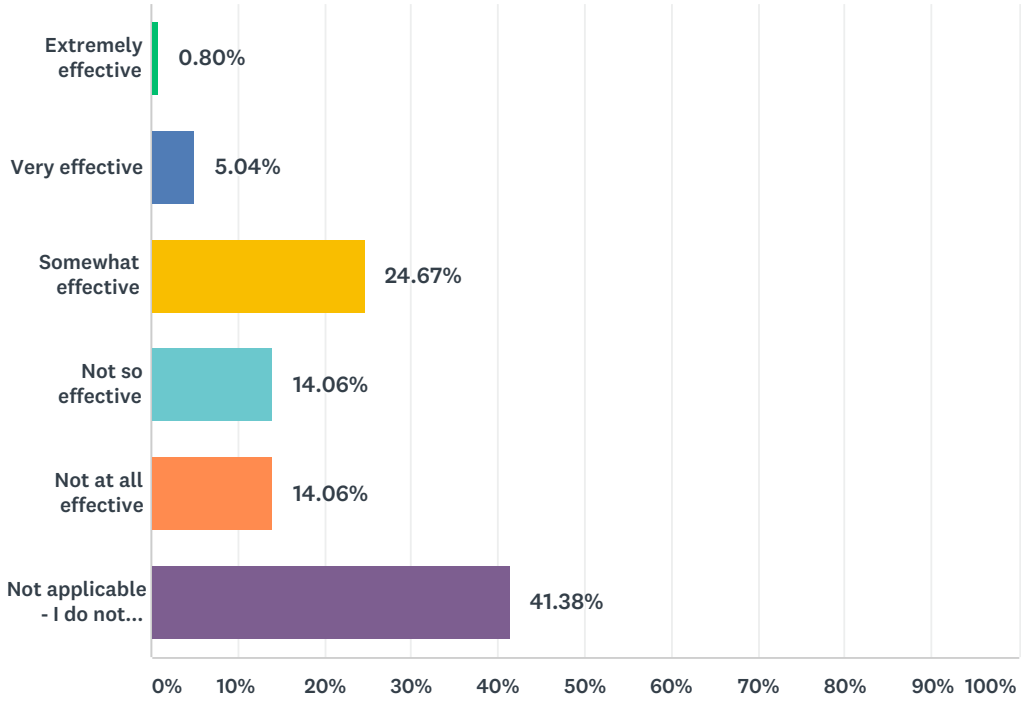
Answered: 383 Skipped: 19



ANSWER CHOICES	RESPONSES	
Extremely helpful	0.52%	2
Very helpful	5.22%	20
Somewhat helpful	12.27%	47
Not so helpful	5.74%	22
Not at all helpful	6.27%	24
I have not attempted to contact Appriss Support	69.97%	268
TOTAL		383

Q15 Rate the overall effectiveness of report cards on changing prescribing patterns.

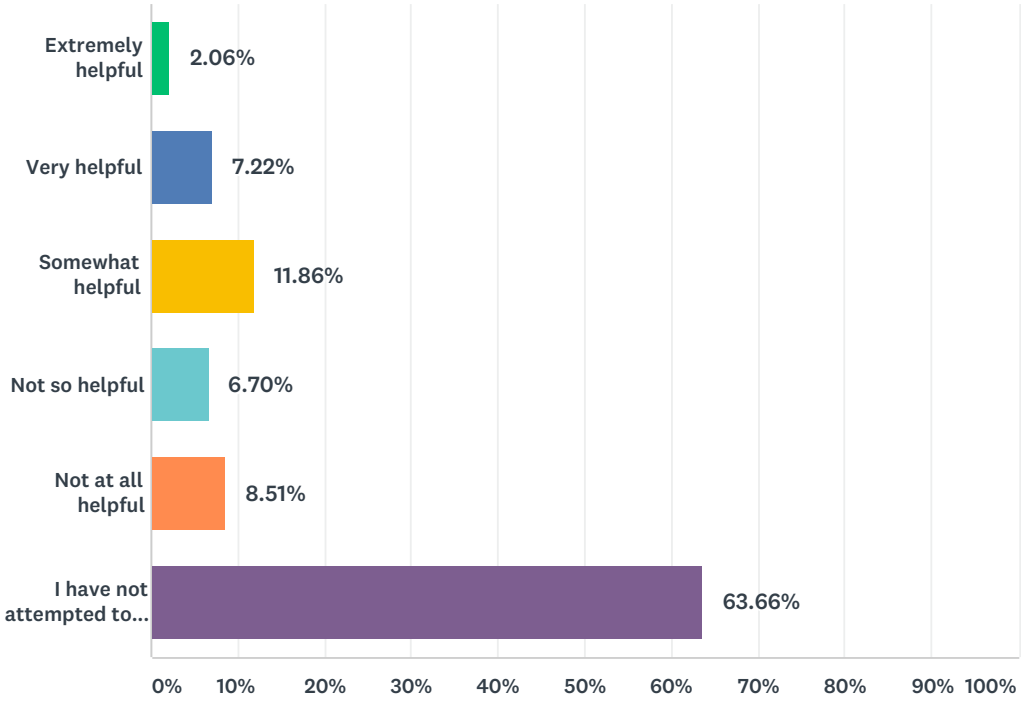
Answered: 377 Skipped: 25



ANSWER CHOICES	RESPONSES	
Extremely effective	0.80%	3
Very effective	5.04%	19
Somewhat effective	24.67%	93
Not so effective	14.06%	53
Not at all effective	14.06%	53
Not applicable - I do not prescribe	41.38%	156
TOTAL		377

Q16 Rate the helpfulness of the state PDMP office in assisting with account issues.

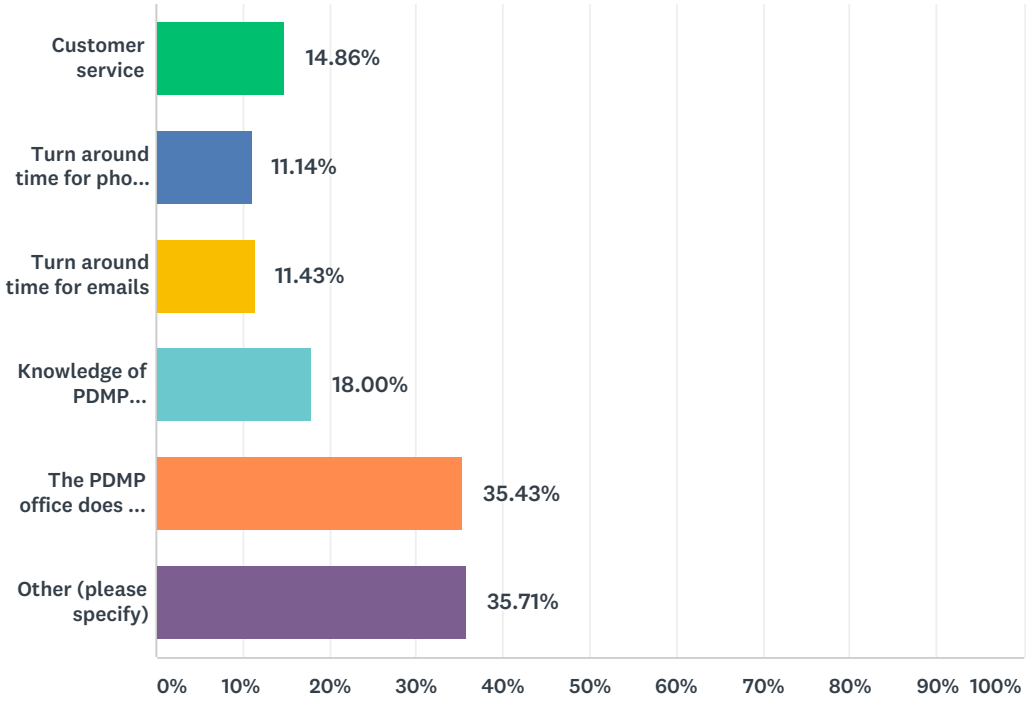
Answered: 388 Skipped: 14



ANSWER CHOICES	RESPONSES	
Extremely helpful	2.06%	8
Very helpful	7.22%	28
Somewhat helpful	11.86%	46
Not so helpful	6.70%	26
Not at all helpful	8.51%	33
I have not attempted to contact the PDMP manager	63.66%	247
TOTAL		388

Q17 In what area(s) does the PDMP office need to improve? (Check all that apply).

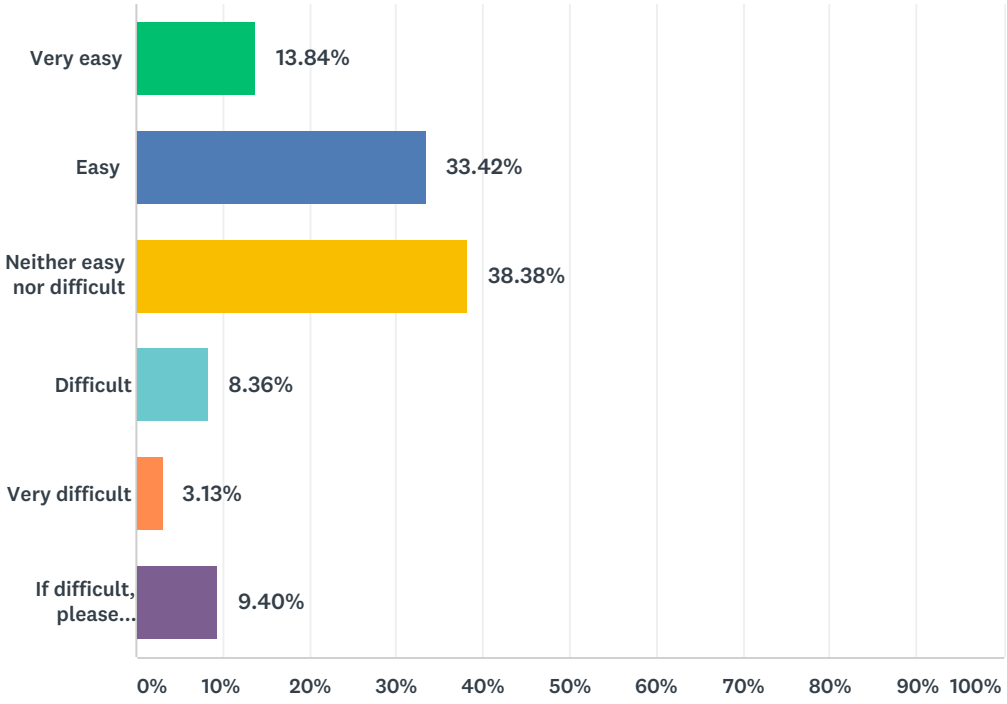
Answered: 350 Skipped: 52



ANSWER CHOICES	RESPONSES	
Customer service	14.86%	52
Turn around time for phone calls	11.14%	39
Turn around time for emails	11.43%	40
Knowledge of PDMP registering, reviewing, and reporting requirements	18.00%	63
The PDMP office does not need to improve	35.43%	124
Other (please specify)	35.71%	125
Total Respondents: 350		

Q18 Rate your experience in registering with the PDMP database through the AWARxE platform (https://alaska.pmpaware.net/).

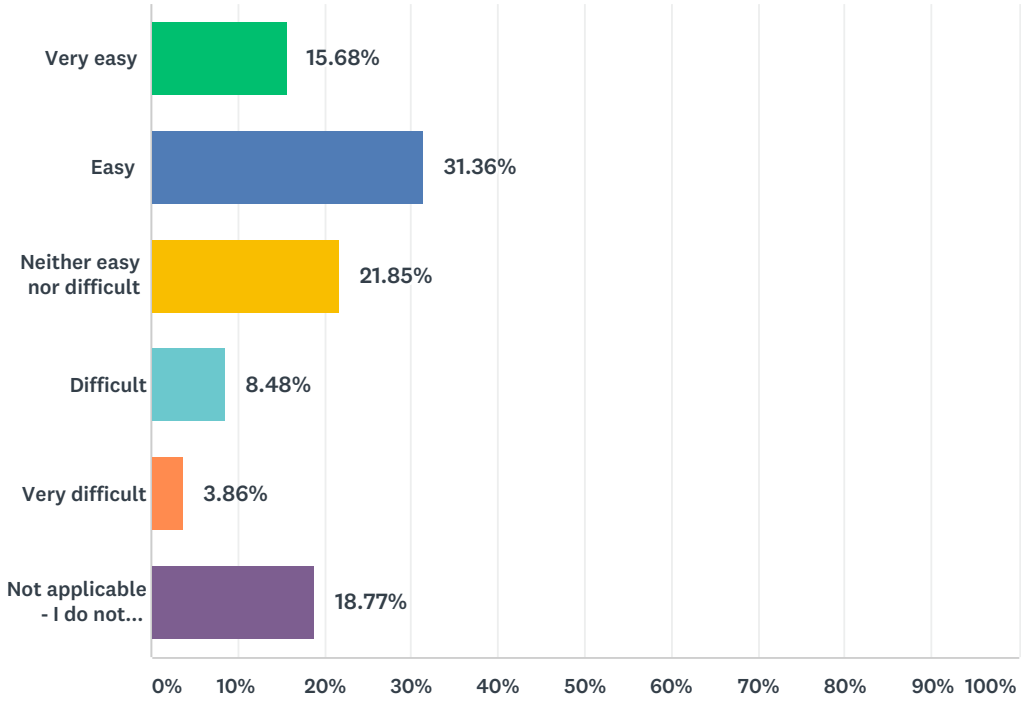
Answered: 383 Skipped: 19



ANSWER CHOICES	RESPONSES	
Very easy	13.84%	53
Easy	33.42%	128
Neither easy nor difficult	38.38%	147
Difficult	8.36%	32
Very difficult	3.13%	12
If difficult, please describe, e.g.: requirement to verify email, time-consuming, too many steps, etc.	9.40%	36
Total Respondents: 383		

Q19 Rate your experience in reviewing patient prescription history in the PDMP through the AWARxE platform (https://alaska.pmpaware.net/).

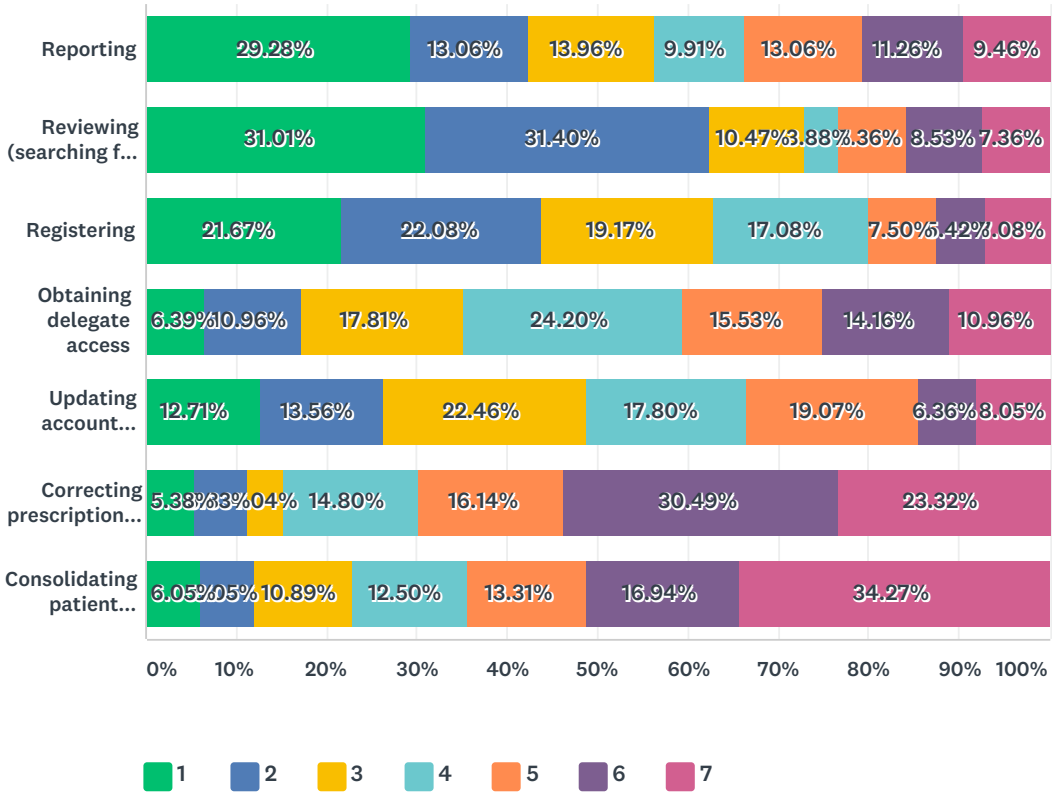
Answered: 389 Skipped: 13



ANSWER CHOICES	RESPONSES	
Very easy	15.68%	61
Easy	31.36%	122
Neither easy nor difficult	21.85%	85
Difficult	8.48%	33
Very difficult	3.86%	15
Not applicable - I do not prescribe or administer prescriptions	18.77%	73
TOTAL		389

Q20 Rank the most challenging aspects of the PDMP (1 = least challenging, 7 = most challenging).

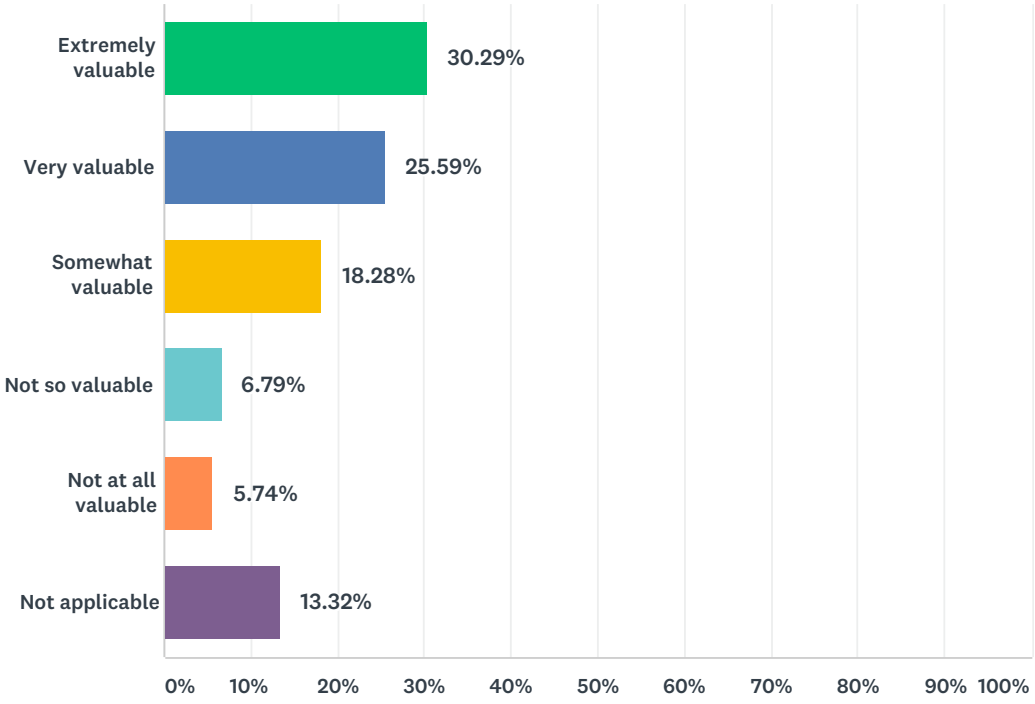
Answered: 326 Skipped: 76



	1	2	3	4	5	6	7	TOTAL	SCORE
Reporting	29.28% 65	13.06% 29	13.96% 31	9.91% 22	13.06% 29	11.26% 25	9.46% 21	222	4.64
Reviewing (searching for patients)	31.01% 80	31.40% 81	10.47% 27	3.88% 10	7.36% 19	8.53% 22	7.36% 19	258	5.20
Registering	21.67% 52	22.08% 53	19.17% 46	17.08% 41	7.50% 18	5.42% 13	7.08% 17	240	4.89
Obtaining delegate access	6.39% 14	10.96% 24	17.81% 39	24.20% 53	15.53% 34	14.16% 31	10.96% 24	219	3.82
Updating account information, e.g.: passwords or specialty designations	12.71% 30	13.56% 32	22.46% 53	17.80% 42	19.07% 45	6.36% 15	8.05% 19	236	4.32
Correcting prescription errors	5.38% 12	5.83% 13	4.04% 9	14.80% 33	16.14% 36	30.49% 68	23.32% 52	223	2.85
Consolidating patient information	6.05% 15	6.05% 15	10.89% 27	12.50% 31	13.31% 33	16.94% 42	34.27% 85	248	2.91

Q21 Rate the value of reviewing patient prescription history in informing clinical decision making.

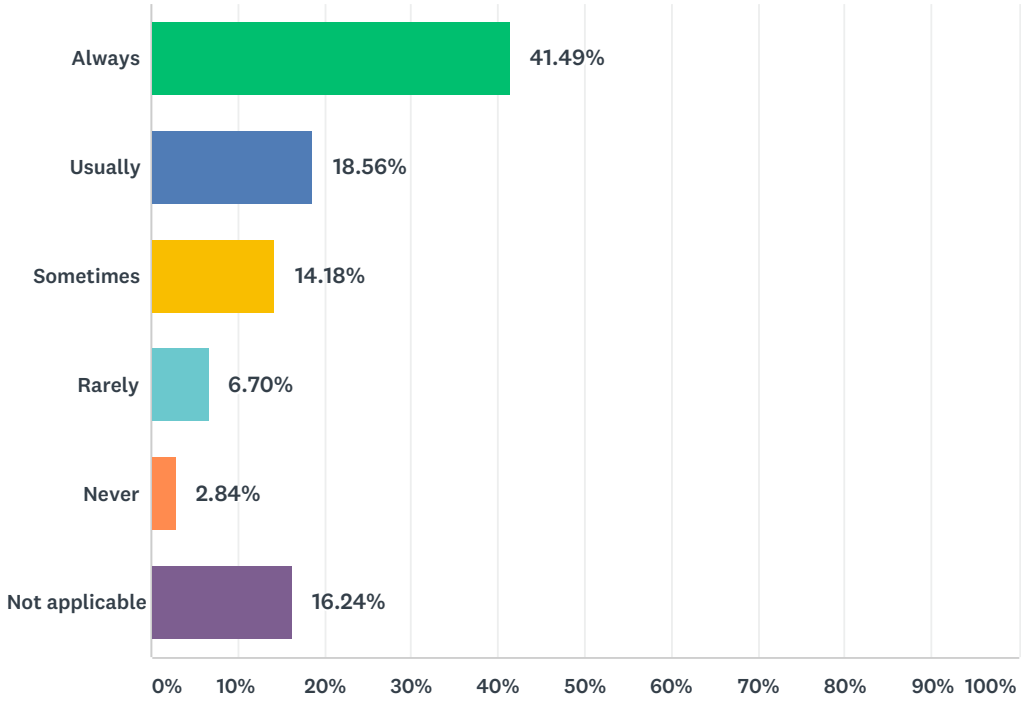
Answered: 383 Skipped: 19



ANSWER CHOICES	RESPONSES	
Extremely valuable	30.29%	116
Very valuable	25.59%	98
Somewhat valuable	18.28%	70
Not so valuable	6.79%	26
Not at all valuable	5.74%	22
Not applicable	13.32%	51
TOTAL		383

Q22 How often do you do query a patient's prescription history before prescribing, administering, or directly dispensing?

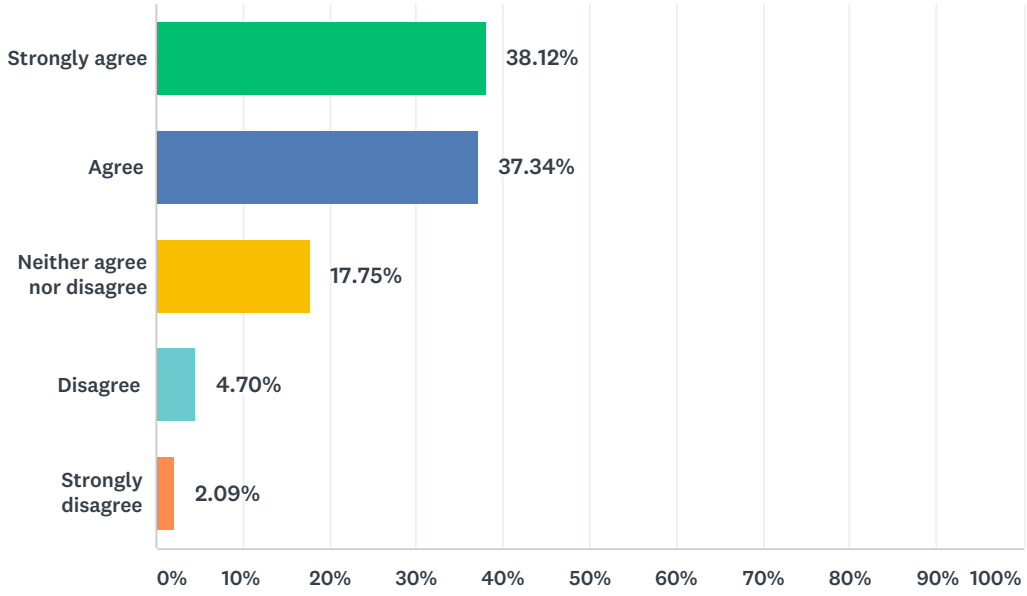
Answered: 388 Skipped: 14



ANSWER CHOICES	RESPONSES	
Always	41.49%	161
Usually	18.56%	72
Sometimes	14.18%	55
Rarely	6.70%	26
Never	2.84%	11
Not applicable	16.24%	63
TOTAL		388

Q23 Reviewing patient prescription history helps reduce inappropriate prescribing.

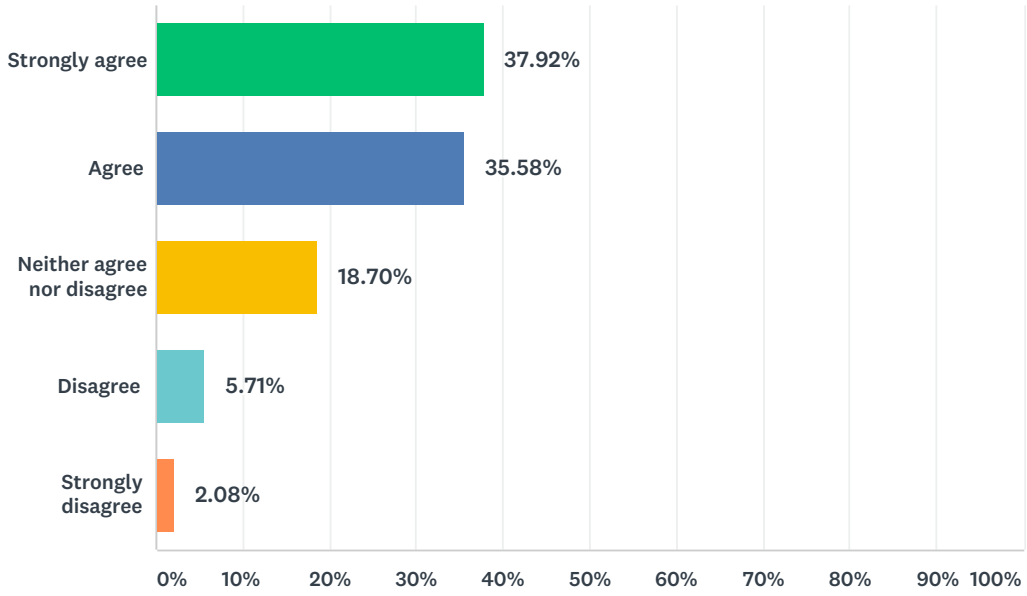
Answered: 383 Skipped: 19



ANSWER CHOICES	RESPONSES	
Strongly agree	38.12%	146
Agree	37.34%	143
Neither agree nor disagree	17.75%	68
Disagree	4.70%	18
Strongly disagree	2.09%	8
TOTAL		383

Q24 Reviewing patient prescription history helps reduce misuse.

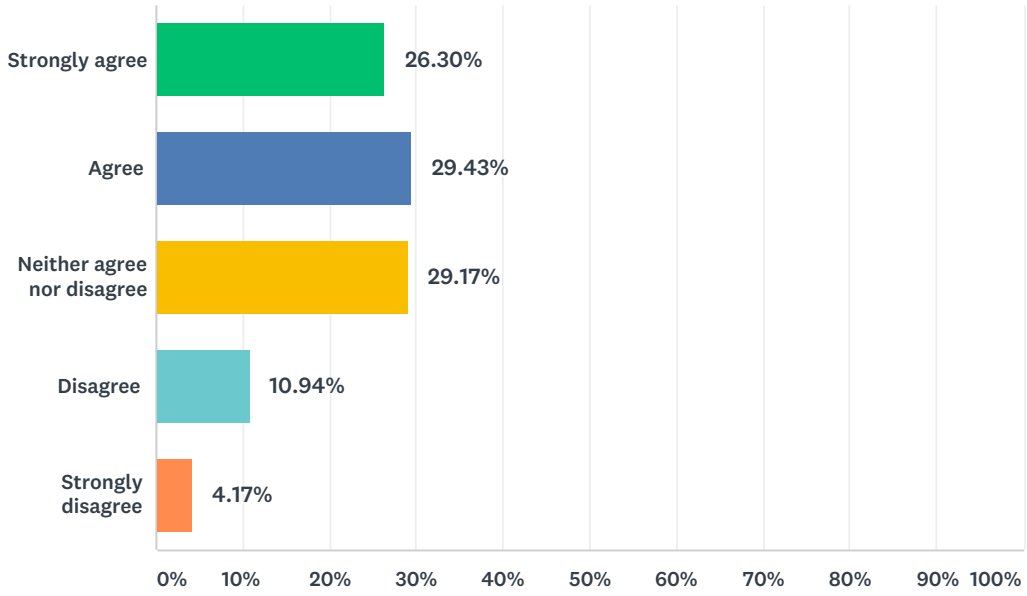
Answered: 385 Skipped: 17



ANSWER CHOICES	RESPONSES	
Strongly agree	37.92%	146
Agree	35.58%	137
Neither agree nor disagree	18.70%	72
Disagree	5.71%	22
Strongly disagree	2.08%	8
TOTAL		385

Q25 Reviewing patient prescription history helps reduce overdose.

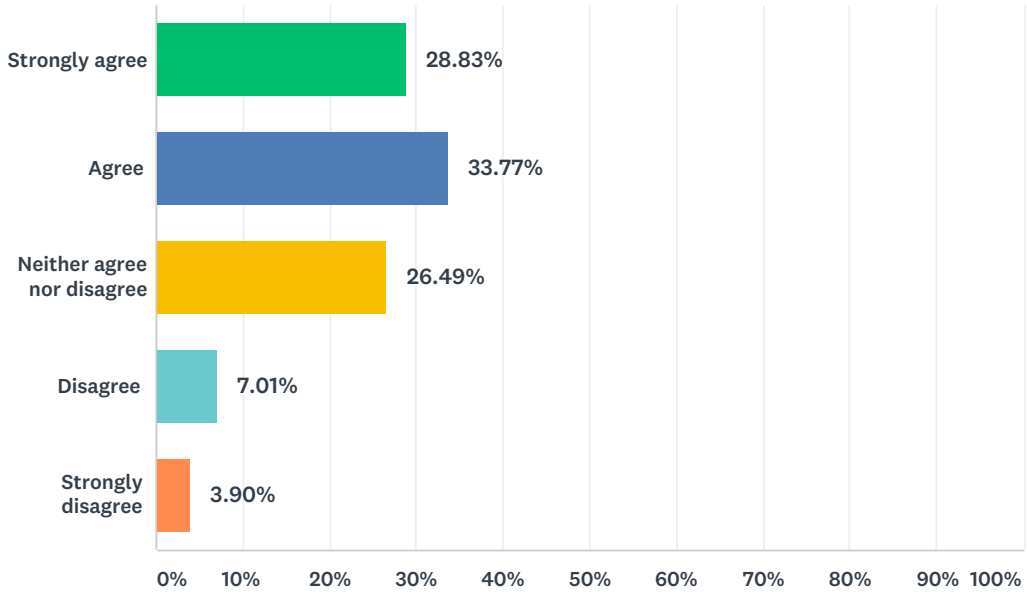
Answered: 384 Skipped: 18



ANSWER CHOICES	RESPONSES	
Strongly agree	26.30%	101
Agree	29.43%	113
Neither agree nor disagree	29.17%	112
Disagree	10.94%	42
Strongly disagree	4.17%	16
TOTAL		384

Q26 Reviewing patient prescription history helps reduce drug diversion.

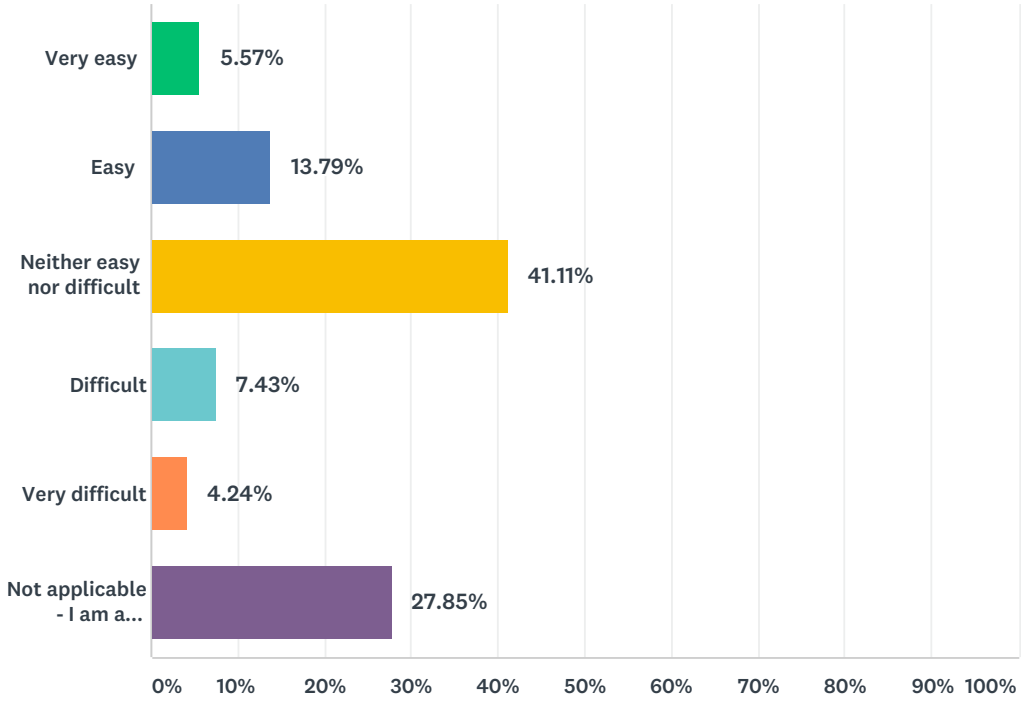
Answered: 385 Skipped: 17



ANSWER CHOICES	RESPONSES	
Strongly agree	28.83%	111
Agree	33.77%	130
Neither agree nor disagree	26.49%	102
Disagree	7.01%	27
Strongly disagree	3.90%	15
TOTAL		385

Q27 Rate your experience in reporting prescriptions information to the PDMP.

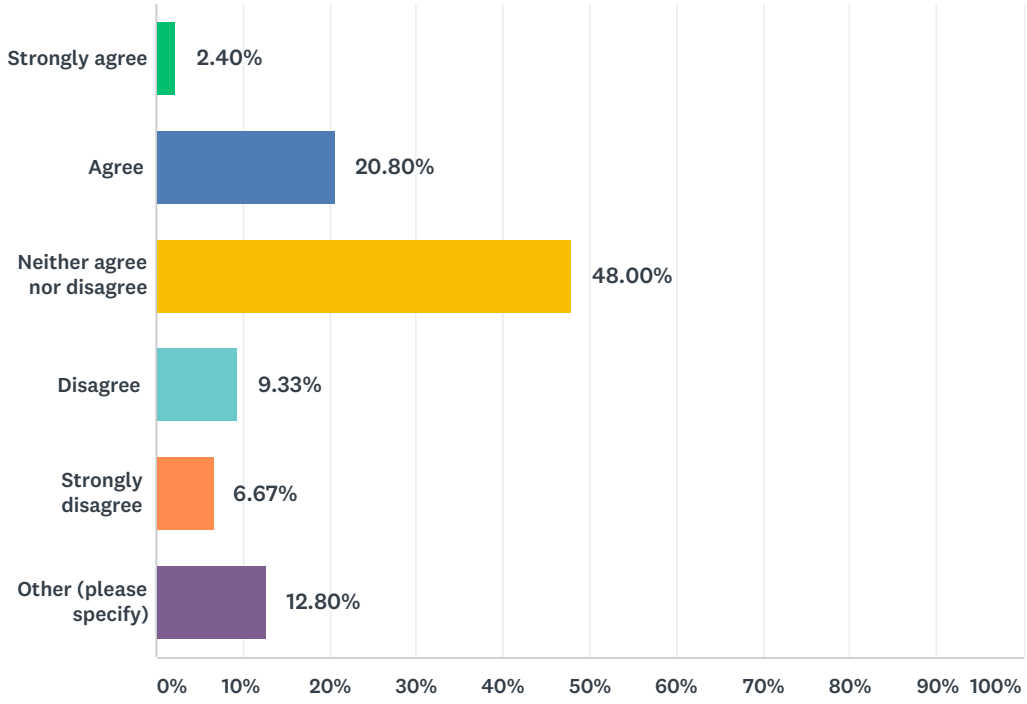
Answered: 377 Skipped: 25



ANSWER CHOICES	RESPONSES	
Very easy	5.57%	21
Easy	13.79%	52
Neither easy nor difficult	41.11%	155
Difficult	7.43%	28
Very difficult	4.24%	16
Not applicable - I am a practitioner that does not prescribe, administer, or directly dispense	27.85%	105
TOTAL		377

Q28 Requirements for delegate access is sufficiently explained and is easy to understand.

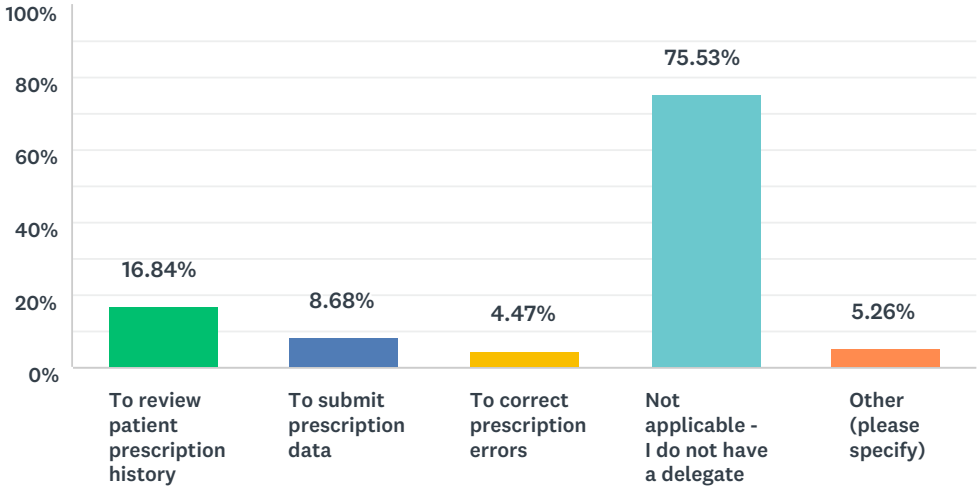
Answered: 375 Skipped: 27



ANSWER CHOICES	RESPONSES	
Strongly agree	2.40%	9
Agree	20.80%	78
Neither agree nor disagree	48.00%	180
Disagree	9.33%	35
Strongly disagree	6.67%	25
Other (please specify)	12.80%	48
TOTAL		375

Q29 I have a delegate interacting with the PDMP on my behalf for the following purposes (Check all that apply).

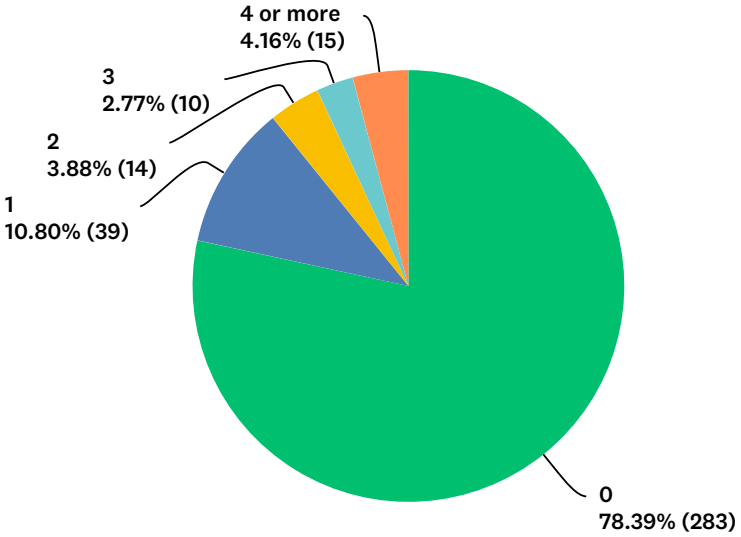
Answered: 380 Skipped: 22



ANSWER CHOICES	RESPONSES	
To review patient prescription history	16.84%	64
To submit prescription data	8.68%	33
To correct prescription errors	4.47%	17
Not applicable - I do not have a delegate	75.53%	287
Other (please specify)	5.26%	20
Total Respondents: 380		

Q30 Indicate the number of delegates associated with your PDMP account.

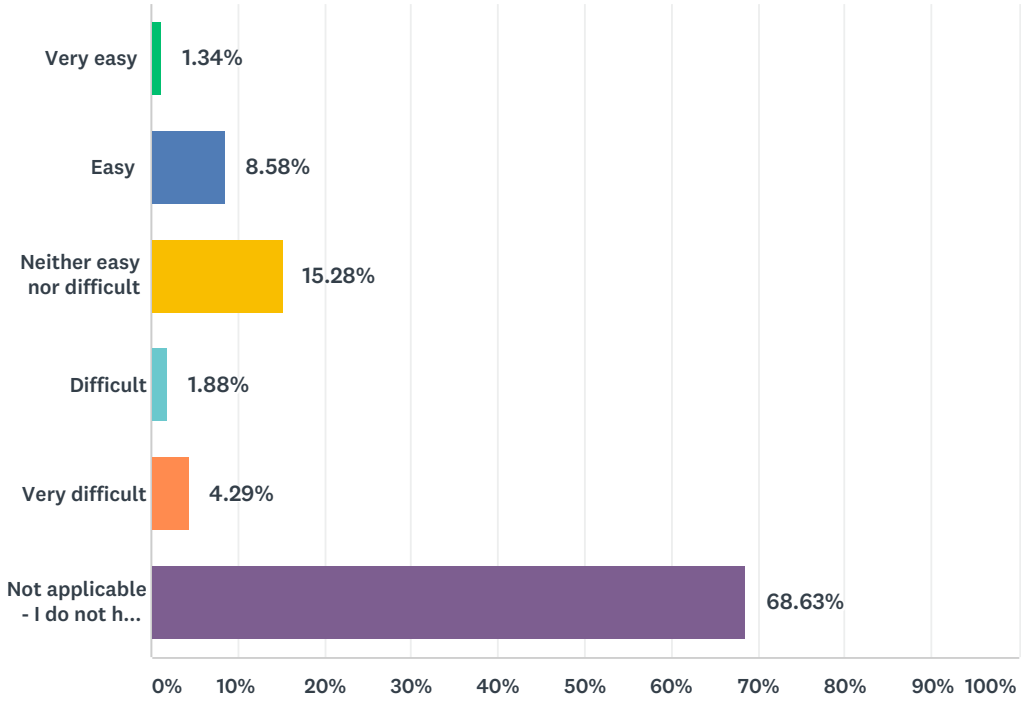
Answered: 361 Skipped: 41



ANSWER CHOICES	RESPONSES	
0	78.39%	283
1	10.80%	39
2	3.88%	14
3	2.77%	10
4 or more	4.16%	15
TOTAL		361

Q31 Rate your experience with adding delegate access to your PDMP account.

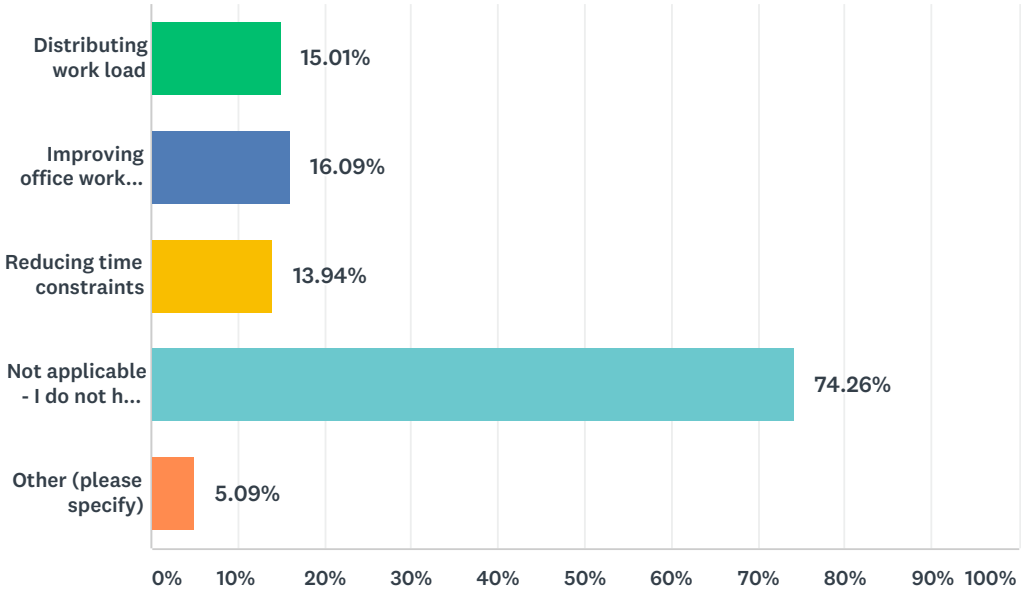
Answered: 373 Skipped: 29



ANSWER CHOICES	RESPONSES	
Very easy	1.34%	5
Easy	8.58%	32
Neither easy nor difficult	15.28%	57
Difficult	1.88%	7
Very difficult	4.29%	16
Not applicable - I do not have a delegate	68.63%	256
TOTAL		373

Q32 Delegate access has been the most useful for the following situations. (Check all that apply).

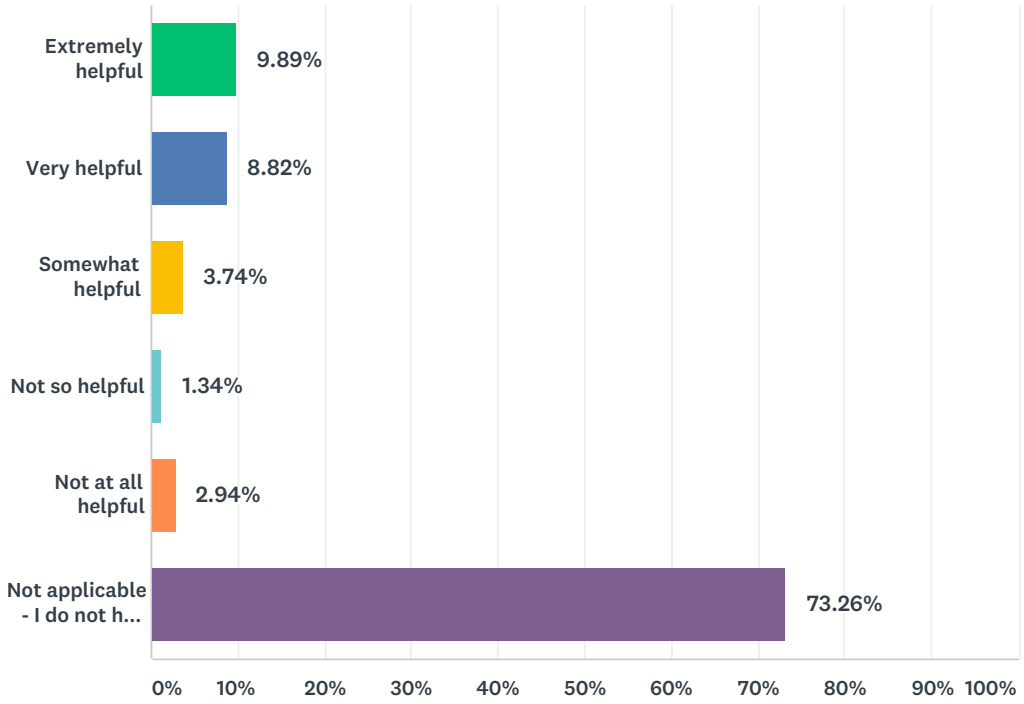
Answered: 373 Skipped: 29



ANSWER CHOICES	RESPONSES	
Distributing work load	15.01%	56
Improving office work flow	16.09%	60
Reducing time constraints	13.94%	52
Not applicable - I do not have a delegate	74.26%	277
Other (please specify)	5.09%	19
Total Respondents: 373		

Q33 Rate the overall helpfulness of delegate access.

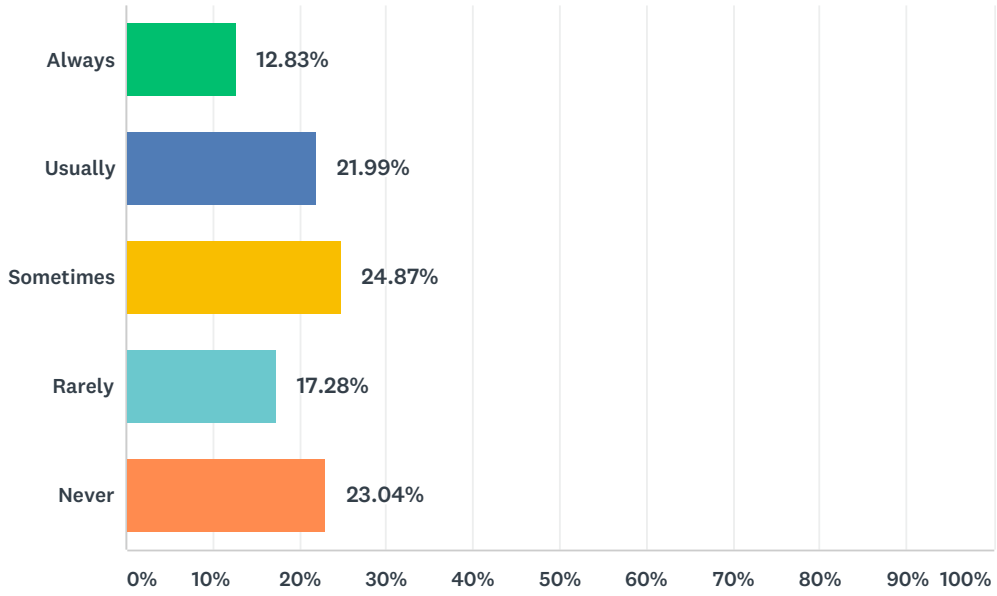
Answered: 374 Skipped: 28



ANSWER CHOICES	RESPONSES	
Extremely helpful	9.89%	37
Very helpful	8.82%	33
Somewhat helpful	3.74%	14
Not so helpful	1.34%	5
Not at all helpful	2.94%	11
Not applicable - I do not have a delegate	73.26%	274
TOTAL		374

Q34 I read PDMP announcements posted in the AWARxE platform.

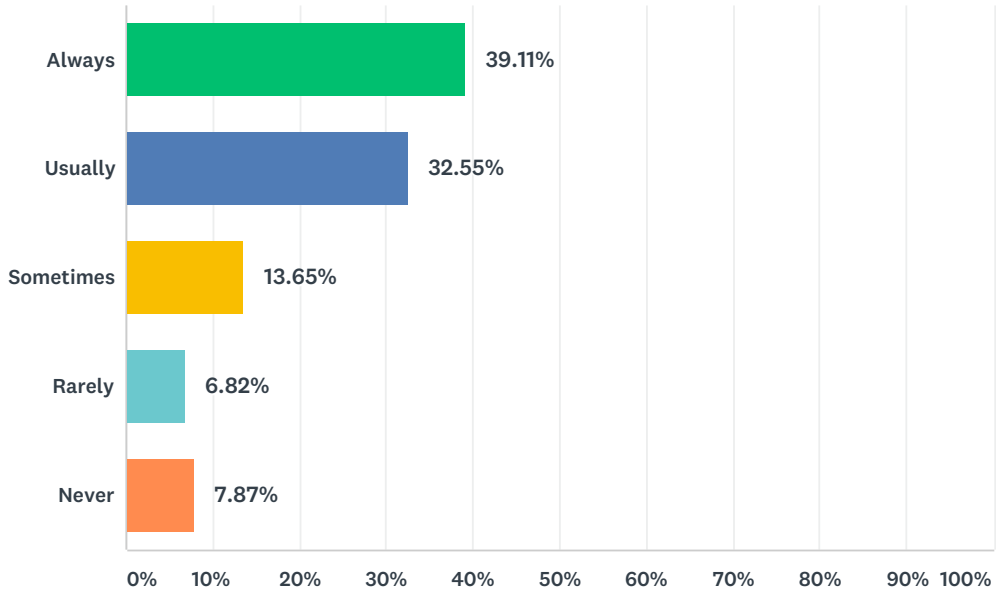
Answered: 382 Skipped: 20



ANSWER CHOICES	RESPONSES	
Always	12.83%	49
Usually	21.99%	84
Sometimes	24.87%	95
Rarely	17.28%	66
Never	23.04%	88
TOTAL		382

Q35 I read PDMP announcements that are sent directly to my email.

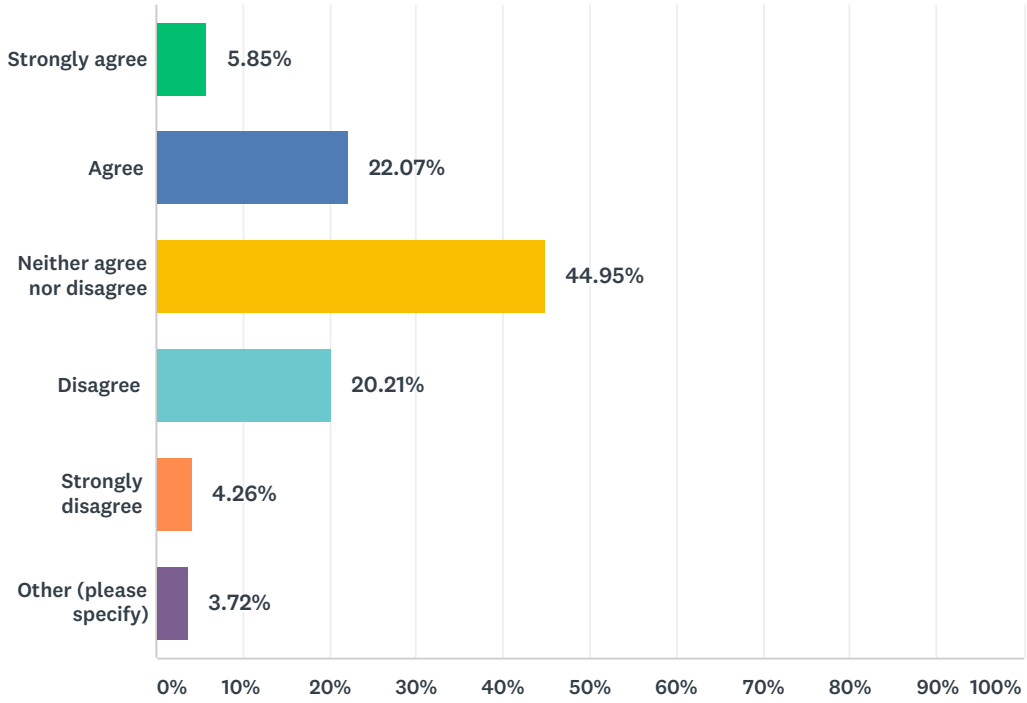
Answered: 381 Skipped: 21



ANSWER CHOICES	RESPONSES	
Always	39.11%	149
Usually	32.55%	124
Sometimes	13.65%	52
Rarely	6.82%	26
Never	7.87%	30
TOTAL		381

Q36 PDMP announcements posted in AWARxE and/or sent directly to my email creates report fatigue and I become overwhelmed with the information.

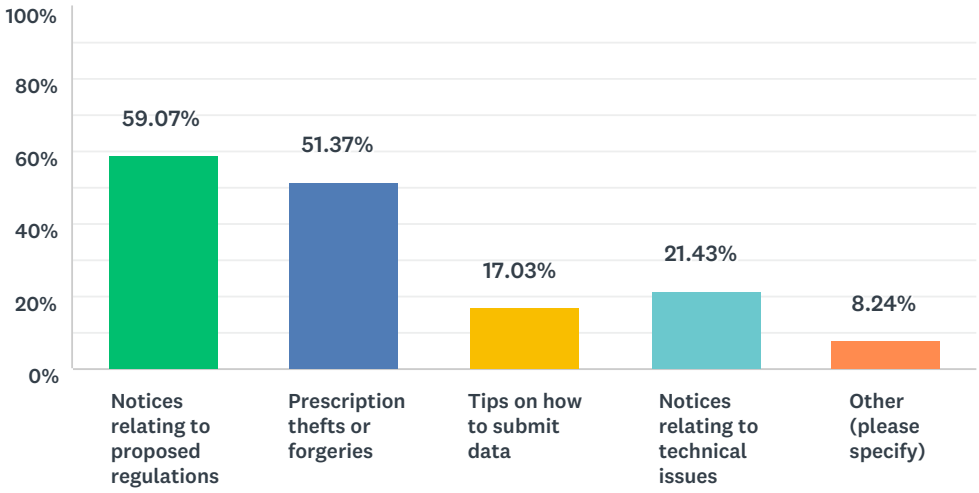
Answered: 376 Skipped: 26



ANSWER CHOICES	RESPONSES	
Strongly agree	5.85%	22
Agree	22.07%	83
Neither agree nor disagree	44.95%	169
Disagree	20.21%	76
Strongly disagree	4.26%	16
Other (please specify)	3.72%	14
Total Respondents: 376		

Q37 Announcements I find most useful include:

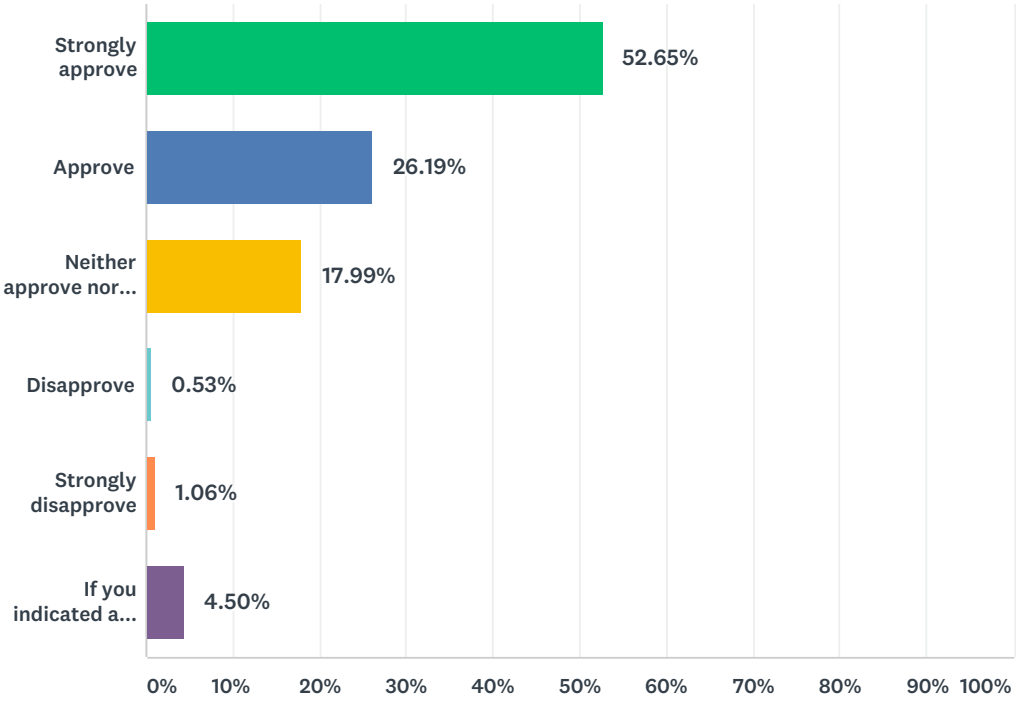
Answered: 364 Skipped: 38



ANSWER CHOICES	RESPONSES	
Notices relating to proposed regulations	59.07%	215
Prescription thefts or forgeries	51.37%	187
Tips on how to submit data	17.03%	62
Notices relating to technical issues	21.43%	78
Other (please specify)	8.24%	30
Total Respondents: 364		

Q38 Patients may cross state lines to obtain prescriptions. Prescribers and dispensers licensed in other states may want to conduct a patient prescription history query for a patient residing in Alaska receiving or asking for a prescription in their state. If given a prescription, prescribers and dispensers may want to report this information to the Alaska PDMP. Rate your support of allowing prescribers and dispensers not licensed in Alaska to review and report prescription history information for patients residing in our state (interstate data sharing).

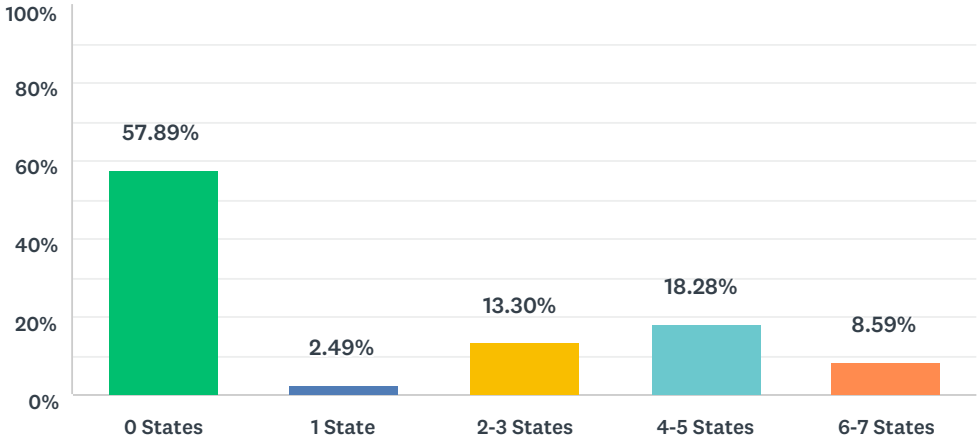
Answered: 378 Skipped: 24



ANSWER CHOICES	RESPONSES	
Strongly approve	52.65%	199
Approve	26.19%	99
Neither approve nor disapprove	17.99%	68
Disapprove	0.53%	2
Strongly disapprove	1.06%	4
If you indicated a neutral or disapproval response, please explain.	4.50%	17
Total Respondents: 378		

Q39 How many states do you know of that Alaska is sharing PDMP information with?

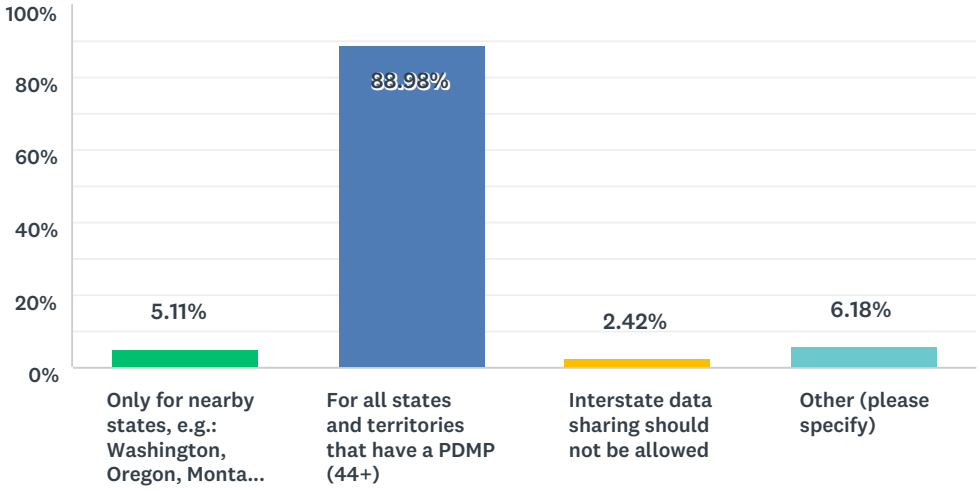
Answered: 361 Skipped: 41



ANSWER CHOICES	RESPONSES	
0 States	57.89%	209
1 State	2.49%	9
2-3 States	13.30%	48
4-5 States	18.28%	66
6-7 States	8.59%	31
Total Respondents: 361		

Q40 Interstate data sharing should be allowed under the following circumstances.

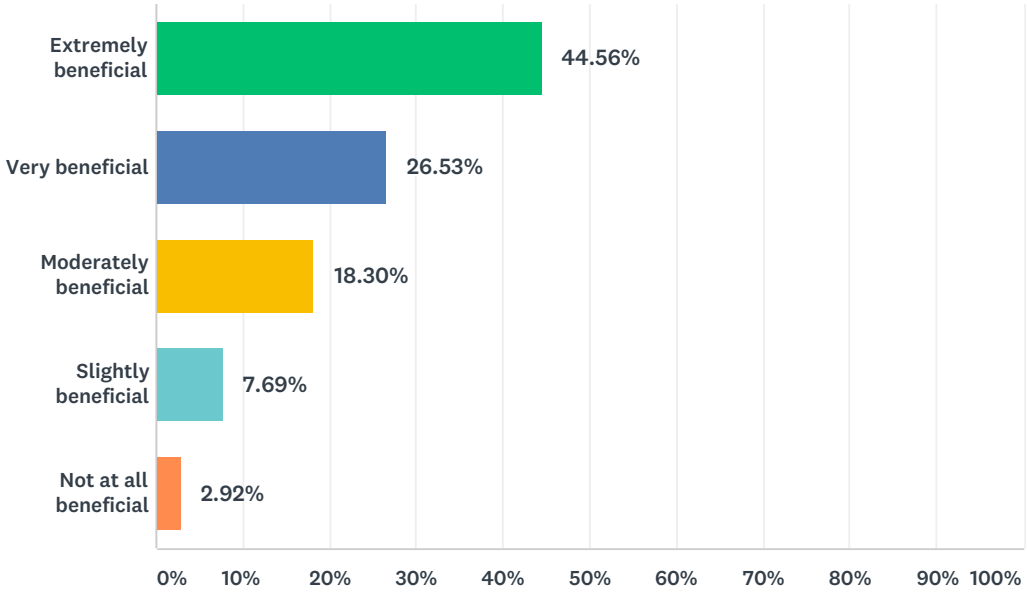
Answered: 372 Skipped: 30



ANSWER CHOICES	RESPONSES	
Only for nearby states, e.g.: Washington, Oregon, Montana, Idaho, California	5.11%	19
For all states and territories that have a PDMP (44+)	88.98%	331
Interstate data sharing should not be allowed	2.42%	9
Other (please specify)	6.18%	23
Total Respondents: 372		

Q41 Rate the level of benefit you feel there is in sharing data with some or all states.

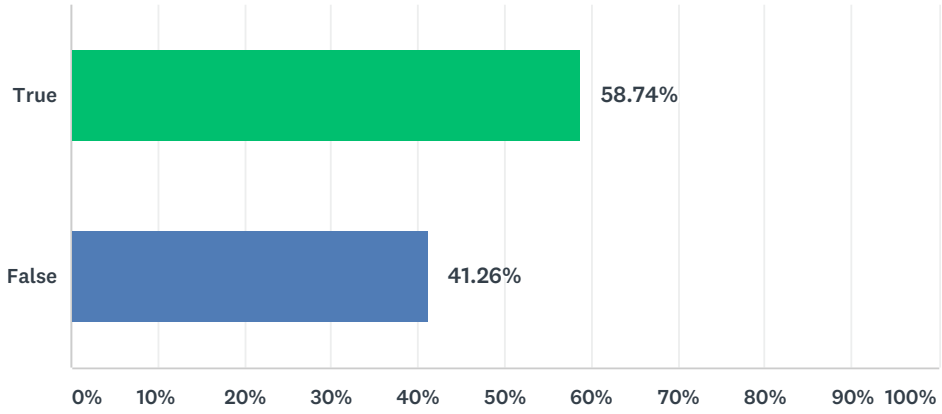
Answered: 377 Skipped: 25



ANSWER CHOICES	RESPONSES	
Extremely beneficial	44.56%	168
Very beneficial	26.53%	100
Moderately beneficial	18.30%	69
Slightly beneficial	7.69%	29
Not at all beneficial	2.92%	11
TOTAL		377

Q42 Practitioners are exempt from interacting with the PDMP when dispensing to a patient for an outpatient supply of 24-hour or less at a hospital with an inpatient pharmacy for use after discharge.

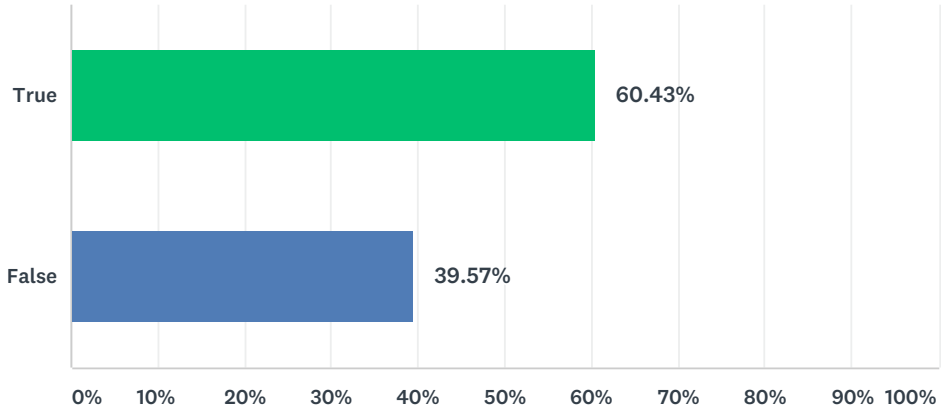
Answered: 366 Skipped: 36



ANSWER CHOICES	RESPONSES	
True	58.74%	215
False	41.26%	151
TOTAL		366

Q43 Practitioners are exempt from interacting with the PDMP when dispensing to a patient for an outpatient supply of 24-hour or less at a hospital emergency department for use after discharge.

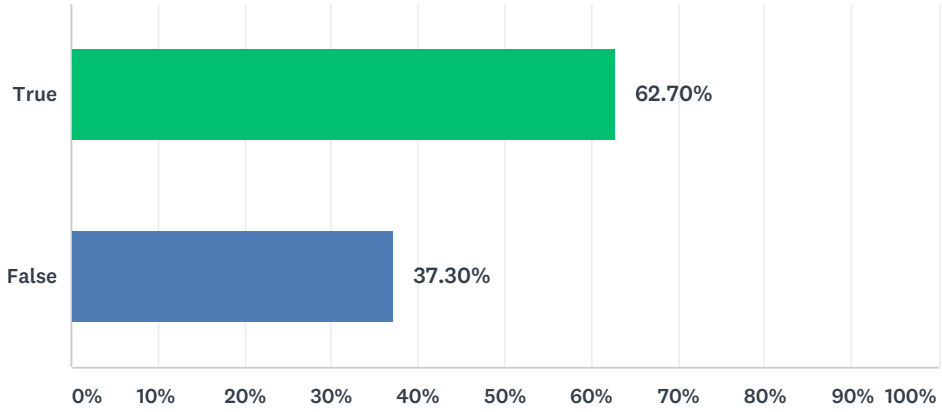
Answered: 369 Skipped: 33



ANSWER CHOICES	RESPONSES	
True	60.43%	223
False	39.57%	146
TOTAL		369

Q44 Practitioners are exempt from interacting with the PDMP when administering to a patient admitted to a health care facility.

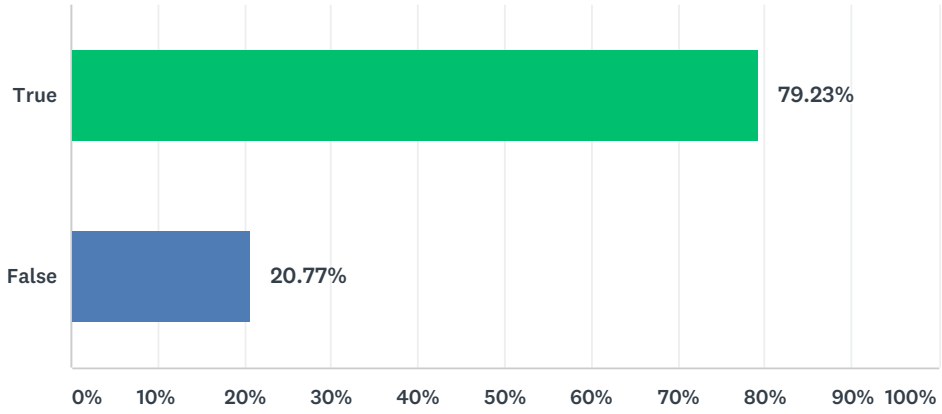
Answered: 370 Skipped: 32



ANSWER CHOICES	RESPONSES	
True	62.70%	232
False	37.30%	138
TOTAL		370

Q45 Practitioners are exempt from interacting with the PDMP when dispensing, prescribing, or administering at the scene of an emergency, in an ambulance, or in an emergency department.

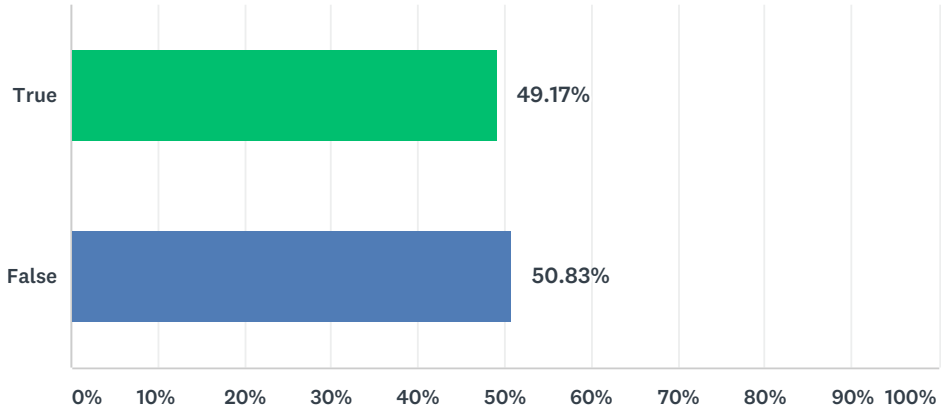
Answered: 366 Skipped: 36



ANSWER CHOICES	RESPONSES	
True	79.23%	290
False	20.77%	76
TOTAL		366

Q46 Practitioners are exempt from interacting with the PDMP when dispensing, prescribing, or administering at a hospice or nursing home that has an inpatient pharmacy.

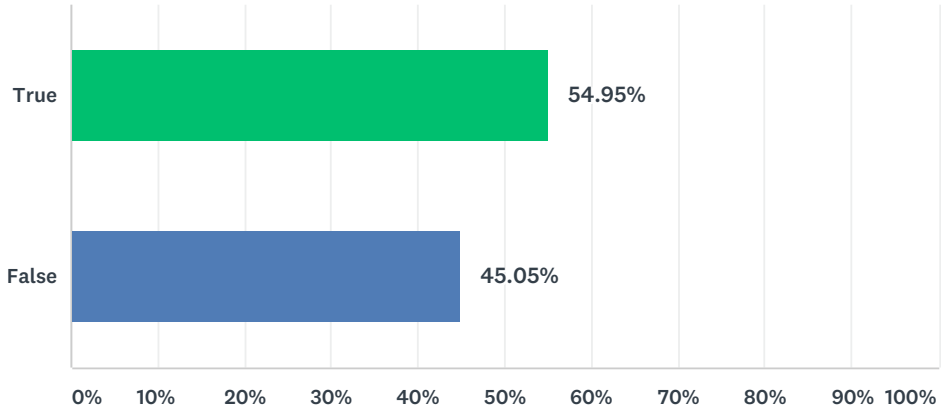
Answered: 360 Skipped: 42



ANSWER CHOICES	RESPONSES	
True	49.17%	177
False	50.83%	183
TOTAL		360

Q47 Practitioners are exempt from interacting with the PDMP when dispensing, prescribing, or administering immediately before, during, or within the first 48 hours after surgery or a medical procedure.

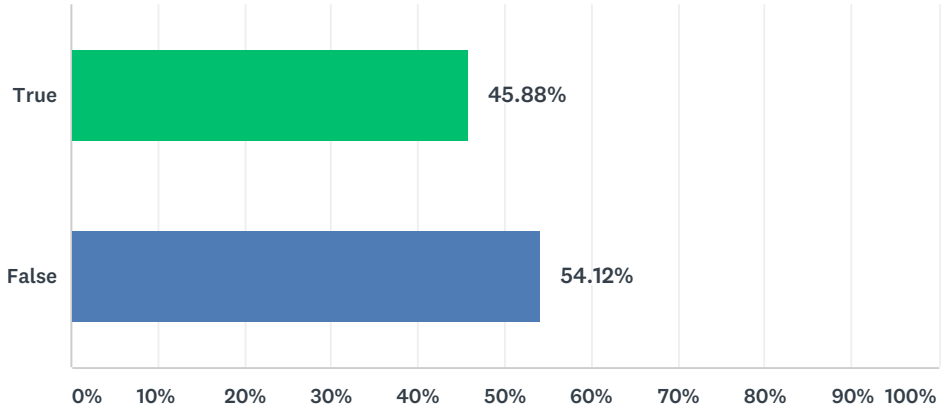
Answered: 364 Skipped: 38



ANSWER CHOICES	RESPONSES	
True	54.95%	200
False	45.05%	164
TOTAL		364

Q48 Practitioners are exempt from interacting with the PDMP when dispensing, prescribing, or administering a non-refillable prescription for a controlled substance in a quantity intended to last for not more than three (3) days.

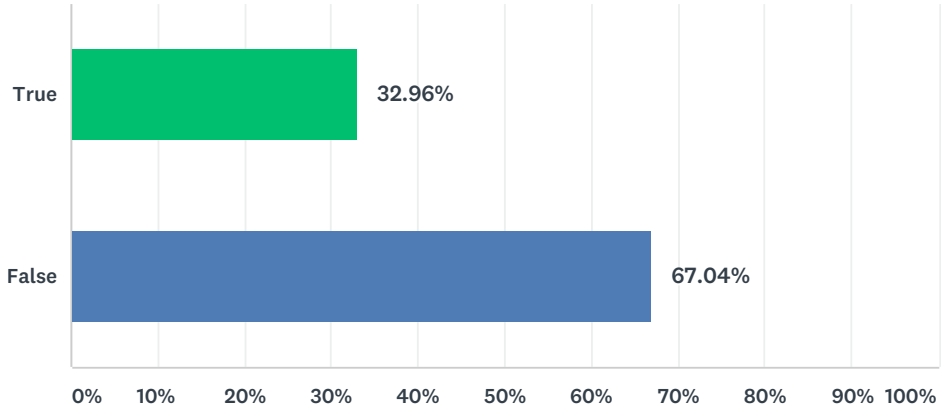
Answered: 364 Skipped: 38



ANSWER CHOICES	RESPONSES	
True	45.88%	167
False	54.12%	197
TOTAL		364

Q49 Practitioners are exempt from interacting with the PDMP when administered to a patient admitted at a correctional facility.

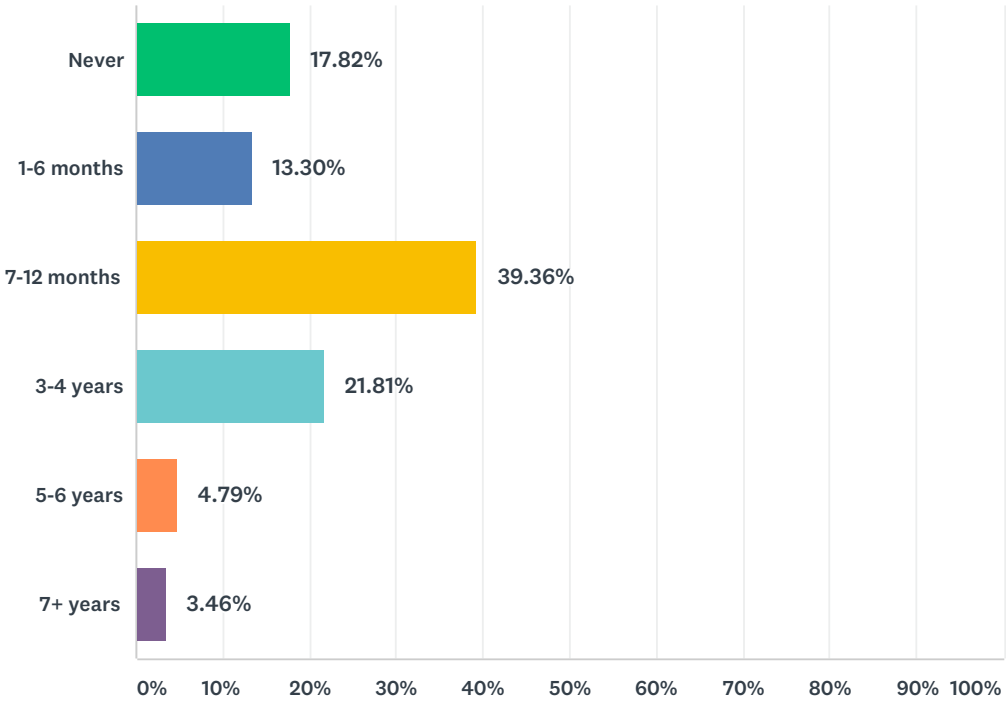
Answered: 361 Skipped: 41



ANSWER CHOICES	RESPONSES	
True	32.96%	119
False	67.04%	242
TOTAL		361

Q50 How long have you used the PDMP?

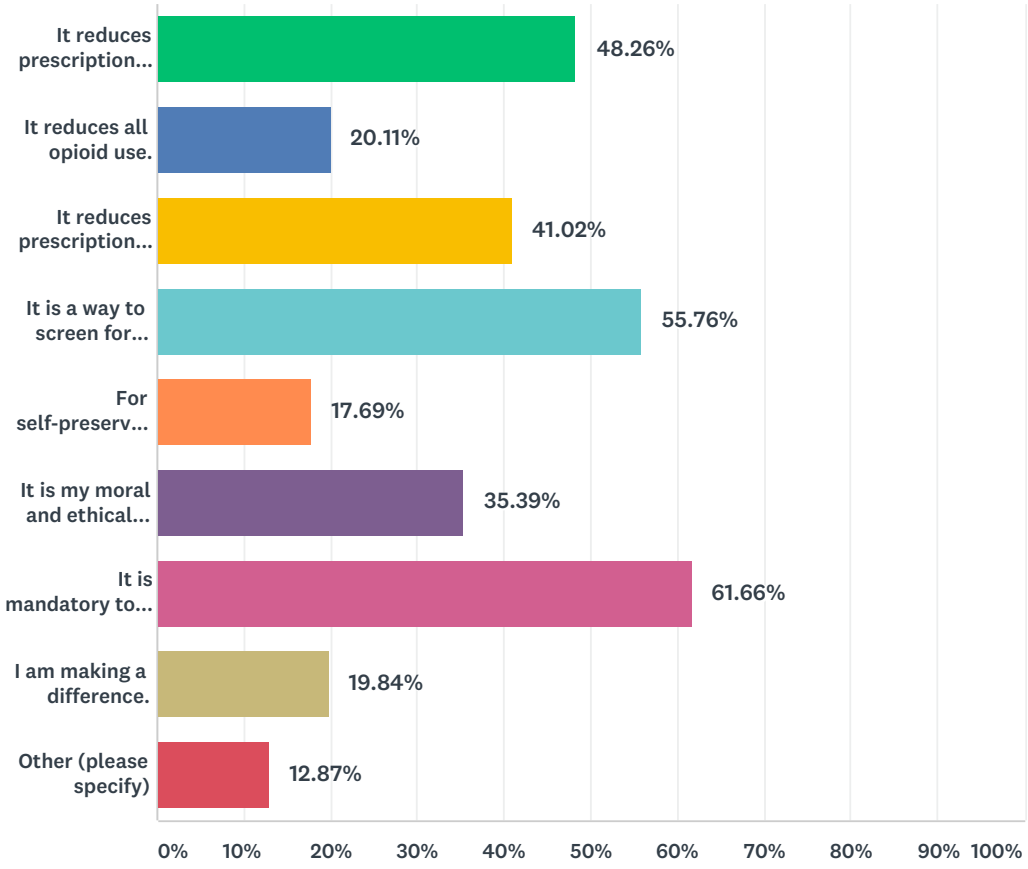
Answered: 376 Skipped: 26



ANSWER CHOICES	RESPONSES	
Never	17.82%	67
1-6 months	13.30%	50
7-12 months	39.36%	148
3-4 years	21.81%	82
5-6 years	4.79%	18
7+ years	3.46%	13
Total Respondents: 376		

Q51 The following are reasons why I use the PDMP. (Check all that apply).

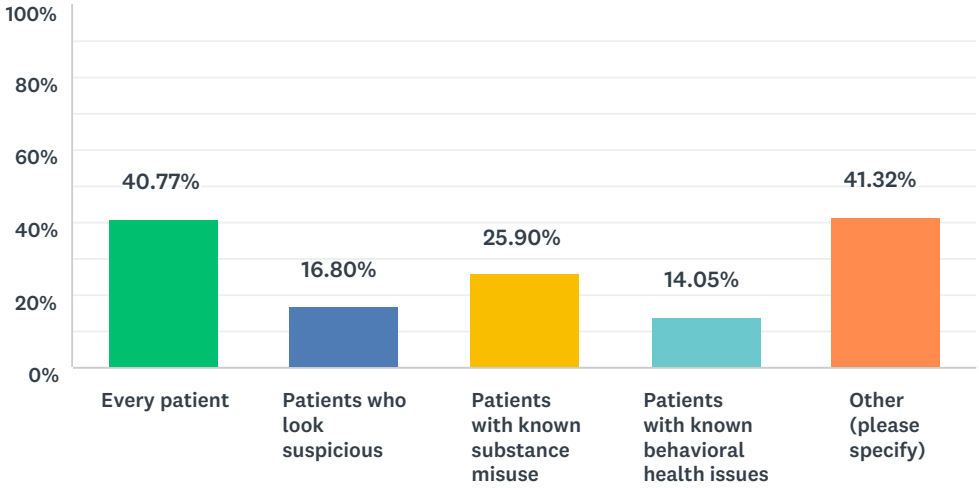
Answered: 373 Skipped: 29



ANSWER CHOICES	RESPONSES	
It reduces prescription opioid misuse.	48.26%	180
It reduces all opioid use.	20.11%	75
It reduces prescription diversion.	41.02%	153
It is a way to screen for substance misuse.	55.76%	208
For self-preservation.	17.69%	66
It is my moral and ethical obligation to do so.	35.39%	132
It is mandatory to do so.	61.66%	230
I am making a difference.	19.84%	74
Other (please specify)	12.87%	48
Total Respondents: 373		

Q52 What patients do you generally check the PDMP on? (Check all that apply).

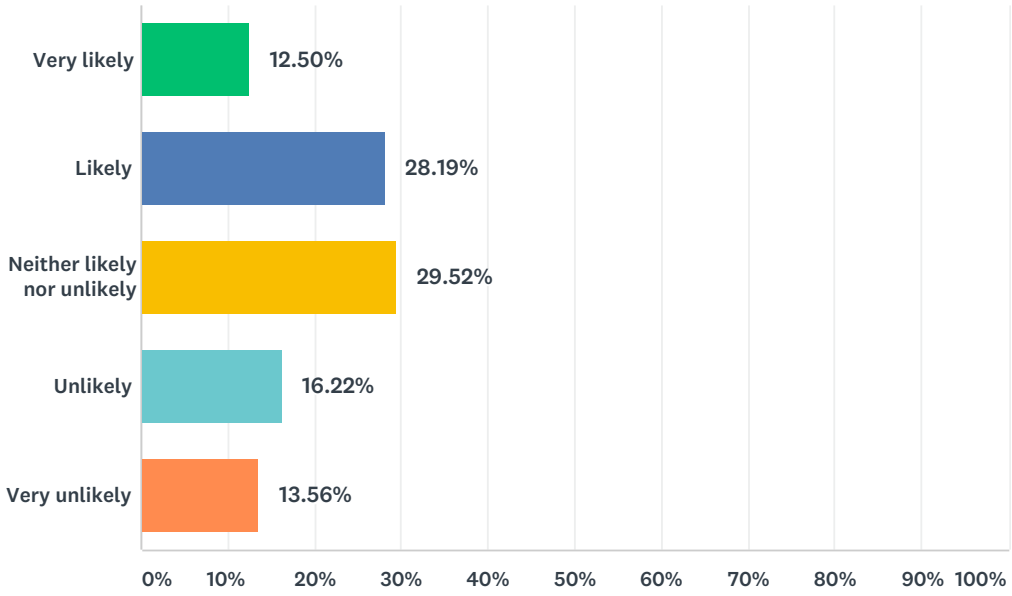
Answered: 363 Skipped: 39



ANSWER CHOICES	RESPONSES	
Every patient	40.77%	148
Patients who look suspicious	16.80%	61
Patients with known substance misuse	25.90%	94
Patients with known behavioral health issues	14.05%	51
Other (please specify)	41.32%	150
Total Respondents: 363		

Q53 How likely are you to engage in a PDMP-specific training?

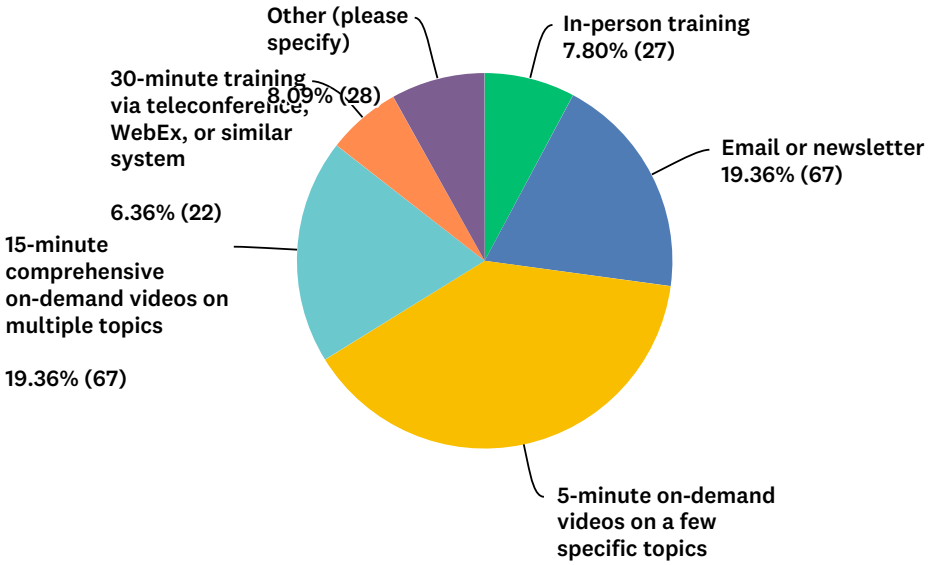
Answered: 376 Skipped: 26



ANSWER CHOICES	RESPONSES	
Very likely	12.50%	47
Likely	28.19%	106
Neither likely nor unlikely	29.52%	111
Unlikely	16.22%	61
Very unlikely	13.56%	51
TOTAL		376

Q54 If you are interested in engaging in PDMP-specific training, what modality would be most useful and effective?

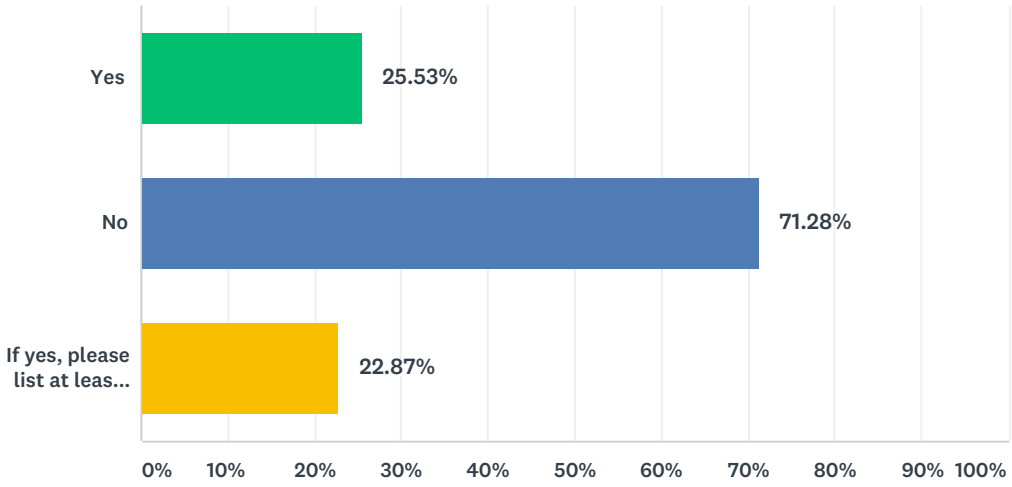
Answered: 346 Skipped: 56



ANSWER CHOICES	RESPONSES	
In-person training	7.80%	27
Email or newsletter	19.36%	67
5-minute on-demand videos on a few specific topics	39.02%	135
15-minute comprehensive on-demand videos on multiple topics	19.36%	67
30-minute training via teleconference, WebEx, or similar system	6.36%	22
Other (please specify)	8.09%	28
TOTAL		346

Q55 Are you currently registered with another state PDMP?

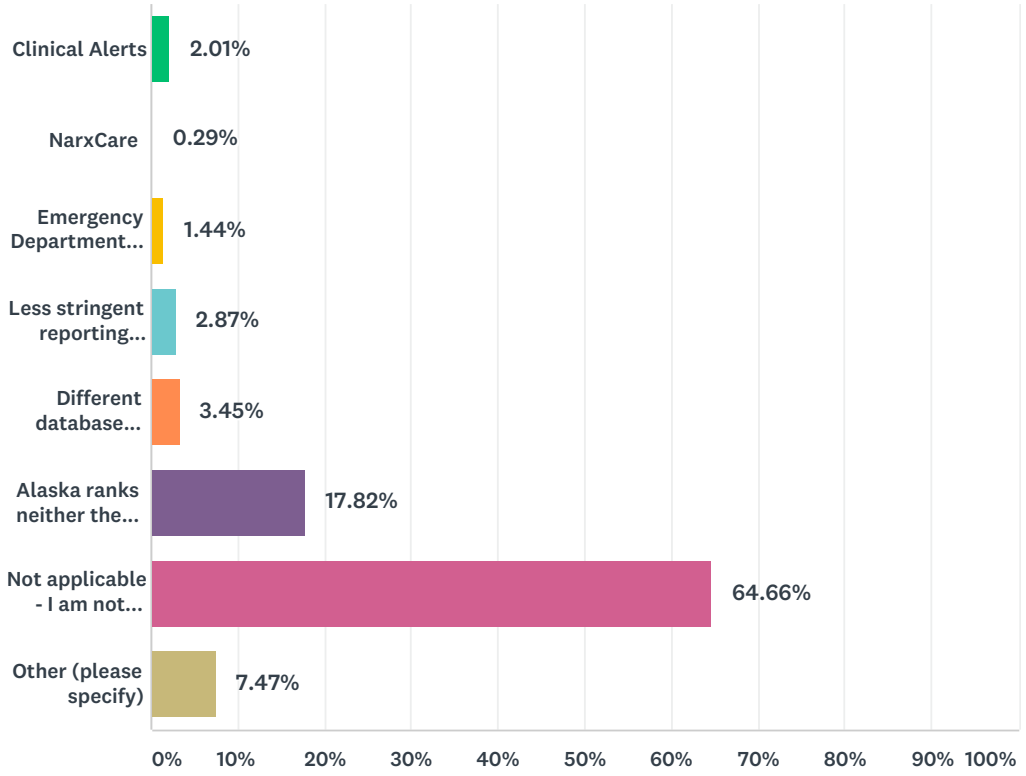
Answered: 376 Skipped: 26



ANSWER CHOICES	RESPONSES	
Yes	25.53%	96
No	71.28%	268
If yes, please list at least one other state:	22.87%	86
Total Respondents: 376		

Q56 Please select a PDMP feature or policy of the other state you indicated above that makes the Alaska PDMP rank worse.

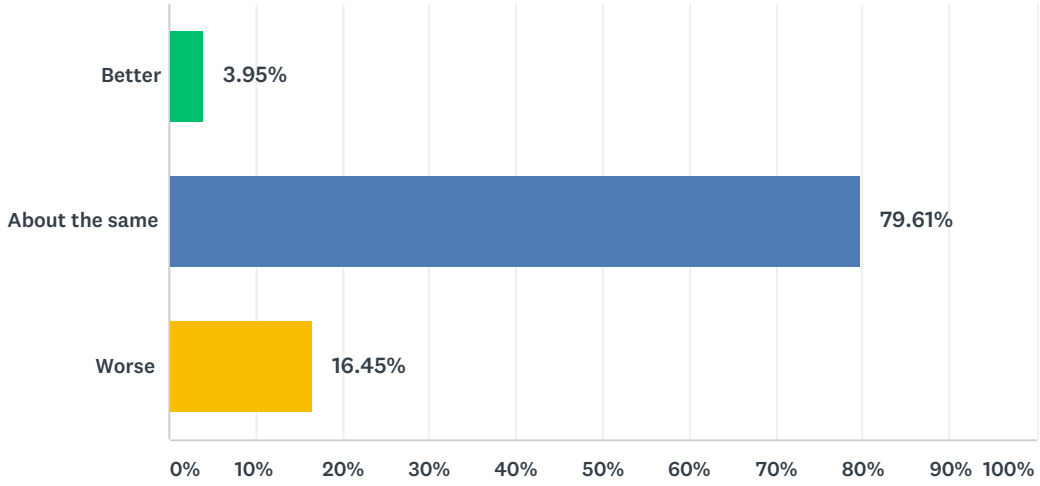
Answered: 348 Skipped: 54



ANSWER CHOICES	RESPONSES	
Clinical Alerts	2.01%	7
NarxCare	0.29%	1
Emergency Department Information Exchange (EDIE) Integration	1.44%	5
Less stringent reporting requirements	2.87%	10
Different database structure or platform	3.45%	12
Alaska ranks neither the same nor worse than the other state	17.82%	62
Not applicable - I am not registered with another state PDMP	64.66%	225
Other (please specify)	7.47%	26
TOTAL		348

Q57 If you are registered with another state PDMP, how does the Alaska PDMP compare?

Answered: 152 Skipped: 250



ANSWER CHOICES	RESPONSES	
Better	3.95%	6
About the same	79.61%	121
Worse	16.45%	25
TOTAL		152

InterConnect Steering Committee

7/24/28

ALASKA

- Idaho
- Louisiana
- Massachusetts
- Minnesota
- Montana
- North Dakota
- Rhode Island

When did Alaska sign MOU? 2015
When did Alaska go live? 2016

Authority: AS 17.30.200 does allow database sharing with practitioners who are not licensed in Alaska, as long as they are licensed in another state; AS 17.30.200(d)(3) only states that the practitioner has to be "licensed" with the "authority to prescribe", but doesn't say they have to be licensed under AS 08. The same is true for pharmacists under AS 17.30.200(d)(4).
→ Danna Droz with NABP says majority of states have similar language saying that folks accessing data must be licensed (without specifying they have to be licensed in a particular state). Florida changed the language in their statutes from "licensed in Florida" to licensed so that they can share with other states.

TASK:
Laura to create InterConnect map for Alaska; there was discussion about Appriss doing this for each state and posting maps to state consoles.

TASK:
Request link to PMPi data sources from Nicole Dubree

TASK:
Re: accessing data only when there is a practitioner/pharmacist relationship with a patient (i.e.: no access with a dead person (famous people), but what about conducting searches on parents of pediatric patients or owners of animals? → AS 17.30.200(d)(3) and (d)(4) has language that says "to the extent the information *relates specifically to a current patient*", for practitioners and pharmacists, respectively.

Animal Owners –language is in VET board statues and PHA board regs:

- VET board: AS 08.98.050(a)(11), does this language "identify resources and develop educational materials to assist licensees to identify an animal owner who may be at risk for abusing or musing an opioid" → identify resources = PDMP? Identify an animal owner = history search in the PDMP?
- PHA board: 12 AAC52.460(1) – pharmacists can't fill a prescription for an animal unless they have the species of animal and the owner's name; labeling requires animal owner to be listed on Rx per 12 AAC 52.480(6) → similarly, VET labeling regulation, 12 AAC 28.900(b)(1) says the prescription has to have the name of the animal owner, also, language in VET's AS 08.98.245 uses phrase "issue prescription *to* the owner"

Parents - only language is in:

- AS 08.68.75 (MED board) relating to maximum dosage for an opioid prescription (7-day limit)
- AS 13.55.010 (HSS statute) relating to non-opioid directive

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Overview

PMP InterConnect – all protected health information is encrypted and not visible to the hub, secure, and HIPAA compliant; no protected health information stored by the hub

- Easy for states
  - Only sign one MOU/Contract with NABP
  - But some states, e.g.: Oregon has state laws that require state-to-state MOU
- 'Each state's rules about access are enforced automatically by the hub'
  - States that sign can be assured that all data is encrypted
- cost-effective; NABP pays for maintenance and operation costs
- Supports states' autonomy over PDMP data
- Kentucky
  - 7 boarder states
  - fruitful patient history queries with these states
  - but too many false positives (person with same name, DOB, etc)

Third party access to PDMP data via PMP InterConnect

- April 2013: unanimous agreement that there is no secondary use, e.g.: collecting, copying or selling of PDMP data by any party; states can't store other state data into their own PDMP
- August 2013: console refined; reviewed security and audit trails of integration pilots
- August 2013: Requested development of technology for health care intergration = PMP Gateway

Physician Request

Physician → Electronic Medial Record → PMP Gateway → NABP PMP InterConnect → PMPs

Response back to Physician

PMPs → NABP PMP InterConnect → PMP Gateway → Electronic Medical Record→ Physician

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Pharmacist Request

Pharmacist → Pharmacy Dispensing Software → PMP Gateway → NABP InterConnect → PMPs

Response back to Pharmacist

PMPs → NABP PMP InterConnect → PMP Gateway → Pharmacy Dispensing Software → Pharmacist

NABP InterConnect = NABP owns, Appriss operates, NABP pays costs

PastRx = reseller of gateway info; but can't sell gateway?
Dr. First = add-on; software developer for Nebraska

InterConnect Steering Committee Meeting

I. Roll Call
II. Agenda Approval
III. Steering Committee Procedure
- Operating principles

- 44 states actively participating (MOU pending with Oregon and FL)
- 25 PDMPs integrated into workflow
- Average # of PDMPs with whom PDMPs share = 20
- Maximum # of PDMP with whom a PDMP shares = 38
- # of requests in past year =200+ million
- # of requests in past month = 24 million
- Growing by 8% average per year

North Carolina case study:
- December 2017: no pdmp sharing
- January 2018: interconnect MOU signed
- February 2018: 15 PDMPs sharing with NC (all border states)
- All 121 Kroger/Harris Teeter pharmacies with PDMP integrated into workflow

PMPi Console Basic Training & New Features

- **PMP InterConnect Home Page**
  - Dashboard statistics
    - # of requests in last 60 min, 24 hrs, and 30 days
    - % processed successfully
    - % denied per business rules
    - Disclosures, e.g.: investigative
  - PMPi Performance report (for all states)
- **PMP Management**
  - → PMP Configuration
  - → PMP level controls "heart of state-to-state data sharing"
    - Check modify settings; ensure that prescriber roles that are allowed to access data
  - Manage InterConnect Users
- **PMP Gateway Management**

PMPi Reports (what's the link to access?—contact Nicole Dubree with Appriss to get this.

- PMPi Disclosures to Other States

PMP InterConnect Alert Notifications (coming soon) Re: gray area in between online and offline, e.g.: when a state is experiencing query response issues (delayed)

- Enhancement adds a configuration to turn on email notifications to administrator staff when a state PDMP has been degraded. Degraded = requests are slower than usual; throttled = manages issue to recover issue
- → Under Management Contact Information in 'PMP Management'; you can opt-in to receiving only home state alert notifications or you can opt-in to receiving shared state alert notifications; these come in via email and notifications are regarding only when requests are slow "degraded", "throttled", or "recovered". → What about receiving notifications when states go offline? Appriss will look into that

Gateway Licensee Auto-Approval

Background: Gateway licensee auto-approval streamlines the approval process for licensees to access multi-state PMP data
Details: enhancement allows Gateway licensees to be automatically approved by states outside of the state where the licensee is located if those outside states also have disclosure authorized for the licensees' home state

- Licensee must be approved by the state PDMP where the licensee is located or the requests will fail
- Licensees in state PDMP A are only auto-approved by State PDMP B when PDMP B has enabled auto approval for PDMP A in the 'Set PMP Level Controls of the PMP InterConnect' console
- State PDMP B must also have disclosures authorized for State PDMP A
- Gateway licensee auto-approval only works for licensees that are located in a specific state. For example, auto-approval will not work for large pharmacy chains that have stores in more than one state and health systems with facilities in more than one state.

→ Provider authorization (optional); you can turn this on, but the health system needs to ensure that the wrong doctor doesn't access another patient's EHR inappropriately

Walmart Integration into Workflow

- 18,000 pharmacists employed with Walmart and Sam's Club
- Integrating into workflow using NarxCare
- PMP Integration approval/NarxCare roll-out status: Alaska listed (never got a notification??) Who approves?

Appriss Roundtable Discussion Topics:

- Additional Data Sources, i.e.: vitals statistics, toxicology data, coroner's office; legal agreements to share that data? Non-fatal and fatal overdose data?
- General functionality; features of PMPi InterConnect
- Patient matching and consolidation

- → Also want to talk about data submission requests; is it possible to see the pharmacy's DEA # in the request? Would be helpful to know if they're registered in AK and have an active account searchable in the 'Compliance' tab
    - **EMS data to PDMP to collect Naloxone (NPLEX)**
    - West Virginia sends EMS data
    - Toxicology results; issue is that you can't tell definitively whether that overdose was a result of an opioid (depending on how it's coded); ICD-10 codes
    - **Allow pharmacists to see a doctor's NPI specialty**
    - Treatment agreements
    - ARCOS – **over the counter medicine**

PMPi to RxCheck – making PMPi work with RxCheck (anticipation that federal gov't will require states to use RxCheck for interoperability purposes)

Patient Matching

- Remove middle initial
- Unique patient ID? → Drivers license # or photo ID#?
- Board does not think we need to implement photo ID laws; most states require a photo ID in order to pick up a controlled substance

Veterinary Prescriptions & PDMP Reporting

- AVMA, AAVSB, & NABP Collaboration for Improved pharmacist/veterinarian communication
    - Resolution # 113-1-17 – Best Practices for Veterinary Compounding
    - "Therefore be it resolved that NABP commission a force of stakeholders, which may include FDA, to develop model regulations for compounding of animal products"
- What are vets telling us?
    - Pharmacies are asking for the veterinarian's birthdate for PMP reporting purposes; vets are giving fictitious DOBs
    - Pharmacies are asking for NPI or DEA #s for non-scheduled prescriptions—both are not OK since DEA and CMS don't provide. CMS doesn't issue NPI #s to vets because they don't fit in the CMS definition of "health care providers"
    - Vets don't have appropriate prescriber identification to use
- Whose birthdate to use?: The pet owner's DOB is the only appropriate birth date to use; pet owner will take possession of the prescription and therefore more likely to divert
- What ID to use for reporting nonscheduled Rx? The VET's state license number: Minnesota suggested using veterinarian's state license number in leu of an NPI or DEA number for reporting vet gabapentin prescriptions to the PDMP.
- National database licensure for veterinarians? NABP will reach to AAVSB to see if they have a national database
- Pharmacies entering vet prescription; how do pharmacies enter these into their system? What is the standard? NABP says that it should by the dog name (species) and owner's name.

National Center for Injury Prevention and Control Data Driven Prevention Initiative

Overview

Awardees Name: Alaska Department of Health and Social Services
Grantee #: 5 U17 CE924872-02
Budget Year: 2018
FOA #: CE16-1606
Title: Data Driven Prevention Initiative (DDPI)
Approved Amount: $1,350,000.00
Reviewed by: Yessenia Ibarra, Minda Reed, Amber Robinson
Base or Enhanced: ENHANCED

Strategy: Prevention in Action

Major Activity: Make PDMPs easier to use and access

Major Activity Summary: The PDMP state website located at www.pdmp.alaska.gov was assessed for its available resources and quality of instructions in November 2017. The PDMP Manager identified four options for making the PDMP platform easier to use and access:

1.) Update registration instructions for primary users and delegates - Instructions were revised and posted to the website on 11/14/2017 to include the step-by-step process of successfully registering with visual cues.

2.) Improve formatting of website for better readability - The layout of resources on the PDMP were rearranged and reconfigured to make instructions and pertinent resources easy to identify. Improvements included adding icons for PDFs and webpages and listing resources in a conceptual rather than fragmented order.

3.) Provide conspicuous contact information for PDMP assistance - The PDMP Manager and AWARxE support contact numbers are redundantly displayed to make contact information easily accessible when questions arise pertaining to PDMP use and access.

4.) The PDMP manager has been conducting outreach activities since January 2018. A survey was developed on 03/27/18 to gauge specific topics practitioners look to that will improve the ease of PDMP use and access.

Major Activity Challenges: Changes to the PDMP state website cannot be done directly; for website maintenance and additions, the PDMP manager must submit change requests to the publications specialist. This can cause changes to be delayed.

Comments

- Major Strengths:
  - Use of survey to inform "ease of use and access" work is a data-driven approach to this activity.
  - Face-to-face meetings are an important tool for generating buy-in and it is good to see them used to gather strategic planning input.

- Major Weaknesses:
  Year 3 work plans were not included for:
    - Move toward universal PDMP registration and use
    - Contact non-enrolled prescribers
    - DHSS access to AKPDMP datasets
    - Enhance communication between programs and partners

- Recommendations:
  - Has the team considered unscheduled visits (e.g. academic detailing model) to conduct PDMP outreach?
  - AK DHSS should work closely with CDC evaluation officer to ensure continued alignment between the evaluation plan, work plan and logic model.
-
- Other Relevant Comments:
  - What is the current percent of user registration in the state of Alaska (in 2016 it was 23%)?
  - Currently, what is the main pain condition that opioids are being prescribed for (i.e., low back pain, post-surgical pain, acute pain, etc.)?
  - In the state of Alaska, is over-prescribing by clinicians more of an issue than opioid misuse/abuse by patients?
  - Will the licensing board be involved in recommending participation in PDMP registration and training?
  - What is the status on the surveys that were mailed to licensed practitioners in Juneau?
  - Is this mailed survey different than the online questionnaire?
  - Is the year 3 questionnaire (March 2019) different than year 2 questionnaire (March 2018) and "consumer satisfaction" survey?
  - Have you explored what it would take to create or purchase a "license integration" feature for the PDMP?
  - What kinds of alerts does the new alert module contain?
  - Who are the stakeholders who have been engaged in the development of the statewide strategic PDOP plan?

Sub-Activity: Enhancing PDMP Use for Clinical Decision-making

Sub-Activity Year 1 Progress: Two websites are under development: 1. Opioids.alaska.gov will consolidate information and assist users to navigate internet-based resource; and 2. Alaska Center for Health Data and Statistics hosting surveillance reports, queriable data sets, and geospatial analysis maps. The website managers solicit input from the AKPDOP advisory group on scope, depth, and usefulness of developed materials; and assures the website URL address is added to other associated State of Alaska websites.

Until a qualified candidate is hired, DHSS is assisting DCCED to develop materials for hosting on both the DHSS and DCCED websites. The PDMP Manager and Division Operations Manager participate as members of the AKPDOP Advisory group and are primary PDMP liaisons to the Board of Pharmacy.

Sub-Activity Year 2 Progress: The PDMP Manager made phone calls to clinics located in the Juneau area to gauge interest in scheduling shadowing visits for the purpose of improving practitioners' understanding of PDMP mandated use. On 01/22/2018, a visit to a clinic was conducted, where the PDMP manager was able to discuss topics relating to mandatory reviewing requirements, data reporting, and delegate access. While the visit was successful (14% success rate; 1 of 7 agreed to visit), this method of scheduling on-site outreach activities was ineffective as there has been a low response rate to participate. On March 15, the PDMP manager drafted a survey as another approach to gauging whether practitioners would be willing to participate. The PDMP manager's supervisor reviewed the draft on 03/23/18, and the survey was finalized on 03/27/18. The PDMP manager plans to mail the survey out to 188 actively licensed practitioners in Juneau by 03/27/18.

Sub-Activity Year 3 Work Plan: By September 2018 (Year-2), the PDMP Manager will increase outreach and education activities by 30%.

The PDMP Manager in collaboration with the AKPDOP advisory group will: 1. continue to assist with the development of content for a consolidated website that provides links to information and resources. Information will include regularly distributed state and national surveillance metrics and reports and educational resources such as clinical practice guidelines for prescribing opioids for chronic pain, and use of PDMP to improve patient safety and protect patients.

The PDMP Manager will continue to assist with the development and improvements to opioid websites that consolidates information and links to other websites to ease navigation of internet and other electronic information including, but not limited to, regularly released reports on surveillance metrics–Essential resources for healthcare providers may cover a broad range of topics, including educating the public on the consequences of misusing drugs, safe storage and disposal of medication, working with older adults with poor medication compliance or instruction retention, patients needing chronic pain management, and working with individuals that have a substance abuse disorder.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding also partially supports personnel costs for a full-time PDMP manager and travel expenses associated with mandatory (required per the grant agreement) to attend a once annual CDC sponsored meeting in Atlanta, GA.

Sub-Activity: Identify AKPDMP Barriers and Limitations

Sub-Activity Description: By March 2018, the PDMP manager, with the assistance of the DDPI Education Coordinator and DDPI advisory group will review a "consumer satisfaction" survey to solicit input from enrolled and non-enrolled prescribers and dispensers and determine awareness statutes, regulations, and policies pertaining to the AKPDMP; and to identify system limitations, barriers, and other improvement needs (e.g., training).

Sub-Activity Year 1 Progress: The part-time (0.5 FTE) PDMP manager continues to support the PDMP along with support from the AKPDMP database contractor. A new position description for a full-time (1.0 FTE) PDMP coordinator has been approve by Alaska Department of Human Resource and the position posted in-state and nationally. A qualified candidate has not yet been hired for the Juneau-based position and has been re-posted for hire. The QPM and Education Specialist have engaged the current PDMP manager to develop training materials and to coordinate key informant interviews to be completed by July 31, 2017.

Sub-Activity Year 2 Progress: The PDMP state website located at www.pdmp.alaska.gov was assessed for its available resources and quality of instructions in November 2017. The PDMP Manager identified four options for making the PDMP platform easier to use and access: 1.) Update registration instructions for primary users and delegates - Instructions were revised and posted to the website on 11/14/2017 to include the step-by-step process of successfully registering with visual cues. 2.) Improve formatting of website for better readability - The layout of resources on the PDMP were rearranged and reconfigured to make instructions and pertinent resources easy to identify. Improvements included adding icons for PDFs and webpages and listing resources in a conceptual rather than fragmented order. 3.) Provide conspicuous contact information for PDMP assistance - The PDMP Manager and AWARxE support contact numbers are redundantly displayed to make contact information easily accessible when questions arise pertaining to PDMP use and access. 4.) The PDMP manager has been conducting outreach activities since January 2018. A survey was developed on 03/27/18 to gauge specific topics practitioners look to that will improve the ease of PDMP use and access.

Sub-Activity Year 3 Work Plan: By October 2018, the PDMP manager, with the assistance of the DDPI Education Coordinator and DDPI advisory group will review a "consumer satisfaction" survey to solicit input from enrolled and non-enrolled prescribers and dispensers and determine awareness statutes, regulations, and policies pertaining to the AKPDMP; and to identify system limitations, barriers, and other improvement needs (e.g., training). The survey will be re-deployed to collect input for further improvements to training and identify new and continuing limitations, barriers and other needed improvements to maximize the use of the AKPDMP.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding also partially supports personnel costs for a full-time PDMP manager and travel expenses associated with mandatory (required per the grant agreement) to attend a once annual CDC sponsored meeting in Atlanta, GA.

Sub-Activity: Assess professional awareness levels and use

Sub-Activity Year 1 Progress: The PDMP manager was hired in September 2017.

Sub-Activity Year 2 Progress: The Awareness and Feedback Questionnaire team developed an implementation plan, including a logic model and timeline in February, 2018. Questions were developed between February - March and are currently being fine-tuned.

Sub-Activity Year 3 Work Plan: By March 2019, the PDMP manager will deploy the online awareness and feedback questionnaire for distribution to 100% of registered users. Survey response will be used to improve PDMP use by healthcare providers to help improve informed treatment decisions for the most appropriate medical care for their patients; assess their understanding of current and pending regulations and providing avenues to comment.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding also partially supports personnel costs for a full-time PDMP manager and travel expenses associated with mandatory (required per the grant agreement) to attend a once annual CDC sponsored meeting in Atlanta, GA.

Major Activity: Move toward universal PDMP registration and use

Major Activity Summary: Increase Enrollment of Dispensers and Prescribers–In 2016, registered Alaska Prescription Drug Monitoring Program (AKPDMP) users represent only 23% of the total potential participants. This low rate of participation suggests the need for increased outreach to prescribers to improve their understanding of addiction and overdose in Alaska and heightened awareness to better identify patients who may have or are developing dependencies. The findings also suggest that dispensers are relying on prescribers to adequately monitor patients' prescription history and ability to manage pain, indicating another area for outreach.

Major Activity Challenges: The challenges were identifying and narrowing down specific individuals to include in distinct partnerships. The PDMP Manager wasn't hired until September, 2017, so becoming familiar with the program itself carried an inherent learning curve that affected the understanding of specific stakeholder roles needed for the program activities.

Sub-Activity Description: By July 1, 2017, the PDMP will identify and contact non-enrolled dispensers and prescribers that must enroll by the July 17th, 2017 deadline.

Sub-Activity Start Date: May 2017

Sub-Activity End Date: December 2017

Sub-Activity Status: Completed

Sub-Activity Year 1 Progress: Three mass mail outs regarding mandatory PDMP registration were sent out in the summer of 2017 between May and August. Following the mandatory registration effective date, the PDMP manager sent out a letter to non-registered users reminding them of this requirement on November 6, 2017. The letter was sent out to over 2,000 licensees who were potentially required to register; the PDMP does not have a license integration feature to readily identify all licensees who are required to register, so the roster of licensees were based on the list of current registered users and the division's internal list of actively licensed professionals housed in its licensing database. Due to the absence of a license integration feature, some practitioners who were in fact registered appeared on the roster of individuals who were not registered; this was caused by discrepancies in names entered in the professional licensing database versus how they were entered in the PDMP. In addition, the division does not track DEA registration status, so some practitioners who did not hold a DEA registration also received the notice. The PDMP manager continues to make salient the registration requirement by posting notices to the PDMP state website.

Sub-Activity: Contact Non-enrolled Prescribers

Sub-Activity Description: By July 1, 2017, the PDMP will identify and contact non-enrolled dispensers and prescribers that must enroll by the July 17th, 2017 deadline. The PDMP manager will develop a list of all licensed dispensers and DEA licensed prescribers and a list of DEA licensed prescribers not yet enrolled in AKPDMP; identify areas of heavy prescribing using AKPDMP data; and develop a plan to increase targeted outreach to healthcare professional by 30% annually.

Sub-Activity Start Date: May 2017

Sub-Activity End Date: December 2017

Sub-Activity Status: Completed

Sub-Activity Year 1 Progress: Three mass mail outs regarding mandatory PDMP registration were sent out in the summer of 2017 between May and August.

Sub-Activity Year 2 Progress: Following the mandatory registration effective date, the PDMP manager sent out a letter to non-registered users reminding them of this requirement on November 6, 2017. The letter was sent out to over 2,000 licensees who were potentially required to register; the PDMP does not have a license integration feature to readily identify all licensees who are required to register, so the roster of licensees were based on the list of current registered users and the division's internal list of actively licensed professionals housed in its licensing database. Due to the absence of a license integration feature, some practitioners who were in fact registered appeared on the roster of individuals who were not registered; this was caused by discrepancies in names entered in the professional licensing database versus how they were entered in the PDMP. In addition, the division does not track DEA registration status, so some practitioners who did not hold a DEA registration also received the notice. The

PDMP manager continues to make salient the registration requirement by posting notices to the PDMP state website.

Sub-Activity Funding Type: Base funds

Major Activity: Conduct public health surveillance with PDMP data and publicly disseminate reports and quarterly or semi-annually on CDC-directed metrics

Major Activity Summary: Develop quarterly and annual data reporting criteria–The PDMP Manager, in collaboration with and assistance from the AKDPOP Epidemiologist and the AKPDMP advisory group, will develop quarterly reporting criteria to supplement annual reports (as required under Alaska statute and regulation) to the Board of Pharmacy and the Alaska Control Substance Advisory Committee.

Major Activity Challenges: Currently the AKPDMP Manager provides AKPDMP reports that can only be generated with the PDMP software package. Additional in-depth analysis and identification of "hot spots" cannot be performed until the amended Alaska Administration Code (regulation) governing access to the AKPDMP data is approved by the Dept. of Law and a policy for administering a data sharing agreement is implemented. It is anticipated that the review by the Dept. of Law will not be completed until May or June of 2018.

Sub-Activity: DHSS Access to AKPDMP datasets

Sub-Activity Description: Within 60 days of the effective date detailed in amended Alaska Administrative Code(s) that regulate access to AKPDMP data, the Dept. of Community Commerce and Economic Development (DCCED) Operations Director and the AKPDMP Manager will develop policy for providing a data to DHSS.

Sub-Activity Start Date: September 2016

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: Amended regulations that will provide access to PDMP data is under review by the Alaska Board of Pharmacy. Once completed, the DCCED (where the PDMP is located) will provide a data agreement to DHSS or will solicit an MOA between DCCED and DHSS. The agreement will allow individuals that are approved by the DHSS Commissioner to have access to the AKPDMP data.

Sub-Activity Year 2 Progress: Amended regulations that will provide access to PDMP data are currently under review by the Alaska Dept. of Law. Once completed, the DCCED will provide either a data agreement to DHSS to allow access to PDMP data to individuals authorized DHSS Commissioner.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Until access is authorized, funding was provided to the AKPDMP to procure an alert module to provide information to prescribers. The APHRIS module allows the PDMP manager/coordinator to set the array and threshold of alerts.

Strategy: Planning

Major Activity: Develop prescription drug and heroin abuse prevention plan

Major Activity Summary: Alaska Prescription Drug Overdose Prevention (PDOP) project will maintain key leadership for an advisory group and statewide strategic plan development workgroup to finalize and implement Alaska's Statewide Strategic AKDPOP Plan. Leadership and workgroup members (along with additional members from the multi-agency Incident Command Structure (ICS) that was established with the Declaration of Health Emergency) will serve as coordinators for Alaska's statewide strategic PDOP planning activities. Subject matter representatives will work with the Strategic Plan Project Leader, in collaboration with other advisory groups, during regularly scheduled meetings to finalize a Statewide Strategic AKPDOP Plan for presentation to stakeholders. This approach will be highly effective and collaborative and aims to prevent redundancy.

Major Activity Challenges: Due to the addition of town hall meetings, the original timeline was pushed back by 6 months. In addition, personnel changes limited capacity to meet the original timeline for completion of the community outreach sessions that were scheduled throughout the state. However, the Strategic Plan Project group worked collaboratively to complete the schedule. As a result of the community outreach, unintended benefits occurred, such as community collaborations and people accessing treatment.

Sub-Activity: Development of Statewide Strategic PDOP Plan

Sub-Activity Description: By September 2018, the Quality Performance Manager (QPM) will review the 2017-18 schedule and coordinate meetings with internal and external entities to finalize and implement a Statewide Strategic PDOP Plan.

The QPM will work with internal and external entities on a variety of topic areas to review strategic input documents, identify objectives, initiatives, measures, and resources to drive the overall statewide plan. Strategic input documents are informed by community outreach feedback, Opioid Policy Task Force recommendations, policies, data, laws and regulations, national recommendations and current funding sources for targeted and broad implementation. In addition to this external input, they will also include internal input.

Sub-Activity Start Date: September 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: The AKPDOP Advisory Committee was established and began to: 1) engage partners across disciplines, sectors, and institutions to promote well-being and positive behaviors, as well as acknowledging cultural diversity to assure affirmative outcomes; and 2) facilitate collaboration among Alaska's diverse professional sectors to recruit expertise in planning activities, identify priority actions, and reduce redundancy of efforts. An annotated outline of a statewide plan based on the Report and Recommendations from the Alaska Opioid Prevention Task Force was used as the foundation for the statewide strategic PDOP plan that incorporated sub-workgroups to draft strategic plan sections for presentation during the Year-1 stakeholder's sessions.

Sub-Activity Year 2 Progress: The QPM and the newly established Office of Substance Misuse and Addiction Prevention staff have partnered with state agencies and community action groups to complete 9 interactive community events and held "meet and greet" meetings in 11 communities with a variety of stakeholders to gather input on the overall statewide strategic plan. The Strategic Planning Project staff continue to engage partners across disciplines, sectors, and institutions to continuously gather input. The community outreach process has facilitated collaboration across different organizations and people where silos previously existed, recruited expertise in planning activities from among Alaska's diverse professionals needed to reduce opioid use and misuse, identify both state- and community-level priority actions, and to continue to identify gaps and redundancy of efforts.

Sub-Activity Year 3 Work Plan: By September 2019, the Quality Performance Manager (QPM) will review the 2018-19 schedule and coordinate meetings to implement and improve a Statewide Strategic AKDPOP Plan. An annual schedule of activities will be developed to gather and incorporate comments from stakeholders including, but not limited to, assessment of emerging issues and identification of new priority actions.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Current funding supports personnel, travel, and other expenses needed to complete work on the statewide plan including transcription costs, web development, telephone conferencing fees, and evaluation processes. Funding also supports travel expenses associated with mandatory (required per the grant agreement) to attend a once annual CDC sponsored meeting in Atlanta, GA.

Sub-Activity: Review of Legislative Actions

Sub-Activity Description: By September 2018, Policy Project Leader will be review and update the PDOP - Alaska Statute, Regulation, and Policy index, as needed, to assure accurate documentation of legislative actions. The updated copy (with documented revision date footnoted) will be posted to the DHSS Opioid Workgroup SharePoint site.

The purpose of this review is to facilitate strategic planning at the state- and community-levels.

This activity was initiated under the Policy Evaluation Strategy and was moved to support the Strategic Plan Strategy.

Sub-Activity Start Date: January 2017

Sub-Activity End Date: August 2019

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: This activity was initiated under the Policy Evaluation Strategy and was moved to support the Strategic Plan Strategy.

Major Activity: Develop Partnerships

Major Activity Summary: For broad implementation of Alaska's statewide strategic PDOP plan necessitates coordinated efforts to attain maximum outcomes of prevention strategies. In addition, partner collaboration is needed to assess community needs, develop new interventions identified in the plan, initiate processes to fill data and knowledge gaps, improve dissemination of surveillance metrics and summary reports, and assess findings from a forthcoming policy analysis, and provide additional recommendations.

DHSS Opioid Workgroup is composed of DHSS program staff that utilize information provided by the ICS and may be participating in the ICS. The combination of these two work groups assist with identifying and developing new partnerships, maintaining the extensive partner working groups effectiveness, and incorporating community input to the strategic planning process.

Sub-Activity: Annual PDOP Project Leaders and Activities

Sub-Activity Year 1 Progress: All permanent and temporary staff were in-place to fill roles as detailed in the Yr-1 work plan. Since several key staff were located with DHSS but outside of the Section of Epidemiology, reimbursable service agreements were developed and approved to provide funding for their work contribution. Due to personnel changes and re-organization, the Informatics position was eliminated and funding of the Quality Performance Manager was expanded from 0.2 to 0.5 FTE.

Sub-Activity Year 2 Progress: Internal DHSS key staff located outside of the Section of Epidemiology continue to participate via reimbursable service agreements to provide funding for their work contribution. External to DHSS, the project has partnered with 9 community-based organizations including: Alaska Native Tribal Health Consortium Substance Abuse Prevention Initiative; Ketchikan Wellness Coalition-Drug-free Communities; North Slope Borough; Bristol Bay Opioid Task Force; Mat-Su Health Foundation, Mat-Su Opioid Task Force, and United Way of Mat-Su Thrive Fairbanks Opioid Working Group and Fairbanks Wellness Coalition; Homer Opioid Task Force; Mobilizing for Action thru Planning and Partnerships (MAPP); Change for Kenai; and Juneau Alliance for Mental Health.

Expanded departmental partners include Department of Public Safety, Alaska Guard, DHSS-Divisions of Behavioral Health, Public Health (including Public Health Nursing, Health Analytics and Vital Records),

Sub-Activity Year 3 Work Plan: By August 2019, the QPM will expand coordination and enhancement of relationships among the following: 1) intra-departmental relationships; 2)

community relationships; 3) inter-departmental relationships; 4) tribal systems relationships; 5) military/VA relationships.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding was used to support work done by DHSS staff including reimbursable service agreements of external SOE key staff and project leaders to provide oversight and coordination of strategic planning, complete assigned strategy activities, and improve and expand key partnerships statewide..

Sub-Activity: Enhance Communication between Programs & Partners

Sub-Activity Description: By September 2018, the Project Director will assure that the ICS leadership provides situation reports that will be posted to a SharePoint file. SharePoint access will be provided to the Opioid Workgroup (PDOP Advisory) to assist with the development of new professional and community partnerships to facilitate activities designed to reduce the impact of licit and illicit opioid and other illicit drug misuse.

Sub-Activity Year 1 Progress: The Opioid Workgroup was adopted as the AKPDOP Advisory that began to:•Engage partners across disciplines, sectors, and institutions to promote well-being and positive behaviors, as well as acknowledging cultural diversity to assure affirmative outcomes; and•Facilitate collaboration among Alaska's diverse professional sectors to recruit expertise in planning activities, identify priority actions, and reduce redundancy of efforts. On February 16, 2017, Gov. Walker signed Administrative Order 283, implementing a multi-agency Incident Command System (ICS) led by the Department of Health and Social Services (DHSS). These actions follow the Governor's Feb. 14, 2017 disaster declaration that establishes a statewide Overdose Response Program under Alaska's Chief Medical Officer and enables wide distribution of naloxone. In response, DHSS has activated the ICS to manage this event. Using the ICS in conjunction with the AKPDOP Advisory Committee incorporates representation from other professional sectors to quickly initiate statewide activities and facilitate real-time strategic prevention planning.

Sub-Activity Year 2 Progress: The Opioid Workgroup and the ICS workgroup are a partnership that is comprised of multi-state agency members. Personnel from the Alaska PDMP, law enforcement, criminal justice, school-based prevention & education, and provider and public information agencies also contribute resources. On a bi-weekly basis, ICS team meets to discuss various updates with the ultimate goal of improving health outcomes in our state. Targeted objectives include efforts to: reduce and control access to opioids; reduce risk of opioid misuse, abuse, and dependence; increase screening, referral, and treatment options; strengthen harm reduction efforts, including overdose prevention and syringe exchange programs; support recovery through reimbursement and support of peer support services and partnerships to support second chance employers hiring people in recovery; enhance collaboration to address barriers to coordinated care, strengthen partnerships with public safety and community coalitions for community prevention, and to mitigate the collateral consequences of incarceration for drug-related offences. The Opioid Workgroup meets monthly to review DHSS activities and provide reports to assure communication across all sectors.

Comments

- Major Strengths:
  -The ADPDOP has facilitated robust multi-agency partnerships to advance Alaska's PDO prevention efforts, including identification of priority areas at the state and county levels and fostering collaborations to reduce redundancy.

- Major Weaknesses:

- Recommendations:

- Other Relevant Comments:
  -Consider highlighting success stories of outcomes due to partnership development and expansion.

Major Activity: DATA

Enhance surveillance of prescription drug and heroin abuse and overdose

Major Activity Summary: Maintaining and improving routine data collection and analysis of fatal and non-fatal drug overdoses is a fundamental objective of the PDOP. Key data needed to understand and fully assess opioid use, misuse, dependency, and overdose includes, but is not limited to, vital records, hospital inpatient discharge /ED visit data, EMS run data, behavioral risk surveys/PRAMS/CUBS data, treatment services data, Medicaid use and Medicaid Part D data, crime reporting statistics, and PDMP data.

Major Activity Challenges: Data managers have different timelines for collection and scheduled release. This is compounded by a decentralized process to access data. While the work of the Substance Abuse Epidemiology Workgroup has made strides to centralize data in one website and compile database information into a "data directory", there is still a multitude of dataset that still need to be incorporated, or if present, enhanced to provide the maximum access to recent and archived datasets.

Comments

- Major Strengths:

- Major Weaknesses:
  ESOOS and its funded NVDRS and morbidity work is not part of DDPI funding and should be removed from DDPI-related reporting. ESOOS is separately funded from DPPI.
- Recommendations:

- Emphasize progress on major activities highlighted in the DDPI evaluation and work plans, e.g. identification of hotspots and improvements in data quality, reporting, utility, etc.

- Other Relevant Comments:
  - Ensure that major activities reported in progress updates have corresponding evaluation activities.

Sub-Activities

Sub-Activity: Coordination of Opioid Surveillance & Reporting

Sub-Activity Description: By September 1, 2017, the Alaska Substance Abuse Epidemiology Workgroup (SEW) chairperson and the PDOP Epidemiologist will continue to maintain and incorporate key data providers into the workgroup, meet monthly to assess and revise an annual schedule of data release timelines, routine reports, and other deliverables.

The SEW functions as the key data provider workgroup whose participants include, but are not limited to, data system and surveillance managers, research and program analysts, and epidemiologists representing surveillance systems collecting vital records/health statistics, hospital discharge systems/ED, EMS, behavioral risk surveys, PRAMS/CUBS, treatment services, Medicaid, crime reporting, and PDMP. As the PD works concurrently as the Lead Epidemiologist for the SEW, the PD will lead surveillance activities to update information in the Alaska Epidemiology Profile on Substance Use. This partnership is essential to timely data collection and dissemination as well as eliminating duplication of efforts.

This activity is on-going throughout the entire 3-year project period.

Sub-Activity Start Date: September 2016

Sub-Activity End Date: August 2019

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: Data collection and analysis is an on-going activity since the release of data varies from department to department and program to program. The SEW continues to meet quarterly to work on updating and revising the Alaska Substance Abuse Epidemiology Profile. The work on the revised updated report is on-going and will be generated using data entered into the Alaska Indicator-Based Information System (AK-IBIS) as well as incorporating summary reports from data providers that are not yet participating to enter data in AK-IBIS.

In addition, the PD and SEW has reviewed the datasets currently available within the AK-IBIS and additional datasets from providers for inclusion in the system generated report. At this time, all indicators have been developed and submitted for approval to be hosted on AK-IBIS.

Data to fill data gaps are being sought for evaluation and future inclusion in AK-IBIS and the Substance Abuse Epidemiology Profile.

Sub-Activity Year 2 Progress: Data collection and analysis is an on-going activity since the release of data varies from department to department and program to program. The SEW continues to meet at least quarterly to work on updating and revising the Alaska Substance Abuse Epidemiology Profile. The work on the revised updated report is on-going and will be generated using data entered into the Alaska Indicator-Based Information System (AK-IBIS) as well as incorporating summary reports from data providers that are not yet participating to enter data in AK-IBIS. A file of updated tables and charts will be posted to the Section of Epidemiology website as work progresses to finalize the report in AK-IBIS.

The PD and SEW continued to review datasets currently available within the AK-IBIS and solicited additional datasets from providers for inclusion in the system generated report. At this time, all additional indicators have been developed and submitted for approval to be hosted on AK-IBIS. Data to fill data gaps are being sought for evaluation and future inclusion in AK-IBIS and the Substance Abuse Epidemiology Profile.

Deliverables in Year-2 include a new opioid data dashboard that can be accessed at: http://dhss.alaska.gov/dph/Director/Pages/heroin-opioids/data.aspx; and a new Section of Epidemiology report entitled, "Health Impacts of Opioid Use in Alaska" that is under review and scheduled for release in mid-May 2018.

Sub-Activity Year 3 Work Plan: By September 1, 2018, the Alaska Substance Abuse Epidemiology Workgroup (SEW) chairperson and the PDOP Epidemiologist will continue to maintain and incorporate key data providers into the workgroup, meet monthly to assess and revise an annual schedule of data release timelines, routine reports, and other deliverables.

The SEW functions as the key data provider workgroup whose participants include, but are not limited to, data system and surveillance managers, research and program analysts, and epidemiologists representing surveillance systems collecting vital records/health statistics, hospital discharge systems/ED, EMS, behavioral risk surveys, PRAMS/CUBS, treatment services, Medicaid, crime reporting, and PDMP. As the PD works concurrently as the Lead Epidemiologist for the SEW, the PD will lead surveillance activities to update information in the Alaska Epidemiology Profile on Substance Use. This partnership is essential to timely data collection and dissemination as well as eliminating duplication of efforts.

This activity is on-going throughout the entire 3-year project period.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports personnel assigned to collect, code, and enter opioid use and overdose data into the NVDRS; and supports personnel costs, supplies, software, and other ITS expenses for data cleaning, analysis, and reporting. Funding also supports travel expenses associated with mandatory (required per the grant agreement) to attend a once annual CDC sponsored meeting in Atlanta, GA.

Sub-Activity: Enhanced Opioid Overdose Death Surveillance

Sub-Activity Year 1 Progress: The Section of Epidemiology (SOE) provided personnel services to maintain key surveillance agreements. The Section's injury epidemiologist is the Project Director and the Principal Investigator for the Alaska Violent Death Report System (AKVDRS) and has established processes for data importation from the Division's Section of Health Analytics and Vital Records (HAVRS) for all manners of death exclude natural deaths, which are then reviewed and coded for opioid drug overdoses prior to entry into the AKVDRS. Currently, mortality data is provide on a monthly schedule to the Section of Epidemiology.

The Alaska NVDRS program expanded its contract's agreement to assist with opioid overdose case abstraction. The contractor is trained in the CDC NVDRS methodology for abstraction and has several years of experience. The contractor is also an instructor for the university's School of Nursing, and is able to provide additional consultative services on various drugs that may be in combination with opioid(s) used.

In addition, the SOE maintains agreements with the State Medical Examiner Office for autopsy and toxicology results along with law enforcement and military investigation reports.

Sub-Activity Year 2 Progress: Currently, mortality data is provide on a monthly schedule to the Section of Epidemiology. The Alaska NVDRS program employed a new contractor to assist with data abstraction and data entry into the NVDRS. The contractor was trained in the CDC NVDRS methodology for abstraction and has several years of experience. The contractor is also an nurse and is able to provide additional consultative services on various drugs that may be in combination with opioid(s) used.

AKVDRS abstractors are able to request key surveillance documents for drug overdose cases including investigation reports from state medical examiners and law enforcement agencies as well as military investigations. The NVDRS captures demographic, circumstance(s), and environment factors, investigation reports and state specific variables also capture information associated with acute drug poisoning pre- and post-event, including route of exposure, history and indications of substance abuse, drug(s) used, medical treatment/therapy, trauma care and survival time that may provide insight on emerging trends and patterns.

Sub-Activity Year 3 Work Plan: By September 1, 2019 (Year-3), the AKVDRS Principal Investigator will approve continuation of data on all drug overdose deaths occurring in Alaska. The abstracted information pertaining to unintentional opioid overdose deaths will be entered into the National Violent Death Reporting System (NVDRS) , coded as "Unintentional opioid drug poisonings" to differentiate the opioid cases from other drug poisonings.

Data entered into the NVDRS will expanded our understanding of circumstances associated with opioid and other drug overdose incidents as well as criminal activities that may be associated with these incidents. Effective January 1, 2018, as part of the CDC's Enhanced State Opioid Overdose Surveillance grant, all decedent suspected of drug use are tested for prescription and illicit opioid drugs to determine drug use as contributory cause of death.

This activity spans across the entire 3-year project period.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports personnel assigned to collect, code, and enter opioid overdose mortality data into the NVDRS; and supports personnel costs, supplies, software, and other ITS expenses for data cleaning, analysis, and reporting. Funding also supports travel expenses associated with mandatory (required per the grant agreement) to attend a once annual CDC sponsored meeting in Atlanta, GA.

Sub-Activity: Enhanced Opioid Morbidity Surveillance

Sub-Activity Year 1 Progress: All MOUs/MOAs have been reviewed and confirmed to assure access to overdose data. The Section of Health Analytics and Vital Records (HAVRS) collects data from all health facilities across Alaska. Facilities are now required to change reporting processes to use the new Health Facility Data Reporting System (HFDRS). Data sets for 2015 (the first data set available using the HFDRS) is available but will need to be revised as facility work to upload data into the new system. Hospital discharge and ED data is provided on an annual basis until all health facilities are capable of submitting data on a quarter schedule. It is anticipated that HFDRS data will become available on a quarterly basis in late 2017. As data release schedules become more stable, an annual schedule will be generated and posted online.

Training has been provided to program and database managers create data indicators in the Alaska Indicator-Based Information System (AK-IBIS) who have begun to upload datasets. AK-IBIS structure is flexible and provides both queryable datasets and visual graphics to aid community planners and program managers to improve and evaluate infrastructure and services. In addition, AK-IBIS allows database managers to retain control of limiting analyses essential to maintaining confidentiality and security. Reporting formats include Borough/Census Areas, economic, behavioral health to assess health outcomes. Applications for tribal health regions are being developed.

Sub-Activity Year 2 Progress: All MOUs/MOAs have been reviewed and confirmed to assure access to overdose data. The HAVRS collects data from all health facilities across Alaska. Facilities are now reporting into the new Health Facility Data Reporting System (HFDRS) with the exception of one health facility. Data sets for 2016 (the second annual data set was available using the HFDRS) is available but needed to be revised as facility work to upload revised and late submission data into the new system. The first three quarters of the 2017 data set was made available and we are currently awaiting the 4th quarter transmission.

Sub-Activity Year 3 Work Plan: By January 1, 2019, the PDOP Epidemiologist will receive quarterly inpatient, outpatient, and emergency department datasets from the Alaska Section of Health Statistics and Vital Records for analysis and an annual summary report for short-, intermediate, and long-term measures for the Data Strategy.

The Alaska Section of Health Statistics and Vital Records (HAVR) is responsible for health facility data collection and reporting from all health facilities in Alaska. The section provides quarterly data set that are available 3-months after the close of the preceding quarter. The section

reports morbidity data uses ICD-10-CM coding (effective in October 2016). Completion of opioid overdose morbidity data indicators will be completed annually.

This activity spans across the entire 3-year project period.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports the activities of the Epidemiologist to analyze and report findings from the analysis.

Major Activity: Enhance public health access and application of data from [multiple] sources

Major Activity Summary: Routine reporting will improve strategic planning and intervention development at the national, state, and local levels. Data dissemination will: 1) improve tracking of project level success; 2) increase access to timely data for project evaluation and modifications to intervention processes and practices; and 3) enhance public and professional access to data for public health application. The Division of Public Health will present regional frequency and rates using public health regions. Whenever possible, data will be presented by behavioral health and tribal health regions to maximize use by PDOP strategic partners.

Major Activity Challenges: None at this time.

Sub-Activities

Major Activity: Identify and provide technical assistance to high-burden communities and counties, especially efforts to address problematic prescribing

Major Activity Summary: The goal of this of this multi-year intervention is to assess and improve public awareness of high-risk behaviors associated with abuse prescription drugs and its consequences. A series of focus groups will be conducted to ascertain level and diversity of awareness within Alaska using selected high-risk communities (both urban and rural) in order to develop communications to improve public knowledge about opioid drug misuse, overuse, and abuse. The first focus groups will aim to improve understanding of community knowledge, attitudes, beliefs and behaviors related to preventing abuse and overdose of prescription drugs and safe storage and disposal. The second focus groups will use that information to create messages that motivate positive behavior changes among the target audience. Prior to creating the public education campaign, the program will conduct a baseline statewide telephone survey of the public to measure knowledge, attitudes, beliefs, intentions, and behaviors that can be monitored for change following the campaign. The AKPDOP Committee will review messages and materials to provide additional feedback on the media and social marketing campaign to include advice and suggestions to improve content and message delivery. Telephone surveys and key informant interviews will be used as performance measures in Year-2 and Year-3 as detailed in our evaluation plan including statewide telephone survey and key

informant interviews. Both will measure effectiveness of program planning and change of knowledge, attitudes, beliefs, intentions and behaviors following implementation of the social marketing/media campaign. In Year-2 and Year-3, a series of community outreach meetings will be scheduled to gather additional input on community-level action plans and community needs. This will then feedback into develop of new education materials, expanded broadcasting, and modification of messages designed to enhance awareness and improve knowledge, well-being and safety of Alaska residents.

Major Activity Challenges: A deeper analysis of key informant interview responses was needed following the initial summary report provide by the contractor. The reason for the deeper analysis was the need more granular information that could distributed to programs and project leaders. These could then be defined into action items inclusively for strategic planning. Carryover funds from Year-1 supported analysis to be conducted and reported by UAA-ISER. The information was also incorporated into their overall evaluation of Year-1 and Year-2 implementation processes associated with these activities.

In addition, the reorganization of personnel and the establishment of the Office of Substance Misuse and Addiction Prevention necessitated the negotiation and establishment of new contractual agreements for media development and placement in Year-2.

Comments

- Major Strengths:

- Major Weaknesses:

- Recommendations:
  - Qualitative analyses is a key technique to understanding a public health outcome and tailor interventions. Consider building internal capacity.
- Other Relevant Comments:
  - How were high-burden communities selected for key informant interviews and focus groups

Sub-Activity: Improving Community Awareness Levels

Sub-Activity Year 2 Progress: The Education Coordinator provided oversight of a contract to conduct the second round of telephone surveys and key informants interviews in urban and rural communities. Telephone surveys for Year-2 were completed in January 2018. Key informant interviews are scheduled for July 2018. The detailed analysis of Year-1 key informant interviews is completed. Year-1 and Year-2 telephone surveys are currently being coded and analyzed by UAA-ISER. Findings will be used to support this activity as well as activities being conducted by the Policy Evaluation, PDMP, RRP-Prescriber Education, and the DDPI Evaluation groups.

Sub-Activity Year 3 Work Plan: By September 1, 2018, the Education Coordinator will review all contract agreements and specifications to conduct needed telephone surveys and key

informant interviews in urban and rural communities and continued development of social media and marketing materials.

Year-3 focuses on the production and placement of social marketing/media in Alaska's urban and rural communities. Alaska communities are diverse and some communities are geographically isolated. Consultation with CDC Education Specialists will help assure uniform messages and facilitate discussions with other rural states.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Base funding supported personnel costs and contracts designated for fulfilling education activities. In addition, supplemental funds were used to expand media reach and frequency especially in rural areas of Alaska..

Sub-Activity: Enhancing Community Action

Sub-Activity Description:

To address the rising incidence of heroin and opioid abuse in Alaska, the Advisory Board on Alcoholism and Drug Abuse, Division of Public Health, and the Alaska Mental Health Trust Authority co-facilitate an Alaska Opioid Policy Task Force (AOPTF). The goal of the AOPTF is to provide recommendations to the Governor and Legislature. The task force consisted of members representing the public systems significantly affected by issues related to opioid abuse while representing the diversity of Alaska's communities. The community outreach process conducted by the Office of Substance Misuse and Addiction Prevention identified 13 communities that were identified as having a higher risk for opioid misuse and overdose and/or having an establish community opioid action plan in-place as the statewide opioid prevention strategic plan was being developed.

Sub-Activity Start Date: January 2018

Sub-Activity End Date: April 2018

Sub-Activity Status: Completed

Sub-Activity Year 1 Progress: This Sub-Activity was not conducted in Year-1.

Sub-Activity Year 2 Progress: Community involvement is vital to curbing substance abuse and establishing a viable statewide strategic plan. The goal of this of this multi-year intervention is to improve public awareness of high-risk behaviors associated with abuse prescription drugs and its consequences as well as capture information on community needs and activities currently in-place or pending funding. This activity is an extension of our Year-1 Rapid Response Project to enhance community awareness and knowledge. The activity is now incorporated into Strategy 2: Community Outreach.

Community hubs included in this year's outreach included Anchorage, Mat-Su (Wasilla), Kenai Peninsula (Homer, Kenai, Soldotna), Lake and Peninsula (Dillingham), Interior (Fairbanks), Northern (Nome, Barrow), Southeast (Juneau, Sitka) Community meetings were facilitated by

the QPM and facilitation notes were transcribed for coding and analysis. The findings will be provided back to the communities and will be used to support strategic plan development activities.

Sub-Activity Year 3 Work Plan: By April 2019, the QPM and representatives from the Office of Substance Misuse and Addiction Prevention will conduct a series of town hall meetings, community cafes, and "meet & greet" sessions to facilitate implementation of the first statewide opioid strategic plan and to gather information as part of a needs assessment/implementation improvement plan and to solicit participation in future prevention activities under development. Key representation from these communities will also participate in stakeholder meetings.

Sub-Activity Funding Type: Supplemental funds

Sub-Activity Funding Description: Funding supported travel to community "hubs". Alaska encompasses 1,391 communities that are spread over a 656,425 square mile area for its source documents. The majority of the source agencies are typically situated in "hub" communities that are not accessible by a road system and only by aircraft. Travel in Alaska does incur transportation costs that other states do not have including the necessity to use air travel to/from population community hubs (e.g., Juneau, Sitka, Bethel, Kotzebue, Barrow).

Sub-Activity: Analysis of Survey and Interview Responses

Sub-Activity Year 2 Progress: Due to the lack of technically proficient personnel in DHSS to complete this form of analysis, UAA-ISER was contracted to perform coding of responses and conducted in-depth analyses of literal text using ATLAS software. Findings will be provided in written reports to the PD, Education Coordinator, and QPM for education development and strategic planning purposes. Information will be posted to the Opioid Work Group SharePoint site for general usability by all team members.

Sub-Activity Year 3 Work Plan: By July 1, 2019, the PD, Ed Coordinator, and QPM will establish a contractual agreement with UAA-ISER to code and in-depth analyzes of literal text collected from Year-3 Community Outreach activities including 1) town hall meetings, community cafes, and "meet & greet" sessions and 2) scheduled telephone surveys and key informant interview response, culminating in written reports of these analysis findings.

Note: Funding will be incorporated in the Year-3 Supplemental budget narrative.

Sub-Activity Funding Type: Carryover funds

Sub-Activity Funding Description: Year-2 utilized carryover funds. Due to the lack of technically proficient personnel, UAA-ISER was contracted to perform coding of responses and conducted literal text analysis using ATLAS software. Findings will be provided in a written report to the Education Coordinator. Information will be posted to the Opioid Work Group SharePoint site for general usability by all team members. Year-3 analyses of survey and interview responses will be supported by Year-3 Supplemental funds, if provided.

Major Activity: Conduct a rigorous evaluation on a law, policy, or regulation designed to prevent opioid overuse, misuse, abuse, and overdose

Major Activity Summary: The University of Alaska Anchorage (UAA) - Institute for Social and Economic Research (formerly part of the UAA - Justice Center) will lead the effort to conduct a rigorous evaluation of laws, policies, and regulations designed to prevent heroin and opioid overuse, misuse, abuse, and overdose. Of particular interest are public health surveillance statutes within and outside of Alaska and the power to use prescription drug monitoring program data to conduct epidemiological investigations involving heroin and prescription opioids. Other areas of interest may include proposed legislation pertaining to naloxone access, pain clinic laws, and recent marijuana use.

Year-1 will focus on an intensive review and compilation of Alaska laws in effect, proposed for scheduling, recently passed and proposed, and repealed and initiate a gap analysis designed to prevent heroin and opioid overuse, misuse, abuse, and overdose. . Of particular interest are public health surveillance statutes within and outside of Alaska and the power to use prescription drug monitoring program data to conduct epidemiological investigations involving heroin and prescription opioids.

Year-2 will focus on reporting of findings to Strategic Planning committees and legislative actions pertaining to scheduling of controlled substances and the Good Samaritan law as it relates to drug overdose events.

Year-3 will focus on Alaska case law on the aforementioned topics as directed by the AKPDOP Advisory, ICS work group, and other partners.

Major Activity Challenges:

Comments

- Major Strengths:
- Major Weaknesses:
- Recommendations:
  - Please share the policy review report when it is complete. Also, if DDPI funds were used to create a report, please reference the DDPI funding number in the acknowledgements.
- Other Relevant Comments:

Sub-Activity: Statute, Regulation, and Policy Review

Sub-Activity Description: By January 2017, the UAA - ISER will initiate a policy and regulation review project. The policy and regulation review will include: • a thorough literature review of

existing publications and reports; • an analysis of statutory and regulatory language as well the impact of legislation with the goal of identifying promising legislative and regulatory practices for consideration; • an assessment of the AKPDMP processes in regard to universal use requirements, real-time reporting, and proactive use in Alaska relative to other states; and • an outline the history of related legislation in Alaska and review best practices regarding laws, policies, and regulations implemented outside of Alaska that are designed to prevent overuse, misuse, abuse, and overdose of heroin and prescription drugs.

By March 2018, a gap analysis will be completed and a draft report will be provided to the PD. A final copy of the gap analysis and index of Alaska Laws will be provided to the Strategic Planning work groups and the Project Leaders.

Sub-Activity Start Date: September 2016

Sub-Activity End Date: June 2018

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: Due to significant delays in approval of a reimbursable service agreement with the University of Alaska Anchorage-Justice Center and discussions with the CDC Evaluation Program Officer, the Policy Review project timeline was pushed back 6 months. In addition, following the Governor's Declaration of Health Emergency, several laws were introduced and/or passed. The information will be included as an appendix to the written gap analysis report.

The project staff initiated – • a literature review of existing publications and reports; • an analysis of statutory and regulatory language as well the impact of legislation with the goal of identifying promising legislative and regulatory practices for consideration; • an assessment of the AKPDMP processes in regard to universal use requirements, real-time reporting, and proactive use in Alaska relative to other states; and • an outline the history of related legislation in Alaska and review best practices regarding laws, policies, and regulations implemented outside of Alaska that are designed to prevent overuse, misuse, abuse, and overdose of heroin and prescription drugs.

Sub-Activity Year 2 Progress:
As part of statewide strategic prevention plan, existing agency rules, policies, and regulations need to be evaluated to assure authority and direction are provided to agencies assigned administrative roles and that emerging issues and challenges can be met. With input from and direction provide by the AKPDOP advisory group, UAA-ISER will continue in-depth review of select policies as part of Alaska's strategic planning initiative. UAA-ISER will complete its written annual report.

A draft of the Policy Review Gap Analysis report was completed and is waiting for comment from the Div. of Public Health (DPH) Director and Office of Substance Misuse and Addiction Prevention (OSMAP). The final report will be presented to the ICS team and AKPDOP (Opioid Workgroup).

Sub-Activity Year 3 Work Plan: By January 2019, the UAA - ISER will update the legislative index of statutes, regulations and policy and update the information for posting to the Opioid Work Group SharePoint site and other DHSS websites.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports a reimbursable service agreement to conduct the aforementioned activities.

Sub-Activity: PDMP Policy Assessments

Sub-Activity Description: By June 2018, UAA-ISER will complete its initial assessment of Alaska laws, policies, and regulations designed to prevent heroin and opioid overuse, misuse, abuse, and overdose and provide a presentation; evaluate level of knowledge and understanding of PDMP users and Board of Pharmacy Board members pertaining to the need for education and training initiatives such as academic detailing; and access to PDMP data by external agency; and written report on its finding to the AKDPOP advisory group and stakeholders, as well as to the boards and advisory councils identified in the assessment.

This activity spans across Year-1 and Year-2 of the activity.

Sub-Activity Start Date: September 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: Following UAA-ISER completion an initial assessment of Alaska laws, policies, and regulations of PDMP laws and policies, a process evaluation of the PDMP will be conducted with the goals of supporting and enhancing PDMP use generally and ensuring PDMP data will be available and used for surveillance purposes and to inform responses to the prescription drug problem. UAA-ISER completed a series of key informant interviews. Questions included– 1. What are the facilitators and barriers to prescribers and their delegates using the PDMP? a. To what extent do prescribers consistently review patient prescription reports and upload prescription data in a timely manner? b. What changes would improve the PDMP? c. What challenges prevent regular use of the PDMP? 2. To what extent do PDMP users perceive that Alaska's current PDMP legislation will reduce misuse, diversion and overdose? 3. What are the barriers and facilitators to using PDMP data for to inform surveillance and responses to the opioid problem?

Information collected is being analyzed and a final report will be provided to the AKPDOP (Opioid Workgroup) as well as the Div. of Public Health (DPH) Director and Office of Substance Misuse and Addiction Prevention (OSMAP).

Sub-Activity Year 2 Progress: To evaluate level of knowledge and understanding of PDMP users and the need for education and training initiatives such as academic detailing (Academic detailing as "university or non-commercial-based educational outreach," UAA-ISER completed a series of key informant interviews. Questions included– 1. To what extent do PDMP users

(and/or other stakeholders) perceive that Alaska PDMP incorporates evidence-based practice and provides educational initiatives that support and promote PDMP use? 2. What are PDMP user's attitudes and beliefs regarding the use of PDMP data for active surveillance to support effective public health prevention and reduce prescription drug overdose? 3. To what extent do user of the PDMP have adequate training in opioid prescribing, pain management, screening for substance abuse, proper storage and disposal of prescription opioids? 4. What changes in knowledge, skills, and attitudes have occurred among PDMP users have resulted from education and training?

Information collected is being analyzed and a final report will be provided to the AKPDOP (Opioid Workgroup) as well as the Div. of Public Health (DPH) Director and Office of Substance Misuse and Addiction Prevention (OSMAP).

Sub-Activity Year 3 Work Plan: Activity is completed.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports a reimbursable service agreement to conduct the aforementioned activities.

Sub-Activity: CSA Policy Assessment

Sub-Activity Description: By August 2018, UAA-ISER will complete an evaluation of the Controlled Substances Act scheduling authority and process is proposed in order to determine whether the content of legislation and manner in which it has been implemented effectively protects Alaskans from novel psychoactive substances and analogues deemed to be dangerous; and provide a written report of its findings.

Sub-Activity Start Date: June 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: Following UAA-ISER completion an initial assessment of Alaska laws, policies, and regulations of – CSA: Alaska statute § 11.71.100 establishes a Controlled Substances Advisory Committee in the Department of Law. The committee, according to § 11.71.110 shall (1) advise the governor of the need to add, delete, or reschedule substances in the schedules in AS 11.71.140 - 11.71.190 which cover scheduled drugs levels as outline in Federal law. The scheduling authority is outlined in § 11.71.120. AS § 11.71.120 indicates that the governor shall introduce legislation for scheduling substances in accordance with the recommendation of the committee to add, delete, or reschedule a substance. Additional authority to address Illicit Synthetic Drugs is addressed in § 17.21.010-§ 17.21.090; –an evaluation of the Controlled Substances Act scheduling authority and process was proposed in order to determine whether the content of legislation and manner in which it has been implemented effectively protects Alaskans from novel psychoactive substances and analogues deemed to be dangerous. Due to significant delays in approval of a reimbursable service

agreement with the University of Alaska Anchorage-Justice Center and discussions with the CDC Evaluation Program Officer, the Policy Review project timeline was pushed back 6 months.

Sub-Activity Year 2 Progress: To evaluate the Controlled Substances Act scheduling authority and process, UAA-ISER completed a series of key informant interviews. Questions included– 1. Does Alaska's Controlled Substances Act provide an efficient and effective process for scheduling novel psychoactive substances and analogues? 2. What are the intended and unintended consequences of the current emergency scheduling process for novel psychoactive substance and/ analogues in Alaska?

Information collected is being analyzed and a final report will be provided to the AKPDOP (Opioid Workgroup) as well as the Div. of Public Health (DPH) Director and Office of Substance Misuse and Addiction Prevention (OSMAP).

Sub-Activity Year 3 Work Plan: By August 2019, UAA-ISER will complete and written report on– Liability waiver - Conduct a feasibility analysis of expanding liability waiver protection (AKA Good Samaritan statute) to include syringe and needle service or exchange programs. Evaluate policies designed to expand protection afforded through liability waivers that protect Good Samaritans not only from prosecution but also from arrest, violations of probation or parole, and violations of domestic violence protection orders; and Emergency scheduling - Evaluation of current policy and policy enhancements that provide for emergency scheduling of novel psychoactive substances (including synthetics, analogues, and designer drugs) through regulation or other more efficient means than statutory change in Alaska.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports a reimbursable service agreement to conduct the aforementioned activities.

Major Activity: Conduct a rigorous evaluation on a law, policy, or regulation designed to prevent opioid overuse, misuse, abuse, and overdose

Major Activity Summary: The purpose of the prescription drug monitoring (PDMP) database is to house data regarding every prescription for a federally scheduled substance (II, III, or IV) dispensed in the state to a person other than those administered to a patient at a health care facility. AS § 17.30.200 (d) 10 authorizes that the Pharmacy Board may allow Department of Health and Social Services (DHSS) access to de-identified PDMP data for the purpose of identifying and monitoring public health issues in the state. No MOU is currently in place to guarantee that PDMP data will be shared with DHSS or to specify a timeline and process for how the data may be shared.

AS § 17.30.200 (d) 11 k notes that pharmacy board regulations must ensure that PDMP data be purged from the PDMP database after two years from the date on which individual prescriptions are dispensed. Legislation does not specify whether any data provided to DHSS must also be periodically purged. Therefore, a process evaluation of the PDMP will be

conducted with the goals of supporting and enhancing PDMP use generally and ensuring PDMP data will be available and used for surveillance purposes and to inform responses to the prescription drug problem.

Major Activity Challenges: We also experienced a challenge to our plan to evaluate changes in knowledge and skill of PDMP users as a result of education and training efforts. Our evaluation plan involved conducting pre-tests of knowledge before education/training events and measuring change with post-tests following education/training events. The challenge we faced stems from the fact that Alaska's current efforts to educate and train PDMP users rely on conveying information via the website and by mailing information to licensees. An opportunity to measure change with pre and post tests may be available when a web-based continuing education course is launched. However, the launch is scheduled to take place in the fall of 2018 precluding our ability to collect and report on data in the second year of the grant as planned.

We experienced a challenge when attempting to evaluate the impact of the Good Samaritan statute objectively. Our evaluation strategy was to measure the extent to which Good Samaritans who call for help on behalf of someone who is overdosing are or are not prosecuted for drug crimes. The Anchorage Fire Department and the Anchorage Police Department, the two largest first responders in Alaska, do not keep records of the names of Good Samaritans. Without a list of Good Samaritans, it is impossible to pull Department of Law data documenting the existence or lack of prosecution for drug crimes. The absence of data on Good Samaritans was supported by a finding from our gap analysis that Alaska does not have a statute requiring the reporting of non-fatal opioid overdoses to the PDMP, state or local health department.

Comments

- Major Strengths:

- Major Weaknesses:

- Recommendations:
  - Consider evaluating knowledge of Good Samaritan laws, rather than the lack of prosecution of those who avail themselves of the laws.
  - Consider diversifying your sample of key informants based on the questions you have selected for them. Are BoP members the best to answer why PDMP use is not more widespread?

- Other Relevant Comments:
  - The PDMP training sub-activity seems better suited to another strategy, rather than the Policy Evaluation strategy.
  - Consider exploring unintended consequences of the regulation to purge PDMP data within 2 years of dispense date.
  - Are you still planning to explore law enforcement attitudes surrounding Good Samaritan laws, per the evaluation plan?

- Evaluation plan does not reflect all of the key policy evaluation questions listed here. Ensure that the evaluation plan is updated to align with work plan and progress reporting.

Sub-Activity: Process Evaluation of the AKPDMP

Sub-Activity Description: By June 2018, the Policy Project Lead will conduct an evaluation of the AKPDMP and provide a report of its findings to the PD, the Opioid Work Group and DHSS Medical Officer. Key interviews will be conducted among Board of Pharmacy members and other select persons. Questions to be posed are–

1. What are the facilitators and barriers to prescribers and their delegates using the PDMP?

a. To what extent do prescribers consistently review patient prescription reports and upload prescript ion data in a timely manner?

b. What changes would improve the PDMP?

c. What challenges prevent regular use of the PDMP?

2. To what extent do PDMP users perceive that Alaska's current PDMP legislation will reduce misuse, diversion and overdose?
3. What are the barriers and facilitators to using PDMP data for to inform surveillance and responses to the opioid problem?

Sub-Activity Start Date: January 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity: Process Evaluation of Alaska CSA

Sub-Activity Description: By June 2018, the Policy Project Lead will conduct an evaluation of processes associated with the Alaska Controlled Substance Act (CSA) and provide a report of its findings to the PD, the Opioid Work Group and DHSS Medical Officer. Key interviews will be conducted among Alaska Controlled Substance Advisory Council members and other select persons. Questions to be posed are– 1. Does Alaska's Controlled Substances Act provide an efficient and effective process for scheduling novel psychoactive substances and analogues? 2. What are the intended and unintended consequences of the current emergency scheduling process for novel psychoactive substance and/ analogues in Alaska?

Sub-Activity Start Date: January 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity: PDMP Training & Initiative Needs

Sub-Activity Description: By June 2018, the Policy Project Lead will conduct key informants interviews to evaluate the level of knowledge and understanding among PDMP users and their needs for education and training. A report of its findings will be provided to the PD, the Opioid Work Group and DHSS Medical Officer. Key interviews will be conducted among Board of Pharmacy members and other select persons. Questions to be posed are–

1. To what extent do PDMP users (and/or other stakeholders) perceive that Alaska PDMP incorporates evidence-based practice and provides educational initiatives that support and promote PDMP use?
2. What are PDMP user's attitudes and beliefs regarding the use of PDMP data for active surveillance to support effective public health prevention and reduce prescription drug overdose?
3. To what extent do user of the PDMP have adequate training in opioid prescribing, pain management, screening for substance abuse, proper storage and disposal of prescription opioids?
4. What changes in knowledge, skills, and attitudes have occurred among PDMP users have resulted from education and training?

Sub-Activity Start Date: January 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity: Policy Evaluation of the Good Samaritan Act

Sub-Activity Description: By August 2018, the Policy Project Lead will initiate key informants interviews to evaluate the level of knowledge and understanding among PDMP users and their needs for education and training. A report of its findings will be provided to the PD, the Opioid Work Group and DHSS Medical Officer. Key interviews will be conducted among Board of Pharmacy members and other select persons. Questions proposed are–

1. To what extent are PDMP users, other stakeholders, and the public aware of the Alaska Good Samaritan statute?
2. To what extent do other laws impact law enforcement in compliance with the Good Samaritan statute?
3. Are there training needs or training improvement that could benefit law enforcement surrounding the Good Samaritan Statute?

Sub-Activity Start Date: June 2018

Sub-Activity End Date: August 2019

Sub-Activity Status: Planned

Sub-Activity Year 1 Progress: Not initiated in Year-1.

Sub-Activity Year 2 Progress: Not yet approved for initiation in Year-2.

Sub-Activity Year 3 Work Plan: By August 2018, the Policy Project Lead will initiate key informants interviews to evaluate the level of knowledge and understanding among PDMP users and their needs for education and training. A report of its findings will be provided to the PD, the Opioid Work Group and DHSS Medical Officer. Key interviews will be conducted among Board of Pharmacy members and other select persons. Questions proposed are–

1. To what extent are PDMP users, other stakeholders, and the public aware of the Alaska Good Samaritan statute?
2. To what extent do other laws impact law enforcement in compliance with the Good Samaritan statute?
3. Are there training needs or training improvement that could benefit law enforcement surrounding the Good Samaritan Statute?

Sub-Activity Funding Type: Base funds

Major Activity: Implement an RRP to advance an innovative prevention approach

Major Activity Summary: By September 31, 2018, the Education Coordinator will initiate the development of a Provider Education Campaign.

In conjunction with Year-1 key informant interview analysis findings concerning training and education needs and the completion of a separate AKPDMP prescriber survey on barriers and limitations to PDMP use, priority areas of improvement will be identified. The information will then be used to increase provider knowledge of pain management and alternative techniques that may be employed by current pain reliever prescribers and future clinicians. Information from this two-pronged approach in assessing needs, limitations, and barriers will assist the State with designing and implementing future improvements and improving the longevity and utility of the PDMP in Alaska to reduce behaviors associated with prescription drug overuse and abuse.

Major Activity Challenges: Challenges include recent legislative requirements for prescribers of controlled substances (i.e., 2-hour continuing education in opioids, pain management and addiction mandated at the time of license renewal). Licensing boards are currently (until July) developing regulation for the mandate. The regulation is scheduled to become effective in July 2018. Providers will need to respond to this mandate at the time of renewal and many licensees will be renewing between the months of September and December. This leaves limited time for the Education Coordinator to consider regulations while developing materials.

Comments

- Major Strengths:

- Major Weaknesses:

- Recommendations:

- Other Relevant Comments:
  - The description of this activity sounds similar to the PDMP training sub-activity above. Are they the same? If not, how are they different?

Sub-Activities

Sub-Activity: Development of Prescriber Education Materials/Media

Sub-Activity Description: By September 2017, the Education Coordinator will initiate exploration of CDC prescriber education materials, best practices by other states, and develop a potential program design for implementation in Year-3.

This activity includes, but not limited to, identifying training modules used by other states and nationally. Developing, implementing, and analyzing results from Survey Monkey queries to collect input from physicians, physician assistants, and nurse practitioners licensed in Alaska.

Sub-Activity Start Date: September 2017

Sub-Activity End Date: August 2018

Sub-Activity Status: In Progress

Sub-Activity Year 1 Progress: Data collection only. This Sub-Activity was consolidated with the PDMP Key Informant Interviews conducted at the end of Year-1 and again in Year-2.

Sub-Activity Year 2 Progress: Due to the lack of support to analyze the responses, a contractual agreement was established with UAA-ISER to complete the coding and analysis of the key informant interviews and provide a written report to the PD, the Strategic Plan Project Leader, Education Coordinator, the PDMP manager, and the Opioid Work Group. A preliminary report will be provided to the Education Coordinator and the newly hired Nurse Consultant who is tasked with development of a prescriber education campaign.

Sub-Activity Year 3 Work Plan: By September 2018, the Education Coordinator and Nurse Consultant/Subject Matter Expert will initiate implementation of CDC and state prescriber education materials, and further develop aspects of the provider education program potentially including elements of academic detailing and “hub and spoke” models for clinician-based prescriber education.

Sub-Activity Funding Type: Base funds

Sub-Activity Funding Description: Funding supports personnel assigned to develop this activity. In addition, supplemental funds, if approved, will be used to further develop materials not otherwise supported.

Planning Indicators

- ## Other Relevant Comments:

PfS Indicators

- Non-categorical PDMP indicators for 2017 are not completed. Please provide information justifying this.
- Indicator 23, 25, 26, and 27 are not completed and the notes fields do not contain an explanation. Please provide information justifying these blanks.
- The rate of MPE doubled in 2016 compared to 2014. Are there hypotheses about this trend?
- Encouraged indicators were not completed. Please provide information justifying this. The encouraged indicators are recommended for exploration and future reporting:
  - #1" High-burden areas have been identified (yes or no)"
  - #5 "Number of academic detailing sessions" if considering this activity for PDMP outreach
  - Policy Evaluation: #21 "Increase in the number/percent of stakeholders aware of policy/law," #24 "Description of policy's implementation status," #25 & 26, "Description of policy's facilitators/barriers"
  - All indicators for the Rapid Response Project-#27-33 to describe the barriers, facilitators, unintended consequences and implementation of the proposed project.

Budget

Comments: The budget included the three separate components for Planning and Data, Prevention in Action and Supplemental activities. Total amount requested is $1,350,000. However, in Grant Solutions, the total amount requested was only $750,000. We will be recommending that the full amount be awarded ($1,350,000).

All contractual elements are included and are in line with the requirements of the funding announcement.

X Yessenia Ibarra

Yessenia Ibarra

May 23, 2018

APPRISS HEALTH

Prescription Drug Monitoring Programs and Appriss Health

April 11, 2018

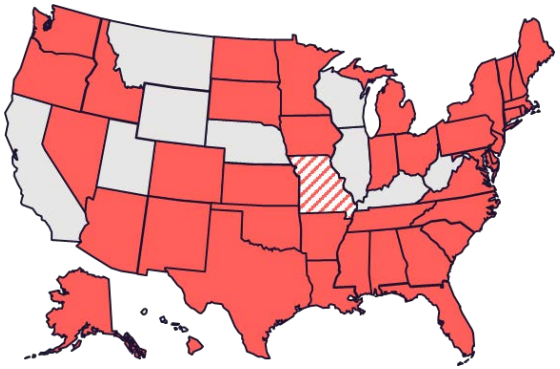
Outline

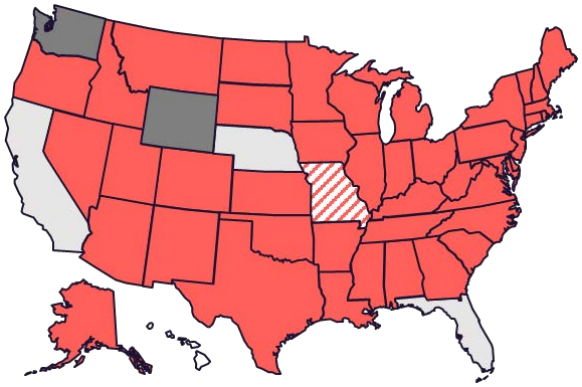
APPRISS HEALTH

- Appriss Health Review
- NarxCare Overview
- Data Science and the PDMP
  - Narx Scores
  - Overdose Risk Score
  - How are doctors using the scores
- New tools to manage the opioid epidemic
  - Messages and Care Notes
  - Criminal justice records (social determinant of risk)
  - Provider Risk Scores
- Discussion

Appriss Health Services

APPRISS HEALTH





PMP InterConnect

- 44 of 52 PDMPs signed to participate in the hub
- 18 million queries and 39 million responses per month
- **Provided free to all states**

PMP Gateway

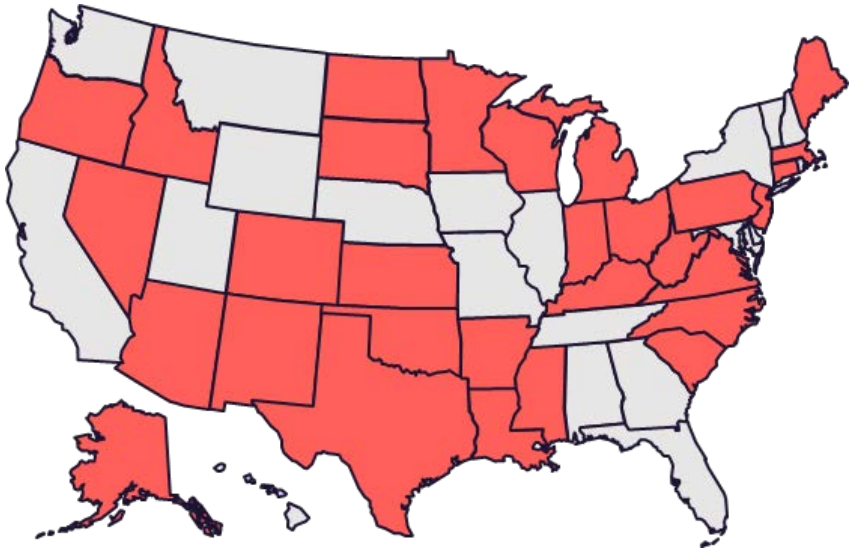
Established integration workflow to accommodate multiple means of PDMP data access including:

- Electronic Health Records (EHR's)
- Pharmacy Dispensation Systems
- Health Information Exchanges (HIE's)
- Electronic Prescribing of Controlled Substances (EPCS) platforms

- Thirty-three (33) states integrating over 25 million patient reports a month

Appriss Health Services Continued

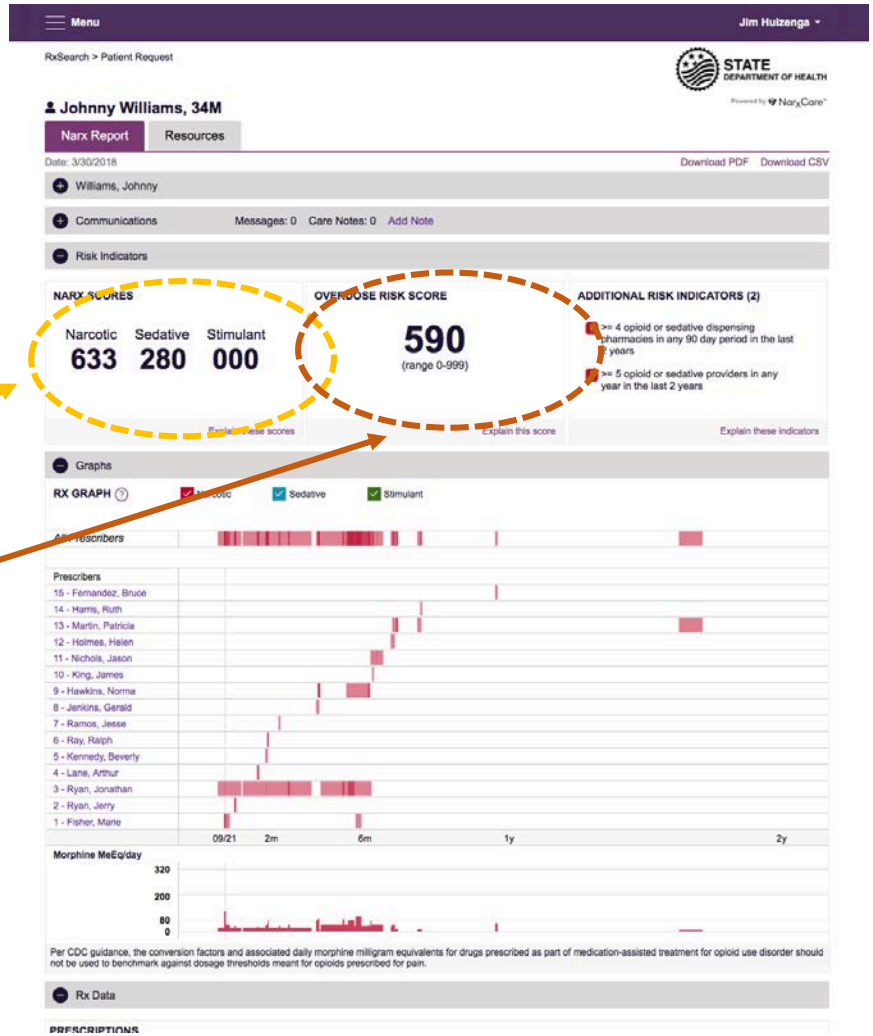
APPRISS HEALTH



NarxCare: Substance Use Disorder Platform

APPRISS HEALTH

- NarxCare is a substance use disorder prevention and management platform
- Use scores and alerts to distill PMDP data into more easily assessed format
  - Similar concept other patient scores (e.g., cardiovascular risk scores)
- Two type of scores:
  1. **Narx Scores**: Percentile-based scores indicating utilization of the PMDP for three different types of controlled substances
  2. **Overdose Risk Score**: Score based on a predictive model of overdose death, creating using machine learning techniques
- Provides a care coordination platform that allows for peer to peer messaging, care notes, referrals – supporting the care of our highest at risk individuals

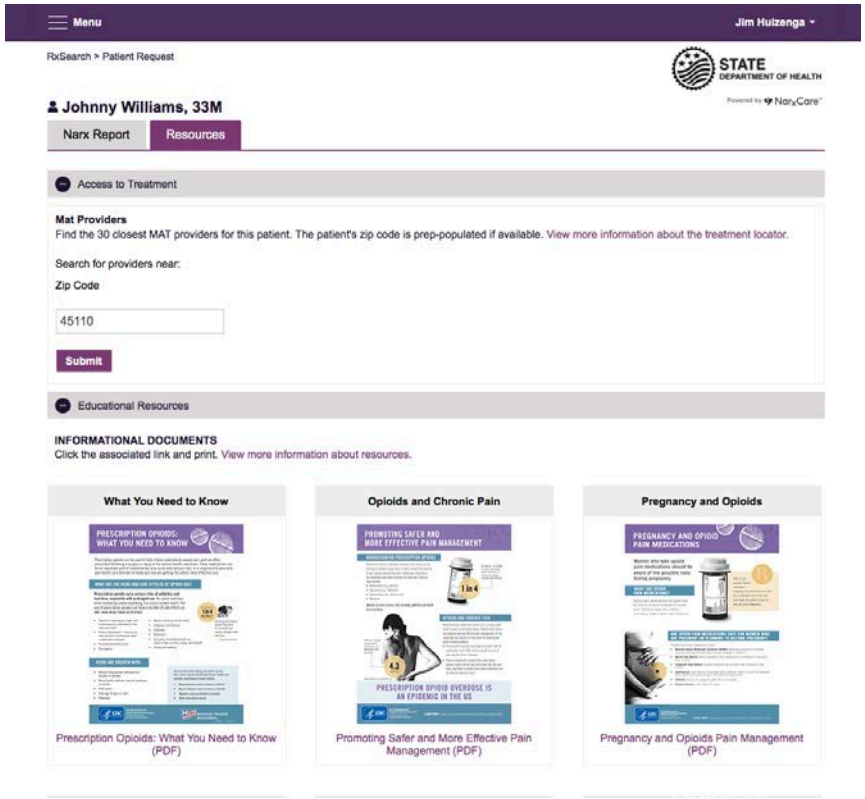


NarxCare: Substance Use Disorder Platform

APPRISS HEALTH

- Resources tab used to introduce "What now"? Functionality such as MAT locator and CDC resources.
  - More advanced technology for obtaining referrals and appointments are in development.

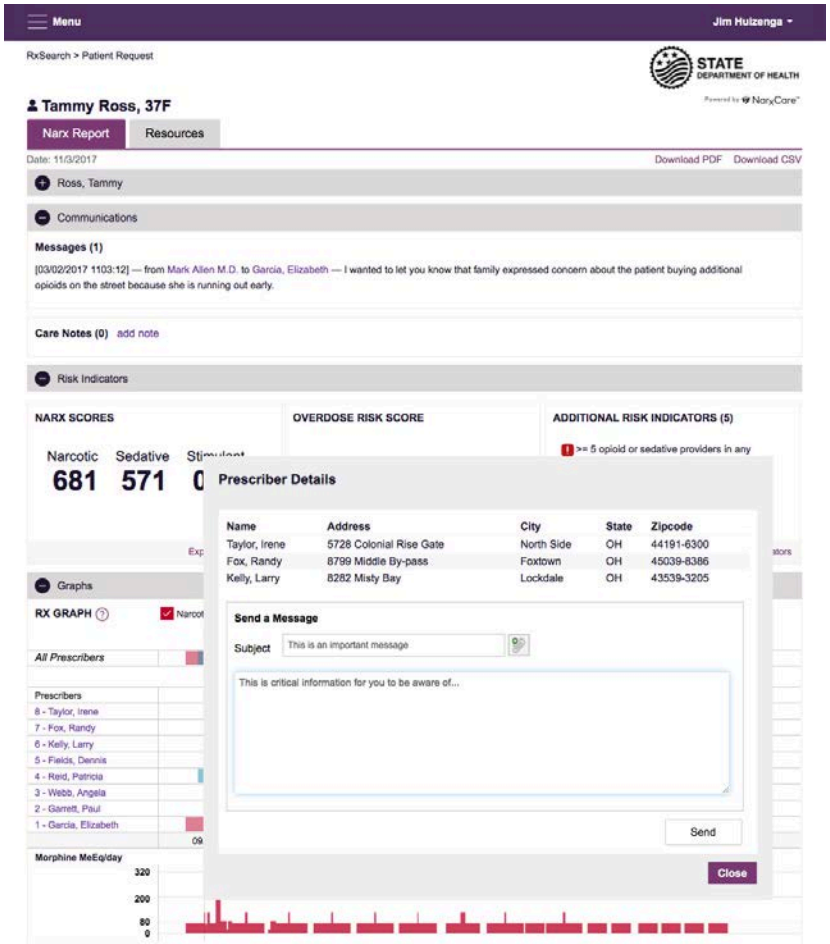
- We believe there are valuable 3rd part resources that could be integrated, and we are in exploratory discussions with several companies.
  - Video DOT
  - Level of care assessments
  - Patient facing applications



NarxCare: Substance Use Disorder Platform

APPRISS HEALTH

- Messages and Care Notes being launched in approving states in 2018
- One Click access to an email style interface to allow for provider to provider (pharmacist to provider) messaging.
- Care Notes can be uploaded and contain important information relevant for any treating provider or pharmacist.
  - Supports document upload and display such as care plans, treatment agreements, etc.



Data Science Team

APPRISS HEALTH

- NarxCare includes state of the art tools and additional access to our Data Science Team

- Team Makeup
  - 25 staff on team
  - 9 PhD, 10 MS

- Disciplines
  - Epidemiology, Biostatistics, Applied Math, Applied Statistics, Computer Science, Criminology, Business, Information Systems, Political Psychology, Economics, Computer Information Systems, Mechanical Engineering

- Universities
  - Princeton, Emory, UCLA, UC Berkeley, UCI, Pepperdine, University of Illinois, Cal Poly, No. AZ Univ., James Madison, Univ. of Iowa, USC, Cal Poly, University of Bristol, Union University, Utica

APPRISS HEALTH

Data Science Applied to Patient Risk Evaluation

Research Timeline

APPRISS HEALTH

Research Timeline (Patient Risk)

Narx Scores
Use Scores – no outcomes available

Overdose Risk Scores
Likelihood of unintentional overdose death

PMP Data Only

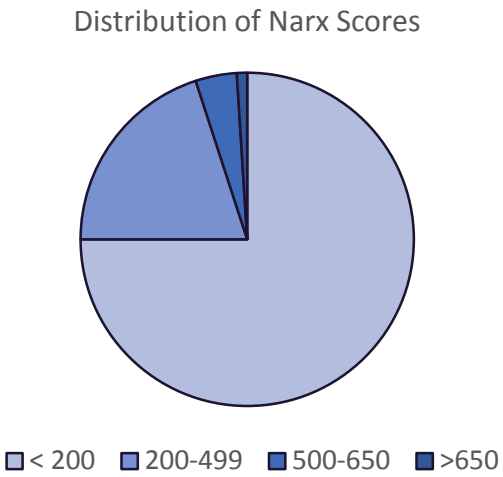
Overdose Risk Scores v2.0
Likelihood of unintentional overdose death

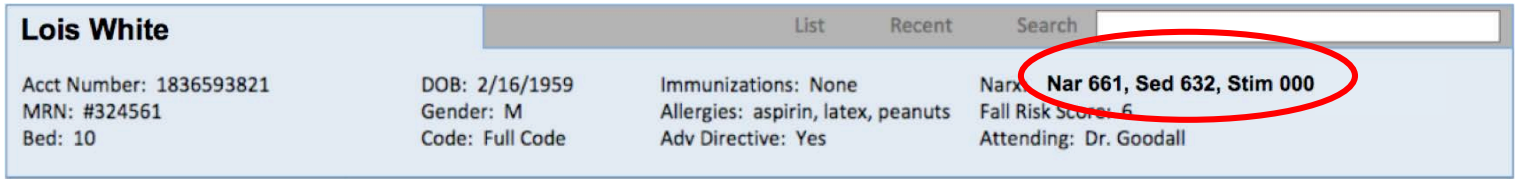
PMP Data
CJIS Data
Non-Fatal Overdose Data
Claims Data

- Developing increasingly accurate risk scores as more data becomes available

APPRISS HEALTH

- Calculated for narcotics, sedatives, and stimulants separately
- Percentile ranking of several frequency of use metrics for a single patient compared to the larger PDMP population, combined to give an even distribution of scores
- Ranges from 000-999
- As the scores increase, so does the presence of:
  - Multiple providers
  - Multiple pharmacies
  - Higher MME
  - Overlaps





Narx Scores In Workflow

APPRISS HEALTH

- Validated Narx Scores on a 1:100 case control sample in Ohio.
- Each unintentional overdose death case was matched to 100 non-deaths at date of death
- Highest Narx Score was computed in the 1-year prior to death date (or sample date for the controls)
- Clear monotonic association seen between higher Narx Score and odds of death
- P < 0.0001 compared to baseline group (Narx Score<100)

Narcotic Score	Living	Deceased	OR	95% Lower CI	95% Upper CI	P-Value
000 - 099	71,701	80	1.0			
100 - 199	27,153	238	7.9	6.1	10.1	P < 0.0001
200 - 299	19,546	220	10.1	7.8	13.0	P < 0.0001
300 - 399	21,002	234	10.0	7.7	12.9	P < 0.0001
400 - 499	16,303	297	16.3	12.7	20.9	P < 0.0001
500 - 599	8,629	305	31.7	24.7	40.6	P < 0.0001
600 - 699	3,005	188	56.1	43.1	73.0	P < 0.0001
700 - 799	1,062	90	76.0	55.9	103.3	P < 0.0001
800 - 899	283	32	101.3	66.2	155.2	P < 0.0001
900 - 999	16	3	168.1	48.0	588.0	P < 0.0001
Total	168,700	1,687				

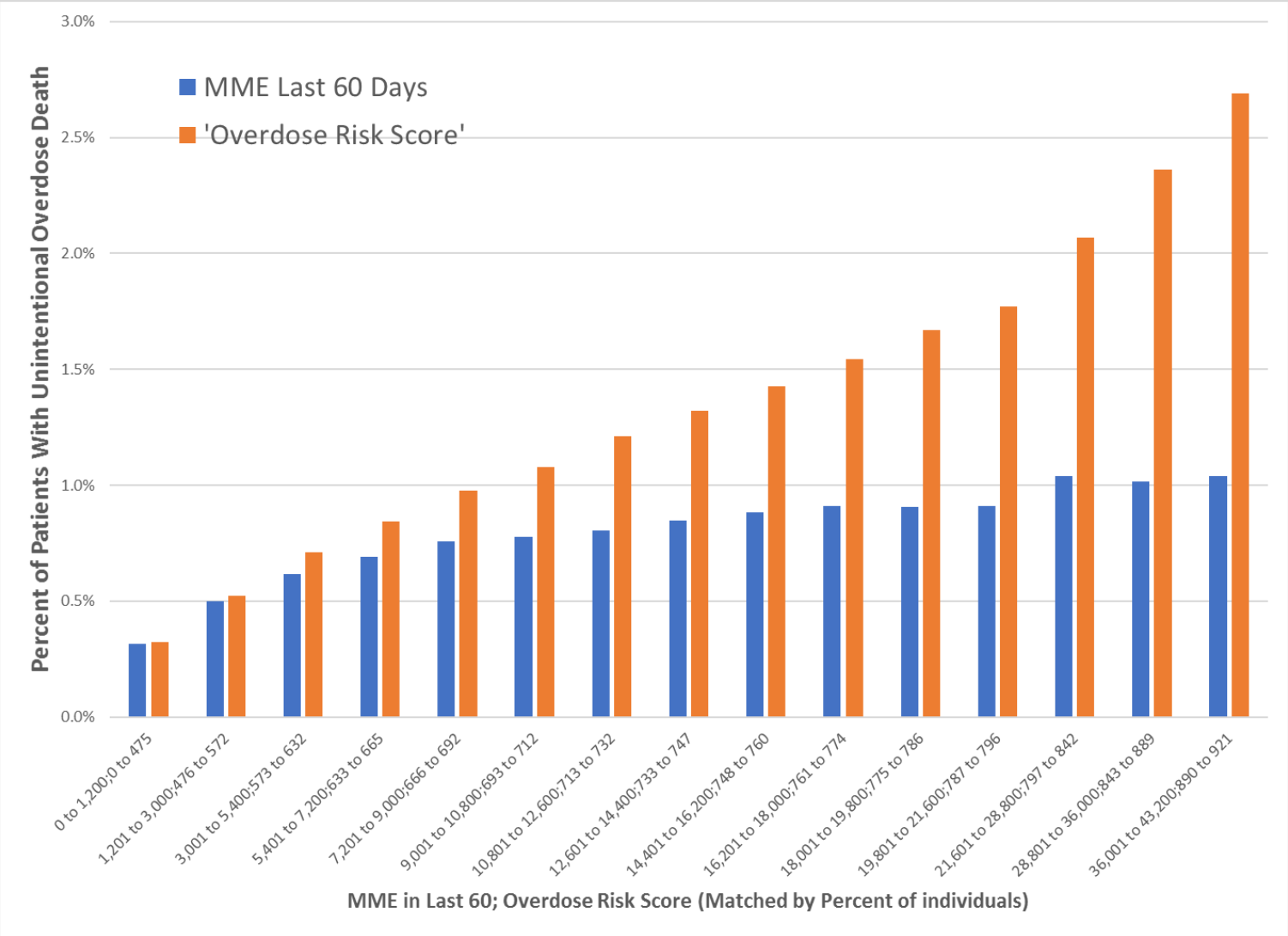
Reference: https://apprisshealth.com/wp-content/uploads/sites/2/2017/02/NARxCHECK-Score-as-a-Predictor.pdf

APPRISS HEALTH

- Predicts a patient's risk of opioid-related overdose death on a 0 to 999 scale
- 10 variables were selected for the final model that capture aspects of:
  - High MME
  - Rate of narcotic use over time
  - Rate of sedative use over time
  - Number of pharmacies visited
  - Number of providers visited
  - Rate of unique providers visited over time

Appriss Health's Overdose Risk Score: Predictive Power
Compared to MME in the Past 60 Days

APPRISS HEALTH



Comparison of Odds Ratio for Drug Overdose Death

APPRISS HEALTH

- Validated in 3 states (OH, AZ, MI) with approximately 20,000 cases of unintentional overdose death

OD Risk	Original Validation Odds Ratio OARRS
0-199	Ref.
200-299	10
300-399	12
400-499	25
500-599	44
600-699	85
700-799	141
800-999	194
900-999	329

OD Risk	Odds Ratio Arizona PDMP 2011-2016 Decedents
0-199	Ref.
200-299	2
300-399	4
400-499	5
500-599	10
600-699	19
700-799	46
800-999	94
900-999	155

OD Risk	Odds Ratio Michigan PDMP 2013-2015 Decedents
0-199	Ref.
200-299	2
300-399	3
400-499	5
500-599	11
600-699	30
700-799	64
800-999	56
900-999	351

How Doctors Are Using the Scores

Instructions on How Prescribers Should Use the Scores

APPRISS HEALTH

NarxCare

Type-Specific Use Scores

Prescribers
Morphine Milligram Equivalency
Pharmacies
Overlapping Prescriptions

NarxCare MAPS

Narx Score

75% score less than 200
5% score more than 500
1% score more than 650

NarxCare MAPS

	60 days	6 mos	1 year	2 years	Avg	Wt	
Prescribers	85	76	84	64	77	1	77
Pharmacies	78	56	62	49	61	1	61
Morphine milligram eq	74	87	88	87	84	3	252
Lorazepam milligram eq	0	0	0	0	0	1	0
Overlaps	41	70	64	52	57	2	114
Weighted Average (sum/8)							63
Number of Active Narcotic Prescriptions							2
Narcotic Score							632

NarxCare MAPS

Score/Range 010 - 200

Notes Approximately 75% of scores fall in this range.
Occasionally, patients in this score range have a remote history of high usage (> 1 year ago).

Recomendations Review use patterns for unsafe conditions.
Discuss any concerns with patient.
If previously high usage exists with recent abstinence consider risk/benefits of new prescription.

NarxCare MAPS

17-year-old
Male
Basketball Player
Severe ankle sprain

NarxCare MAPS

Score/Range > 650

Notes Approximately 1% of scores fall in this range.
Some patients records may still be within prescriber expectations, with some level of multiple provider episodes, overlapping prescriptions, or elevated milligram equivalency.

Recomendations Review use patterns for unsafe conditions.
Discuss any concerns with patient.
Consider contacting other providers directly, pharmacy lock-in program, taper and/or discontinuation of medication, or inpatient admit or outpatient evaluation and treatment.

NarxCare MAPS

81-year-old
Female
Decreased level of consciousness
Closed head injury

NarxCare MAPS

NarxCare Survey Results

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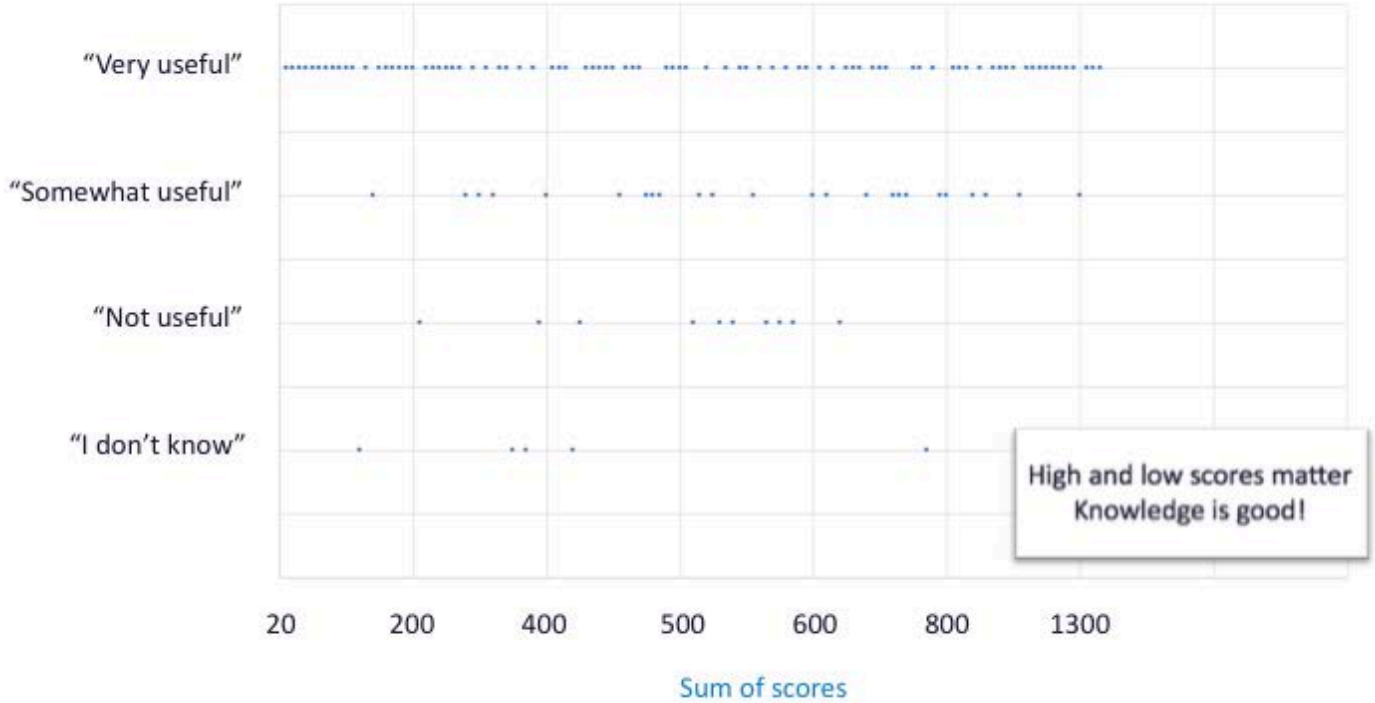
Provider Survey 1:

- *In line survey during actual patient encounter*
  - *16,030 questions asked, 2197 responses (13.7%)*
  - *Single question per report*

Results:

- *Time savings associated with scores and graphs approximately 60 seconds per report*
- *Usefulness and appropriateness of scores rated highly*



NarxCare Survey Results

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Provider Survey 2:

- *Off line survey with 10 questions*
  - *Response rate 21% (47/223)*
- *Net promotor score 50*
- *Time savings assessment 75 seconds*
- *Satisfaction received high marks (>90% in all categories)*

Q1 - Overall, how well does NarxCare meet your needs?

Extremely well	26	55.3%
Very well	13	27.7%
Somewhat well	7	10.6%
Not so well	0	0.0%
Not at all well	1	2.1%

Q2 - How helpful is it to have NarxCare Scores available on every patient?

Extremely helpful	29	61.7%
Very helpful	11	23.4%
Somewhat helpful	5	10.6%
Not so helpful	1	2.1%
Not at all helpful	1	2.1%

Q3 - How well do the NarxCare Scores represent the underlying PDMP data?

Extremely well	17	37.0%
Very well	15	32.6%
Somewhat well	12	26.1%
Not so well	1	2.2%
Not at all well	1	2.2%

Q4 - How useful are the prescription and MME graphs on the NarxCare Report?

Extremely useful	17	29.8%
Very useful	15	42.6%
Somewhat useful	12	23.4%
Not so useful	1	2.1%
Not at all useful	1	2.1%

Q5 - NarxCare has made me aware of prescribing risks I might have missed previously?

Strongly agree	17	36.2%
Agree	19	40.4%
Neither agree nor disagree	8	17.0%
Disagree	2	4.3%
Strongly disagree	1	2.1%

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New Tools Being Incorporated

Future Projects and Services

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- **Unified Patient Identification**
  - Appriss ID—Appriss proprietary identity system
- **Expansion of the Overdose Risk Score**
  - Boosting analysis by incorporating criminal justice data
  - Claims data
- **New Scores**
  - Misuse
  - Substance Use Disorder
- **State Administrator Support**
  - Identification of high risk prescribers (Prescriber Risk Score)
  - Statewide Opioid Assessments
- **Pharmacy Monitoring Platform**
  - Appriss monitors pharmacy inventory and provides an analytics platform for retailers such as Walmart to identify fraudulent events which involve personnel in the supply and distribution chain
- **Retail Fraud**
  - Approached one retailer to examine association of non-receipted returns with opioid use
- **Publications**

Boosting Analysis by Incorporating Criminal Justice Data

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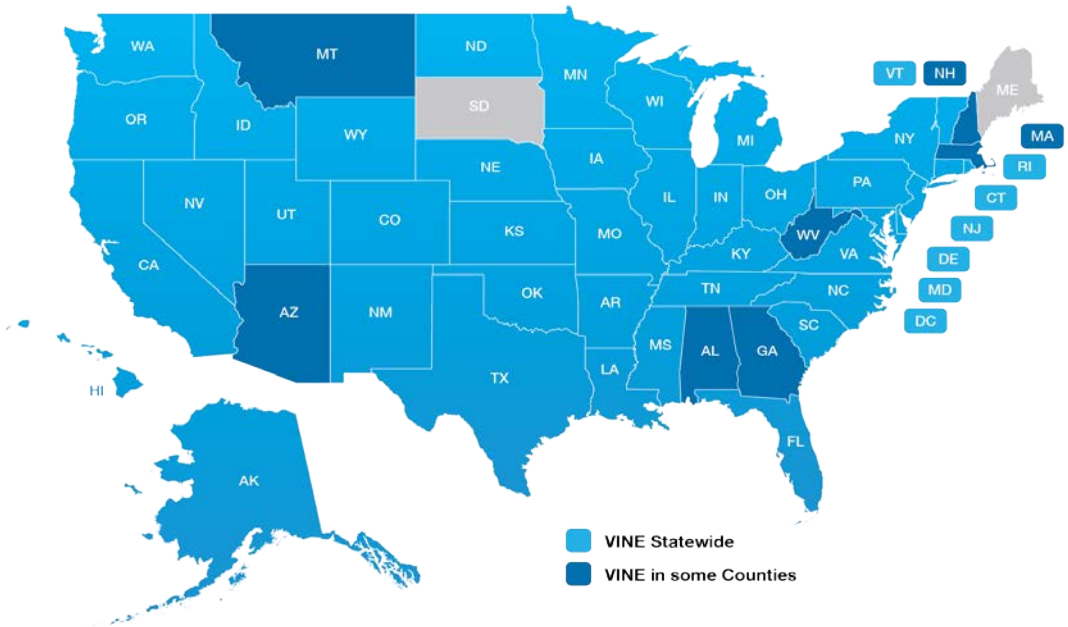
Appriss collects more than 9 million incarceration records annually from over 2,300 facilities

- Partnership with Ohio to assess the added value of criminal justice data being incorporated into the overdose risk score
- **56%** of patients who died of a drug-related overdose were ever incarcerated at an Ohio jail
- **7.5 times higher** death rate among patients with bookings, compared to the death rate among all patients
- Death rate is **14.5 times higher** among patients charged with a drug-related offense than among all patients

- Appriss is in the process of rolling out AL
- Appriss is in discussions with AZ, GA, MA, ME and MT for statewide VINE



	Non-Decedents	Decedents	Total	Death Rate per 100
All Ohio PDMP Patients	*7,990,898*	*6,716*	*7,997,614*	*0.08*
All Patients Ever Incarcerated	622,019	3,780	625,799	0.60
Patients with a Drug-Related Charge	74,080	869	74,949	1.16
-With a Schedule I-V Drug-Related Charge	6,347	55	6,402	0.86
-With a Heroin-Related Charge	5,479	81	5,560	1.46

Time from Release to Death (n=3,933)

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31.0% of decedents died within 3 months of their final release

Time from Release to Death	Percent of Decedents
Within 3 months	31.0%
Within 6 months	43.6%
Within 1 year	60.1%
More than 2 years	21.9%

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- With minimal additional criminal justice data, the overdose risk score correctly identifies more decedents than it can using only PDMP history
- KS score improved by 34%
- 28.8% more decedents were identified by the top 10% of scores

Top 10th Percentile of Score	Number of Decedents	Number of Patients	Death Rate per 1,000
Original Overdose Risk Score	709	33,546	21
Including Criminal Justice Data	913	33,546	27
Improvement	+28.8%		+6

Source: Ohio PDMP Data 2011-2016; Ohio 2013-2016 drug-related deaths; Ohio 2005-2016 criminal justice booking records
Notes: *Odds ratios are calculated using case-control sampling. For every death, 200 random controls are selected who had a prescription within the year preceding the date of death of the case. For both cases and controls, their maximum overdose risk score within that year period was taken as their exposure.*

State Administrator Support: Outlier Prescriber Score

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What does the model predict?

60 Day Death Rate for the Prescriber's Patients =

$$\frac{Number\ of\ patients\ who\ die\ within\ 60\ days\ of\ a\ prescription}{Total\ number\ of\ patients\ for\ the\ prescriber}$$

What information does Appriss Health use to predict risk?

50+ variables are created which characterize the prescriber (example categories below):

- Prescriber characteristics (e.g. specialty)
- Prescribing behavior (e.g. average MME/LME)
- Prescriber's patient characteristics (e.g. average age)
- Prescriber's patient behavior (e.g. proportion of patients seeing 2+ prescribers)

What technology/methods does Appriss Health use?

Machine learning models combine information to predict death rates

Findings to date:

Top 10% of scoring providers associated with almost half of all deaths in a state.

Recap and Questions

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- NarxCare is a substance use disorder platform with built in risk scores, integrated care coordination, and patient management functionality
- NarxCare tools have been built with a world class Data Science Team (DST)
- Providers greatly approve of our scores, visualization, and tools.
- We are constantly innovating with new scores, new data usage, and improved functionality

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Appendix

Reduction in Abusive Narcotic Dispensations

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- **Defining a Dispensation to an Abusive Patient**
  - Marked abusive if all key variables are in the top 10 percentile for a patient
    - Number of narcotic prescriptions in the last 365 days
    - Number of narcotic prescribers in the last 365 days
    - Number of narcotic pharmacies in the last 365 days
    - Total narcotic supply in days in the last 365 days
    - Total Morphine-Milligram-Equivalent in the last 365 days
  - In each state, using this method on average ~1% of narcotic dispensations were identified as to abusive patients. This equates to ~0.15% to 0.3% of patients.

- **How Well Does a Prescriber Use the Aware PMP Program**
  - To measure the impact of PMP the enrolled doctors were divided into 4 categories ranking from the highest to the lowest usage of the PMP,
    - RX User 5%: Top 5 percentile by RX search request count (best users of PMP)
    - RX User 25%: Top 25 percentile by RX search request count.
    - RX User 50%: Top 50 percentile by RX search request count.
    - RX User: All doctors enrolled in the PMP with at least one request.
    - Control Group: Doctors that have never made a request using the state's PMP.

Narx Scores vs. Abusive Definition

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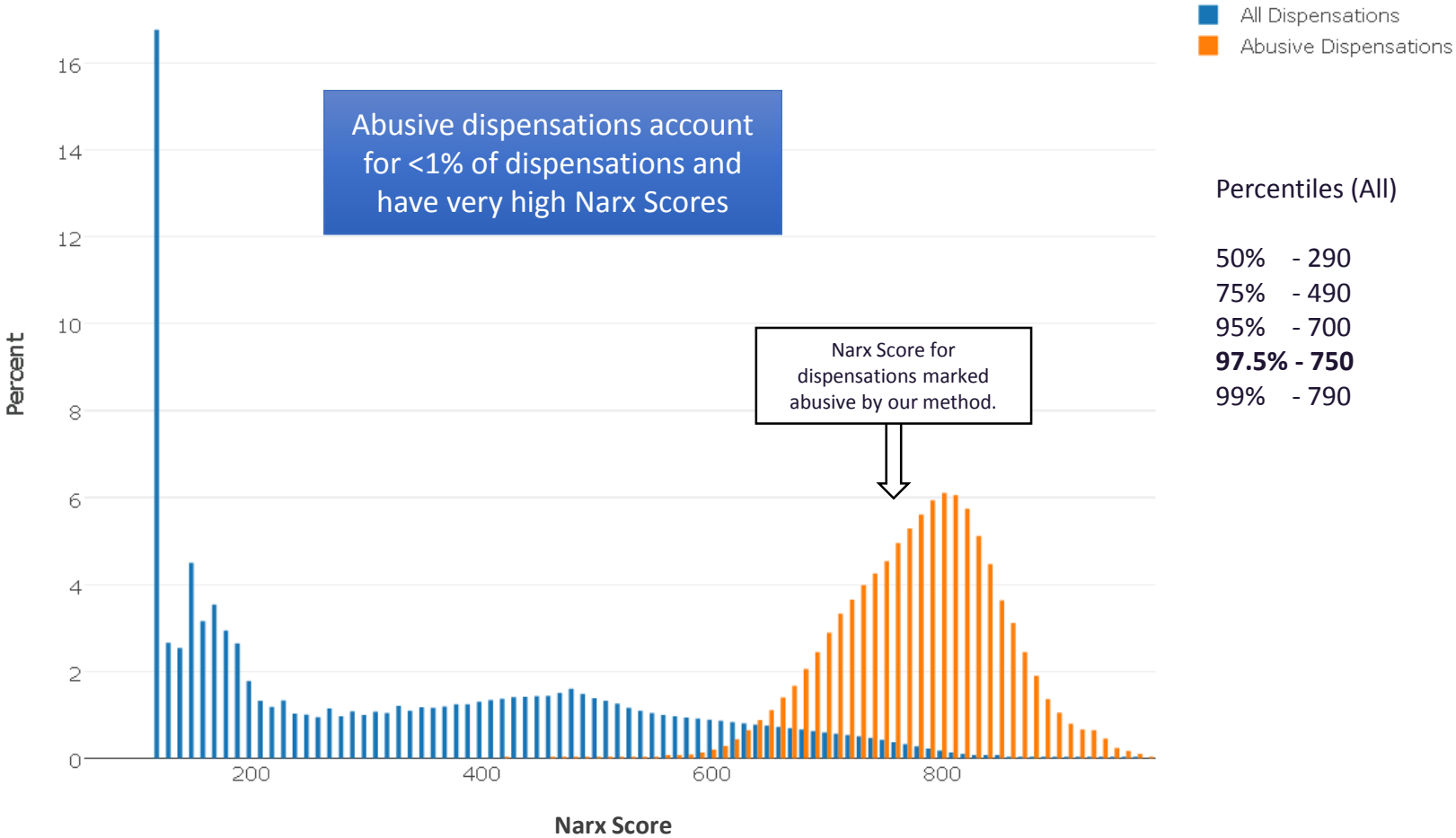

Percentiles (All)

50% - 290
75% - 490
95% - 700
97.5% - 750
99% - 790

Reduction in Narcotic Dispensations to Abusive Patients

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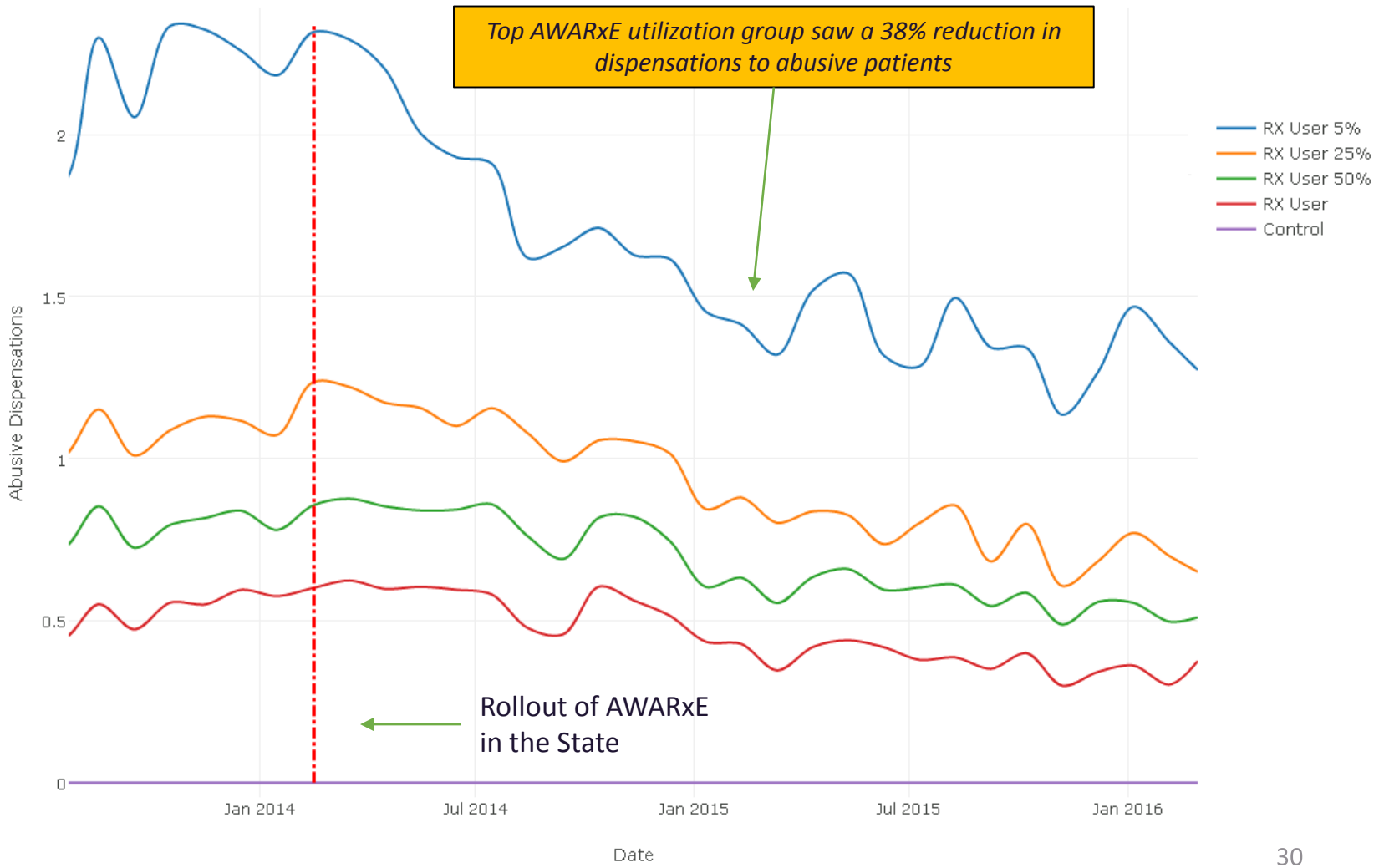
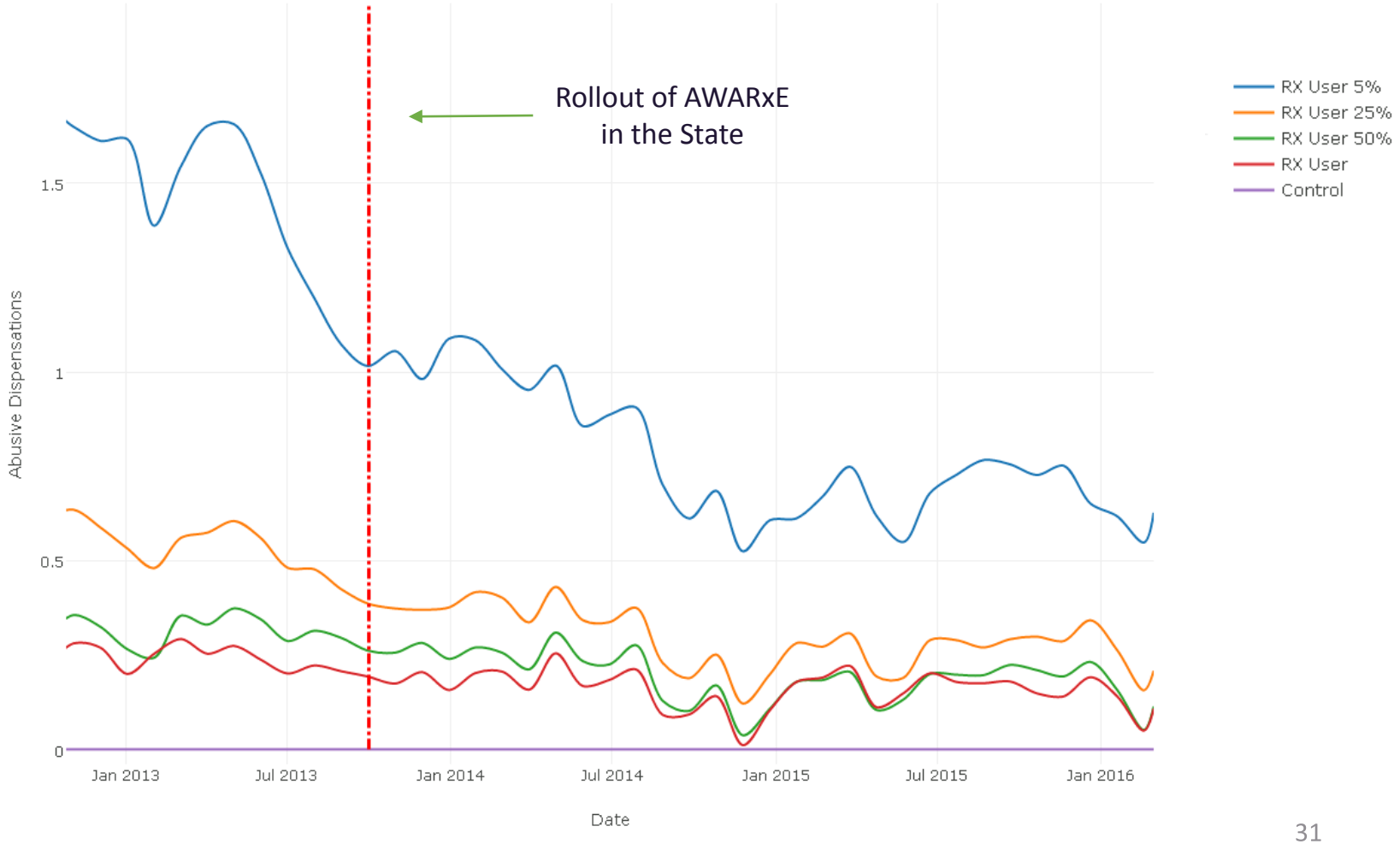


Reduction in Narcotic Dispensations to Abusive Patients

APPRISS HEALTH



Number of PDMP Patients Meeting Same-Day Multiple Prescriber Episode Criteria

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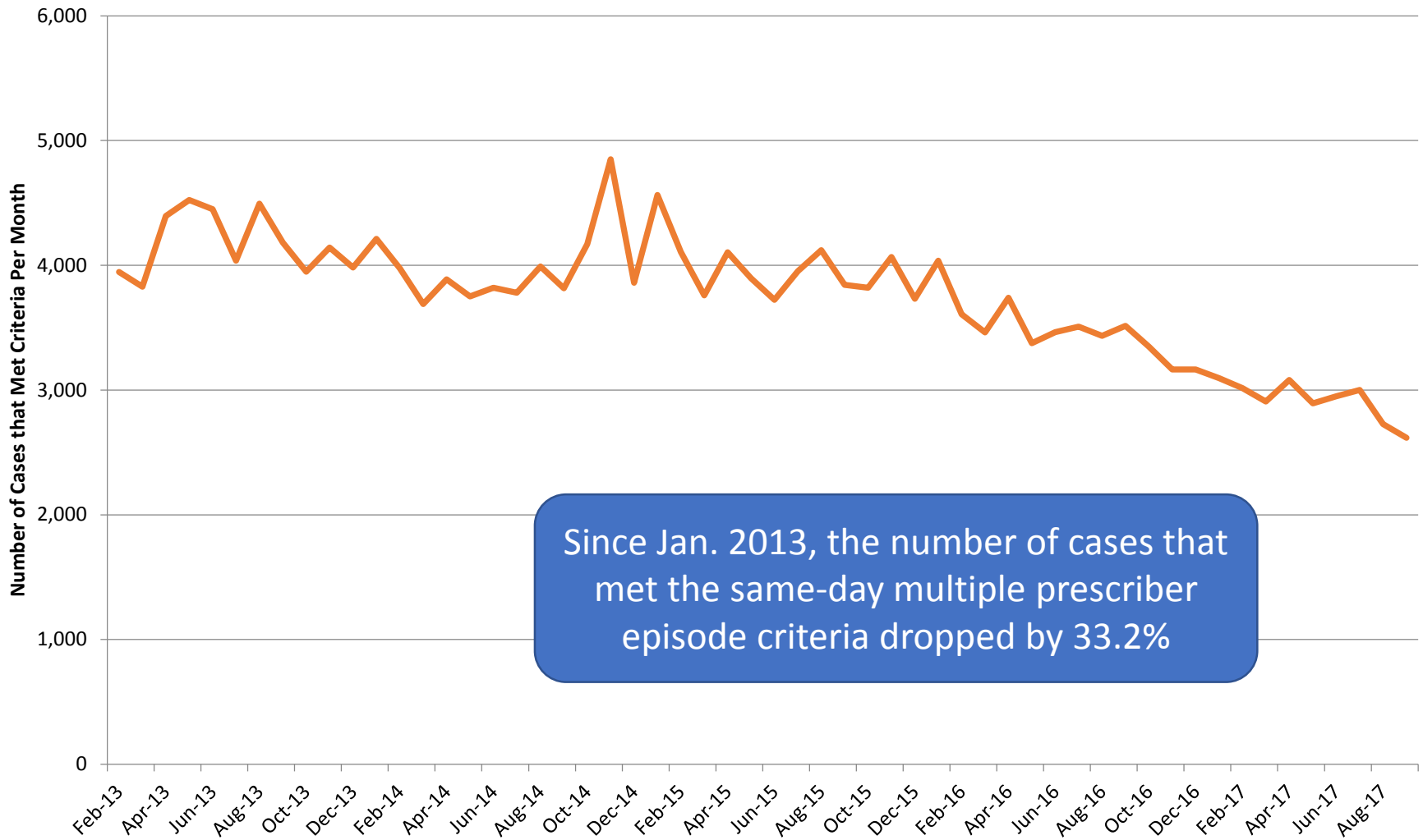

State: Michigan PDMP Oct. 2012-Oct. 2017, All PDMP Prescriptions
Criteria: Same person, at least two prescriptions from two different provider DEA numbers filled on same day, AND at least two different pharmacies visited on same day

Change Order	
Description:	Clinical Alerts
Appriss Service (the "Service"):	PMP AWARE The Service shall be considered completed upon delivery in production
Date Created:	1/26/2018
Billing Agent:	Alaska Department of Commerce, Community, and Economic Development
Billing Address:	Alaska Department of Commerce 550 W 7th Avenue Suite 1500 Anchorage AK 99501
Billing Contact:	license@alaska.gov
Customer Relationship Manager:	*Jacob Cooper* *jcooper@apprisshealth.com*

High Level Description of Project
Clinical Alerts module to be added to the AK PMP AWARxE.
Background/Business Justification
The Clinical Alerts module includes a configuration screen to allow for the PMP State Administrator to configure custom automated alerts and/or notifications for registered Prescribers. When this feature is enabled, these alerts run on a schedule configured by the Admin in the background delivering custom alerts and notifications (if configured) without the need for manual input from the PMP State Administrator. • Prescriber & Dispenser Thresholds: Generates an alert when a specified number of Prescribers and/or Dispensers is met or exceeded within a set time period. • Daily Active MME Threshold: Generates an alert when the daily active MME is greater than or equal to a specified value. • Opioid & Benzodiazepine Threshold: Generates an alert when Opioids and Benzodiazepine are prescribed within a set time period. • Daily Active Methadone Threshold: Generates an alert when the daily active MME (morphine milligram equivalent) for Methadone is greater than or equal to specified value. • Opioid Consecutive Days Threshold: Generates an alert when Opioids have been received daily for longer than a set time period.

In Scope
The Clinical Alerts Module consists of five alert types for Prescribers with three alert methods, all configurable by the State Administrator. **Alert Types:** **Prescriber & Dispenser Thresholds** This customizable Clinical Alert is triggered when a patient meets of or exceeds the values entered for "Count of Prescribers" and/or "Count of Pharmacies" within a set time period. This Clinical Alert can be configured to deliver automatic alerts and/or notifications via Patient Alerts, Email, PMP Reports, and Letters. This alert supports optional custom disclaimer text to be displayed in the selected alert or notification. The threshold period can be set to a customizable number of days. It can be configured to expire after a customizable number of days, and can be configured to send only to selected user role types (Healthcare Professional, Agency Administration, Law Enforcement, Other, or Restricted Admin). **Daily Active MME Threshold** This customizable Clinical Alert is triggered when a patient meets or exceeds the value entered for "Daily Active MME". This Clinical Alert can be configured to deliver automatic alerts and/or notifications via Patient Alerts, Email, and PMP Reports. This alert supports optional custom disclaimer text to be displayed in the selected alert or notification. It can be configured to exclude treatment drugs. It can be configured to expire after a customizable number of days, and can be configured to send only to selected user role types (Healthcare Professional, Agency Administration, Law Enforcement, Other, or Restricted Admin). **Opioid & Benzodiazepine Threshold** This customizable Clinical Alert is triggered when a patient has active concurrent prescriptions for both an Opioid and a Benzodiazepine within any time period. This Clinical Alert can be configured to deliver automatic alerts and/or notifications via Patient Alerts, Email, and PMP Reports. This alert supports optional custom disclaimer text to be displayed in the selected alert or notification. It can be configured to expire after a customizable number of days, and can be configured to send only to selected user role types (Healthcare Professional, Agency Administration, Law Enforcement, Other, or Restricted Admin). **Daily Active Methadone Threshold** This customizable Clinical Alert is triggered when the daily active MME (morphine milligram equivalent) for Methadone is greater than or equal to specified value. This Clinical Alert can be configured to deliver automatic alerts and/or notifications via Patient Alerts, Email, PMP Reports, and Letters. This alert supports optional custom disclaimer text to be displayed in the selected alert or notification. It can be configured to exclude treatment drugs. It can be configured to expire after a customizable number of days, and can be configured to send only to selected user role types (Healthcare Professional, Agency Administration, Law Enforcement, Other, or Restricted Admin).

Opioid Consecutive Days Threshold
This customizable Clinical Alert is triggered when Opioids have been received daily for longer than a set time period. This Clinical Alert can be configured to deliver automatic alerts and/or notifications via Patient Alerts, Email, PMP Reports, and Letters. This alert supports optional custom disclaimer text to be displayed in the selected alert or notification. It can be configured to exclude treatment drugs. It can be configured to expire after a customizable number of days, and can be configured to send only to selected user role types (Healthcare Professional, Agency Administration, Law Enforcement, Other, or Restricted Admin).

Alert Methods:

Prescriber Alert Method – Patient Alerts
The Patient Alerts Alert Method is the default alert type and is displayed within the AWARxE application to Prescribers. An overview is available on the My Dashboard screen with additional, specific patient detail listed in the Patient Alerts screen. This alert is triggered when a Clinical Alert threshold has been met or exceeded. Optional Email notifications may be enabled for this alert type.

Prescriber Notification Method – Email Notification
The Email Notification Method is an optional additional Prescriber notification available for the default Patient Alerts. The email notifies the prescriber that a patient under their care has met or exceeded a Clinical Alert threshold. The prescriber is directed to login to their My Dashboard Patient Alerts in the AWARxE application to identify and view the specific patient alert details. No patient information is contained in the email. Examples of notification emails for each Clinical Alert are listed below. PMP Administrators may configure the text and format of these emails utilizing the PDF mailing template.

Prescriber Letter Method – Letters
The Letter Notification Method is an optional Prescriber notification available for the Patient Alerts. This option is independent of the Patient Alerts and Email Notification Methods. A letter will be generated for the prescriber that a patient under their care has met or exceeded a Clinical Alert threshold. The letter will be made available for the Admin to print and manually sent to the prescriber. PMP Administrators may configure the text and format of these Letters utilizing the PDF mailing template.

Fees and Conditions	
This Change Order form must be signed, and returned by the expiration date to move forward with this request. Once a signed Change Order is received, the task will be planned for estimated completion month listed below. All Fees are payable to Appriss Inc. as set forth in the Agreement without set-off, deduction, or other withholding. The fees are non-cancelable and non-refundable. Unless otherwise modified herein, the terms of the Agreement remain in place and unmodified.	
Estimated Completion Month	February 2018
Fee(s)	$2,500 one-time fee $5,000 annual recurring fee
Form Expiration Date	2/28/18

Appriss Inc.

_____
Robert Cohen, President Appriss Health

_____
Date

Alaska Department of Commerce, Community, and Economic Development

_____
Authorized Signatory

_____
Date

Opioid Prescribing Practices and Provider Education

Vision

Alaskans have access to and are engaged by medical professionals who are supported in their decision-making through:

1. Efficient access to critical clinical information and data;
2. Availability of treatment options that are most appropriate and evidence-based for the individual's health status;
3. Easy access to quality training, education, and resources; and
4. A collaborative professional environment

So that

- Individuals are supported using means that confer resiliency and
- Iatrogenically-induced chemical dependencies are eliminated.

Objectives and Strategies

Objective 1 – Data Informed: Facilitate real-time integration of opioid utilization data into prescribers' workflow.

Strategy 1.1 – Convene multidisciplinary group to review clinical alerts available in the Prescription Drug Monitoring Program (PDMP) to guide enhancement (i.e., real-time clinical alerts, push notifications, reports, etc.) decisions. Incorporate input into enhancement development and selection.

Audience: All registered utilizers of PDMP regardless of practice model
Suggested Ownership: DCCED, Professional Boards
Key Stakeholders: Professional societies reflective of registered utilizers of PDMP (e.g., ASMA, ASIPP, ASEP, AAFP); Controlled Substance Advisory Board; APCA; ASHNHA
Means: Public Meeting, Public Notice, and targeted outreach; alternatively, an Advisory Committee

Strategy 1.2 – Expand delegate access (e.g., Medical Assistants).

Audience: All registered utilizers of PDMP regardless of practice model
Suggested Ownership: DCCED;
Key Stakeholders: Professional societies reflective of registered utilizers of PDMP (e.g., ASMA, ASIPP, ASEP, AAFP); Controlled Substance Advisory Board; APCA; ASHNHA
Means: Legislative

Strategy 1.3 – Explore avenues for Electronic Health Record (EHR)/PDMP integration and identify funding sources to facilitate assistance and incentives to practice sites.

Audience: All registered utilizers of PDMP regardless of practice model
Suggested Ownership: DHSS, HHS

Key Stakeholders: Professional societies reflective of registered utilizers of PDMP (e.g., ASMA, ASIPP, ASEP, AAFP); APCA; ASHNHA; EHR Vendors; Practice Owners and Business Managers; AHEN

Means: Legislative, Federal and State

Strategy 1.4 – Engage federal and tribal healthcare entities to encourage 100% participation in PDMP reporting and utilization.

Audience: Federal health care organization, Tribal health organizations

Suggested Ownership: DCCED & DHSS

Key Stakeholders: Veterans Affairs; Department of Defense; Controlled Substance Advisory Board; APCA; ASHNHA

Means: Legislative

Strategy 1.5 – Require PDMP reporting and utilization by opioid treatment programs (OTP; 42 CFR Part 8) within the state of operation as part of accreditation and certification and remove barriers to clinical information sharing (42 CFR Part2).

Audience: Opioid Treatment Programs

Suggested Ownership: SAMHSA

Key Stakeholders: SAMHSA; Controlled Substance Advisory Board

Means: Legislative

Objective 2 – Provider Education: Increase providers' knowledge and subsequent incorporation of evidence-based medicine (EBM) guidelines for specific conditions and circumstances into practice (e.g., palliative care, hospice, peri-procedural, acute and chronic pain).

Strategy 2.1 – Formally adopt Washington State's AMDG Opioid Prescribing Guidelines (as updated from time to time) as state-wide practice standard.

Audience: Health professionals

Suggested Ownership: DCCED, Professional Boards

Key Stakeholders: Professional societies; Controlled Substance Advisory Board; APCA; ASHNHA

Means: Regulatory

Strategy 2.2 – Develop, support and maintain a state-specific sanctioned resource tool for Alaskan healthcare providers to include, but not limited to, sanctioned continuing education and adopted practice standards/guidelines.

Audience: Health professionals

Suggested Ownership: DCCED, Professional Boards; DHSS, Public Health; AHEC (funding)

Key Stakeholders: Professional societies; Controlled Substance Advisory Board; APCA; ASHNHA; DEA

Means: AHEC

Strategy 2.3 – Provide state-supported and sanctioned professional consultative resource to support prescribers with complex opioid management, i.e., peri-procedural, opioid tapering.

Audience: Health professionals

Suggested Ownership: DCCED, Professional Boards; AHEC

Key Stakeholders: Professional societies; Controlled Substance Advisory Board; APCA; ASHNHA

Means: Regulatory

Strategy 2.4 – Establishing a mechanism to assist prescribing professionals (i.e., MD, DO, PAC, APRN, DMD, etc.) who fall outside peer prescribing norms prior to licensure action, such as directed educational modules, peer resources, etc.

Audience: Health professionals
Suggested Ownership: DCCED, Professional Boards; AHEC
Key Stakeholders: Professional societies; APCA
Means: Legislative, Regulatory

Strategy 2.5 – Leverage lessons learned from other public health initiatives (e.g., antibiotic stewardship, ECHO, palliative care networks, etc.) to aid in the education of Alaskan health providers.

Audience: Health professionals
Suggested Ownership: DCCED, Professional Boards; DHSS, Public Health; AHEC
Key Stakeholders: Professional societies; APCA
Means: Grants; campaigns

Objective 3: Practice Model: Expand utilization of integrated care team models throughout the state.

Strategy 3.1 – Provide tools and incentives to practice sites to incorporate integrated care team models.

Audience: All registered utilizers of PDMP regardless of practice model
Suggested Ownership: DCCED, Professional Boards; DHSS, Public Health; AHEC (funding)
Key Stakeholders: Professional Societies reflective of registered utilizers of PDMP (e.g., ASMA, ASIPP, ASEP, AAFP); Controlled Substance Advisory Board; APCA; ASHNHA
Means: Grants

Strategy 3.2 – Provide sustainable reimbursement mechanisms to support integrated care team models and other evidence-based clinical coordination services.

Audience: Payers
Suggested Ownership: DCCED, Division of Insurance; DHSS, Division of Health Care Services
Key Stakeholders: Practice Owners and Business Managers; APCA; ASHNHA; AHEN
Means: Legislative, Regulatory

Strategy 3.3 – Strengthen and support retention of coverage of evidence-based alternative therapies demonstrated to reduce opioid utilization, such as rehabilitation services, as essential health benefits.

Audience: Payers
Suggested Ownership: DCCED, Division of Insurance;
Key Stakeholders: DHSS, Division of Health Care Services; APCA; ASHNHA; AHEN; Professional Societies including rehabilitative professionals and societies (e.g., APTA)
Means: Legislative, Regulatory

Strategy 3.4 – Support workforce development of supportive staff (e.g., health coaches, etc.) necessary for effective integrated care teams.

Audience: Workforce Development
Suggested Ownership: Department of Labor and Workforce Development; DHSS; AHEC
Key Stakeholders: DHSS; APCA; educational organizations; Practice owners and business managers
Means: Grants, Educational curriculum development; AMA “Steps Forward”

From: Carrillo, Laura N (CED)
To: Weigand, Megyn A (LAW); Chambers, Sara C (CED)
Cc: Lonergan, Patricia (CED)
Subject: RE: request for attorney assistance re:VET/PDMP Rx Searches
Date: Thursday, August 02, 2018 2:11:00 PM
Attachments: PDMP QA from Veterinary Board MAG edits.docx

Thank you, Megyn and Sara. I do recall the information in red being presented and discussed by the board of pharmacy back in November. Following this meeting, I forwarded the attached document to the VET board but am unsure of where it went from there. Since there remains confusion surrounding reviewing an owner's prescription history, I find the below recommendation particularly helpful and will emphasize this suggestion to both boards:

We recommend the Vet Board, in consultation with the Pharmacy Board, develop rules for entering prescriptions into the PDMP and rules for how to thoroughly check the PDMP. Until the Board issues guidance on how to input and check information on the PDMP, we recommend providers use their best judgment, check the owner's profile (or multiple owners if there are multiple owners), and report suspicious client requests or PDMP profiles to law enforcement and the PDMP Program Manager.

Thank you,

Laura Carrillo
Pharmacy Board Records & Licensing Supervisor
Prescription Drug Monitoring Program Manager
Telemedicine Business Registry Manager
CBPL - Professional Licensing
State of Alaska – DCCED
Board of Pharmacy/Telemedicine Phone: 907-465-1039
PDMP Phone: 907-269-8404
E-mail: laura.carrillo@alaska.gov
Fax: 907-465-2974

From: Weigand, Megyn A (LAW)
Sent: Thursday, August 02, 2018 12:28 PM
To: Chambers, Sara C (CED) <sara.chambers@alaska.gov>
Cc: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Subject: RE: request for attorney assistance re:VET/PDMP Rx Searches

Hi Sara,

That advice went to the Pharmacy Board December 1, 2017 after we discussed it at their meeting the day before (I think it was 11/30).

Megyn A. Weigand
Assistant Attorney General

From: Chambers, Sara C (CED)
Sent: Thursday, August 02, 2018 11:47 AM
To: Weigand, Megyn A (LAW) <megyn.weigand@alaska.gov>
Cc: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Subject: RE: request for attorney assistance re:VET/PDMP Rx Searches

Thank you, Megan. As always, your advice is thorough, contextual, and timely.

Could you provide the date the advice in red was provided to the Board of Pharmacy and to whom it was sent? This will help Laura look it up in the board minutes and gather any intel on their discussion prior to presenting to the Vet board.

Sara Chambers
Deputy Director

Alaska Division of Corporations, Business and Professional Licensing
P.O. Box 110806, Juneau, AK 99811-0806
commerce.alaska.gov/web/cbpl
Phone: (907) 465-2144
FAX: (907) 465-2974

From: Weigand, Megyn A (LAW)
Sent: Thursday, August 2, 2018 10:46 AM
To: Chambers, Sara C (CED) <sara.chambers@alaska.gov>
Cc: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Subject: RE: request for attorney assistance re:VET/PDMP Rx Searches

Greetings!

Question 1: Is the board required to adopt regulations to comply with AS 08.98.050(a)(11), or may they simply identify resources on potential drug diversion by pet owners and make them accessible on their web site.

The Board is not required to adopt regulations to identify resources and develop educational materials under AS 08.98.050(a)(11). Posting resources on the Board's website is a good start. Here are a few examples:

- I've attached a brochure Fairfax County Virginia developed for veterinarians.
- Here's a link to Colorado's Vet Board website where you can see the resources they posted https://www.colorado.gov/pacific/dora/Veterinary_News
- And here's a link to Maine's Vet Board website (check out the FAQs in the link on the right) https://www.maine.gov/dhhs/samhs/osa/data/pmp/veterinarians.htm

Question 2: Could you confirm that veterinarians are compelled to check the owner's—not the pet's—information in the PDMP prior to prescribing opioids to the animal?

I'm so glad this matter was referred to me because I've advised the Pharmacy Board on this same issue. I'm told that animals are entered into the PDMP but there are a few problems with that practice: 1) animals names can change, 2) animals aren't listed with last names, 3) the same animal may be listed multiple times, 4) birthdates aren't included, or are entered as 01/01/01.

As of today, this question cannot be answered with a simple Yes or No because not everyone is inputting data into the PDMP in the same way. Some clinics are putting in animals' info, some are putting in owners' info, some are putting in multiple owners' info. Using the owner's name is advisable as multiple providers and pharmacies can then check the same profile. We recommend the Vet Board, in consultation with the Pharmacy Board, develop rules for entering prescriptions into the PDMP and rules for how to thoroughly check the PDMP. Until the Board issues guidance on how to input and check information on the PDMP, we recommend providers use their best judgment, check the owner's profile (or multiple owners if there are multiple owners), and report suspicious client requests or PDMP profiles to law enforcement and the PDMP Program Manager.

Here's the question the Pharmacy Board received and our response in red.

Question: Am I required to research each owner before writing the prescription? -- many animals are under one name, but are presented by another for treatment, and still another for pick-up when they go home -- who do we research?

Answer: A practitioner is required to review the PDMP record of the "patient," but I see how this creates a loophole that could be abused. For example: A black lab is presented by a woman who claims to be the owner. The clinic documents that owner, reviews her history, and issues her a prescription for a controlled substance she then fills at a pharmacy that checks her history. A week later that same dog is presented by a man who claims to be the owner. The clinic documents that owner, reviews his history, and issues him a prescription for a controlled substance he then fills at a pharmacy that also checks his history. Another week goes by and a new woman appears and presents the same dog claiming to be its owner. The same thing happens. Each of the three "owners" has an unremarkable PDMP history, none of the prescriptions are cross-referenced, but now three times the amount of controlled substance has been collected by the band of "owners."

Veterinary clinics might be able to solve part of the problem by requiring one owner to be designated as the 'patient' for PDMP purposes. Any other owner who brings the animal in or picks it up would have to give the designated patient's name. Then all prescriptions issued to that animal show up under the same name. But this doesn't solve the problem of multiple people using an animal to secure multiple prescriptions who are able to evade the system. How can the animal be identified? Maybe a picture in the file?

We advise reaching out to the Veterinary Board to better understand the needs and challenges they face vis a vis the PDMP and request their suggestions on how to craft a solution.

One issue I noticed in the email thread – AS 08.98.050(a)(10) does require the Board to adopt a regulation.

This provision is a directive to the Board to require all licensees who have a federal DEA

number to register with the PDMP. The cleanest way to require licensees to register with the PDMP is with a regulation. AS 08.98.050(b) gives the Board authority to do what it has been directed to do by adopting regulations. Therefore, I suggest something like this –

"**12 AAC 68.905. Prescription Drug Monitoring Program Registration.** A licensee who has a federal Drug Enforcement Administration registration number shall register with the controlled substance prescription database under AS 17.30.200(o)."

Please let me know if you would like to discuss this advice or have additional questions. Thank you.

Megyn A. Weigand
Assistant Attorney General

From: Steinberg, Stacy K (LAW)
Sent: Wednesday, August 01, 2018 9:55 AM
To: Chambers, Sara C (CED) <sara.chambers@alaska.gov>; Cain, Rebecca (LAW) <rebecca.cain@alaska.gov>
Cc: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>; Weigand, Megyn A (LAW) <megyn.weigand@alaska.gov>
Subject: RE: request for attorney assistance re:VET/PDMP Rx Searches

Hi Sara,
AAG Megyn Weigand will review your questions and respond.
Stacy

From: Chambers, Sara C (CED)
Sent: Tuesday, July 31, 2018 3:06 PM
To: Steinberg, Stacy K (LAW) <stacy.steinberg@alaska.gov>; Cain, Rebecca (LAW) <rebecca.cain@alaska.gov>
Cc: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Subject: request for attorney assistance re:VET/PDMP Rx Searches

Dear Stacy/Rebecca:

Staff for the Board of Veterinary Examiners (Patricia Lonergan) and our Prescription Drug Monitoring Program Manager (Laura Carrillo) have requested that I pose the following questions to Law regarding mandates on the board and veterinarians pertaining to opioid education and misuse. These changes in statute are fairly recent; I've provided my opinion based on intimate involvement with the legislative hearings and drafting but, alas, I am not an attorney. (Backstory for Rebecca: I was DCCED's lead on SB74 and related opioid bills and worked with AAG Kraly who represented DHSS.)

These should not be too onerous:

Question 1: Is the board required to adopt regulations to comply with AS 08.98.050(a)(11), or may they simply identify resources on potential drug diversion by pet owners and make them accessible on their web site. (My understanding is that they do not need a regulation to accomplish this goal.)

Question 2: Could you confirm that veterinarians are compelled to check the owner's—not the pet's—information in the PDMP prior to prescribing opioids to the animal? (My understanding from statute (AS 17.30.200 and AS 08.98) and legislative testimony is that the PDMP is designed and enacted to track humans, and the potential for diversion lies with the human, not the pet. Therefore, veterinarians are mandated to look up owner—not pet—information prior to dispensing or prescribing a controlled substance.)

Please contact Laura, Patricia, or me to follow up on this. They are copied on this message.

Many thanks for your assistance,

Sara Chambers
Deputy Director

Alaska Division of Corporations, Business and Professional Licensing
P.O. Box 110806, Juneau, AK 99811-0806
commerce.alaska.gov/web/cbpl
Phone: (907) 465-2144
FAX: (907) 465-2974

From: Chambers, Sara C (CED)
Sent: Thursday, July 26, 2018 4:19 PM
To: Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>; Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Childress, Chelsea S (CED) <chelsea.childress@alaska.gov>
Subject: RE: VET/PDMP Rx Searches

AS 08.98.050(a)(10) doesn't require that the board adopt regulations, so if the board is fine with the statute being the only regulatory guidance (both in this chapter and the PDMP statute), then that's okay. Perhaps the board would benefit from seeing what other boards have adopted to implement their similar statute. If other boards are just reiterating statute in regulation, that's unnecessary.

AS 08.98.050(a)(11) states the board must "identify resources…"; however, it does not require them to do so in regulation. The question about checking the owner's info would be good to send to Law. I can also give my opinion based on legislative testimony that the owner is the subject of the required PDMP search prior to prescribing, but it would be preferable to have attorney advice.

Please remind me early next week if you haven't seen me send something to AAG Steinberg.

Sara Chambers
Deputy Director

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commerce.alaska.gov/web/cbpl
Phone: (907) 465-2144
FAX: (907) 465-2974

From: Lonergan, Patricia (CED)
Sent: Thursday, July 26, 2018 4:01 PM
To: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>; Childress, Chelsea S (CED) <chelsea.childress@alaska.gov>
Cc: Chambers, Sara C (CED) <sara.chambers@alaska.gov>
Subject: RE: VET/PDMP Rx Searches

Hi Laura,

It is my understanding that board did not believe it was necessary to create a regulation for AS 08.98.050(10). The Veterinary Board has not met since their Board Meeting in May, they meet again October 12, 2018. Currently there are no teleconferences scheduled.

RE: AS 08.98.050(11) During the May meeting the board Dr. Berngartt shared with the Board the AVMA resource site that was created to help Veterinarians with diversionary resources. That link is currently on the VET Board Web page under the PDMP fee notice, labeled Veterinary Resources & Educational Information. The Opioid Resources for Veterinarians link is within that box.

To my knowledge the Board has not requested a legal interpretation from law.

If you could provide me with the educational materials that you mentioned, I could forward that to the Board for review. It sounds like it would fit with the AVMA information that is currently on the website. When I send that out to the Board it would be an opportunity to inquire if the Board would be willing to schedule a conference call to review the information and review progress on tasks identified during the last board meeting, as well as, review if a legal interpretation from law is something they want to pursue.

Patricia Lonergan, Licensing Examiner

From: Childress, Chelsea S (CED)
Sent: Thursday, July 26, 2018 3:02 PM
To: Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Subject: FW: VET/PDMP Rx Searches

Hi Patricia,

If possible, would you please follow up with Laura's email before the PDMP meeting tomorrow at 11am?

Thank you,

Chelsea Childress
Records and Licensing Supervisor
Social Work, Marital & Family Therapy, and Naturopathy
chelsea.childress@alaska.gov
Corporations Business and Professional Licensing
P.O. Box 110806
Juneau, AK 99811-0806
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From: Carrillo, Laura N (CED)
Sent: Wednesday, July 25, 2018 8:09 AM
To: Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>; Childress, Chelsea S (CED) <chelsea.childress@alaska.gov>
Cc: Chambers, Sara C (CED) <sara.chambers@alaska.gov>
Subject: VET/PDMP Rx Searches

Hi Patricia/Chelsea,

In advance of the PDMP touch-base meeting on Thursday, could you let me know if the board has developed regulations to implement AS 08.98.050(a)(11) or have sought a legal interpretation since my last presentation to them in May? In revisiting this citation, I think "identify resources" in and of itself is the PDMP and "identify an owner who may be at risk..." translates to the ability to conduct a prescription history query on the owner of the animal. There's been some comments from vets that they're prohibited from looking up animal owners based on the limited owner information they're allowed to collect, but VET and PHA have similar prescription labeling requirements to include the animal owner's name, so my opinion is that since animal prescriptions are issued to the owner, it's okay to search their Rx history. If accurate with LAW's opinion, the development of educational materials piece could be easily created, i.e.: a VET manual on how to search a patients's owner with supporting documents relating to prescriptive guidelines. There's been some work done on this already, so they wouldn't have to re-invent the wheel entirely. I can assist as needed.

Thank you,

Laura Carrillo
Prescription Drug Monitoring Program Manager
Pharmacy Board Records & Licensing Supervisor
Telemedicine Business Registry Manager
DCCED - CBPL

State of Alaska

CONTACT:

Prescription Drug Monitoring Program (PDMP)
Phone: 907-269-8404
Email: akpdmp@alaska.gov

Board of Pharmacy
Phone: 907-465-1039
Email: laura.carrillo@alaska.gov

Telemedicine Business Registry (TBR)
Phone: 907-465-1039
Email: telemedicinebisinessregistry@alaska.gov

Sent from my iPhone

PDMP TEMPLATE FOR VET AND PHA RX SUBMISSIONS

(CAN BE USED AS A REFERENCE FOR CHECKING OWNER RX HISTORY)

PART I. PATIENT

PART II. PHARMACY

PART III. PRESCRIBER

PART IV. PRESCRIPTION

PART IV. DRUG

PART IV. PHARMACIST

PART IV. OTHER (DISPENSATION SURROGATES)

BOARD MEMBER NAME: _____

August 2, 2018 **DATE:** _____

PART I. PATIENT

Manual Submission Form

Patient

Patient Type:
Human Animal

Animal Name*

First Name*

Address*

ID Type

Middle Name

Address Line 2

ID Number

Last Name*

City*

Patient Location

DOB*
mm/dd/yyyy

State*
Select State

Phone Number

Gender*
Unknown

Postal Code*

NOTES:

PART II. PHARMACY

Pharmacy

Pharmacy Name*

Address*

Address Line 2

City*

State*

Select State

Postal Code*

Pharmacy DEA #*

Pharmacy NPI #

Pharmacy NCPDP #

Pharmacy Chain Site ID

Permit Number

Contact Name

Contact Phone

NOTES:

PART III. PRESCRIBER

Prescriber

First Name*	Address One	**Prescriber DEA #***
Middle Name	Address Two	Prescriber XDEA #
Last Name*	City	DEA Suffix
Phone Number	State Select State	Prescriber NPI #
	Postal Code	State License #

NOTES:

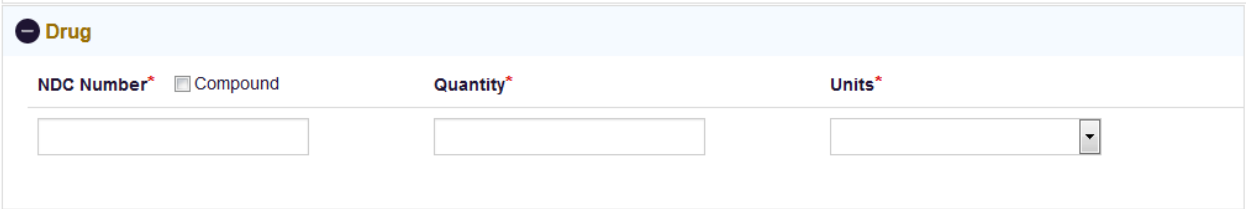
PART IV. PRESCRIPTION

Prescription

Prescription Number*	Electronic Rx Order #	**Payment Type***
Fill Date* mm/dd/yyyy	Electronic Rx Reference #	Date Sold mm/dd/yyyy
Written Date* mm/dd/yyyy	RxNorm Code Type	Rx Transmission Form
Refills*	RxNorm Code	Directions
Authorized Refills*	Rx Serial #	Treatment Type
Days Supply*	Rx Serial # Issuer	Diagnosis Code (ICD-10)
Partial Fill	Quantity Prescribed	

NOTES:

PART V. DRUG



NOTES:

PART VI. PHARMACIST

Pharmacist

First Name

Prescriber NPI #

Middle Name

State License #

Last Name

NOTES:

PART VII. OTHER

Other (Dispensation Surrogates)

First Name

Middle Name

Last Name

Patient Relationship

Drop-off/Pick-up Type

Drop-off/Pick-up ID #

NOTES:

Investigative Guidelines for PDMP

- Grace period for registering, e.g.: within 10 days of receiving a license?
- Grace period for renewing?

THE STATE of ALASKA

GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING

550 West Seventh Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Main: 907.269.8160
Text phone: 907.465.5437
Programs fax: 907.269.8195

MEMORANDUM

DATE: August 1, 2018

TO: Alaska Board of Pharmacy

THROUGH: Sonia Lipker, Senior Investigator

FROM: Brian Howes, Investigator

RE: Investigative Report for the Board of Pharmacy / August 30-31, 2018 Meeting

The following information was compiled as an investigative report to the Board for the period of May 7, 2018 through July 31, 2018. This report includes all investigations, complaints, and intake matters handled since the last report.

Matters opened by the Paralegal in Juneau, regarding continuing education audits and license action resulting from those matters are not covered in this report.

OPEN – 16

Case #	Violation	Case Status	Profession	Status Date
2018-000625	Violation of licensing regulation	Intake	PHARMACIST	06/06/18*
2018-000623	Violation of licensing regulation	Intake	PHARMACIST	06/14/18*
2018-000624	Violation of licensing regulation	Intake	PHARMACIST	06/14/18*
2018-000627	Violation of licensing regulation	Intake	PHARMACIST	06/14/18*
2018-000840	Violation of licensing regulation	Intake	PHARMACIST	06/14/18*
2018-000841	Violation of licensing regulation	Intake	PHARMACIST	06/14/18*
2018-000633	Violation of licensing regulation	Intake	PHARMACIST	06/18/18*
2018-000707	Unprofessional conduct	Intake	PHARMACIST	07/02/18
2018-000795	Unlicensed practice or activity	Intake	OUT OF STATE PHARMACY	07/16/18
2018-000839	Violation of licensing regulation	Intake	PHARMACIST	07/26/18*
2018-000846	Violation of licensing regulation	Intake	PHARMACIST	07/30/18*
2018-000850	Violation of licensing regulation	Intake	PHARMACIST	07/31/18*

*PDMP related

2017-000945	Fraud or misrepresentation	Complaint	OUT OF STATE PHARMACY	09/06/17
2018-000213	Unprofessional conduct	Complaint	PHARMACIST	05/21/18
2018-000628	Violation of licensing regulation	Complaint	PHARMACY	06/20/18
2018-000820	Negligence	Complaint	PHARMACIST	07/31/18

Closed - 12

Case #	Violation	Case Status	Profession	Status Date	Closure
2017-000659	License application problem	Closed-Intake	OUT OF STATE PHARMACY	05/17/18	Review Complete
2018-000626	Violation of licensing regulation	Closed-Intake	PHARMACIST	06/21/18	Review Complete*
2018-000653	Compliance Inspection	Closed-Intake	PHARMACY	06/26/18	Compliance
2018-000500	Unprofessional conduct	Closed-Intake	PHARMACIST	07/03/18	Incomplete Complaint
2018-000632	License application problem	Closed-Intake	DRUG ROOM	07/06/18	Review Complete
2018-000516	Compliance Inspection	Closed-Division Inspection	PHARMACY	05/24/18	Compliance
2018-000517	Compliance Inspection	Closed-Division Inspection	PHARMACY	05/24/18	Compliance
2018-000161	Violation of licensing regulation	Closed-Complaint	PHARMACIST	06/01/18	No Action - No Violation
2018-000109	Violating professional ethics	Closed-Complaint	PHARMACIST	06/04/18	No Action - No Violation
2017-000557	Unprofessional conduct	Closed-Investigation	PHARMACIST	05/24/18	License Action
2016-001338	Drug diversion	Closed-Investigation	PHARMACIST	07/11/18	No Action - Insufficient Evidence
2016-000938	Falsified application	Closed-Investigation	PHARMACY TECHNICIAN	07/27/18	License Lapsed - Flagged Do Not Renew

-End of Report-

*PDMP related

From: Chambers, Sara C (CED)
To: Carrillo, Laura N (CED)
Subject: RE: Cooperative Practice Agreements with Pharmacists
Date: Friday, May 25, 2018 3:26:29 PM

Please also evaluate how to include DHSS:

7 AAC 120.110. Covered outpatient drugs and home infusion therapy (d) The department will pay for vaccine administration if provided to a recipient under 21 years of age by a pharmacist whom the Board of Pharmacy has approved to exercise collaborative practice authority under 12 AAC 52.240. Payment for recipients 21 years of age or older is subject to 7 AAC 110.405(b)(2) and (3).

Sara Chambers
Deputy Director

Alaska Division of Corporations, Business and Professional Licensing
P.O. Box 110806, Juneau, AK 99811-0806
commerce.alaska.gov/web/cbpl
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From: Carrillo, Laura N (CED)
Sent: Friday, May 25, 2018 1:23 PM
To: Stovern, Debora J (CED) <debora.stovern@alaska.gov>; Bernth, Gail A (CED) <gail.bernth@alaska.gov>; Hoffard, Renee (CED) <renee.hoffard@alaska.gov>; Treston, Amber M (CED) <amber.treston@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Cc: Richard Holt <dokholt@mac.com>; Chambers, Sara C (CED) <sara.chambers@alaska.gov>; Maiquis, Jun C (CED) <jun.maiquis@alaska.gov>; Zinn, Sher K (CED) <sher.zinn@alaska.gov>
Subject: Cooperative Practice Agreements with Pharmacists

Hi all,

The PHA board intends to remove language in their regulations relating to cooperative practice agreements between practitioners and pharmacists. Specifically, they want to remove the requirement of board approval such that staff will simply receive and file these away. While this currently only affects the medical board (12 AAC 40.983(k) explicitly states that the agreement must be approved by the Board of Pharmacy), a practitioner may also include an advanced practice nurse with prescriptive authority, a veterinarian, optometrist, or dentist. Rich: if the intent is only to have

an agreement with physicians rather than any practitioner, this might need to be clarified in regulation since 'practitioner' is defined in AS 08.80.480(28) and AS 11.71.900(19) as being inclusive of others.

The PHA board will be revisiting this regulation project in the future, and at the suggestion of Sara, it was recommended that we include other practitioner boards in the loop. I did a quick skim of your program regulations to find language relating to cooperative practice agreements, but aside from MED, was unable to locate language specifically relating to agreements with pharmacists. Here's what I found:

Dental – 12 AAC 28.956 (relates to agreements between dental hygienists and dentists only)
Optometry – no language
Nursing – no language
Veterinary – no language

Please keep this on your radar. I'll follow-up after the PHA board has had some time to discuss.

Thank you,

Laura Carrillo
Pharmacy Board Records & Licensing Supervisor
Prescription Drug Monitoring Program Manager
Telemedicine Business Registry Manager
CBPL - Professional Licensing
State of Alaska – DCCED
Board of Pharmacy/Telemedicine Phone: 907-465-1039
PDMP Phone: 907-269-8404
E-mail: laura.carrillo@alaska.gov
Fax: 907-465-2974

Authority: AS 08.01.070 AS 08.64.326 AS 08.64.380
AS 08.64.100 AS 08.64.364 AS 17.30.200
AS 08.64.101

12 AAC 40.970. PROFESSIONAL INCOMPETENCE. As used in AS 08.64 and these regulations, "professional incompetence" means lacking sufficient knowledge, skills, or professional judgement in that field of practice in which the physician or physician assistant concerned engages, to a degree likely to endanger the health of his or her patients.

Authority: AS 08.64.100 AS 08.64.326

12 AAC 40.975. PRESCRIBING CONTROLLED SUBSTANCES. When prescribing a drug that is a controlled substance, an individual licensed under this chapter shall create and maintain a complete, clear, and legible written record of care that includes

(1) a patient history and evaluation sufficient to support a diagnosis;

(2) a diagnosis and treatment plan for the diagnosis;

(3) a plan for monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate;

(4) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.380

12 AAC 40.980. COLLABORATING PHYSICIAN. *Repealed 9/1/2007.*

12 AAC 40.981. FEDERAL LICENSURE EXEMPTIONS FOR PERSONS WHO PRACTICE IN AN ALASKA TRIBAL HEALTH PROGRAM. (a) A person who practices medicine, podiatry, or osteopathy, or who practices as a physician assistant or mobile intensive care paramedic, in a tribal health program in this state must be licensed by the board unless they notify the board that they are practicing under another license in accordance with 25 U.S.C. 1621t (sec. 221, Indian Health Care Improvement Act). Notice required under this section must be received no later than 14 days after employment at a tribal health program in this state, and must include

(1) proof of a current active license in another state;

(2) proof of employment by a tribal health program that is operating under an agreement with the federal Indian Health Service under 25 U.S.C. 450 – 458ddd-2 (Indian Self-Determination and Education Assistance Act).

(b) A person practicing under the exemption may not practice beyond the scope of the other state license.

Authority: AS 08.64.107 AS 08.64.170 AS 08.64.313

12 AAC 40.983. COOPERATIVE PRACTICE AGREEMENTS WITH PHARMACISTS. (a) A physician may enter into a cooperative practice agreement with a pharmacist licensed under AS 08.80 as provided in this section. The initial agreement may not exceed two years and is subject to renewal under (j) of this section.

(b) A physician planning to enter into a cooperative practice agreement with a pharmacist must submit to the board a written proposed agreement that meets the requirements of this section. The proposed agreement must be approved by the board before cooperative practice under the agreement, if approved, begins. A proposed modification to an agreement must be submitted to the board for approval, before the modification, if approved, is implemented. The board will approve a proposed agreement or modification if it is medically appropriate and provides for the safety of the patient. If the board disapproves a proposed agreement or modification, the board shall state the reasons for its action.

(c) A cooperative practice agreement between a physician and a pharmacist must include

(1) the physician's authorization to a pharmacist or group of pharmacists to manage a patient's medication therapy;

(2) the full name, medical license number, date of issuance of license, and specialty, if any, of each physician who is a party to the agreement;

(3) the full name, place of employment, mailing address, pharmacist license number, and date of issuance of license, of each pharmacist who is a party to the agreement;

(4) a statement of the duration of the agreement, which may not exceed two years;

(5) the types of cooperative practice decisions that the physician is authorizing the pharmacist to make under the agreement, including

(A) types of diseases, medications, or medication categories involved and the type of cooperative authority to be exercised in each case; and

(B) procedures, decision criteria, or plans the pharmacist must follow when making therapeutic decisions, particularly when initiating or modifying medication;

(6) requirements that a pharmacist must follow when exercising cooperative authority, including documentation of decisions made, and a plan for communication and feedback to the physician concerning specific decisions made;

(7) a plan for the physician to review the decisions made by the pharmacist at least once every three months;

(8) a plan for providing to the physician patient records created under the agreement;

(9) a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate;

(10) an acknowledgement that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement;

(11) a prohibition on the administration or dispensing of any schedule I, II, III, or IV controlled substances.

(d) The physician, or a physician assistant under the supervision of the physician, must physically examine and evaluate a patient before that patient may be included under a cooperative practice agreement to which that physician is a party. The physician must issue a prescription or medication order for each patient valid for up to one year. The physician, or a physician assistant under the supervision of the physician, must conduct a physical examination of a patient at least once a year while that patient is included under a cooperative practice agreement to which that physician is a party. The requirements of this subsection do not apply to a cooperative practice agreement allowing the administration of emergency contraception, immunizations of persons 18 years of age or older, and those immunizations recommended to be given on a yearly basis by the United States Department of Health and Human Services Centers for Disease Control and Prevention.

(e) Only a physician in active practice in this state may enter into a cooperative practice agreement under this section. An authority authorized by a physician must be within the physician's current scope of practice.

(f) A physician who enters into a cooperative practice agreement shall keep a copy of the written agreement and the records of all patients treated under it during the period of the agreement. The physician shall retain the agreement and records required by this subsection for at least seven years after the termination of the agreement.

(g) A cooperative practice agreement is terminated upon written notice by either the physician or the pharmacist. The physician shall notify the board in writing within 30 days after an agreement is terminated.

(h) The board may periodically review cooperative practice agreements approved under this section.

(i) The requirements of this section do not apply to cooperative practice agreements adopted by the physicians on medical staff of a hospital or nursing facility licensed under AS 47.32 for treatment of patients of that facility.

(j) The physician may seek renewal of a cooperative practice agreement for additional two-year periods.

(k) Notwithstanding the requirements of (b) of this section, a physician who, before the effective date of this section, has entered into a collaborative practice agreement with a pharmacist that has been approved by the Board of Pharmacy under 12 AAC 52.240 and is still current, must obtain the board's approval of that agreement under this section within six months after this section takes effect. After that time, a physician may not participate in a cooperative practice agreement with a pharmacist except as allowed under this section.

(*l*) In this section, "cooperative practice agreement" means an agreement between a physician and a pharmacist by which a physician authorizes the pharmacist to manage a patient's medication therapy as specified in the agreement.

Authority: AS 08.64.100 AS 08.64.326

12 AAC 40.985. GENERAL ANESTHETIC. A commercially prepared mixture of 50 percent oxygen and 50 percent nitrous oxide, when self-administered by a patient as a part of the outpatient care provided by a licensed podiatrist, is an analgesic and not a general anesthetic referred to in AS 08.64.380(9)(B).

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.380(9)

12 AAC 40.986. WITHDRAWAL OF APPLICATION. (a) An application for a permit or license may be withdrawn from consideration by the board at the applicant's request. To withdraw an application, the applicant must submit a request for withdrawal in writing signed by the applicant. The request for withdrawal must be received by the division no later than five business days before the board's meeting where the application is to be initially considered.

(b) The board will not approve a request for the withdrawal of an application under this section for an application that has been reviewed and considered by the board, or considered abandoned under 12 AAC 02.910.

(c) An application approved for withdrawal under this section will be reported to the Federation of State Medical Boards's Board Action Data Bank.

(d) An application that is approved for withdrawal under this section will be retained on file in the department for at least 10 years after the date of withdrawal and will be returned to the board if the applicant reapplies for a permit or license.

Authority: AS 08.64.100

12 AAC 40.987. RETENTION OF ABANDONED APPLICATIONS. (a) An application that is abandoned under 12 AAC 02.910 will be retained on file in the department for at least 10 years after the date of abandonment.

From: Carrillo, Laura N (CED)
To: Bernth, Gail A (CED)
Subject: RE: Cooperative Practice Agreements with Pharmacists
Date: Monday, August 27, 2018 5:17:00 PM

Thank you, Gail. Are you aware the pharmacists have been arranging collaborative practice agreements with NUR licensees?

Thank you,

Laura Carrillo
DCCED – CBPL – Program Coordinator I
Prescription Drug Monitoring Program | Board of Pharmacy |
Telemedicine Business Registry
PDMP Phone: 907-269-8404 | Pharmacy/TBR: 907-465-1039
PDMP Email: akpdmp@alaska.gov | Email: laura.carrillo@alaska.gov
Fax: 907-465-2974

From: Bernth, Gail A (CED)
Sent: Monday, August 27, 2018 4:19 PM
To: Carrillo, Laura N (CED) <laura.carrillo@alaska.gov>
Subject: RE: Cooperative Practice Agreements with Pharmacists

The Board of Nursing does not have any cooperative/collaborative practice agreements and have none planned in the future.

Gail

Gail Bernth MSN, APRN
Executive Administrator
Alaska Board of Nursing

From: Carrillo, Laura N (CED)
Sent: Wednesday, August 15, 2018 1:03 PM
To: Stovern, Debora J (CED) <debora.stovern@alaska.gov>; Bernth, Gail A (CED) <gail.bernth@alaska.gov>; Hoffard, Renee (CED) <renee.hoffard@alaska.gov>; Treston, Amber M (CED) <amber.treston@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>; Childress, Chelsea S (CED) <chelsea.childress@alaska.gov>
Cc: Chambers, Sara C (CED) <sara.chambers@alaska.gov>; Maiquis, Jun C (CED) <jun.maiquis@alaska.gov>; Zinn, Sher K (CED) <sher.zinn@alaska.gov>; Kautz, Colleen K (CED) <colleen.kautz@alaska.gov>
Subject: RE: Cooperative Practice Agreements with Pharmacists

Hi all,

Please provide a quick update as to whether your board (other than MED) have since addressed cooperative/collaborative practice agreements or whether there are plans to do so in the future.

Thank you,

Laura Carrillo
Pharmacy Board Records & Licensing Supervisor
Prescription Drug Monitoring Program Manager
Telemedicine Business Registry Manager
CBPL - Professional Licensing
State of Alaska – DCCED
Board of Pharmacy/Telemedicine Phone: 907-465-1039
PDMP Phone: 907-269-8404
E-mail: laura.carrillo@alaska.gov
Fax: 907-465-2974

From: Carrillo, Laura N (CED)
Sent: Friday, May 25, 2018 1:23 PM
To: Stovern, Debora J (CED) <debora.stovern@alaska.gov>; Bernth, Gail A (CED) <gail.bernth@alaska.gov>; Hoffard, Renee (CED) <renee.hoffard@alaska.gov>; Treston, Amber M (CED) <amber.treston@alaska.gov>; Lonergan, Patricia (CED) <patricia.lonergan@alaska.gov>
Cc: 'Richard Holt' <dokholt@mac.com>; Chambers, Sara C (CED) <sara.chambers@alaska.gov>; Maiquis, Jun C (CED) <jun.maiquis@alaska.gov>; Zinn, Sher K (CED) <sher.zinn@alaska.gov>
Subject: Cooperative Practice Agreements with Pharmacists

Hi all,

The PHA board intends to remove language in their regulations relating to cooperative practice agreements between practitioners and pharmacists. Specifically, they want to remove the requirement of board approval such that staff will simply receive and file these away. While this currently only affects the medical board (12 AAC 40.983(k)) explicitly states that the agreement must be approved by the Board of Pharmacy), a practitioner may also include an advanced practice nurse with prescriptive authority, a veterinarian, optometrist, or dentist. Rich: if the intent is only to have an agreement with physicians rather than any practitioner, this might need to be clarified in regulation since 'practitioner' is defined in AS 08.80.480(28) and AS 11.71.900(19) as being inclusive of others.

The PHA board will be revisiting this regulation project in the future, and at the suggestion of Sara, it was recommended that we include other practitioner boards in the loop. I did a quick skim of your program regulations to find language relating to cooperative practice agreements, but aside from MED, was unable to locate language specifically relating to agreements with pharmacists. Here's what I found:

Dental – 12 AAC 28.956 (relates to agreements between dental hygienists and dentists only)
Optometry – no language
Nursing – no language
Veterinary – no language

Please keep this on your radar. I'll follow-up after the PHA board has had some time to discuss.

Thank you,

Laura Carrillo
Pharmacy Board Records & Licensing Supervisor
Prescription Drug Monitoring Program Manager
Telemedicine Business Registry Manager
CBPL - Professional Licensing
State of Alaska – DCCED
Board of Pharmacy/Telemedicine Phone: 907-465-1039
PDMP Phone: 907-269-8404
E-mail: laura.carrillo@alaska.gov
Fax: 907-465-2974

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development

BOARD OF PHARMACY

P.O. Box 110806
Juneau, AK 99811-0806
Main: 907.465.2589
Fax: 907.465.2974

August 9, 2018

FRED MEYER PHARMACY #00485
3755 AIRPORT WAY
FAIRBANKS, AK 99709

Collaborative Practice Agreement #: 130577

Dear Facility,

This letter is to inform you that the **collaborative practice agreement** application submitted under the authority of the Alaska State Medical Board (12 AAC 40.983) and the Alaska Board of Pharmacy (12 AAC 52.240) for the purpose of **immunization** initiations or modifications was **approved** by the Board of Pharmacy during the **July 20 – August 3, 2018** application review period. The agreement, **#130577**, is effective **08/09/2018** through **08/09/2020** and is enclosed in this letter.

Please note: Collaborative practice agreements are valid for two years from the date of issuance. A notice of termination of an existing collaborative practice agreement must be submitted to the board within 30 days of the termination.

Collaborative Practice Summary:

Pharmacy	License #	Pharmacist(s)	Practitioner(s)	Type
Fred Meyer Pharmacy #00485	PHAR391	Marshall Heaster	Leanne Mercier	Immunizations

The Board of Pharmacy endeavors to promote, preserve, and protect the public health, safety, and welfare by and through the effective control and regulation of the practice of pharmacy. In renewing your license, please keep these principles in mind and adhere to all applicable provisions in AS 08.80 and 12 AAC 52.

Sincerely,

Alaska Board of Pharmacy | Email: boardofpharmacy@alaska.gov | Phone: 907-465-2550

Stale Pharmacist Applications

Regulation(s): 12 AAC 52.090(f)(g)

Observation: The only language addressing re-applying for licensure pertains to passing the NAPLEX exam. 12 AAC 52.090(f) doesn't address having to re-apply for licensure if the MPJE exam isn't passed within one year, but does provide for continuous attempts to retake the exam. 12 AAC 52.090(f) assumes the NAPLEX exam will be passed but does address not address what an applicant must do if the exam results in a failed score.

Issue: This allows an individual who hasn't passed the NAPLEX or MPJE exam to make infinite attempts to become licensed with no limit on the maximum number re-examinations. Centralized regulations only address abandoned applications, which is defined as 12 months having elapsed since the date the last correspondence was received from or on behalf of an application; this does not address applicants that maintained communication regarding their application status but have not yet met all the requirements to become licensed.

Scenario: An individual submits an initial application for pharmacist licensure and is approved to take the MPJE exam. Within one year of applying, the applicant does pass the MPJE but does not pass the NAPLEX exam. After more than one year has passed without passing the NAPLEX, the applicant has to re-take the MPJE exam as directed by 12 AAC 52.090(f) and passes with flying colors. By this time, it has been 1.5 years since submitting the initial application, and there have already been two failed attempts at completing the NAPLEX exam. Another year passes and the applicant retakes the MPJE again as directed but still doesn't pass the NAPLEX exam. Still, the applicant is dedicated to obtaining an Alaska pharmacist license, so continues to take and pass the MPJE 3 more times but still does not pass the NAPLEX exam. At what point is the applicant told they have to reapply for licensure?

Suggestion: Include language addressing reapplying for licensure if all requirements are not met within _____ months.

12 AAC 52.090. EXAMINATION REQUIREMENTS AND REGISTRATION. (a) In addition to the requirements in AS 08.80.110, an applicant for a pharmacist license shall pass the

(1) North American Pharmacy licensing examination (NAPLEX) administered by the National Association of Boards of Pharmacy with a NAPLEX scaled score of 75 or above; and

(2) Alaska pharmacy jurisprudence examination with a scaled score of 75 or above.

(b) An applicant for a temporary pharmacist license shall pass the Alaska pharmacy jurisprudence examination with a scaled score of 75 or above.

(c) An applicant for a pharmacist license that has passed the NAPLEX examination in another licensing jurisdiction shall make arrangements for the National Association of Boards of Pharmacy to send verification of examination scores directly to the department.

(d) An applicant for licensure by examination must submit an application under 12 AAC 52.070 and be approved under 12 AAC 52.092 before sitting for examination under this section.

(e) An applicant who has failed the Alaska pharmacy jurisprudence examination specified in (f) of this section may not retake the examination for at least 30 days.

(f) The Multistate Pharmacy Jurisprudence Examination administered by the national Association of Boards of Pharmacy (NABP) is the examination adopted by the board as the Alaska pharmacy jurisprudence examination. An applicant shall satisfy all other license requirements within one year after passing the Alaska pharmacy jurisprudence examination or retake the examination.

(g) An applicant applying for a pharmacy license by examination shall make application within one year of successfully passing the NAPLEX. An applicant applying more than one year after passing the NAPLEX shall retake the NAPLEX or apply for a pharmacy license under AS 08.80.145.

New section for Out-of-State Pharmacists?

- Not a separate license category
- Same requirements as in AS 08.80.110 and 12 AAC 52.70/95
- Purpose is only to determine:
    - which pharmacists are living outside of the State (currently there are 429 or 42% with out-of-state addresses)
    - which pharmacists are *required* to be registered with the PDMP and pay the fees (registration requirement only applies to pharmacists dispensing federally scheduled II – IV controlled substances in Alaska).

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Interstate Data Sharing

- Alaska already signed MOU with NABP's InterConnect in 2015, but the approval process is still unclear.
- Recommendation: codify LAW's opinion
    - LAW opined that AS 17.30.200(d)(3)(4) allows pharmacists and practitioners not licensed in Alaska to have access to our database, so long as they hold a license in another state.
    - New Section: "12 AAC 52.860(f): A dispenser or practitioner not licensed or registered under AS 08 may receive information from the database through multi-state agreements signed and executed by the department."

Photo Identification for Picking up Rx

- DEA addresses photo ID laws but none in 12 AAC 52
- Continue to receive inquiries from concerned individuals about no state ID law
- Feedback from dispensers saying this should be a requirement
- Don’t think it would require statute change’ 12 AAC 52.875 already addresses photo ID, but for purpose of obtaining prescription history from PDMP. Why wouldn’t we require photo ID before obtaining the Rx?

(1) date of issue of the prescription;
(2) address of the patient;
(3) strength of the drug prescribed;
(4) drug dosage form;
(5) drug quantity prescribed;
(6) directions for use;
(7) DEA registration number.

(d) After oral consultation with the prescribing practitioner, a pharmacist may modify the types of information described in (c)(2) – (7) of this section. However, any modification to the information concerning drug quantity must be limited to strength of the drug prescribed and may not result in an increase in the original total dosage prescribed.

(e) A pharmacist may not change the name of non-generic drugs, the name of the patient, or the signature of the practitioner.

Authority: AS 08.80.005 AS 08.80.030

12 AAC 52.470. REFILLS. (a) A pharmacist may dispense a refill of a prescription drug order only in accordance with the prescribing practitioner's authorization as indicated on the prescription drug order. If there are no refill instructions on the prescription drug order, or if all refills authorized on the original prescription drug order have been dispensed, a pharmacist shall obtain authorization from the prescribing practitioner before dispensing a refill.

(b) A pharmacist may not dispense a refill of a prescription drug order for a noncontrolled substance after one year from the date of issue of the original prescription drug order.

(c) Each time a prescription drug order is dispensed, the pharmacist shall record the refill electronically or on the back of the prescription drug order by listing the date of dispensing, the written initials or identification code of the dispensing pharmacist, and the amount dispensed if different from the quantity on the original prescription drug order.

(d) If an original prescription drug order is prescribed as a 30-day supply, the pharmacist may dispense up to a 100-day supply on refills if the

(1) total quantity of dosage units dispensed does not exceed the total quantity of dosage units authorized by the prescriber on the prescription, including refills;
(2) drug is not a federal or state scheduled controlled substance; and
(3) the pharmacist is exercising professional judgment.

(e) To indicate that an increased supply may not be dispensed under this section, a prescriber may indicate "no change to quantity", or words of similar meaning, on the prescription drug order.

(f) Nothing in this section requires a health care service plan, health insurer, workers' compensation insurance plan, pharmacy benefits manager, or any other person or entity, including a state program or state employer, to provide coverage for a drug in a manner inconsistent with a beneficiary's plan benefit.

Authority: AS 08.80.005 AS 08.80.030

12 AAC 52.480. LABELING. One or more labels containing the following information shall be affixed to every container in which a prescription drug order is dispensed:

(1) name, address, and phone number of the dispensing pharmacy;
(2) unique identification number of the prescription drug order;
(3) date the prescription drug order is dispensed;
(4) initials of the dispensing pharmacist;
(5) name of the prescribing practitioner;
(6) name of the patient or, if the drug was prescribed for an animal, the species of animal and the name of the owner;
(7) directions for use;
(8) quantity dispensed;
(9) appropriate ancillary instructions or cautions;
(10) if the prescription drug order is for a schedule II-V controlled substance, the statement, "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed";
(11) the name and strength of the actual drug product dispensed, unless otherwise directed by the prescribing practitioner; and
(12) the accepted generic drug name and strength of the drug dispensed; if the drug product dispensed has multiple ingredients, the pharmacist shall provide this information in writing to the patient or the patient's agent.

Authority: AS 08.80.005 AS 08.80.295 AS 08.80.480
AS 08.80.030

12 AAC 52.490. PRESCRIPTIONS BY ELECTRONIC TRANSMISSION. (a) Legend drug and controlled substance prescriptions may be transmitted electronically under this section, consistent with state and federal laws.

A pharmacist may dispense a prescription transmitted electronically under this section only if the prescribing practitioner includes the following information on the prescription before it is transmitted:

(1) name, address, and telephone number of the prescribing practitioner;

(2) electronic signature or manual signature of the prescribing practitioner;

(3) the information required in 12 AAC 52.460(a)(1) - (8); and

(4) any other information required by federal law.

(b) A pharmacist may dispense a prescription that has been received electronically.

(c) The system for electronic transmission of prescriptions must address the following:

(1) patient's choice of pharmacy; the system may not restrict the patient's choice of pharmacy;

(2) security of the system; the system must have security and system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription information; the system must include

(A) documented formal procedures for selecting and executing security safeguards;

(B) physical safeguards to protect computer systems and other applicable equipment from an unauthorized access, modification, or manipulation of the information;

(C) processes to protect, control, and audit access to confidential patient information; and

(D) processes to prevent unauthorized access to the prescription information when transmitted electronically;

(3) confidentiality of patient information; the system must maintain the confidentiality of patient information consistent with state and federal laws;

(4) authentication; to be valid prescriptions transmitted by an authorized prescriber or the prescribing practitioner's authorized agent from computer to a facsimile machine or from computer to computer must use an electronic signature; the prescribing practitioner's system must authenticate the sender's authority and credentials to transmit a prescription to a pharmacy and

(A) the prescribing practitioner's system must provide an audit record of all prescriptions electronically transmitted that documents for retrieval all actions and persons who have acted on a prescription, including authorized delegation of transmission;

(B) the right of the board to access the prescribing practitioner's electronically transmitted prescriptions for purposes of investigations;

(5) a prescribing practitioner's system that utilizes intermediaries in the electronic communication of prescriptions to pharmacies is responsible to ensure that the contracts with the intermediaries require security measures that are equal to or better than those provided by this section and prohibit the modification of a record of a prescription after it has been transmitted by the prescribing practitioner to the pharmacist;

(6) if a paper copy prescription that is generated by the pharmacist or pharmacy technician from the electronic prescription system is printed, an electronic signature may be substituted for a manual signature;

(7) the system must maintain the integrity and confidentiality of patient information transmitted electronically for its system as required by this chapter, other state law, and federal law.

(d) In this section,

(1) "electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a prescription and executed or adopted by an authorized person with the intent to sign the prescription;

(2) "electronic transmission of prescriptions" means the communication from an authorized prescribing practitioner or the prescribing practitioner's authorized agent to a pharmacy of the patient's choice, by computer, by the transmission of an exact visual image of a prescription by facsimile, or by other electronic means other than electronic voice communication, of original prescription information or prescription refill information for a legend drug or controlled substance consistent with this section, other state law, and federal law;

(3) "security" means a system to maintain the confidentiality and integrity of prescription information, including

(A) documented formal procedures for selecting and executing security safeguards;

(B) physical safeguards to protect computer systems and other pertinent equipment from unauthorized access, modification, or manipulation of the information;

(C) processes to protect, control and audit access to confidential patient information; and

(D) processes for its system to prevent unauthorized access to the prescription information when transmitted electronically.

Authority: AS 08.80.005 AS 08.80.030

12 AAC 52.500. TRANSFER OF A PRESCRIPTION DRUG ORDER. (a) For the purpose of dispensing a refill of a prescription drug order, original prescription drug order information may be transferred between pharmacies if the requirements of 12 AAC 52.460 and this section are met.

(b) Original prescription drug order information for controlled substances listed in schedules III, IV, or V may be transferred only by the pharmacy that originally received the prescription drug order from the prescribing practitioner. The transfer must be communicated directly between two licensed pharmacists.

NABP
National Association of Boards of Pharmacy
www.nabp.pharmacy

1600 Feehanville Drive
Mount Prospect, IL 60056
T) 847/391-4406
F) 847/375-1114

TO: EXECUTIVE OFFICERS – MPJE Jurisdictions

FROM: Maureen Garrity, Competency Assessment Director

DATE: July 5, 2018

RE: 2018 MPJE State-Specific Review and Pre-test Item Selection

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The National Association of Boards of Pharmacy® (NABP®) will host the Multistate Pharmacy Jurisprudence Examination® (MPJE®) State-Specific Review on September 6-7, 2018. The purpose of the review is to ensure that the most current and valid items are available for testing in each of the jurisdictions. In addition to the review, new items must be selected for pre-testing in each jurisdiction. Both the review and selection of new items are integral to the validity and the sustainability of the examination program.

The tentative meeting schedule is (all times are CDT):

Thursday, September 6: 8:30 AM - 4:30 PM (Group dinner to follow)
Friday, September 7: 8:30 AM - 4 PM

NABP will reimburse approved expenses (travel, food, and lodging) for up to two participants from each jurisdiction to attend the review. However, NABP may need to limit the attendance from any jurisdiction to one participant if responses exceed space and resource limitations.

If your jurisdiction chooses to conduct the review and new item selection remotely, the item pools will be available on a password-protected, secure website. We encourage your designated remote reviewers to schedule specific days and times to complete the review, just as if they were traveling to the NABP office. NABP will send complete details to the designated remote reviewers in mid-August.

Reviewers will also be responsible for selecting new items to pre-test. These new items were developed in spring 2018, and have been reviewed, edited, and coded by the MPJE Review Committee.

Please provide contact information on the response form for the individual(s) you designate to attend the workshop or who will remotely complete the state assignment. Please email the form directly to MPJE@nabp.pharmacy by July 13, 2018. The NABP Meeting Services department will forward travel and hotel information to designees approximately six weeks prior to the meeting. Detailed instructions will be sent to those individuals designated as reviewers prior to the start of the remote review window.

Feel free to contact me at mgarrity@nabp.pharmacy, or Anne Woolridge at awoolridge@nabp.pharmacy.

Attachment: 2018 MPJE State-Specific Review Participant Form

cc: NABP Executive Committee
Carmen A. Catizone, Executive Director/Secretary

Controlled Substance Advisory Committee (CSAC) Meeting
July 16, 2018

Update from Lana Bell (Chair effective 09/26/18):

- Letter to the Committee - from a provider in Anchorage who is concerned about a situation regarding "forged" prescriptions for controlled substances. The group decided that the provider's concern was a Board of Pharmacy matter and should be forwarded to the Board of Pharmacy. Rob Henderson will be sending it to us.
- Kratom- APD is concerned that it will become a problem in Anchorage and wanted to know if we could help. We determined that the only thing we can do at this time is track usage. There were a number of ideas, the best being testing folks for Kratom when they visit the ER for one month. In about 18 months, test again to see if there is an increase in users. Law enforcement will look into the issue further and see if there are funding sources, etc. We will discuss again at a future meeting.

Board of Pharmacy
Schedule of Revenues and Expenditures

	FY 12	FY 13	FY 14	FY 15	FY16	FY17	FY18 1st - 3rd Qtr
Licensing Revenue	$ 500,238	$ 159,341	$ 673,100	$ 269,646	$ 802,230	$ 208,755	$ 128,879
Allowable Third Party Reimbursement	-	-	1,701	-	-	3,256	$ 210
Total Revenue	500,238	159,341	674,801	269,646	802,230	212,011	129,089
Direct Expenditures							
Personal Services	162,493	158,574	182,280	164,266	225,050	215,674	174,877
Travel	15,713	18,850	24,054	24,548	16,676	11,119	10,522
Contractual	19,799	11,798	24,633	9,149	14,812	41,331	100,186
Supplies	1,385	365	69	90	111	519	-
Equipment	-	-	-	-	-	-	-
Total Direct Expenditures	199,390	189,587	231,036	198,053	256,649	268,643	285,585
Indirect Expenditures*	213,722	228,785	197,912	145,863	192,296	222,916	167,187
Total Expenses	413,112	418,372	428,948	343,916	448,945	491,559	452,772
Annual Surplus (Deficit)	87,126	(259,031)	245,853	(74,270)	353,285	(279,548)	(323,683)
Beginning Cumulative Surplus (Deficit)	201,801	288,927	29,896	275,749	201,479	554,764	275,216
Ending Cumulative Surplus (Deficit)	$ 288,927	$ 29,896	$ 275,749	$ 201,479	$ 554,764	$ 275,216	$ (48,467)

** For the first three quarters, indirect costs are based on the prior fiscal year's total indirect amount on a percent of year completed basis.
The 4th quarter board reports reflect the current year's actual indirect expenses allocated to the boards.

Appropriation	(All)
Sub Unit	(All)
Activity Code	PHA1

Sum of Expenditures Object Code	Object Name	Object Type Code 1000 - Personal Services	2000 - Travel	3000 - Services	Grand Total
1011	Regular Compensation	87,527.75			87,527.75
1014	Overtime	10.05			10.05
1023	Leave Taken	9,918.36			9,918.36
1028	Alaska Supplemental Benefit	6,164.33			6,164.33
1029	Public Employee's Retirement System Defined Benefits	9,993.94			9,993.94
1030	Public Employee's Retirement System Defined Contribution	2,832.14			2,832.14
1034	Public Employee's Retirement System Defined Cont Health Reim	2,230.92			2,230.92
1035	Public Employee's Retiremnt Sys Defined Cont Retiree Medical	565.40			565.40
1037	Public Employee's Retiremnt Sys Defined Benefit Unfnd Liab	6,445.30			6,445.30
1039	Unemployment Insurance	305.88			305.88
1040	Group Health Insurance	27,082.06			27,082.06
1041	Basic Life and Travel	41.25			41.25
1042	Worker's Compensation Insurance	970.37			970.37
1047	Leave Cash In Employer Charge	2,316.63			2,316.63
1048	Terminal Leave Employer Charge	1,203.38			1,203.38
1053	Medicare Tax	1,372.14			1,372.14
1069	SU Business Leave Bank Contributions	97.99			97.99
1077	ASEA Legal Trust	142.48			142.48
1079	ASEA Injury Leave Usage	16.81			16.81
1080	SU Legal Trst	30.82			30.82
1970	Personal Services Transfer	15,609.33			15,609.33
2000	In-State Employee Airfare		320.78		320.78
2001	In-State Employee Surface Transportation		20.00		20.00
2002	In-State Employee Lodging		398.00		398.00
2003	In-State Employee Meals and Incidentals		150.00		150.00
2005	In-State Non-Employee Airfare		2,159.53		2,159.53
2007	In-State Non-Employee Lodging		4,128.00		4,128.00
2008	In-State Non-Employee Meals and Incidentals		1,650.00		1,650.00
2009	In-State Non-Employee Taxable Per Diem		202.00		202.00
2010	In-State Non-Employee Non-Taxable Reimbursement		908.09		908.09
2012	Out-State Employee Airfare		375.87		375.87
2970	Travel Cost Transfer		210.18		210.18
3000	Training/Conferences			745.00	745.00
3001	Test Monitor/Proctor			-	-
3005	Management/Consulting			-	-
3030	Information Technology Consulting			90,902.12	90,902.12
3035	Long Distance			221.53	221.53
3044	Courier			14.20	14.20
3045	Postage			43.77	43.77
3046	Advertising			1,237.11	1,237.11
3057	Structure, Infrastructure and Land - Rentals/Leases			57.62	57.62
3069	Commission Sales			63.00	63.00
3088	Inter-Agency Legal			6,901.84	6,901.84
Grand Total		**174,877.33**	**10,522.45**	**100,186.19**	**285,585.97**

REPORT OF THEFT OR LOSS OF CONTROLLED SUBSTANCES

Federal regulations require registrants to submit a detailed report of any theft or loss of controlled substances to the Drug Enforcement Administration. This form is filled out consistent with your entries in the fields on the previous pages. You should print this form and save it for your records. This form was submitted through the Internet, please do NOT send a copy to DEA.

OMB APPROVAL No. 1117-0001 Expires 9/30/2017

1. Name and Address of Registrant

CARR-GOTTSTEIN FOODS, CO.
5600 DEBARR ROAD
SUITE 8
ALASKA MANAGED CARE PHARMACY #1829
ANCHORAGE , AK 99504

2. Phone No. When Submitted

Amendment Key / Date Submitted

2H3JTDEIFODW / 06-05-2018 17:36:56

3. DEA Registration Number

BA4059514

4. Date of Theft / Loss

May 10, 2018 Amendment # 0

5. Registrant's Principal Business

CHAIN PHARMACY

6. Registrant's County

ANCHORAGE

7. Theft Reported to Police?

No

8. Name and Phone of Police Dept.

9. Number of Thefts / Losses Registrant Has Experienced in Past 24 Months?

3

10. Type of Theft / Loss

Other - unknown

11. Killed / Injured Due to Armed Robbery

12. (Purchase) Value of Controlled Substances

$1.00

13. Pharmaceuticals or Merchandise Taken?

No

14. The following applies when Type of Theft / Loss (Box 10) is "Lost In Transit":

A. Name of Common Carrier

B. Name of Consignee

C. Consignee's DEA Registration Number

D. Did the Customer Receive the Carton?

E. Was Carton Tampered With?

F. Theft or Loss From This Same Carrier in the Past

15. What identifying marks, symbols or price codes were on the labels of these containers that would assist in identifying them?

16. Numbers of Official Controlled Substances Order Forms (DEA-222)

17. What security measures have been taken to prevent future theft / loss?

Double count controls when dispensing and back count remaining stock.

18. Comments

19. Filer Name, Title, Phone:

Laureen Heath, Pharmacist (907)339-2960

The following is a list of the controlled substances that were lost or stolen:

NDC Number	Trade Name	Dosage Str.	Quantity Lost/Stolen
00228203910	ALPRAZOLAM 2 MG TABLET	2 MG	17 EA

Print Close

From: Julie Loftus
To: Carrillo, Laura N (CED)
Subject: DEA Form #106 8.08.2018 (date of loss 8.05.2018) Safeway Pharmacy #1808
Date: Wednesday, August 08, 2018 3:16:29 PM
Attachments: image001.png
1808 08.05.18 Form 106.pdf

Please see the attached DEA 106 Form filed for Safeway Pharmacy #1808 on 8/08/2018.

Thank you,

Julie Loftus, Licensing Specialist
Pharmacy Professional Services
250 E. Parkcenter Blvd. | Boise, ID 83706
Office: 208.395.4320 | Fax: 208.395.4157
Julie.Loftus@albertsons.com

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From: Julie Loftus
To: Roesch, Deborah C (CED); Bay, Thomas L (CED); Dulebohn, Dawn L (CED)
Cc: Carrillo, Laura N (CED)
Subject: FW: DEA Form #106 8.07.2018 (date of loss 7.22.2018) Safeway Pharmacy #1808
Date: Tuesday, August 07, 2018 3:37:52 PM
Attachments: image001.png
1808 07.22.18 Form 106.pdf

All please see attached. Just want to make sure this is received by the board timely.
Thank you,

Julie Loftus, Licensing Supervisor
Pharmacy Professional Services
250 E. Parkcenter Blvd. | Boise, ID 83706
Office: 208.395.4320 | Fax: 208.395.4157
Julie.Loftus@albertsons.com

From: Julie Loftus
Sent: Tuesday, August 07, 2018 5:33 PM
To: 'laura.carrillo@alaska.gov' <laura.carrillo@alaska.gov>
Subject: FW: DEA Form #106 8.07.2018 (date of loss 7.22.2018) Safeway Pharmacy #1808

Good evening Laura,
I'm not sure who to send this 106 report to now that Donna is gone. Please let me know so that I may update my records.
Thank you,

Julie Loftus, Licensing Supervisor
Pharmacy Professional Services
250 E. Parkcenter Blvd. | Boise, ID 83706
Office: 208.395.4320 | Fax: 208.395.4157
Julie.Loftus@albertsons.com

From: Julie Loftus
Sent: Tuesday, August 07, 2018 5:29 PM
To: Bellino, Donna M (CED) <donna.bellino@alaska.gov>

Subject: DEA Form #106 8.07.2018 (date of loss 7.22.2018) Safeway Pharmacy #1808

Please see the attached DEA 106 Form filed for Safeway Pharmacy #1808 on 8/07/2018.

Thank you,

Julie Loftus, Licensing Supervisor
Pharmacy Professional Services
250 E. Parkcenter Blvd. | Boise, ID 83706
Office: 208.395.4320 | Fax: 208.395.4157
Julie.Loftus@albertsons.com

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REPORT OF THEFT OR LOSS OF CONTROLLED SUBSTANCES

Federal regulations require registrants to submit a detailed report of any theft or loss of controlled substances to the Drug Enforcement Administration. This form is filled out consistent with your entries in the fields on the previous pages. You should print this form and save it for your records. This form was submitted through the Internet, please do NOT send a copy to DEA.

OMB APPROVAL No. 1117-0001 Expires 9/30/2017

1. Name and Address of Registrant

SAFEWAY INC
3627 AIRPORT WAY
SAFEWAY PHARMACY #2754
FAIRBANKS , AK 99709 9073397790

2. Phone No. When Submitted

Amendment Key / Date Submitted

7R1NIMWJN1GW / 07-06-2018 11:32:51

3. DEA Registration Number

BS8171643

4. Date of Theft / Loss

Jul 01, 2018 Amendment # 0

5. Registrant's Principal Business

CHAIN PHARMACY

6. Registrant's County

FAIRBANKS NORTH STAR

7. Theft Reported to Police?

No

8. Name and Phone of Police Dept.

9. Number of Thefts / Losses Registrant Has Experienced in Past 24 Months?

0

10. Type of Theft / Loss

Other - Unknown

11. Killed / Injured Due to Armed Robbery

12. (Purchase) Value of Controlled Substances

$1.00

13. Pharmaceuticals or Merchandise Taken?

No

14. The following applies when Type of Theft / Loss (Box 10) is "Lost In Transit":

A. Name of Common Carrier

B. Name of Consignee

C. Consignee's DEA Registration Number

D. Did the Customer Receive the Carton?

E. Was Carton Tampered With?

F. Theft or Loss From This Same Carrier in the Past

15. What identifying marks, symbols or price codes were on the labels of these containers that would assist in identifying them?

16. Numbers of Official Controlled Substances Order Forms (DEA-222)

17. What security measures have been taken to prevent future theft / loss?

Double count and back count CS.

18. Comments

19. Filer Name, Title, Phone:

Matthew Reichert, Pharmacist (907)374-4060

The following is a list of the controlled substances that were lost or stolen:

NDC Number	Trade Name	Dosage Str.	Quantity Lost/Stolen
65862045560	ALPRAZOLAM ER 1 MG TABLET	1 MG	30 EA

Print Close

NABP
National Association of
Boards of Pharmacy
www.nabp.pharmacy

1600 Feehanville Drive
Mount Prospect, IL 60056
T) 847/391-4406
F) 847/375-1114

TO: EXECUTIVE OFFICERS – STATE BOARDS OF PHARMACY

FROM: Carmen A. Catizone, Executive Director/Secretary

DATE: July 12, 2018

RE: Performance Audits

The Louisiana Legislative Auditor recently conducted performance audits for the Louisiana Board of Pharmacy operations as well as the Board's oversight of the state prescription monitoring program. The Louisiana Board of Pharmacy has offered to share these reports with the state boards of pharmacy as they may be useful to other boards facing similar audits.

The reports have been posted to the NABP website in the Member Services section, under "Operational Resources for the Boards" (https://nabp.pharmacy/member-services/operational-resources-for-the-boards/). The report on the Board's operations refers to a National State Auditors Association (NSAA) best practices document which may be used by other state auditors. The NSAA document is attached for your reference in case this guideline may be used in your state.

Attachment

cc: NABP Executive Committee

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Carrying Out a State Regulatory Program

A National State Auditors Association Best Practices Document

Published by the
National State Auditors Association

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For additional information, contact the National State Auditors Association, 2401 Regency Road, Suite 302, Lexington, KY 40503, (859) 276-1147, www.nasact.org.

Best Practices in Carrying Out a State Regulatory Program

Purpose

The Performance Audit Committee of the National State Auditors Association developed this document as a tool for audit organizations and government agencies to use in identifying and evaluating best practices in carrying out a state regulatory program. Although the document was intended to address many of the best practices that could apply in these situations, it should not be considered all-inclusive. Further, the practices listed here may not be applicable in all situations, and other practices may accomplish the same things. However, this document can be extremely helpful as a starting point for both agency managers and auditors in deciding what types of practices are more likely to result in a well-designed regulatory program.

Planning

State regulatory programs are designed to safeguard the public's health or welfare. They generally are established to protect the state's most vulnerable populations from harm (such as seniors in nursing homes or children in day care), to protect the public from unqualified or unscrupulous practitioners, or to safeguard the state's natural resources. Regulatory agencies usually are given the statutory authority and power to decide who can operate within the regulated industry, and what requirements they must adhere to. Having a well-designed regulatory program greatly increases the likelihood that the state's regulation will adequately protect its citizens and resources.

Standard Setting

The regulatory agency needs to develop norms for acceptable qualifications, behaviors, and conditions within the regulated industry, based on the law. To do this, it should establish standard definitions, guidelines, criteria, qualifications, etc. for each type/level of person/entity to be regulated. These should address such things as:

1. What each person/entity being regulated is required to have or to do to be eligible **to get** a license or permit.

2. What each regulated person or entity is required to do—or is prohibited from doing— **after** getting a license or permit.

3. Any additional education/training/other requirements that must be met after getting a license or permit, and the timeframe for meeting them.

Gatekeeping: Identifying the People/Entities To Be Regulated

Members of the regulated industry aren't always aware of the need to obtain or renew a license or permit to operate within that industry, or of the requirements they must adhere to. At the same time, some people/entities may be operating intentionally without getting the necessary licenses or permits. As part of its regulatory efforts, the agency should develop procedures that allow it to do the following:

1. Identify the people/entities required to have a new license or permit to operate (for example, through schools, professional organizations, and various lists or directories; through

consumer education regarding requirements imposed on the regulated industry; through complaints filed against people operating without a license; etc.).

2. Notify these people/entities of the requirements they must meet to operate within the regulated industry, the steps they must take to get a new license or permit, and the penalties for noncompliance.

3. Before existing licenses or permits expire, notify people/entities of the need to renew them and of any requirements or fees that have changed.

4. Make new and renewal applications and other needed materials available to them on a timely basis (by mail, on the agency's Web site, or through some other source).

Gatekeeping: the Licensing and Permitting Process

Requiring people to get and maintain a current license or permit is one way the state can try to make certain only qualified individuals who meet certain standards are allowed to operate within the regulated industry. The agency should develop a systematic and fair process for issuing both new and renewal licenses/permits to qualified applicants. As part of a good licensing/permitting process, the agency would be expected to:

1. Require applicants to submit an application or renewal form, and any supporting documents needed to help determine whether the applicant is qualified.

2. Take reasonable steps for the initial application and subsequent renewals to ensure that the applicant meets all current requirements (could involve reviewing or verifying the information the applicant submitted, testing the applicant's knowledge, inspecting the applicant's facilities, investigating the applicant's background, etc.).

3. Issue licenses/permits on a timely basis and for a specified period of time to applicants who meet requirements, and collect any applicable fees.

4. Notify applicants who don't meet requirements that they've been denied, and make them aware of any appeals process.

5. Track and oversee the application process to ensure that applications are handled as intended and don't get lost, and that the amount of fees collected reconciles to the number of licenses and permits issued.

6. Maintain a record of the applications and supporting documents submitted, the screening process followed and its results, the licenses or permits held, etc.

Monitoring: the Inspection Process

The agency should develop a systematic process for monitoring regulated people's/entities' activities to ensure that they are following applicable requirements and that the public is adequately protected. As part of a good inspection process, the agency would be expected to:

Best Practices in Carrying Out a State Regulatory Program

1. Develop standard criteria or categories for the following:

   a. The types of violations that may occur within the regulated industry.
   b. How serious they are.
   c. The types of corrective actions needed for each type of violation.
   d. When those corrective actions must be taken.
   e. The consequences of not taking corrective action as required.

2. In some situations, the monitoring process may begin with or be limited to receiving reports from licensees or permit-holders. In such cases, the agency should do the following:

   a. Specify who should report, what they should report on, and how often.
   b. Review that information and verify it as needed.
   c. Follow-up as needed on any noncompliance or on any questionable or "bad" results reported.
   d. Conduct periodic on-site reviews/inspections to verify what's being reported, etc.

3. Set up a schedule for periodically inspecting regulated people/entities. Factors that are often considered in setting up a reasonable schedule:

   a. They should be frequent enough to provide reasonable safeguards to the public.
   b. They should be risk-based if possible.
   c. They should comply with any legal/regulatory requirements.

4. Develop standardized checklists, guides, or other documents covering the areas of compliance/requirements to be checked during the inspection, and the level of reporting required. Some factors to be considered regarding these documents:

   a. They should incorporate all significant statutory, regulatory, or agency requirements or standards related to the regulated industry.
   b. They should provide inspectors with appropriate guidance for conducting the inspection, including how violations will be measured or detected (for example, to determine if there's a violation, the inspector should be able to either observe (see) or test that it exists).
   c. They should be designed so the inspector can demonstrate that he or she checked the licensee's compliance with all applicable laws and requirements.
   d. They should be easily understood, and any terms, classifications, procedures, etc., should be clearly defined.

5. Provide formal training to new inspectors and periodic training to all inspectors on how to use, interpret, and apply these standardized checklists or guides accurately, consistently, and fairly.

6. Require inspectors to periodically disclose any actual or perceived impairments they may have to carrying out their duties impartially (for example, relatives operating a regulated business within their region).

7. Conduct inspections in a timely, efficient, and effective manner. Factors that are often indicative of efficient and effective inspections:
   a. Having appropriate performance goals and measures for inspectors, such as the number of full inspections they are expected to conduct each year.
   b. Assigning inspectors to regions within the state, and having them follow the most efficient routes in traveling between inspection sites.
   c. Cross-training inspectors when agencies are responsible for different types of inspections within the same industry—or for inspections across multiple industries.
   d. Using part-time staff when programs are seasonal in nature and don't operate year-round.
   e. Rotating inspectors between regions to ensure they don't develop too cozy a relationship with the people they are regulating.
   f. Conducting unscheduled inspections.
   g. Conducting all required inspections.
   h. Conducting inspections that are thorough and as complete and needed under the circumstances.
   i. Allowing the regulated person/entity to correct minor problems while the inspector is on-site, and requiring immediate corrective action if the violations or problems found threaten life or health.
   j. Providing inspectors with the equipment and technology they need to efficiently and effectively carry out their jobs.

8. Document the results of the inspection/investigation, including any violations found and how serious they are. Factors that are often considered to be important in recording these results:
   a. Having inspectors record and discuss the violations they found and any preliminary conclusions or recommendations with the regulated person/entity while they are on-site
   b. Allowing the regulated person/entity to provide additional information that may have a bearing on the inspector's findings.
   c. Having a supervisor review the results of the inspector's work to ensure that it was conducted in a way that is consistent with applicable laws, regulations, and agency policies, and that any conclusions and recommendations are based on clear and sufficient evidence. (A supervisor should not be able to override an inspector's recommendations without management's review and approval, and a written record should be kept of any changes made and the rationale for each.)

9. Provide formal written notification to the person/entity that was inspected about the final results of the inspection, including any violations or other problems found, corrective actions that need to be taken, and timeframes.

10. Track the inspections conducted, violations found, and actions taken to ensure that they are being addressed appropriately and that things don't slip through the cracks. Depending on the industry being regulated and the severity of the problems found, this may entail one or more on-site re-inspections.

11. Maintain a record of the monitoring process and its results, and make those results available to inspectors for future inspections so they are aware of the licensee's inspection history and past violations.

Monitoring: the Complaint-Handling Process

Complaints are an important source of information for determining whether the people/entities operating within the regulated industry are in compliance with all applicable requirements and standards. Complaints can be handled within the regulatory agency, or as part of an independent or centralized service. Wherever this process is located, there should be a systematic process for handling complaints. As part of a good complaint-handling process, the agency would be expected to:

1. Establish a method for receiving complaints that encourages valid complaints but discourages invalid ones. Depending on the industry being regulated, the types of factors to be considered in establishing a complaint-handling process can include:
   a. Making information available on the agency's Web site or through some other source so members of the public will know that the complaint-handling process exists and how to use it. This information can include the requirements that exist for people operating within the regulated industry, a description of the agency's complain-handling process, and complaint forms, if applicable.
   b. Allowing complaints to be submitted formally (i.e., in writing or electronically), or informally through a complaint-intake process (i.e., in person or over the phone).
   c. Providing for complaints to be called in after regular business hours.
   d. Collecting at least the minimum information needed to take the appropriate initial action on the complaint.
   e. Taking anonymous complaints when there's a good reason to do so.
   f. Screening out complaints that have no merit on their face or that the agency has no jurisdiction over. For valid complaints that are outside the agency's jurisdiction, procedures should be in place for referring them to or notifying the appropriate agency(ies).

2. Establish appropriate policies and procedures for maintaining the confidentiality of complaints and pending investigations.

3. Set guidelines/requirements for which complaints need action, and how quickly complaints should be handled (will depend on the type and severity of the problems alleged).

4. Screen complaints against these guidelines to identify those needing action, and assign them to someone to review or investigate.

5. Investigate complaints as needed to determine whether problems exist, and how serious they are. This could be accomplished through separate investigations, as part of the inspection process, or through other types of reviews.

6. When applicable, provide timely feedback to the person who submitted the complaint about the outcome of the complaint review or investigation.

7. Track and oversee complaints to ensure that they are being addressed appropriately and that things don't slip through the cracks.

8. Maintain a record of the complaints received, the investigation results, and any actions taken.

Enforcement Process

When people/entities operating within the regulated industry are found **not** to be in compliance with all requirements and standards and won't voluntarily come into compliance, the agency must take action to compel them to comply or to stop operating. The agency should develop a systematic, fair, and progressively stringent enforcement process to ensure that the public is adequately protected. As part of a good enforcement process, the agency would be expected to:

1. Establish a graduated and equitable system of sanctions (i.e., letters of non-compliance, increasing levels of fines, license suspension, license revocation, criminal punishment, etc.) that addresses any legal or regulatory requirements. The sanctions should be set sufficiently high to help achieve the desired results (compel the person or entity to comply or stop operating).

2. Specify the number or severity of violations or "occurrences" that should trigger each level of sanction, and any applicable timeframes. Again, immediate action should be taken if the violations or problems found threaten life or health.

3. Establish an administrative process for appealing these sanctions.

4. Track and flag people/entities that have not come into compliance after problems or violations were identified, including those operating without a required license or permit.

5. Formally notify these people/entities of the enforcement actions that are going to be applied, the basis for the enforcement action(s), the applicable timeframes, and their right to appeal.

6. Take appropriate, consistent, and timely enforcement actions that address the violations cited against these people/entities (including collecting any fines levied).

7. Follow-up as needed (i.e., through written reports, the inspection process, special investigations, etc.) to determine whether the problem has been corrected or whether additional enforcement action is needed.

8. Track and oversee the enforcement actions taken to ensure that they are being addressed appropriately and that things don't slip through the cracks.

9. Maintain a record of the enforcement actions taken.

10. Ensure that information about any disciplinary actions taken is readily available to the public.

Management Analysis and Reporting Process

The regulatory agency should establish a systematic process for analyzing program-related information, making appropriate adjustments to improve the effectiveness and efficiency of the program, and reporting relevant summary information to the public and policy-makers about the results of the regulatory program. As part of this process, management would be expected to do the following types of things on a periodic basis:

Best Practices in Carrying Out a State Regulatory Program

1. Monitor the regulated industry for changes that may impact the public's health, safety, or welfare, or that could otherwise affect the regulatory program.

2. Evaluate the nature and volume of complaints and of violations identified during inspections/investigations.

3. Evaluate the adequacy and consistency of inspections and enforcement actions, and their effectiveness in protecting the state's citizens and resources from harm.

4. Evaluate the extent to which program staff complied with agency policies and procedures in carrying out their responsibilities.

5. Evaluate the reliability of the program data compiled and maintained by the agency.

6. Evaluate how efficiently the agency is carrying out its responsibilities, including a review of any duplicative regulation that may be provided at different levels of government.

7. Propose or adopt needed changes in laws, regulations, standards, policies, processes, sanctions, fees, etc., to help ensure the regulatory program is operating as intended and accomplishing its purpose.

8. Periodically report to the public on its activities in regulating the industry, and on relevant trends and conditions within that industry.

NABP
National Association of Boards of Pharmacy
www.nabp.pharmacy

1600 Feehanville Drive
Mount Prospect, IL 60056
T) 847/391-4406
F) 847/375-1114

TO: EXECUTIVE OFFICERS – STATE BOARDS OF PHARMACY

FROM: Larissa Doucette, Marketing Senior Manager

DATE: July 12, 2018

RE: NABP 2018 Consumer Education Campaign Promotes Boards of Pharmacy, Pharmacists as a Resource in the Opioid Abuse Epidemic

---

On June 12, 2018, the National Association of Boards of Pharmacy (NABP) launched a consumer education campaign with a satellite media tour featuring NABP Chairperson Jeanne D. Waggener, RPh, DPh, and NABP Past President Joe Adams, RPh. During the four-hour event, 24 television and radio stations from across the country interviewed the NABP members about the opioid epidemic. Waggener and Adams talked about what NABP and the boards of pharmacy are doing to help patients and how pharmacists can be relied on as a resource. This campaign, which will run from June 2018 through May 2019, is a result of Waggener's 2017-2018 presidential initiative to educate pharmacists, students, consumers, and other stakeholders about state boards of pharmacy and their role educating pharmacists and protecting the public health.

The key message of the campaign is: "The state boards of pharmacy and NABP are focused on ensuring that pharmacies and pharmacists are providing medications and patient services that are safe for you and your family." Consumers are encouraged to use their state board of pharmacy as a resource in addition to NABP and their local pharmacist. The campaign message will be pushed out to consumers through a variety of advertising vehicles:

- Banner ads will be displayed on websites according to consumers' keyword searches during the months of July 2018 and August 2018
- Public service announcements (PSAs) for TV and radio will be distributed nationwide in July 2018
- Video ads will be displayed on premier websites from October 2018 to January 2019
- Digital ads (video and/or banner) will run on *WebMD.com* from February 2019 to May 2019

NABP will make the PSAs available to the boards of pharmacy for their use once they have been distributed to the television and radio stations. An interview from the June 12 satellite media tour can be found on NABP's YouTube channel.

If you have any questions about this campaign, please contact me via email at ldoucette@nabp.pharmacy or via phone at 847/391-4468.

cc: NABP Executive Committee

Wall Certificates for Board Signatures

Name	License #	Issue Date
Emily McCarville	133956	8/8/2018
Gina Heffern	134459	8/7/2018
John Gionet	136039	8/2/2018
Matthew Bruno	135772	8/6/2018
Rebecca Insall	135244	8/17/2018
Robert Hopkins	135765	8/7/2018
Whitney Stubbs	135857	8/7/2018

TASK LIST

(Tasks from previous meeting)

□ Ms. Carrillo will inquire with Appriss Health as to who would receive the clinical alerts.

□ MS. Carrillo will correct the typo on the DEA Registration Status form #08-4763.

□ Chair Holt will sign the voluntary surrender document and return it to the department.

□ Ms. Carrillo will correct the last name typo, will capitalize the 'a' in Anchorage before forwarding the annual report to the publications specialist, and will update Leif Holm's duty station from Fairbanks to North Pole.

□ Ms. Carrillo will add to the board's agenda for the next meeting the regulation topic of adding language to accommodate authorized presenters of approved providers.

□ Staff will work towards updating in-state and out-of-state inspection reports in coordination with Chair Holt. Ms. Carrillo will have fillable versions updated by the August 2018 meeting for the board to review.

□ Rich Holt will work on draft language to be added to regulation regarding pharmacy closures.

□ The board will continue looking at addiction resources offered by the NABP.

□ Ms. Carrillo will add interstate datasharing as a regulation project for discussion at the board's August meeting.

□ Ms. Carrillo will follow-up with Gerald Brown to respond to the PDMP-specific questions he submitted to the board.

□ Ms. Carrillo will fix the typo on the continuing education audit letter.

□ Ms. Carrillo will consult with Investigations as to whether boards have fines for similar situations involving failure to notify the department of a required change.

□

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

Board of Pharmacy
State Office Building, 333 Willoughby Avenue, 9th Floor
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 465-2550

Pharmacy Self-Inspection Report

Pharmacy Name: _____ **Date:** _____

Owner Name: _____

Mailing Address: _____

Pharmacy License or Registration #: _____ **Expiration:** _____

Date of Inspection: _____ **Telephone Number:** _____

Hours of Operation: _____ **Fax Number:** _____

DEA Registration #: _____ **DEA Expiration:** _____

The responsibility of the pharmacist-in-charge include compliance with all laws and regulations governing the operation of the pharmacy (12 AAC 52.200(b)(1)). Please identify the pharmacist-in-charge of the above-named pharmacy as well as other pharmacists working in the pharmacy.

Pharmacist-in-Charge: _____ **License #:** _____

List additional Pharmacists (attach a separate page if necessary):

Name: _____ **License #:** _____

Name: _____ **License #:** _____

Name: _____ **License #:** _____

Name: _____ **License #:** _____

Please Check:

- ☐ Initial Application
- ☐ Renewal
- ☐ Change in Ownership
- ☐ Change in Location
- ☐ Re-Inspection

Please Check:

- ☐ Retail
- ☐ Institutional
- ☐ Sterile Compounding
- ☐ Non-Sterile Compounding

Authority	Item	Yes	No	Comments
PHARMACY PERSONNEL (GENERAL)				
AS 08.80.330, 12 AAC 52.200	1) The pharmacy has designated a licensed pharmacist who practices in this location as the pharmacist-in-charge.	☐	☐	
AS 08.80.030, 12 AAC 52.210, 12 AAC 52.220	2) Only the pharmacist or intern, under direct supervision of the pharmacist receives oral prescription drug orders.	☐	☐	
	3) Only the pharmacist or intern, under direct supervision of the pharmacist interprets the prescription drug order and determines the product required.	☐	☐	
	4) Only the pharmacist does the final check on all aspects of the completed prescription.	☐	☐	
AS 08.80.030, AS 08.80.480, 12 AAC 52.220	5) ALL interns, graduate or undergraduate, paid or unpaid, are currently licensed by the Alaska Board of Pharmacy.	☐	☐	
	6) Interns do not represent themselves to be pharmacists.	☐	☐	
	7) Interns perform the duties of a pharmacist only under the direct supervision of a licensed pharmacist.	☐	☐	
	8) Interns do not solely sign or initial any document required to be done by the pharmacist.	☐	☐	
AS 08.80.030, 12 AAC 52.230	9) Interns do not dispense prescriptions before a final check is made by the supervising pharmacist.	☐	☐	
AS 08.80.030, AS 08.80.480, 12 AAC 52.140	10) ALL pharmacy technicians are currently licensed by the Alaska Board of Pharmacy.	☐	☐	
	11) All pharmacy technicians are under direct supervision of the pharmacist.	☐	☐	
FACILITY STANDARDS (GENERAL)				
AS 08.80.157, 12 AAC 52.400	1) The pharmacy department has a sink with hot and cold running water and is maintained in a sanitary condition.	☐	☐	

	2) The temperature of the pharmacy is maintained within a range compatible with the proper storage of drugs.	☐	☐	
	3) The pharmacy has refrigeration facilities with a thermometer and the temperature is maintained within 36 to 46 degrees Fahrenheit.	☐	☐	
AS 08.80.157, 12 AAC 52.410	4) The pharmacy has the equipment, supplies, and reference materials necessary to compound, dispense, label, administer, and distribute drugs and devices.	☐	☐	
AS 08.80.157, 12 AAC 52.420	5) All drugs and devices that have exceeded their expiration date are removed from stock, and quarantined until properly disposed of.	☐	☐	
	6) All drug, devices, and poisons restricted to sale by a pharmacist are kept in the prescription department.	☐	☐	
	7) The pharmacy department is always locked when the pharmacist is not on site.	☐	☐	
	8) The pharmacy has a separate telephone number if its hours differ from the remainder of the store.	☐	☐	
	9) Filled prescriptions are stored in the prescription department only and are not removed unless a pharmacist is present.	☐	☐	
PRACTICE STANDARDS				
AS 08.80.030, 12 AAC 52.470	1) The pharmacy maintains its prescriptions in legible form for the required two year period.	☐	☐	
	2) No prescriptions are refilled after one year from the date of issue.	☐	☐	
AS 08.80.030, 12 AAC 52.480	3) All refills are recorded electronically or on the back of the prescription drug order. 4) All schedule II - V controlled substances dispensed have the label "Caution: Federal Law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."	☐	☐	
AS 08.80.030, 12 AAC 52.490	5) All Prescriptions are labeled with the name, address, and telephone number of pharmacy, Rx number, date and pharmacist's initials.	☐	☐	

	6) All Prescriptions are labeled with patient name, prescribing practitioner, patient instructions, appropriate cautions, name, strength, and quantity of drug.	☐	☐	
AS 08.80.030, 12 AAC 52.490	7) Electronically transmitted prescriptions are only being received directly from the prescribing practitioner or the prescribing practitioner's agent. 8) All transferred prescriptions for controlled substances in Schedule III, IV, and V are transferred only once from the pharmacy which has the original prescription drug order. 9) Unless the two pharmacies share a common database, transfers of non-control prescriptions may be transferred verbally, electronically or by facsimile. 10) All transfer information is recorded can keep prescriptions, unless an automated data processing system is able to do so.	☐	☐	
AS 08.80.030, 12 AAC 52.510	11) Prescription orders transferred to another pharmacy are no longer refilled by the original pharmacy.	☐	☐	
AS 08.80.030, 12 AAC 52.520	12) When dispensing an equivalent drug product instead of the prescribed drug, the pharmacist notes on the prescription drug order either the manufacturer, distributor, NDC #, short name code, or trade name.	☐	☐	
AS 08.80.030, 12 AAC 52.530	13) If customized patient medication packages (med-paks) are prepared by the pharmacy, records are made and filed for each med-pak.	☐	☐	
AS 08.80.030, 12 AAC 52.52	14) Except in the case of a pharmacy serving an institutional facility, drugs are not accepted for return or exchange after the drugs have been taken from the premises.	☐	☐	
AS 08.80.030, 12 AAC 52.580	15) Patient records are reviewed for over or under utilization, therapeutic duplication, drug-disease, drug-food, and drug-drug interactions, reasonable dose, known allergies, and adverse drug reactions. 16) When a data processing system is used it is capable of producing an audit trail printout for all dispensing.	☐	☐	
AS 08.80.030, 12 AAC 52.585	17) When a data processing system is used it has adequate safeguards to prevent loss of data and reasonable security.	☐	☐	
	18) The pharmacist verbally provides counseling to the patient or the patient’s agent with each new patient of the pharmacy, new medication for an existing patient, or a change in dose, strength, route of administration, or directions for use of an existing prescription previously dispensed.	☐	☐	

INSTITUTIONAL PHARMACY STANDARDS (IF APPLICABLE)				
AS 08.80.390, 12 AAC 52.700, 12 AAC 52.710	1) The institutional pharmacy is managed by a licensed pharmacist, designated to be the pharmacist-in-charge.	☐	☐	
	2) When the institutional pharmacy is closed, no access is permitted unless a person licensed to handle drugs is designated by the pharmacist-in-charge to enter the institutional pharmacy.	☐	☐	
AS 08.80.030, 12 AAC 52.720	3) When the institutional pharmacy is closed, the designated person licensed to handle drugs records the removal of any drug.	☐	☐	
	4) All E.R. outpatient prepackaged medications bear a label with the name, address, and telephone number of hospital; name, strength, quantity, lot number, and expiration of drug; appropriate cautions; and initials of pharmacist	☐	☐	
	5) Only one prepackaged container of a drug is delivered to emergency room patients unless more than one is required to sustain the patient until a retail pharmacy is open in the community.	☐	☐	
STERILE PHARMACEUTICALS (IF APPLICABLE)				
AS 08.80.030, 12 AAC 52.430	1) A policy and procedure manual is present for the compounding, dispensing, and delivery of sterile pharmaceuticals.	☐	☐	
	2) The pharmacy has a functionally separate area used only for the preparation of sterile pharmaceuticals.	☐	☐	
	3) The pharmacy has appropriate environmental control devices capable of maintaining at least a Class 100 environment condition for preparing sterile pharmaceuticals.	☐	☐	
	4) Cytotoxic sterile pharmaceuticals are prepared in appropriate biological safety cabinets.	☐	☐	
	5) The pharmacy uses temperature controlled delivery containers, if appropriate, for delivery of sterile pharmaceuticals to the patient.	☐	☐	
	6) The pharmacy has its laminar airflow hoods or clean rooms re-certified at least every six months.	☐	☐	
	7) The pharmacy has its laminar flow hood or clean room pre-filters replaced and documented on a regular basis.	☐	☐	

	8) The pharmacy has current copy of reference material related to sterile pharmaceutical preparation in the pharmacy.	☐	☐	
	9) All personnel participating in the preparation of sterile pharmaceuticals are trained in this specialized function.	☐	☐	
	10) The pharmacy has a licensed pharmacist accessible 24 hours a day if providing parenteral pharmaceuticals to non-hospitalized patients.	☐	☐	
	4) Cytotoxic sterile pharmaceuticals are prepared in appropriate biological safety cabinets.	☐	☐	
	5) The pharmacy uses temperature controlled delivery containers, if appropriate, for delivery of sterile pharmaceuticals to the patient.	☐	☐	
	6) The pharmacy has its laminar airflow hoods or clean rooms re-certified at least every six months.	☐	☐	
	7) The pharmacy has its laminar flow hood or clean room pre-filters replaced and documented on a regular basis.	☐	☐	
	8) The pharmacy has current copy of reference material related to sterile pharmaceutical preparation in the pharmacy.	☐	☐	
	9) All personnel participating in the preparation of sterile pharmaceuticals are trained in this specialized function.	☐	☐	
	10) The pharmacy has a licensed pharmacist accessible 24 hours a day if providing parenteral pharmaceuticals to nonhospitalized patients.	☐	☐	
	11) All sterile pharmaceuticals dispensed bear the expiration date of the preparation.	☐	☐	
	12) All cytotoxic waste is disposed of in compliance with all applicable local, state, and federal requirements.	☐	☐	
	13) A licensed pharmacist is involved in patient training that relates to sterile pharmaceuticals.	☐	☐	
	14) The pharmacy has a quality control and quality assurance program that is utilized for sterile pharmaceutical preparation and dispensing.	☐	☐	

CONTROLLED SUBSTANCES				
Controlled Substances Act of 1970	1) A Schedule V record bound book is maintained which contains name and address of purchaser, name and quantity of drug, date, and initials of pharmacist. Record book is maintained two years from date of last transaction.	☐	☐	
	2) Prescriptions are not used to supply office stock or "medical bag" for physicians.	☐	☐	
	3) All prescriptions for controlled substances are dated, contain the full name and address of the patient, and the name, address, and DEA number of the physician.	☐	☐	
	4) Schedule II prescriptions are manually signed by the physician, and Schedule II prescriptions are not refilled.	☐	☐	
	5) Schedule III, IV and V prescriptions are refilled only if authorized. Refills are not dispensed more than six months after the issue date or refilled more than five times after the issue date.	☐	☐	
	6) Controlled substances are securely locked or dispersed throughout the non-controlled inventory.	☐	☐	

Pharmacy Self-Inspection Report
Signature Page

NOTE: If any areas on the self-inspection report were checked off as not being in compliance, you must still send in the report. You then have 90 days to bring those areas into compliance. A new report will be sent to you to fill out.

Attestation: I, the pharmacist-in-charge, state that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this self-inspection report may be grounds for denial or revocation of the drug room license.

Pharmacist-in-Charge: _____ **Date:** _____

Pharmacist-in-Charge Signature: _____ **Phone:** _____

Notary Stamp:	Notary Public For State of:		Subscribed and Sworn to Before me on This Day:	
	Notary's Signature:		My Commission Expires:	