PDMP TTAC

Prescription Drug Monitoring Program Training and Technical Assistance Center

Technical Assistance Guide

Prescription Drug Monitoring Programs Administrators' Orientation Package

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Brandeis University The Heller School For Social Policy and Management

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BJA Bureau of Justice Assistance U.S. Department of Justice

Contents

I. Introduction

There has been growing concern among Prescription Drug Monitoring Program (PDMP) Administrators about the misinformation and misperception being disseminated at all levels regarding the workings and operations of these programs. As a result, several PDMP Administrators felt it was crucial to bring the PDMP community together to discuss issues impacting PDMPs and identify efforts to ensure proper and accurate information is shared with stakeholders, policy makers, and the public. The Bureau of Justice Assistance (BJA) was asked to support such a meeting and the PDMP Training and Technical Assistance Center (TTAC) to provide logistical and program support.

The meeting was held in Overland Park, Kansas on August 10-11, 2017. All fifty-two (52) PDMPs were invited to the meeting with thirty (30) agreeing to participate. The Kansas PDMP took the lead in organizing and facilitating the meeting. Twenty-eight (28) PDMPs attended (AL, AK, AZ, CT, GA, IA, ID, IL, KS, KY, LA, MA, MI, MO, MS, NC, NE, NH, NJ, NV, OH, OK, OR, PA, RI, SD, TN, and WY). The meeting covered several topics:

- Unsolicited reporting, data analysis, prescriber report cards, identifying at-risk patients, and referrals for treatment options
- Supplemental information for PDMPs to track
- Data quality and integrity
- Law Enforcement and PDMPs
- Interstate data sharing
- EHR integration, data from VA and tribal nations
- PDMP operations: In-House v. Vendors
- Open record and researcher requests for data
- Orientation package for new PDMP administrators
- Statewide awareness and marketing programs
- Prescription Drug Monitoring Act of 2017 and national PDMP.

Although the purpose of many of the topics was to share ideas and experiences by PDMP Administrators around the country, one of the needs identified at the meeting was the creation of an orientation package for new PDMP Administrators. This package could be used by new and less experienced PDMP Administrators as a guidance and reference tool. A committee was created to work on this document. The committee consisted of: representatives from Kentucky (Jean Hall), Kansas (Reyne Kenton), Idaho (Teresa Anderson), Illinois (Stan Murzynski), Nebraska (Kevin Borcher), Pennsylvania (Meghna Patel and Jared Shinabery) and TTAC. The following Orientation Package is the result of their work with input and feedback from other PDMP Administrators. This should be considered a “living” document which will be updated as needed.

II. PDMP Overview

History of PDMPs

Introduction

Prescription drug monitoring programs are designed to facilitate the collection, analysis, and reporting of information on the prescribing, dispensing, and use of prescription drugs within a state. An overriding goal of PDMPs is to uphold both the state laws ensuring access to appropriate pharmaceutical care by citizens and the state laws deterring diversion.

The earliest PDMPs were established primarily as enforcement and regulatory tools providing data to officials responsible for enforcing drug laws and overseeing the prescribing and dispensing of these drugs by health care professionals. While this role continues in almost all current PDMPs, the focus of PDMPs has, for the most part, shifted to enhance patient care and assist in developing drug abuse prevention and treatment strategies

Forty-nine (49) states, District of Columbia, and one (1) U.S. Territory (Guam) currently have PDMP legislation in place. The only state without enacted PDMP legislation is Missouri. Recently, St. Louis County implemented a PDMP and has made the program available to any other Missouri county or city wanting to join. At this time, the St. Louis County PDMP serves more than half the population of Missouri.

The state agency which houses the PDMP can vary from state to state and falls into four (4) major categories: public health, law enforcement, licensing or regulatory boards, and substance abuse facility licensing authorities. Regardless of which agency houses the program, PDMPs share common goals, including enhancing patient care, education and information, curtailing the abuse and diversion of controlled substances, and enhancing prevention and treatment programs.

While in recent years PDMPs have gained notoriety and have been recognized as important programs, it was not always that way. The history of PDMPs spans almost a century and is riddled with opposition, misperception, and misinformation regarding their purpose and value.

Early PDMPs faced many legal and political battles as they tried to establish their programs. Opposition from the pharmaceutical industry, practitioner organizations, and various advocacy groups eventually led one state to take the fight to the US Supreme Court.

Role of the Federal Government

During the early years of PDMPs, only one federal agency supported PDMPs: the Drug Enforcement Administration (DEA). Later, the federal Department of Justice (DOJ) would play a significant role in the establishment and growth of PDMPs. In 2003, DOJ began the Harold Rogers Prescription Drug Monitoring Grant Program (HRPDMP). DOJ, through its Bureau of Justice Assistance (BJA), made funding available to states that were interested in establishing, implementing, and enhancing PDMPs. The availability of federal funds through the HRPDMP played an integral role in the proliferation of PDMPs.

Today, major federal agencies (i.e., SAMSHA, ONC, ONDCP, VA, IHS) and others recognize the value of PDMPs and fully support their mission. Additionally, they have established policies and enacted laws and regulations which allow participation into PDMPs and provide their own funding for the enhancement of existing PDMPs.

The First PDMP (1918)

The origin of PDMPs goes back to the early 20th century. In the early 1900's, drugs such as heroin and cocaine were allowed by federal and state laws to be prescribed by doctors and dispensed in pharmacies. In 1918, New York State became concerned with a growing drug problem and passed sweeping drug legislation to address the crisis. One part of the laws required a doctor prescribing a certain quantity of heroin, cocaine, morphine, opium, or codeine to use "serially numbered official prescriptions blanks" issued by the state health department. A pharmacy was then required to send a copy of the prescription to the health department within 24 hours of dispensing the drug. These laws remained in effect for three (3) years until they were rescinded. Even though the program was eliminated, New York State had drawn the blueprint for what years later would become known as prescription drug monitoring programs.

Early PDMPs (1939-1989)

Established in 1939, California is the oldest continuously operated PDMP program in the country. The 1939 law placed the administration of the PDMP in a newly created Bureau of Narcotic Enforcement. It was followed by Hawaii (1943) which housed their program in the state Narcotic Enforcement agency. Eighteen years later Illinois (1961) established their program and was the first program to be housed within a Department of Health. In 1967, Idaho was the first to house the PDMP in a Board of Pharmacy

The 1970's saw three (3) additional programs come into existence: Pennsylvania (1972) which was originally housed in the Attorney General's Office and moved to the state health

department in 2016; New York (1973); and Rhode Island (1978). In the 1980's, two (2) additional programs were established: Texas (1981) and Michigan (1988).

During these first 50 years, all of the PDMPs had the same characteristics:

- A tool for the enforcement of drug laws;
- Collected prescription information only on Schedule II controlled substances;
- Required multi-copy (duplicate or triplicate) state issued prescription forms to prescribe and dispense Schedule II medications; and
- Required sending prescription information to the state within 30 days from the time the drug was dispensed.

Official Prescription Forms

The early PDMPs relied on state-issued prescription forms to obtain data. These forms, known as multi-copy prescriptions, came in both a three-part form (triplicate prescription) and a two-part (duplicate) form. The triplicate form consisted of an original copy, which was the top form doctors would write on and two additional forms. One form would stay with the practitioner, one with the pharmacy and one would be mailed to the PDMP. The duplicate form contained one original and the state copy. These forms were serialized and purchased by practitioners and health care institutions. A "book" of official prescriptions generally included 25 to 100 prescriptions at a cost of approximately five cents per form. Some PDMPs were able to use the monies obtained through the sale of the forms to fund the PDMP. It was a generally accepted practice for the PDMP to contract the printing of these forms to an outside vendor, but the actual distribution to the doctors would occur by the state. The PDMP recorded the serial numbers issued to a practitioner or institution. Several PDMPs actually had one form for a practitioner and a separate form for institutions. Different color prescriptions and serial number sequence would distinguish practitioner's prescriptions from institutional ones. Practitioners and institutions were required to report to the PDMP any of these forms which were lost or stolen. The PDMP would record the serial number of the lost or stolen prescriptions and would provide that information to a pharmacist upon request.

When a practitioner prescribed a Schedule II controlled substance, he/she would write the prescription using an official prescription form. If it was a triplicate form, a prescriber would keep one copy and give the patient the other two. The patient would then take the other two parts to the pharmacy where the pharmacist would dispense the medication to the patient. The pharmacist would file one copy in the pharmacy and mail the third copy to the state. In states that employed the duplicate official form, the practitioner would give both copies to the patient and the pharmacist would keep one copy and mail the other copy to the state.

State issued paper prescription forms were used by all of existing PDMPs (1939-1989) because it was a means by which information was sent through the mail to the agency housing the PDMP. The state agency would then enter the data into a state database and reports generated; modern technology and World Wide Web were just starting to take hold.

Taking advantage of emerging technology, Oklahoma (1990), broke the mold of previous PDMPs with its landmark legislation requiring electronic transmission of prescription data from a pharmacy directly to the state. As time went on, the majority of the earlier PDMPs, who had state issued paper forms, eliminated the forms in favor of electronic transmission. Today, only Texas and New York continue to employ, in a limited capacity, state issued forms.

The Oklahoma experience opened the door for other states to consider establishing a PDMP because electronic transmission lowered the cost to operate such a program by eliminating the costs associated with the printing and distribution of the forms and data entry.

The Nineties also saw another major change in PDMPs operations when Nevada (1995) became the first state to require its PDMP to collect prescription data for Schedules II through V controlled substances. Many existing PDMPs were aware of the problem with only collecting Schedule II controlled substance data. Unscrupulous individuals turned to other controlled substance schedules to divert. Knowing these were not being monitored by the state, the diversion of these drugs went either undetected or were difficult and time consuming to investigate.

Along with Oklahoma and Nevada in 1990's, five (5) other states passed PDMP legislation: Massachusetts (1992), Utah (1995), Indiana (1997), Guam (1998), and Kentucky (1998).

In this last decade of the 20th century, seventeen (17) PDMPs were operational (Guam's program became operational in 2013), almost the same number of programs as established in the entire first half of the century.

U.S. Supreme Court Decision

In 1972, New York State passed its Controlled Substance Act commonly referred to as the Rockefeller Laws. The newly enacted laws were nationally known for the mandatory sentencing of drug offenders. A part of these laws allowed the Commissioner of Health to establish a PDMP. Immediately upon passage of the law, court challenges ensued that questioned the legality of such a program. This question would be argued in various state and federal courts until it was finally brought before the US Supreme Court.

The issue before the Supreme Court was whether New York State had the legal authority to collect information on the prescribing and dispensing of controlled substances and whether

patient confidentiality was being violated under the U.S. Constitution. While the arguments for and against the PDMP program were specific to New York State, any decision contrary to New York would have had a devastating ripple effect to existing PDMP programs and would possibly have eliminated future PDMPs from being established in other parts of the country or, at the very least, considerably delayed their establishment.

The Supreme Court ruled (*Roe v. Whalen*, 1977) that New York State does have the authority to collect the information as part of its "police powers." The Supreme Court went further to state the PDMP was not unconstitutional and did not violate patient confidentiality. The decision allowed continuation of New York's program and, in an indirect way, confirmed the legitimacy of the other existing programs and opened the door for other states to consider passing PDMP laws.

21st CENTURY

By the beginning of the 2000's, PDMPs began to take root around the country. The old mantra by detractors of how PDMPs were detrimental to patient care in that their mere existence produced a chilling effect on prescribers and dispensers was still being tried, but was no longer effective. Research into the effectiveness of PDMPs began to provide evidence that PDMPs were a valuable instrument for providing patient safety and identifying patients at risk for drug overdose. Drug manufacturers, who once vigorously opposed PDMPs, began to publicly support them.

The first decade of the 21st century saw the largest number of states implementing PDMPs. A total of 27 PDMPs were established from 2000-2010. In 2002, the state of Virginia passed legislation to implement a PDMP; this was followed in 2003 by Maine and Tennessee. New Mexico, Wyoming and Alabama passed legislation in 2004. In 2005, five (5) states passed legislation including Colorado, North Dakota, Ohio, Mississippi, and North Carolina. In 2006, five (5) more states enacted PDMP legislation which included Connecticut, Vermont, Iowa, Louisiana, and South Carolina. In 2007, Arizona, Washington, and Minnesota saw their legislation become effective. Finally, the last three (3) years of the first decade saw eight (8) additional states pass laws: New Jersey, Alaska, and Kansas in 2008; Oregon and Florida in 2009; and Delaware, South Dakota, and Wisconsin in 2010.

By 2010, there were 44 PDMPs with more still to come. In 2011, Arkansas, Georgia, Montana, Maryland and Nebraska passed their laws. The last New England state to implement a PDMP law was New Hampshire in 2012 followed two (2) years later by the District of Columbia (2014). By 2015, Missouri became the only state without PDMP legislation; however, in 2016, St. Louis County, MO passed legislation to implement a PDMP. The law allowed other Missouri counties

or cities to participate in the PDMP. This was the first and only time that a PDMP was being operated under a local jurisdiction and not at the state level. The most recent PDMP legislation was passed by Puerto Rico (2016). Seventy (70%) percent of all current PDMPs were established in the first 15 years of this century.

Building on the experience and knowledge of earlier programs, more recent PDMPs have been implemented faster, employing best practices, and breaking new ground themselves in bringing PDMPs to their full potential. PDMPs continue to evolve into one of the most efficient and effective tools in the battle to reduce prescription drug abuse and diversion. States are continuously improving their programs and being more responsive to stakeholders with more timely and accurate information. In contrast to early programs, today's PDMPs are recognized as an important tool in addressing the drug abuse epidemic. Health care professionals, regulatory boards, and the law enforcement community all look to PDMPs to provide them with information. All PDMPs allow access to their data by prescribers and dispensers. Some PDMPs are now allowing other non-traditional stakeholders to access their data (i.e. drug courts, medical examiners, drug abuse counselors). Starting with Oklahoma in 1990, 44 states have reduced their data collection intervals to one business day or less. In 2010, five (5) states (CO, DE, LA, NV and OK) had mandatory query laws, and today 40 states have such requirements. In 2010, Utah was the only state that allowed prescribers to have delegates to access the PDMP on their behalf and today a total of 49 states have delegate legislation in place. PDMPs in some states have become more than just a repository of prescription information. Wisconsin (2016) and Utah (2016) collect data on individuals who have overdosed and those who have been found guilty of a drug violations and report this information to doctors querying the PDMP. Other improvements and best practices have been put in place which includes interstate data sharing (now available in 47 states) and integration of PDMP data with health information exchanges (HIEs), electronic health records (EHRs), and pharmacy dispensing systems (PDS).

The effectiveness of PDMPs and the role they are playing in reducing drug abuse and diversion is very evident. Studies provide proof of the impact PDMPs have had in curtailing the prescription drug problem. What started as embattled and fragile programs among a small number of states has grown into one of the most effective resource tools in the fight against prescription drug abuse and diversion. The future of PDMPs is on solid ground, and the full impact of these programs is just now beginning to be realized.

PDMP Technology

PDMP Software System Management

In House Solutions

An in-house solution is where the software solution for PDMP functions, such as data collection and data presentation, as well as the hardware to support the system, is managed by the agency responsible for the PDMP or the state's Information Technology resources. Some states use contracted resources to staff projects or for staff augmentation.

- Benefits

The key difference between this and third-party solutions (described below) lies in the prioritization of initiatives. Since the resources are internal to the state and often dedicated to the system, identification of initiatives and prioritization may not be in competition with other customers. Often, issues can be resolved more quickly with an in-house solution because the workforce can be dedicated to the project until such time as the issues are resolved. Depending on the number of resources available, in-house solutions can develop specialization by the staff to meet the needs of the PDMP.

- Challenges

In-house solutions require a strong information technology organization within the state. Having sufficient staff to accommodate new projects as well as day-to-day operations of the systems can be challenging. Moreover, hiring skilled information technology staff on state budgets may be difficult depending on the state salary structure. Small IT staffing models can have negative outcomes when turnovers occur causing a backlog of projects.

Third-Party Vendor Solutions

Third party hosted solutions are PDMP software solutions developed, maintained, and hosted by a third-party software vendor and sold to the state PDMP. Third party hosted solution vendors will typically manage the software for multiple state PDMPs. Most third party hosted solution vendors will maintain standard core software offered across all customers with some ability to customize per customer.

- Benefits

This model can be effective for states with limited financial or staff resources. The economy of scale for a vendor who builds a common core platform for various customers can allow them to offer functionality for less cost and fewer staff requirements.

- Challenges

Changes to the core platform may require: consensus agreement from all customers; change orders may result in additional costs to the state PDMP; delays in implementation due to competing priorities; or reluctance on the part of the vendor to dedicate resources if the initiatives are not financially beneficial to the vendor.

Third Party Supported Solutions

Third party supported solutions are solutions that are hosted in-house with part of the information technology functions supported by a third-party vendor. Third party supported functions can range from software development to integration support. Some states have contracted the development of their PDMP system to a third party with the daily system management responsibilities falling to in-house staff. Others have contracted some aspects of the functionality, such as data collection or integration, to a third party.

- Benefits

This model may allow state PDMPs to expand functionality without increasing staffing. Each project can be bid out to different entities that have expertise in the desired solution. Highly specialized information technology staff can be costly. Using highly specialized staff on limited scope projects through a third-party staffing support solution can be more effective than hiring staff permanently. This solution requires fewer full-time employees compared to an in-house solution. The data is still hosted and managed by the PDMP or its state information technology resources.

- Challenges

The most significant problem with this method is that it can be difficult to piece different projects from the different vendors together. This type of solution requires strong administration skill sets in the PDMP and IT leadership to manage the contracts and the coordination of projects and resources. In addition, the PDMP will need to ensure that vendors have a strong understanding of the PDMP business goals and objectives as well as the PDMP software lifecycle.

PDMP Software System Functionality

There are many aspects to PDMP software solutions: data collection, user registration, patient report dissemination, data analysis and reporting, and integration. The core PDMP software can perform all or some of these duties.

Data Collection

Data collection is the submission of data by designated dispensers to state PDMPs. Data collection frequency varies based on individual state law. For more information on data collection frequency, go to: Data Collection Map.

- Standards

Data collected by PDMPs is submitted in the American Society for Automation in Pharmacy (ASAP) Standard format. The latest version of this standard is ASAP 4.2A. The standard defines the data elements as either "required" or "situational." While individual state PDMPs may require a situational element, required elements will not be made "situational" in order to ensure a level of continuity across PDMPs nationwide. For more information on the American Society for Automation in Pharmacy, visit their Website.

- Methods

Data collected by PDMPs is typically done by one of three methods: real time transmission, batch uploads, or individual data entry. **Real time transmission** involves the submission of each individual record from the pharmacy dispensing system to the state PDMP as it is dispensed. This method is relatively uncommon. Oklahoma and Utah are the only states who are doing real time data submission. **Batch uploads** occur when the dispenser uploads data for a particular timeframe. For example, the dispenser may upload all records for a given day on the following day. These files are transmitted electronically through a secure data transmittal system. **Individual data entry** is used to enter one prescription at a time through a manual data

entry process in a PDMP web portal. This is often used by very low volume dispensers such as a dispensing prescriber or to correct an individual record.

- Ensuring Quality Data

PDMPs are very concerned with receiving quality data. To assist in ensuring the submission of quality data, PDMPs may apply controls to the submission of data which will identify errors. These controls will warn dispensers of potential data quality issues or reject data with known quality issues. The following are some examples of error codes: Dispenser DEA Invalid, DOB Irrational, Customer Last Name Blank, and NDC (National Drug Code) Not Found. These error codes can have various degrees of severity. The following is an example of error (controls) thresholds and tolerances:

- There are three types of errors:
  - **Minor** – Incorrect data in non-vital field
  - **Serious** – Record can be loaded with missing or inappropriate data
  - **Fatal** – Record cannot be loaded
- An individual record may be rejected or, if a threshold percentage of records are rejected in an individual file, the entire file will be rejected.
- An individual record will be rejected if it contains a fatal error.
- An entire file will be rejected if either of the following are true:
  - More than 10% of the records have fatal errors; or,
  - More than 20% of the records have serious errors.

When an entire file is rejected, **no records** in it are loaded, including those without any errors.

- Uploader Accounts

For some PDMPs, the user accounts used to upload data to the system may differ from the user accounts used to access controlled substance prescription data for a patient.

- Data storage

After data is received by the PDMP, databases allow the data to be stored in a format that allows for easy retrieval. Different databases have different capabilities that make them more or less suitable for PDMP systems. Length of data storage must also be a consideration. States have different laws for the length of time PDMP data is allowed to be held. These laws may even have certain stipulations such as “data may only be retained for one year and must be de-identified after that for statistical purposes.”

Patient Report Dissemination

For PDMPs, the viewing system is a portal/website that allows prescribers, dispensers and, under some circumstances, law enforcement and other users to log in to view current or prospective data. As time and technology progress, it has been shown that integrating into electronic health records (EHR) systems allows PDMP data to be accessed in the users electronic health record or pharmacy system software. Integration offers ease of use and has resulted in more frequent viewing of patient reports for many PDMPs.

PDMP Portals

The web-based solutions provide patient reports and other functionality to the user who has entered patient demographic information into a query request screen. The patient reports are typically presented in an HTML (web page view) or a PDF format.

Interstate data sharing

Interstate data sharing refers to the sharing of PDMP reports by one state with another state based on the request of an authorized person (i.e., practitioner, pharmacist) or agency (i.e., regulatory boards, law enforcement). The Prescription Monitoring Information Exchange (PMIX) National Architecture is a nationwide framework designed to enable standards-based sharing of information between PDMPs and their stakeholders. PMIX is an information exchange standard and related guidelines that is comprised of a formal set of technical requirements that apply to state PDMP systems, data sharing "hubs", and other exchange partners or intermediaries. For additional information about PMIX, visit their Website:

There are two (2) data sharing "hubs" currently being used by PDMPs: RxCheck and PMP InterConnect.

- **RxCheck** provides states the ability to easily participate in PDMP data sharing and integration. RxCheck is the only fully operational hub owned and operated by the states that enables states to securely and efficiently share PDMP data. RxCheck was developed with support from the U.S. Bureau of Justice Assistance (BJA), using the PMIX National Architecture specifications. RxCheck was designed with the involvement of state PDMP administrators, private industry, and the federal government. RxCheck is currently operated by BJA and is governed by the RxCheck Governing Body consisting of PDMP representatives from participating states. The RxCheck Governing Body exercises full operational control of the hub. The participating states maintain full ownership and control of their data.

- **PMP InterConnect** facilitates the transfer of PDMP data across state lines. It allows participating state PMPs across the United States to be linked, providing a more effective means of combating drug diversion and drug abuse nationwide. The PMP InterConnect is a highly secure communications exchange platform that facilitates the transmission of PDMP data across state lines to authorized requestors, while ensuring that each state's data-access rules are enforced. The PMP InterConnect does not house any data and the system will not inhibit the legitimate prescribing or dispensing of prescription drugs.

Integration

There are several models for integration that states may consider. They include:

- EHR/Pharmacy system connects directly to a state PDMP using their native data exchange format. The state PDMP translates the request to and response from its system into the native format.
- EHR/Pharmacy system connects to a hub which connects to the PDMP.
- EHR/Pharmacy system connects to third-party intermediary which connects to the PDMP through a hub.
- EHR/Pharmacy system connects to an HIE which connects to the PDMP or to the PDMP through a hub.

PDMPs should consider:

- What legal agreements they need to have in place to protect the PDMP's interests;
- The audit trail available to show who has accessed PDMP data;
- The resources needed to accommodate the change in volume of requests;
- The ability to offer interstate data through the integration model;
- The resources required to provide the software capability in the PDMP and the partner system;
- The policies and procedures required to provide support to users and to manage the integration relationships.

The Office of the National Coordinator for Health Information Technology (ONC) formed the Standards and Interoperability (S&I) Framework to create harmonized health information technology specifications for use throughout the United States. ONC convened a Standards Coordination project to bring together the PDMP and Health IT (HIT) system communities to

standardize data format and transport protocols to exchange patient's controlled substances prescription data between PDMP and HIT systems. This initiative focused on translating queries to and responses from PDMP and HIT Native information exchange formats. The initiative produced two deliverables, a PDMP & HIT Integration Initiative Implementation Guide and a guide to Non-Technical Considerations for PDMP Health IT Integration. Additional information on this initiative can be found at their Website.

III. Resources

PDMP Capabilities

The links listed below contain general information as well as the policies and capabilities for every PDMP. The information was primarily obtained from the PDMP Administrators through bi-annual questionnaires. The information is also updated as legislation and regulations are enacted.

Individual State Profiles

General PDMP Information

- PDMP Program Status
- PDMP Regions
- PDMP by Operating State Agency Type
- Drugs Monitored
- Data Collection Frequency
- Major Source of Funding

PDMP Policies and Procedures

- Mandatory Enrollment of Prescribers and Dispensers
- Listing of Mandatory Enrollment Conditions
- Mandatory Query by Prescribers and Dispensers
- Listing of Mandatory Query Conditions
- Mandatory PDMP Training of Prescribers and Dispensers
- Required Data Field – Payment Method
- Required Data Field – Positive Identification
- Release of PDMP Data for Research, Epidemiological, or Educational Purposes
- Law Enforcement PDMP Access Methods

Technology

- Interstate Data Sharing Status

- PDMP Integration Status
- Data Transmission by Pharmacies
- Data Transmission by Dispensing Practitioners
- Data Transmission by Federal Agencies
- Data Collection Entity
- ASAP Version Utilized by PDMP

PDMP Requestors

- PDMP Requestors - Health Care Entities
- PDMP Requestors – Regulatory Entities
- PDMP Requestors – Law Enforcement Entities
- PDMP Requestors – Public and Private Insurance Entities
- Solicited/Unsolicited Reports to Prescribers
- Solicited/Unsolicited Reports to Dispensers
- Solicited/Unsolicited Reports to Licensing Boards
- Solicited/Unsolicited Reports to Law Enforcement

Types of Available PDMP Reports

- Reports Available to Prescribers
- Reports Available to Dispensers
- Reports Available to Licensing Boards
- Reports Available to Law Enforcement

Funding Opportunities

Federal agencies routinely offer grant funding to support the PDMPs. Typically, the funds must be used for a specific purpose, and the grantees must periodically report progress and performance measures to the funding agency. Below are links to recent grant opportunities and a guidance document describing alternative funding options for PDMPs.

- Bureau of Justice Assistance (BJA) – Comprehensive Opioid Abuse Program (COAP)
- Centers for Disease Control and Prevention (CDC) – Prevention for States Program
- Substances Abuse and Mental Health Services Administration (SAMHSA) – PDMP Data Integration; Strategic Prevention Framework for Prescription Drugs

TTAC has also developed some guidance for funding options PDMPs may wish to consider. This guide has two parts. Part I describes funding methods currently employed by PDMPs, while Part II describes other funding options, not yet in use, which PDMPs may wish to consider. The guide also categorizes PDMPs by their current funding methods so that PDMP administrators may contact their colleagues for more information on particular methods.

- Suggestions for Funding of PDMPs

PDMPs with Existing Grants

Appendix A lists the states that currently have federal grant funding to enhance the PDMP and execute opioid and heroin overdose prevention, intervention, treatment and recovery activities in their own respective states. This will be a useful chart for all the new PDMP administrators as well as for existing state administrators to understand how states are prioritizing their innovative projects. It also gives a great opportunity for peer-to-peer state collaboration and understanding the lessons learned from implementation activities.

Grant writing

There are numerous grant opportunities available to PDMPs from the federal government. Each grant announcement has certain criteria which must be met in order to receive the grant funds. PDMPs seeking federal grants should carefully review each announcement and make sure that all requirements are met. Below are links to several documents with grant writing tips to assist when applying for these grants:

- https://www.federalgrantswire.com/writing-a-federal-grant-proposal.html#.Wjl9pzdG12E
- https://www.cdc.gov/stltpublichealth/grantsfunding/grant-writing.html
- https://grants.nih.gov/grants/grant_tips.htm
- https://www.bja.gov/gwma/
- https://www.bja.gov/publications/grantwritingmanual.pdf

State Statutes and Regulations

TTAC maintains a database of state statutes and regulations which is continually updated. In addition, TTAC monitors pending and enacted legislation for each state during their legislative sessions. A comprehensive compilation is published annually and is available on the TTAC website. Topical summaries are available upon request. See Appendix B for citations by topic and state.

Statutes and Regulations

- 2017 PDMP Introduced and Enacted Legislation and Regulations
- 2016 PDMP Enacted Legislation and Regulations
- Prescribing Restrictions for Acute and Chronic Pain – October 2017
- PDMP Model Act

IV. Contacts

The links listed below contain the contact information for a variety of entities: PDMP Administrators, licensing/regulatory boards, state substance abuse agencies, controlled substance scheduling authorities, DEA Diversion Control offices and Tactical Diversion Squads, federal agencies, and national organizations relevant to PDMP Administrators.

State PDMP Administrators

State Controlled Substance Resource Directory

Federal Agencies

National Organizations

V. Guides

The links listed below are guidance documents and case studies for various features and capabilities of PDMPs around the country. These TTAC publications were created through workgroups and interviews with PDMP Administrators.

Guidance Documents and Case Studies

PDMP Enhancements

- Prescriber Report Cards
- PDMP Delegate Account Systems
- Options for Unsolicited Reporting

PDMP Evaluations

- Tracking PDMP Enhancement: The Best Practices Checklist
- Implementing Best Practices: A Comparison of PDMP Changes 2010 to 2016
- PDMP: An Assessment of the Evidence for Best Practices

Training Guides

- Training Law Enforcement
- Practitioner Education

Technical Guides

- Suggested Practices to Ensure Pharmacy Compliance and Improve Data Integrity
- Promoting PDMPs
- Recommended PDMP Reports to Support Licensing/Regulatory Boards and Law Enforcement Investigations
- Additional Data Fields for PDMPs to Consider Collecting from Dispensers
- PDMP Data Management Solutions
- Patient Linking Software Options
- Estimating Numbers and Rates of Prescriptions Collected by PDMPs
- Calculating the Level of Prescriber Enrollment in a PDMP
- Using PDMP Data to Guide Interventions with Possible At-Risk Prescribers

MME Calculator

- Calculating Daily MMEs
- Calculator Tool

Vendor User Manuals

PDMPs manage their data uploads, error resolution, user accounts, and reporting either in-house or by contracting with a vendor. PDMPs post training materials and user guides on their websites to assist authorized data reporters and users. See Appendix C for links to the manuals currently used by the PDMPs.

ASAP Manual

The ASAP format standard (version 4.2A) organizes prescription data into "segments" and is transmitted as a single file or transaction. Each file or transaction is a collection of segments and each segment is a collection of data elements or fields. There are ten (10) segments in the ASAP format:

- Transaction Header Segment (TH): indicates the start of a transaction.
- Information Source Segment (IS): conveys the name and identification numbers of the entity supplying the information.
- Pharmacy Header Segment (PHA): identifies the pharmacy or the dispensing prescriber.
- Patient Information Segment (PAT): contains the patient's name and basic information as contained in the pharmacy record.

- Dispensing Record Segment (DSP): identifies the basic components of a dispensing of a given prescription order including date and quantity.
- Prescriber Information Segment (PRE): identifies the prescriber of the prescription.
- Compound Drug Ingredient Detail Segment (CDI): contains information when a dispensed medication is a compound and one of the ingredients is a PDMP reporting drug.
- Additional Information Reporting Segment (AIR): contains a prescription blank serial number, information on a person dropping off or picking up the prescription, and information regarding the prescription that is not included in the other detail segments.
- Pharmacy Trailer Segment (TP): indicates the end of data for a given pharmacy and provides the total number of detail segments including for the pharmacy.
- Transaction Trailer Segment (TT): indicates the end of the transaction.

The ASAP manual is available upon request (a fee may be charged). Visit ASAP's website for additional details.

VI. Recommendations/Considerations

This section includes information and recommendations on several varied topics which PDMP Administrators may wish to consider, including important meetings or conferences relevant to an Administrator's work, staffing recommendations, and some program innovations which may be of interest to Administrators.

Conferences/Meetings

BJA Harold Rogers PDMP National Meeting / BJA Comprehensive Opioid Abuse (COAP) Program National Meeting

The BJA Harold Rogers PDMP National Meeting assists government agencies and partnering organizations to better understand PDMPs, their capabilities, interstate data sharing, and how stakeholders and policy makers can collaborate to use PDMPs to most efficiently address the issues of prescription drug abuse and diversion. It is an annual meeting that is open to anyone who would like to attend, and there is no registration fee. Starting in 2018, this meeting will be part of the larger BJA COAP Program National Meeting which will follow the same format and have tracks for the six (6) categories of COAP grants: Overdose Outreach Projects; Technology-Assisted Treatment Programs; System-Level Diversion and Alternatives to Incarceration Projects; Statewide Planning, Coordination, and Implementation Projects; Harold Rogers PDMP Implementation and Enhancement Projects; and Data-Driven Responses to Prescription Drug Misuse.

TTAC Regional Meetings

TTAC hosts two (2) regional meetings per year and encourages attendance from each state/territory/district in the region. View the TTAC REGIONS. The regional meetings provide a great opportunity to meet and strategize with fellow PDMP Administrators in the same geographic region, as well as obtain information on what is happening with PDMPs both nationally and locally.

National Rx Drug Abuse & Heroin Summit

The National Rx Drug Abuse & Heroin Summit is the largest national collaboration of professionals from local, state, and federal agencies, business, academia, treatment providers, and allied communities impacted by prescription drug abuse and heroin use. It is *the* event for decision makers and allied professionals working to address this public health emergency. The Summit is now the annual gathering for stakeholders to discuss what's working in prevention and treatment. Notable speakers in past years have included President Barack Obama in 2016 and U.S. Department of Health and Human Services Secretary Tom Price in 2017.

National Association of State Controlled Substances Authorities (NASCSA)

NASCSA provides an annual conference for the exchange of ideas, information, and views on legal and regulatory issues relating to controlled substances and educational opportunities and information to persons responsible for legislation, regulation, and enforcement of controlled substances laws and regulations through various methods, such as publications, resolutions, model acts, and surveys.

PDMP Staffing

Currently, the average staff size for PDMPs is 3-4 employees (median is 3 employees). There are a variety of positions that a state may have related to the PDMP. Available State resources often dictate which positions are filled. Below is an alphabetical listing of possible positions associated with PDMPs:

- **Business Analyst:** A business analyst analyzes the business owner's or customer's needs, business model and processes, and assesses its integration with technology. The business analyst bridges the business and technology world acting as an interpreter for both sides. Business analysts will document business, functional and technology requirements.
- **Data Analyst**: A data analyst compiles and analyzes data contained in a database. Data analysts are often charged with data quality, data validation and scrubbing, data standardization, data normalization, statistical analysis, and trending. Some data analysts for PDMP systems may be responsible for management of tools such as SAS and/or for the development and maintenance of patient matching algorithms. A data analyst often requires a higher skill level than a report writer.
- **Database Administrator**: A database administrator oversees the data repository of the PDMP. Their tasks include inserting, updating, and removing data as well as maintaining a strong level of database security, writing queries, and granting information technology resources access to the data. A database administrator should have a vast knowledge of the querying language as well as an understanding of the language used by the data analyst, such as Python and/or SAS. Most databases in use are Microsoft SQL; extensive knowledge of this platform may typically be required.
- **Developer**: A developer works mainly on the coding of the website and other PDMP projects, such as EHR integration. A developer will need programming skills as well as an understanding of the internal workings of the PDMP infrastructure. Developers can also be responsible for the security aspects of the web code written. Most developers will program in languages such as .NET, JAVA, PHP, and/or HTML.
- **Helpdesk Support**: The helpdesk support answers phone calls and emails from users. While these phone calls are normally about PDMP access, such as forgotten usernames and passwords, they can also be about regulatory questions, such as new laws.

- **Program Manager**: This position is responsible for the program development and direction of the program which may include the development and implementation of policies and procedures. Program Managers set program direction, recommend program policies and procedures, and oversee program operations. Generally, Program Managers hire and direct support staff. Program Managers ensure program quality, integrity and compliance with state and federal rules and requirements. They work to establish and promote relationships and partnerships with other programs, departments, stakeholders, legislation, and the public.
- **Project Manager:** A technology project manager has the responsibility for planning, procurement and execution of projects. A project manager acts as the client representative to technology resources and the technology representative to business resources. The project manager is responsible for the management of resources, budgets, and timelines. In the PDMP software system arena, project managers often fill the dual role of project manager and product manager.
- **Report Writer:** A report writer writes queries to extract data and publish standard and *ad hoc* reports for users and business owners. A report writer may use tools such as SQL Server Report Services, Crystal Reports, Business Objects, and Tableau to extract data and publish reports. Report writers require experience in requirements analysis to develop strategies to meet the user's or business owner's information needs, as well as skills in the presentation of information.
- **Server Administrator:** The server administrator oversees the aspects of the PDMP server. This includes scheduling website updates, upgrading server software, and handling security. The server administrator should have a vast knowledge of the server architecture and operating system as well as the web server and database software. While a cursory understanding of the languages known by the developers and database administrators is preferred, languages such as C, Perl, and/or SHELL are necessary.
- **Support Staff/Information Coordinator:** These employees advise users how to obtain or submit information to the PDMP. They serve as the helpdesk for system related inquires or problems, and maintain contact with pharmacies to update, resolve issues, or correct database errors. They provide reports as requested by users. Individuals in this position are considered the program experts in day-to-day operations. They train users on system usage and work with the Program Manager to develop program-related training.

PDMP Innovations

PDMPs are constantly evolving and incorporating new ideas into their programs. Many of the innovations are put in place through statutory authority in an attempt to curb the prescription drug epidemic and improve healthcare in the United States. Below are links to reports and presentations detailing a variety of recent PDMP innovations.

- Prescriber Report Cards - Arizona
- Drug Diversion Investigator PDMP Certification Course – Arkansas
- PDMP Integration into Health IT Systems - Illinois
- PDMPs and Drug Courts - Kentucky
- Overdose Prevention - Maryland
- Data Quality and Compliance - Minnesota
- Naloxone Tracking - Nebraska
- E-prescribing – New York
- Real-time Reporting - Oklahoma
- PDMPs and Medical Examiners - Virginia
- Sharing Data with Medicaid and Workers Compensation - Washington

VII. Frequently Asked Questions (FAQs)

To alleviate the number of telephone calls and emails from PDMP customers and stakeholders, PDMPs have developed FAQ webpages. Answering commonly asked questions through an effective FAQ presence on the PDMP's website frees up valuable staff time for other activities and provides immediate information. Appendix D contains examples of questions and responses from these pages. The questions are grouped into several categories: General, Access, Use, Dispenser, Delegates, Privacy, and Training. PDMP Administrators are encouraged to review the questions to determine which are applicable and customize responses per their state's laws, regulations, and policies.

VIII. Acronyms and Definitions

The following is a compilation of terms and acronyms used by and for PDMPs. Additional information may be found on the TTAC website or the ONC Health IT Playbook glossary.

- *AATOD (American Association for the Treatment of Opioid Dependence)*

AATOD was founded in 1984 to enhance the quality of patient care in treatment programs by promoting the growth and development of comprehensive methadone treatment services throughout the United States.

- *ARCOS (Automation of Reports and Consolidative Order System)*

ARCOS is an automated, comprehensive drug reporting system operated by DEA. ARCOS is designed to monitor the flow of controlled substances and provides comprehensive tracking beginning at the manufacturer and ending with dispensing.

- *ASAP (American Society for Automation in Pharmacy)*

A national organization that develops reporting standards for pharmacies and other dispensers to report prescription data to PDMPs

- *ATTC (Addiction Technology Transfer Center)*

The ATTC develops and strengthens the workforce which provides addictions treatment and recovery services to those entering the treatment system. The ATTC network consists of 14 Regional Centers and a National Office.

- *Authentication*

The process of verifying the identity and credentials of a person before authorizing access to prescription data.

- *BJA (Bureau of Justice Assistance)*

BJA is a component of the Office of Justice Programs, U.S. Department of Justice. BJA supports law enforcement, courts, corrections, treatment, victim services, technology, and prevention initiatives that strengthen the nation's criminal justice system.

- *CDC (Centers for Disease Control and Prevention)*

CDC is one of the major operating components of the Department of Health and Human Services. CDC's mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.

- *CMS (Centers for Medicare and Medicaid Services)*

CMS, previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.

- *Controlled Substances*

Certain drugs or substances whose possession and use are regulated by the federal Controlled Substances Act, 21 CFR Part 1300 and state law because of their potential for abuse and diversion. States may impose their own determination of what drugs are controlled substances by statute. For example, tramadol (before it was reclassified to the controlled substance category by the DEA) was classified as a controlled substance by many states.

- *Controlled Substance Schedule*

A hierarchy of classification of controlled substances determined by the DEA. Schedules are designated by roman numerals I, II, III, IV, V. Schedule I: A substance, with no legitimate medical purpose, that has a highest potential for physiological and psychological dependence. Illicit drugs, such as crack cocaine, MDMA, methamphetamine, and heroin, are contained in this schedule. Schedules II, III, IV, V: Drugs in this category have a legitimate medical purpose and have descending potential for abuse. Schedule II is the highest of this group and Schedule V the lowest.

- *CSAT (Center for Substance Abuse Treatment)*

CSAT is part of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS). CSAT promotes the quality and availability of community-based substance abuse treatment services for individuals and families who need them. CSAT works with states and community-based groups to improve and expand existing substance abuse treatment services under the Substance Abuse Prevention and Treatment Block Grant Program. CSAT also supports SAMHSA's free treatment referral service to link people with the community-based substance abuse services they need.

- *CSG (Council of State Governments)*

CSG is the nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy.

- *DAWN (Drug Abuse Warning Network)*

DAWN is a public health surveillance system that monitors drug-related hospital emergency department (ED) visits and drug-related deaths to track the impact of drug use, misuse, and abuse in the U.S. The DAWN system is operated and managed by SAMHSA.

- *DEA (Drug Enforcement Administration)*

DEA is within the U.S. Department of Justice. The mission of the DEA is to enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.

- *Dispensers*

The entities designated by state law that must submit prescription data to the PDMP for drugs they have dispensed. Dispensers may include pharmacies (both in- and out-of-state), hospitals for outpatient use, dispensing prescribers (including veterinarians), and correctional facilities.

- *DOJ (Department of Justice)*

DOJ's mission is to enforce the law and defend the interests of the United States according to the law; to ensure public safety against threats foreign and domestic; to provide federal leadership in preventing and controlling crime; to seek just punishment for those guilty of unlawful behavior; and to ensure fair and impartial administration of justice for all Americans.

- *FDA (Food and Drug Administration)*

FDA is the federal agency charged with protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; ensuring the safety of foods, cosmetics, and radiation-emitting products; and regulating tobacco products. The FDA is responsible for classifying and determining the appropriate schedule for all regulated drugs in the United States.

- *FSMB (Federation of State Medical Boards)*

FSMB is a national nonprofit representing the 70 medical and osteopathic boards of the United States and its territories. Since its founding, the FSMB has grown in the range of services it provides – from assessment tools to policy documents, from credentialing to disciplinary alert services – while continuing to serve the interests of its member boards. The ultimate objective is to promote excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.

- *FTP (File Transfer Protocol)*

A standard network protocol used for the transfer of computer files between a client and server on a computer network. See also SFTP.

- *GAO (U.S. Government Accountability Office)*

GAO is an independent, nonpartisan agency that works for Congress. Often called the "congressional watchdog," GAO investigates how the federal government spends taxpayer dollars. The head of GAO, the Comptroller General of the United States, is appointed to a 15-year term by the President from a slate of candidates Congress proposes.

- *HHS (Department of Health and Human Services)*

HHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS administers the Medicare program which is the nation's largest health insurer, handling more than 1 billion claims per year.

- *HIPAA (Health Insurance Portability and Accountability Act)*

HIPAA is a federal law enacted in 1996 and provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, HIPAA is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. PDMPs are not considered covered entities under HIPAA.

- *HL7 (Health Level-7)*

A not-for-profit organization that develops a set of international standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery, and evaluation of health services.

- *HRPDMP (Harold Rogers Prescription Drug Monitoring Program)*

HRPDMP is administered by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. HRPDMP provides three categories of grants: planning, implementation, and enhancement. To be eligible for funding, the state must already have a statute or regulation permitting the establishment of a PDMP.

- *IHS (Indian Health Service)*

IHS is an agency within the federal Department of Health and Human Services that is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes.

- *IJIS (Integrated Justice Information Systems Institute)*

IJIS is a nonprofit membership organization dedicated to joining forces with its member companies to unite the private and public sectors for improving mission-critical information sharing. IJIS is funded by its members and by grants from the U.S. Department of Justice, the Bureau of Justice Assistance, and the U.S. Department of Homeland Security.

- *Interstate Compact (Prescription Monitoring Program Compact)*

CSG has drafted a new Interstate Compact that would enable states to develop an interoperable system to share prescription data. Since November 2009, CSG has worked with a variety of federal, state and local officials as well as national stakeholder organizations representing a variety of PDMPs nationwide.

- *Interstate Data Sharing*

The sharing of PDMP reports by one state with another state based on the request of an authorized person (i.e., practitioner, pharmacist) or agency (i.e., regulatory boards, law enforcement).

- *Legend Drug*

A medication approved by the FDA that is required by federal or state law to be dispensed to an ultimate user pursuant to a prescription from a licensed practitioner.

- *Medication Reconciliation*

The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route of administration — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital and the continuum of care.

- *Model Act (Prescription Drug Monitoring Program Model Act)*

The Model Act, prepared by the ASPMP, provides a statutory framework for establishing and operating a PDMP. It also provides a framework for states with existing PDMPs to update their statutes. The Model Act is a consensus document that reflects the best practices of the states that currently run PDMPs as well as the knowledge of other states that have a long-standing interest in PDMPs.

- *NABP (National Association of Boards of Pharmacy)*

NABP is a 501(c)(3) nonprofit association that protects public health by assisting its member boards of pharmacy and offers programs that promote safe pharmacy practices for the benefit of consumers. NABP is the independent, international, and impartial association that assists its member boards and jurisdictions for the purpose of protecting the public health.

- *NAMSDL (National Alliance for Model State Drug Laws)*

NAMSDL is a resource for governors, state legislators, attorneys general, drug and alcohol professionals, community leaders, the recovering community, and others striving for comprehensive, effective state drug and alcohol laws and policies. NAMSDL will draft, research, and analyze model drug and alcohol laws and related state statutes; provide access to a national network of drug and alcohol experts; and facilitate working relationships among state and community leaders and drug and alcohol professionals.

- *NASCSA (National Association of State Controlled Substance Authorities)*

NASCSA has a primary purpose to provide a continuing mechanism through which state and federal agencies, as well as others, can work to increase the effectiveness and efficiency of state and national efforts to prevent and control drug diversion and abuse, and to provide an educational forum to further this purpose.

- *NASPER (National All Schedules Prescription Electronic Reporting Act)*

NASPER is a federal law passed in 2005 which established a grant program for PDMPs within the Federal Department of Health and Human Services.

- *NCPDP (National Council for Prescription Drug Programs)*

An ANSI-accredited, organization providing standards for electronic healthcare transactions used in prescribing, dispensing, monitoring, managing, and paying for medications and pharmacy services.

- *NCSL (National Conference of State Legislatures)*

NCSL is a bipartisan organization that serves the legislators and staffs of the nation's 50 states, its commonwealths, and territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues.

- *NDC (National Drug Code)*

Federal law requires drug products be identified and reported by drug manufactures to the FDA using a unique, three-segment number, called the National Drug Code (NDC), which is a universal product identifier for human drugs. FDA inputs the full NDC number and the information submitted as part of the listing process into a database known as the Drug Registration and Listing System (DRLS). Each listed drug product is assigned a unique 10-digit, 3-segment number. This NDC number identifies the labeler, product, and trade package size.

- *NSDUH (National Survey on Drug Use and Health)*

NSDUH provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs), and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

- *OJP (Office of Justice Programs)*

OJP provides innovative leadership to federal, state, local, and tribal justice systems by disseminating state-of-the art knowledge and practices across America, and providing grants for the implementation of these crime fighting strategies. Because most of the responsibility for crime control and prevention falls to law enforcement officers in states, cities, and neighborhoods, the federal government can be effective in these areas only to the extent that it can enter into partnerships with these officers. Therefore, OJP does not directly carry out law enforcement and justice activities. Instead, OJP works in partnership with the justice community to identify the most pressing crime-related challenges confronting the justice system and to provide information, training, coordination, and innovative strategies and approaches for addressing these challenges.

- *ONC (Office of the National Coordinator for Health Information Technology)*

ONC is the principal federal entity within the US Department of Health & Human Services charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.

- *ONDCP (Office of National Drug Control Policy)*

ONDCP is a component of the Executive Office of the President. The principal purpose of ONDCP is to establish policies, priorities, and objectives for the Nation's drug control program. The goals of the program are to reduce illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences.

- *Opioids*

Pain-reducing drugs that are chemically or structurally similar to opium and interact with opioid (mu-receptors) in the brain and body producing morphine-like effects. Opioids include legal prescription drugs such as morphine, fentanyl, hydrocodone, and oxycodone as well as illegal opioids such as heroin.

- *OTC (Over-the-Counter)*

A drug that is safe and effective for use by the general public without supervision or treatment by a health professional and does not require a prescription.

- *PDMP (Prescription Drug Monitoring Program)*

A state administered system of collecting, monitoring, and disseminating information regarding dispensed controlled substances, such as opioids, benzodiazepines, stimulants, and other selected prescription drugs (drugs of concern).

- *PMP (Prescription Monitoring Program)*

Used interchangeably by some states/organizations with PDMP (See PDMP). Used in some unrelated venues as Project Management Professional.

- *PMP Gateway*

PMP Gateway connects to PMP Interconnect, providing an interface for healthcare providers to query patient prescription data.

- *PMPi (NABP PMP InterConnect)*

NABP PMP InterConnect® facilitates the transfer of PDMP data across state lines. It allows participating state PDMPs across the United States to be linked, providing a more effective means of combating drug diversion and drug abuse nationwide.

- *PMIX (Prescription Monitoring Information Exchange)*

PMIX National Architecture is a formal set of technical requirements that existing and future interstate data hubs need to comply with to enable hub-to-hub communication. A critical component of the architecture is the use of open standards (IT design elements that are in the public domain and available free of charge). Adopting open standards helps ensure a state's ability to remain flexible and reduce costs.

- *Prescribers*

Prescribers are those who have authority under state or federal law to prescribe controlled substances and are typically the group that requests the most reports from a PDMP. This group can include: medical doctors, osteopathic doctors, nurse practitioners, physician assistants, dentists, veterinarians, naturopathic doctors, optometrists, and podiatrists.

- *RxCheck Hub*

The RxCheck hub is the baseline implementation of the PMIX architecture and was developed, with BJA support, to create an operational data sharing hub to implement the PMIX specifications and to deliver a functional interstate data-sharing solution. The RxCheck Governance group (comprised of states connected to, or with plans to connect to, the RxCheck hub) continues to own the hub and provides guidance, stewardship, and leadership. The IJIS Institute manages the RxCheck hub and operates as an agent of the RxCheck Governance group in its maintenance and operation.

- *SAMHSA (Substance Abuse and Mental Health Services Administration)*

SAMHSA is a branch of the federal Department of Health and Human Services (HHS) and oversees the NASPER grant program. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

- *SFTP (Secure File Transfer Protocol)*

SFTP (also referred to as "SSH File Transfer Protocol"); provides file transfer and manipulation functionality over any reliable data stream

- *Solicited Reporting*

A product of a PDMP where PDMP data is provided to an authorized user in the form of a report based upon the user's request for the information from the PDMP. The reports can be produced through an automated online system or manually by PDMP staff. Entities that receive these reports can include: prescribers, dispensers, law enforcement, and regulatory boards.

- *SSL (Secure Sockets Layer)*

SSL is a cryptographic protocol that provides secure communications for data transfers

- *TTAC (Training and Technical Assistance Center)*

The TTAC is a partnership of BJA and Brandeis University's Heller School for Social Policy and Management. The partnership is funded by BJA to provide assistance and training to governments and other entities regarding PDMPs. The TTAC assists BJA grantees and others in planning, implementing, and enhancing PDMPs.

- *UCF (Universal Claim Form)*

UCF is an electronic form used by a pharmacy that has Internet access, but is unable to submit its data in a batch upload.

- *Unsolicited Reporting (also known as proactive reporting or unsolicited alerts)*

A product of a PDMP where prescription information is analyzed by PDMP staff and questionable activities are then reported to appropriate personnel based on thresholds established by the PDMP. Entities that receive these reports can include: prescribers, dispensers, law enforcement, and regulatory boards.

Appendix A – PDMPs with Existing Grants

State	Grant Name	Grant Period	Grant Amount	Staff Hired	Programs/Projects Proposed	Additional Information
Alabama	BJA PDMP	10/1/2016-9/30/2018	$400,000	none	PDMP Enhancements	
Alabama	CDC Data Driven Prevention Initiative (DDPI)	9/1/2016-8/31/2019	$900,000	Project Manager; Evaluator	Write & Implement Opioid Overdose Prevention Strategic Plan & conducting prevention awareness campaign	
California	BJA 2015 Harold Rogers (Category 2)	October 1 2015-September 30, 2018	$750,000	None	Evaluate the implementation of CURES 2.0 and estimate overall effect of planned PDMP enhancements on prescribing behaviors and health outcomes. Compare the custom-built record linking program used by CURES 2.0 against existing record linking software programs. Design, test, and compare advanced data-driven algorithms for identifying high-risk prescribing and dispensing patterns to inform law enforcement, public health, and regulatory enforcement activities. Engage law enforcement, regulatory, and public health agencies to identify the kinds of proactive PDMP reports that will best advantage each agency's goals.	CA DOJ partners with a University of California Davis research team on this grant effort. As a side note, although CA DOJ's PDMP is not a recipient for other grants, we collaborate with other state agencies on their federal grant-supported activities by providing PDMP data.

District of Columbia	CDC Prescription Drug Overdose: Data-Driven Prevention Initiative (DDPI)	9/1/2016 through 8/31/2019	$1,140,000	Public Health Analyst	Develop a Strategic Plan; Establish a PDMP Advisory Committee; Analyze PDMP data with Advanced Analytics software; Develop a Data Dashboard to provide an up-to-date snapshot of key metrics that describe the current opioid crisis in the District; Develop a Website that D.C. DOH can easily point to that includes an overview of our opioid-related activities, as well as a public-facing space that includes resources	
Florida	Harold Rogers Prescription Drug Monitoring Program Enhancement Grant	$499,991		Senior Pharmacist; Law Enforcement Analyst	Grant funds for this award are being used to enhance existing proactive reporting efforts and analysis of the impact on prescriber behavior and law enforcement efforts; develop algorithms to further automate proactive notifications; and advocate for legitimate and appropriate use of controlled substances while not interfering with physician prescribing practices.	
Guam	BJA Harold Rodgers Grant	October 2016 - September 2018	$386,061	PDMP Administrator	Implementation and enhancement	
Illinois	CDC Supplemental	September 2017 – August 2018	$499,152	None	Prescriber Education;Evaluation;PDMP Integration	
Illinois	CDC Expansion Grant	September 2017 – August 2018	$734,129	None	Prescriber Education;Evaluation;PDMP Integration; academic detailing; continuing medical education	

Illinois	SAMHSA	May 2017 – April 2018	$440,847	Two Contract I.T. Positions	E.H.R. Integration; Marketing; Advertising	
Illinois	Harold Rogers 2016	October 2016 – September 2018	$399,961	None	E.H.R. integration; advertising; evaluation	
Iowa	BJA Harold Rodgers Grant	10-1-2017 to 9-30-2019	$400, 000	Possibly will hire a data analyst	Upgraded PMP software; PMP Integration with EHRs; Enhanced user education	
Iowa	SAMHSA Iowa Opioid State Targeted Response Grant	5-1-2017 to 4-30-2018	$200,000	None	PMP integration with EHRs; Prescriber education on PMPs	
Kansas	CDC Prescription Drug Overdose Prevention	September 2016 to September 2019	$3,000,000	Epidemiologist	State wide Integration of all E.H.R.'s with the state PDMP; Education and Training for Prescriber and Dispensers	
Kansas	Harold Rogers Grant	September 2017 to August 2019	$178,680	None	Prescriber Report Card	
Kentucky	2015 Harold Rogers PDMP Enhancement Grant	10/1/2015 to 9/30/2018	$488,342	Grant project manager; business analyst	Develop and implement a modular PDMP data collection system	
Kentucky	2016 Harold Rogers PDMP Enhancement Grant	10/1/2016 to 9/30/2018	$399,463	Grant project manager; senior system developer	Develop and implement a prescriber dashboard (prescriber report card); implement a mandatory PDMP usage compliance enforcement process; support use of PDMP data for studies and research	

Kentucky	2017 SAMHSA State Targeted Response Grant	05/1/2017 to 04/30/2018	$10,528,093	PDMP related: epidemiologist	PDMP related: implement the ability in the PDMP to allow providers to determine whether a patient has positive drug toxicity screen results from a suspected non-fatal drug overdose in an ED	
Kentucky	2013 SAMHSA HER and PDMP Data Integration	10/1/2013 to 9/30/2017	$307,814	Integration Project Manager	Upgrade to ASAP 4.2, Integrate with one hospital emergency department, one physician practice, one retail pharmacy and the Kentucky Health Information Exchange.	
Kentucky	FY2014 Data driven grant, BJA	10/1/2014 - 9/30/2017	$399,889	Supported: 1) percent effort for University of KY faculty researchers; 2) part time University of KY data analyst; 3) partial funding for a KASPER developer and KASPER business analyst	Developed multi agency data sharing agreements and initiated a multi-source data collection for drug overdose fatality surveillance including death certificates, postmortem toxicology results, and PDMP history data; Developed automated scheduled monthly linkages of death certificate and PDMP data; implemented an algorithm for the calculation of the cumulative daily dose of prescribed opioids measured in morphine milligram equivalents (MME), and included a historical trend line of daily MME dose on the eKASPER patient report; enhanced KASPER quarterly reports with county-specific rates of patients with high MME and rates of overlapping opioid and benzodiazepine prescriptions; produced research papers related to patterns of opioid use, misuse, and overdose in the state	

Kentucky	FY2017 Category 6, BJA	10/1/2017-9/30/2020	$600,000	will support: 1) percent effort for University of KY faculty researchers; 2) part time University of KY data analyst.	1) Evaluate the effect of KY SB32 2017 (requiring inclusion of drug conviction data in KASPER) on prescriber and dispenser behaviors; 2) develop and deliver continuing education for prescribers and dispensers on interpretation of drug conviction data; 3) Evaluate patterns of gabapentin prescribing, co-prescribing, misuse and diversion after gabapentin became schedule V controlled substance in KY in July 2017.	
Maryland	CDC Prescription Drug Overdose Prevent for States Grant	3/1/2016 - 8/31/2019	$1,401,568.00	Overdose Program Manager, PDMP Epidemiologist, Overdose Prevention Coordinator	PDMP Integration; Evaluation; Hospital Based Interventions; Pharmacy Education	
Maryland	2015 Harold Rogers Prescription Drug Monitoring Program: High Risk Prescription Drug Users	10/1/2015 - 9/30/2018	$743,566.00	None	PDMP Practitioner and Research Partnership; Development of predictive risk model to identify potential risk factors of overdose and opioid-related adverse health outcomes	
Michigan	CDC: Prescription Drug Overdose: Data Driven Prevention Initiative	October 1, 2016 to August 31, 2018	$214,507	N/A for MAPS	MAPS Piece (LARA): Appriss create de-identified indicators, LARA provide MAPS education in conjunction with MDHHS (MDHHS-CDC Guidelines, LARA-MAPS)	LARA is a sub-recipient and working in conjunction on this project with MDHHS

Michigan	SAMSHA: State Targeted Response to the Opioid Crisis Grants	October 1, 2017 to September 30, 2019	$1,000,000	N/A for MAPS	First year: Implement NarxCare; Second year: NarxCare outcome study	LARA is a sub-recipient and working with MDHHS on this project
Michigan	Harold Rogers 2016 – PM-BX-0010	October 1, 2016 to August 31, 2018	$381,483	N/A for MAPS	Pilot EMR Integrations with MAPS	
Michigan	Harold Rogers 2016 – PM-BX-0010	October 1, 2016 to August 31, 2019	$594,138	N/A for MAPS	Appriss to create Prescriber Report Cards; Appriss to produce PMP Alerts enhancement, Appriss to create advanced analytics reports, and Appriss to overlay our MI overdose death data with MAPS 1 year previous to patients' date of death for years 2013-2017	
Mississippi	Harold Rogers	October 1, 2016 – Sept 30, 2018	$352,018	None	Various	
Missouri	BJA Category 5 Grant (PDMP)	October 1, 2017-September 30, 2019	$400,000	Biostatistician	Cover all subscribing counties' participation costs for PDMP; increase engagement, education, and reporting.	
Missouri	BJA Category 6 Grant (data-driven responses)	October 1, 2017-September 30, 2020	$600,000	Project Coordinator (to be hired)	Increase regional collaboration to spread innovative solutions; support the development of community-based interventions; evaluate efforts.	

Montana	Harold Rogers	4/1/2016 – 12/31/2017	$364,304	None	Continued development of automated system, travel. All daily operating expenses are now covered by MPDR Fees collected during the license renewal process.	We had a couple of smaller grants, which I believe were part of the Harold Rogers program, obtained in support of legislative efforts to create the MPDR. I cannot locate any details about these very small grants, but they were expended prior to mid-2011.
Nebraska	CDC Prescription Drug Overdose Prevention	September 1, 2015 to August 31, 2019	$3,084,996	Project Manager, PDO Epidemiology Surveillance Coordinator; Contracted Staff	PDMP enhancements; conduct public health surveillance; Develop, implement and educate on statewide pain guidance document; educate on expanded access to naloxone; evaluation	
Nebraska	CDC Prescription Drug Overdose Prevention - supplemental	September 1, 2017 to August 31, 2018	$661,999	Contracted Staff	PDMP enhancements; pain management education; toxicology testing (focus on improvements of data quality of death certificate data)	
Nebraska	Department of Justice - Harold Rogers Grant	October 1, 2015 to September 30, 2017	$500,000	Contracted Staff	PDMP training development and implementation; PDMP enhancements	

Nebraska	Department of Justice - Harold Rogers Grant COAP Cat 6 Grant	October 1, 2017 to September 30, 2020	$600,000	Contracted Staff	Data Dashboard development; Workgroup for data dashboard; toxicology testing (focus on improvements of data quality of death certificate data)	
Nevada	CDC Prescription Drug Overdose Prevention for States (PFS)	August 2016 to July 2019	$1,158,632		Expand and improve proactive reporting; Conduct public health surveillance with PMP data and disseminate quarterly reports; Identify and provide technical assistance to high-burden communities and counties to address problematic prescribing; Create an opioid data dashboard; Link deaths, hospitalizations and prescriptions of individuals; Create mapping of funding activities to find gaps; Policy analysis and implementation; CDS's statewide media campaign; Link health data sets and law enforcement data sets	
Nevada	CDC Enhanced State Surveillance of Opioid Involved Morbidity and Mortality (ESOOS)	September 2017 to August 2019	$387,763		Increase timeliness of aggregate nonfatal opioid overdose reporting; Increase the timeliness of fatal opioid overdose and associated risk factor reporting; Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses	

Nevada	SAMHSA State Targeted Response to the Opioid Crisis (STR)	May 2017 to April 2019	$5,663,328		Treatment Infrastructure; Law enforcement collaboration; Naloxone purchase and distribution center; Training and education activities for health care providers, who care for people with opioid use disorder or who are at risk of opioid overdose; Linkage to treatment services, including mobile outreach	
Nevada	BJA Harold Rogers Prescription Drug Monitoring	October 2015 to September 2018	$492,993		-Analyze PDMP data in order to identify high-risk populations, geographic hotspots, and the relationship between heroin arrests and opioid prescription	
Nevada	BJA Harold Rogers Prescription Drug Monitoring	October 2015 to September 2018	$304,000		Enforce mandatory use of the PDMP; Measure effectiveness of new mandate on number of nonfatal and fatal overdoses	
New Hampshire	BJA COAP Cat 5 Grant	October 2017 to September 2019	$400,000	Sustain current staff	data compliance & integrity; drug court pilot; data sharing with partners	
New Jersey	CDC-RFA-CE16-16060201 SUPP17 Prescription Drug Overdose: Data-Driven Prevention Initiatives	SEPTEMBER 1, 2017 – AUGUST 31, 2018	$582,150	Data Scientist; Data Architect	PMP integration into hospital emergency department software systems	The NJPMP will receive $177,500 of the total grant award to accomplish the proposed project

New Jersey	BJA-2015-4189 Harold Rogers Prescription Drug Monitoring Program	OCTOBER 1, 2015 – SEPTEMBER 30, 2018	$482,451	Data Analyst	Suspicious Activity Monitor; Law Enforcement Module; De-Identified Data Extract; Enhanced Data Analytics; Public Awareness and Educational Pilot Program	One-year extension added to original grant period (October 1, 2015 – September 30, 2017)
New Mexico		Until 12-31-2017				
New York	CDC Prescription Drug Overdose Prevention (PDOP) for States Grant	September 2015 to August 31, 2019	$8,800,000	Electronic Health Record Program Manager; Information Technology Manager; Technical Architects	PDMP Mobile Responsive Website; PDMP integration with electronic health records; Prescriber Education	
Pennsylvania	CDC Prescription Drug Overdose Prevention for States (PFS)	September 2015 to August 31, 2019	$3,760,000	Epidemiologist; Statistician; and PDMP Assistant Administrator	Prescriber Education Initiative; and Policy and Program Evaluation;	
Pennsylvania	CDC Prescription Drug Overdose Prevention for States (PFS) Supplemental	September 2016 to August 31, 2019	$3,000,000	None	EMR and Pharmacy System Integration	

Pennsylvania	CDC Enhanced State Surveillance of Opioid Involved Morbidity and Mortality (ESOOS)	September 2016 to August 31, 2019	$1,470,000	Program Analyst	Rapid data collection and surveillance of ED and EMS overdoses + Overdose death data from Medical Examiners and Coroners in PA	
Pennsylvania	CDC Enhanced State Surveillance of Opioid Involved Morbidity and Mortality (ESOOS) Supplemental	September 2017 to August 31, 2018	$196,000	Program Specialist (contractor)	Rapid data collection and surveillance of ED and EMS overdoses + Overdose death data from Medical Examiners (ME) and Coroners in PA + 60% of the funds provided to the ME/Coroners	
Pennsylvania	SAMSHA: State Targeted Response to the Opioid Crisis Grants	May 2017 to April 2019	$2,100,000	None	- $250,000 for Prescriber Education Initiative - $800,000 for EMR and Pharmacy System Integration	
Pennsylvania	SAMSHA: Strategic Prevention Framework (SPF) for Prescription Drug (Rx)	October 2016 to September 2021	$750,000	None	Academic Detailing/Prescriber Education Initiative focusing on youth patient population in 2 counties of PA	

Rhode Island	CDC Prescription Drug Overdose Prevention (PDOP) for States Grant	September 2015 to August 31, 2019	$7,274,000	Epidemiologist; Data Manager; Academic detailer; PDMP project director (part time)	Prescriber Education ;Evaluation;PDMP Integration; PDMP automatic alerts	
South Carolina	CDC Prescription Drug Overdose Prevention (PfS) for States Grant	March 1, 2016 to August 31, 2019	$2,625,000	Epidemiologist, Grant Coordinator/Evaluator, Admin Specialist to assist PMP	Academic Detailing, GuideMed patient monitoring and assessment, evaluation, policy evaluation, Prescriber Reports, PMP/EHR Integration	
Washington	2017 BJA Cat 6	10/01/2017 – 09/30/2020	$520,165	1 - Epi 3	Provide quarterly PDMP data to health care facility Chief Medical Officers (CMO) to support local (facility) Quality Improvement Interventions and prescriber education.	
Washington	2017 BJA Cat 5	10/01/2017 – 09/30/2019	$333,489	1 - MA 5	Provide information, education and onboarding coordination and assistance to HCOs working to integrate PMP to EHR	
Washington	CURES - STR	8/10-2017 - 4/30/2018	$242,987	1 – Epi 3; 1 - HSC	Production of prescriber feedback reports; Production of PMP metrics and measures at school district level	
West Virginia	CDC Prescription Drug Overdose Prevention (PDOP) for States Grant	September 2017 to August 2018	$868,000	2 Epidemiologists and a data analyst	Prescriber Education and Evaluation; PDMP Integration; PDMP Enhancements	

Appendix B – State Statutes and Regulations

Prescription Drug Monitoring Program Statutes and Regulations		
State/Title of Program	**Statutes**	**Regulations**
Alabama Controlled Substances Prescription Database	§§ 20-2-210 to -220 (2017) §§ 34-24-604 to -605 (2017)	420-7-2-.11 to -.13 (2017) 540-X-4-.01, -.03, -.05, -.09, Appendix B (2017) 540-X-12-.05, -.06, -.16, Appendix B (2017) 540-X-18-.05, -.06, -.14, Appendix B (2017) 540-X-19-.02 to -.05, -.08, Appendix A (2017) 540-X-21-.03 (2017) 540-X-20-.04 (2017) 930-X-1-.10, -.11, -.13, -.31, -.32 (2017)
Alaska Controlled Substance Prescription Database	§§ 08.36.070, 08.64.101, 08.68.100, 08.72.060, and 08.80.030 (2017) § 11.71.900 (2017) § 17.30.200 (2017) § 47.07.038 (2017)	12 AAC 52.855 – 52.895 (2017)
Arizona Controlled Substances Prescription Monitoring Program	§§ 23-1026 and 23-1062.02 (2017) §§ 36-2601 to -2610 (2017) §§ 32-1501, 32-1907, and 32-3219 (2017)	R4-23-501 to -505 (2017) R4-19-513 (2017) R9-17-202 and R9-17-204 (2017)
Arkansas Prescription Drug Monitoring Program	§§ 20-7-601 to -615 (2017) § 10-3-309 (2017) § 12-18-622 (2017) § 17-92-1004 (2017) § 17-95-102 (2017) § 20-7-707 (2017)	007.07.4-I to –XV (2017) 060.00.1-2 and 060.00.1-19 (2017) 067.00.4-VIII and 067.00.4-XII (2017) 069.00.1-V-IX1 (2017)
California Utilization Review and Evaluation System (CURES)	Bus. & Prof. Code §§ 208, 209, 2196.8, and 4068 (2017) Civ. Code § 56.36 (2017) Health & Safety Code §§ 11164.1, 11165, 11165.1, 11165.2, 11165.3, 11165.4, 11165.5, and 11190 (2017)	Tit. 16, § 1715.5 (2017)
Colorado Prescription Drug Monitoring Program (DORA)	§§ 12-42.5-401 to -409 (2017) §§ 24-72-601 to -602 (2017) §§ 18-4-412 and 24-34-104 (2017)	Tit. 2 § 502-1:21.320.3, .4, .7 (2017) Tit. 3 §§ 709-1:IX and XXIII (2017) Tit. 3 § 716-1:15-6 (2017) Tit. 3 § 719-1:23.00.00 (2017) Tit. 7 § 1101-3:17, Ex. 1, Ex. 3 to Ex. 9 (2017) Tit. 7 §1101-3:18 (2017)

Connecticut Prescription Monitoring and Reporting System (CPMRS)	§ 20-578 §§ 21a-240, 21a-254, 21a-254a, and 21a-317 (2017)	§§ 21a -254-2 to -7 (2017) §§ 21a-408-1, -2, -38 & -50 (2017)
D.C Prescription Drug Monitoring Program	§§ 48-853.01 to 48-853.10 (2017) § 48-901.02 (2017)	17 DCMR §§ 10300 to 10399 (2017)
Delaware Prescription Monitoring Program	16 § 4798 (2017)	24 CSA 9.0 (2017)
Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE)	§ 381.986 (2017) §§ 893.055 and 893.0551 (2017)	64K-1.001 – .007 (2017) 64B16-27.831 (2017)
Georgia Electronic Database of Prescription Information	§§ 16-13-57 to -65 (2017)	360-8-.02 (2017)
Hawaii Electronic Prescription Accountability System	§§ 329-101 to -104 (2017) §§ 329-1 and 329-59 (2017)	§§ 23-200-2, -17, -22 (2017)
Idaho Controlled Substances Prescriptions Database	§ 74-106 §§ 37-2716, 37-2726, and 37-2730A (2017)	R. 27.01.01.204 (2017)
Illinois Prescription Monitoring Program	720 § 570/314.5 and §§ 570/316 to 570/320 (2017) 720 §§ 570/102, 570/313, and 570/507.2 (2017)	Tit. 77, §§ 2080.10 to -.30, -.50, -.70, -.90, -.100, -.190 to -.250 (2017) Tit. 77 §§ 2081.10 to -.80 and App. A (2017) Tit. 77 § 3100.85 (2017)
Indiana Scheduled Prescription Electronic Collection and Tracking Program (INSPECT)	§§ 12-23-18-5.3, 12-23-18-8 (2017) §§ 25-1-13-1 to -6 (2017) §§ 25-14-1-15 and 25-14-1-235 (2017) §§ 25-23-1-15 and 25-23-1-199 (2017) § 25-26-135-15 (2017) §§ 25-29-1-17 and 25-29-1-105 (2017) §§ 25-225-1-105 and 25-225-13-7 (2017) §§ 25-275-2-75, and 25-275-5-45 (2017) § 34-30-2-152.5 (2017) §§ 35-48-7-2.3 to -17 (2017)	440 ADC 10-1-24.5, 10-2-3, and 10-4-19 (2017) 844 ADC 5-6-7, 5-6-8, and 22-3-8 (2017) 845 ADC 2-1-8 (2017) 848 ADC 5-4-8 (2017) 856 ADC 6-1-1 to -4 (2017)
Iowa Drug Prescribing and Dispensing Information Program	§§ 124.550 to -.558 (2017)	653-13.2 (2017) 657-37.1 to 37.9 (2017) 657-24.3 (2017)
Kansas Tracking and Reporting of Controlled Substances (K-TRACS)	§§ 65-1627 and 65-1681 to -1694 (2017)	68-21-1 to -7 (2017)

Kentucky All Schedule Prescription Electronic Reporting (KASPER)	§§ 218A.172, 218A.202, 218A.205, 218A.240, 218A.245, 218A.278, 218A.390 and 218A.391 (2017) §§ 315.035, 315.0351, 315.340, and 315.342 (2017)	201 ADC 5:030, 5:130, 8:532, 8:540, 9:016, 9:230, 9:240, 9:250, 9:260, 9:270, 9:310, 20:057, 20:063, 20:215, 25:011, 25:021, 25:031, and 25:090 (2017) 902 ADC 20:420, 20:430, 55:045, and 55:110 (2017) 907 ADC 1:677 (2017)
Louisiana Prescription Monitoring Program	§§ 40:973, 40:975, 40:978, 40:1046, 40:1001 to -1014 (2017)	Tit. 40, Pt., I, §§ 2003, 2103, 2119, 2203, 2311 and 2317 (2017) Tit. 46, Pt. LIII, §§ 523, 2901 to 2929 (2017) Tit. 46, Pt. XLV, §§ 6506, 7403, 7705 and 7717 (2017) Tit. 46, Pt. XLVII, § 4505 (2017) Tit. 48, Pt. I, §§ 7831 and 7861 (2017)
Maine Controlled Substances Prescription Monitoring	22 §§ 7245 to 7254 (2017) 22 §§ 7261 to 7274 (2017) 32 § 4878 (2017)	14-118-11 ADC § 1 to 12 (2017) 02-313-21 ADC § III (2017) 02-373-2 ADC §§ 3 and 5 (2017) 02-373-21 ADC § III (2017) 02-380-21 ADC § III (2017) 02-383-2 ADC §§ 3 and 5 (2017) 02-383-21 ADC § III (2017) 02-396-21 ADC § III (2017) 10-144-101 ADC §§ 65 and 93 (2017)
Maryland Prescription Drug Monitoring Program	Criminal Law § 5-304 (2017) Health General §§ 21-2A-01 to -10 (2017) State Govmt. §§ 2-10A-02, 8-401 to -411 (2017)	10.47.07.01 to -.09 (2017)
Massachusetts Prescription Monitoring Program	Ch. 94C §§ 7A, 18, 18B, 24A, 24B, and 49 (2017)	105 ADC 164.302, 164.308, 700.001, 700.003, 725.010, 700.012, and 700.105 (2017) 234 ADC 5.06 (2017) 243 ADC 2.07 (2017) 244 ADC 4.07 (2017) 247 ADC 5.01 - 5.04, 9.04 (2017) 249 ADC 4.02 (2017) 263 ADC 5.07 (2017)
Michigan Automated Prescription System (MAPS)	§§ 333.7112 to -.7113, -.7333a, -16204c, -16315 (2017)	§§ 338.3162b to .3162e and 338.3056 (2017) § 418.101008a (2017)
Minnesota Prescription Monitoring Program	§ 152.126 (2017) § 245A.192 (2017) § 245G.22 (2017) § 256B.0638 (2017)	5221.6105 and 5221.6110 (2017)

Mississippi Computerized Program to Track Prescriptions for Controlled Substances	§§ 73-21-97, 73-21-103 and 73-21-127 (2017)	§ 24-2:54.3 (2017) § 30-17-2640:1.15 (2017) § 30-18-2840:1.1 (2017) §§ 30-20-3001:IV, 30-20-3001:V, 30-20-3001:VII, 30-20-3001:IX, 30-20-3001:XXIII, 30-20-3001:XXXIV, and 30-20-3001:XLIII (2017) §§ 30-20-3002:2.1 and 30-20-3002:4.1 (2017)
Missouri, St. Louis County Prescription Monitoring Program	St. Louis Co. Ord. 602.800 to .808 (2017)	None
Montana Prescription Drug Registry (MPDR)	§§ 37-7-101, 37-7-1501 to 1514 (2017) § 39-71-1110 (2017)	24.174.1701 to .1715 (2017)
Nebraska Prescription Drug Monitoring Program (NEHII)	§§ 71-2454 to 71-2456 (2017) § 84-712.05 (2017)	None
Nevada Computerized Program to Track Prescriptions	§§ 453.126, 453.162 to 453.165, and 453.221 (2017) §§ 639.23507 and 639.310 (2017)	§§ 631.045 and 631.230 (2017) § 639.926 (2017)
New Hampshire Controlled Drug Prescription Health and Safety Program	§§ 318-B:31 to -41 (2017)	Den. 301.02, 301.04, 502.01, and 503.06 (2017) Med 401.03, 401.05, 501.02, and 502.06 (2017) Nat. 501.06 (2017) Nur. 501.04 and 502.06 (2017) Ph. 401.04 and 1501.01 to 1506.02 (2017) Vet. 301.01 (2017)
New Jersey Prescription Monitoring Program	§§ 45:1-44 to -52 (2017) §§ 24:21-15.2 and 24:21-54 (2017)	§ 13:35-7.6 (2017) § 13:37-7.9A (2017) § 13:38-2.5 (2017) § 13:30-8.18 (2017) §§ 13:45A-35.1 to 35.11 (2017)
New Mexico Prescription Monitoring Program	§§ 26-1-16.1 and 30-31-16 (2017)	§ 8.351.2 (2017) § 11.4.4 (2017) § 16.5.57 (2017) § 16.10.14 (2017) § 16.11.2 (2017) § 16.12.9 (2017) § 16.16.15 (2017) § 16.17.5 (2017) §§ 16.19.4, 16.19.20, and 16.19.29 (2017) § 16.21.9 (2017)
New York Prescription Monitoring Program Registry (I-STOP)	Public Health Law § 12-b Public Health Law §§ 3302, 3309-a, 3331, 3333, 3343-a, 3361, 3364, 3370, 3371, 3371-a, and 3396 (2017)	Tit. 10, §§ 80.63, 80.68, 80.70, 80.71, 80.73, 80.78, and 80.107 (2017) Tit. 14 § 822.16 (2017)

North Carolina Controlled Substances Reporting System	§§ 90-5.2, 90-21.106, and 90-106.1 (2017) §§ 90-113.70 to -113.76 (2017) § 132-1.1 (2017)	10A ADC 26E.0601 to -.0603 (2017) 21 ADC 16U.0103, 32Y.0101, and 46.3501 (2017)
North Dakota Prescription Drug Monitoring Program	§ 19-03.4-08 (2017) §§ 19-03.5-01 to -10 (2017) § 19-24.1-37 (2017) § 50-31-08 (2017)	20-02-01-12 and 20-02-01-13 (2017) 54-01-03-01 and 54-05-03.1-10 (2017) 61-12-01-01 to -04 (2017) 75-09.1-10-10 (2017)
Ohio Automated Rx Reporting System (OARRS)	§§ 4729.01, 4729.75 to -.861, -.99 (2017) § 2925.141 (2017) §§ 3796.01 and 3796.20 (2017) § 4121.447 (2017) §§ 4715.14 and 4715.302 (2017) §§ 4723.486 and 4723.487 (2017) §§ 4725.092 and 4725.16 (2017) §§ 4729.12, 4729.162, 4729.50, and 4729.771 (2017) §§ 4730.49 and 4730.53 (2017) §§ 4731.055, 4731.22, 4731.30, and 4731.281 (2017) §§ 5167.10 and 5167.14 (2017)	§§ 4729-37-01 to -12 (2017) §§ 4123-6-21.4 and 4123-6-21.7, §§ 4715-6-01 and 4715-19-04 (2017) §§ 4723-1-10, 4723-8-04, 4723-9-02, 4723-9-08, 4723-9-09, and 4723-9-12 (2017) § 4725-16-04 (2017) §§ 4729-1-02, 4729-5-01, 4729-5-20, 4729-16-04, and 4729-29-02 (2017) § 4730-2-10 (2017) §§ 4731-11-04, 4731-11-04.1, 4731-11-11, 4731-11-12, and 4731-29-01 (2017)
Oklahoma Anti-Drug Diversion Act	Tit. 22 § 751 (2017) Tit. 63 §§ 2-105, 2-302, 2-309A to -309H (2017)	317:30-5-20.1 (2017) 475: 45-1-1 to -6 (2017) 535:15-3-9 (2017)
Oregon Prescription Monitoring Program	§ 431.990 (2017) §§ 431A.850 to .900 (2017) § 689.005 (2017)	333-023-0800 to 333-023-8030 (2017) 847-005-0005 (2017) 851-002-0020 to 851-002-0035 (2017) 852-010-0080, 852-050-0006, 852-080-0030 (2017) 855-110-0005 (2017)
Pennsylvania Achieving Better Care by Monitoring All Prescriptions (ABC-MAP)	35 §§ 872.1 to 872.40 (2017) 35 §§ 5202, 873.5, 10231.103, 10231.403, 10231.502 (2017)	28 ADC § 25.131 (2017)
Rhode Island Electronic Prescription Database	§§ 21-28-3.02, 21-28-3.18, 21-28-3.20, and 21-28-3.32 (2017)	31-2-1 §§ 1.0 to 7.0 (2017) 31-2-6 §§ 4.4 and 4.5 (2017) 31-2-7 § 3.4 (2017) 46-1-13 § 45.0 (2017)
South Carolina Prescription Monitoring Program (SCRIPTS)	§§ 16-1-90 and 16-1-100 (2017) §§ 44-53-1610 to -1680 (2017)	None
South Dakota Prescription Drug Monitoring Program	§§ 34-20E-1 to 34-20E-20 (2017)	20:47:07:01 (2017) 20:51:32:01 to -11 (2017)
Tennessee Prescription Safety Act (CSMD)	§§ 53-10-301 to -312 (2017) §§ 53-11-308 to -309 (2017) § 63-51-115 (2017) § 68-1-128 (2017)	0800-02-25-.03 (2017) 0940-05-35-.02, -.12, -.15 (2017) 0940-05-42-.01, -.07, -.15, -.17 (2017) 1140-11-.01 to -.08 (2017) 1200-34-01-.07 and 1200-34-01-.10 (2017)

Texas Prescription Monitoring Program	Health & Safety Code §§ 481.074 to -.0765, -.127, -.128 (2017) Health & Safety Code §§ 481.351 to 481.354 (2017) Government Code § 552.118 (2017) Occupations Code § 554.006 (2017)	22 §§ 111.2, 170.3, 175.1, 175.2, 273.4, 291.6, 295.5 (2017)
Utah Controlled Substances Database	§ 26-1-36 (2017) §§ 58-17b-201, 58-17b-504, and 58-17b-803 (2017) §§ 58-37f-101 to -704 (2017) § 58-31b-803 (2017) § 63A-13-202 (2017)	R156-16a (2017) R156-17b (2017) R156-37f (2017) R384-203 (2017)
Vermont Prescription Monitoring System (VPMS)	Tit. 18 §§ 4218, 4255, 4281 to 4290 (2017) Tit. 28 § 801 (2017) Tit. 33 §§ 2004 and 2004a (2017)	12-5-21 §§ 1 to 10 (2017) 12-5-53 §§ 4.0, 6.0, and 8.0 (2017) 12-5-55 § 4.0 (2017) 12-5-102 § 2, 3.0, 6.0, and 7.0 (2017) 12-7-5 § 7502 (2017)
Virginia Prescription Monitoring Program	§ 2.2-3705.5 (2017) §§ 32.1-127.1:03 and 32.1-372 (2017) §§ 54.1-2505, 54.1-2519 to -2526 (2017) §§ 54.1-2708.4, 54.1-2928.2, 54.1-3434, 54.1-3434.1, and 54.1-3456.1 (2017)	12 §§ 30-130-5050, 30-130-5060, 35-105-940 (2017) 18 § 60-21-70 (2017) 18 §§ 76-20-10 to -70 (2017) 18 §§ 85-20-27 and 85-50-175 (2017) 18 § 90-40-130 (2017) 18 § 110-20-25 (2017)
Washington Prescription Monitoring Program	§§ 70.225.0001 and 70.225.010 to -.900 (2017) § 74.09.215 (2017)	§§ 246-470-001 to -100 (2017) §§ 246-817-915, -935, -945 (2017) §§ 246-840-467, -477, -483 (2017) §§ 246-853-663, -667, -669 (2017) §§ 246-854-243, -247, -249 (2017) §§ 246-918-803, -807, -809 (2017) §§ 246-919-853, -857, -859 (2017) §§ 246-922-663, -667, -669 (2017) §§ 296-20-03035, 296-20-03056 to -03059 (2017) § 388-877B-0440 (2017)

West Virginia Controlled Substance Monitoring	§ 16-1-4 (2017) § 16-5H-4 (2017) § 16-5T-2 (2017) § 16-5Y-2 and 16-5Y-5 (2017) § 16-46-6 (2017) § 16-52-4 (2017) § 16A-2-1, 16A-4-3, 16A-5-2 (2017) § 30-5-7 and (2017) §§ 60A-8-7, 60A-9-1 to -9 (2017) § 61-12-10 (2017)	§§ 5-10-1 to -5 (2017) §§ 5-11-2 to -4 (2017) §§ 11-1B-2, 11-1B-14, 11-1B-15 (2017) §§ 11-6-2, 11-6-3 (2017) §§ 11-10-1 to -5 (2017) § 14-10-4 (2017) § 15-3-4 (2017) §§ 15-8-1 to -7 (2017) §§ 19-14-1 to -5 (2017) §§ 24-1-3, 24-1-15, 24-2-2, 24-2-11, 24-2-12, 24-7-1 to -6 (2017) §§ 69-7-3, 69-7-25, 69-7-27, 69-7-29, 69-7-42, 69-8-2, 69-8-9, and 69-8-10 (2017)
Wisconsin Prescription Drug Monitoring Program	§§ 50.60 and 50.65 (2017) § 146.82 (2017) § 450.01 (2017) §§ 961.36, 961.37, and 961.385 (2017)	CSB §§ 4.01 to 4.15 (2017)
Wyoming Controlled Substances Prescription Tracking Program (WORx)	§ 35-7-1060 (2017)	Wyo. Bd. Of Pharmacy, Comm. of Drugs & Sub. Control, Ch. 8 §§ 1-9 (2017)

Mandatory Query Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama		540-X-4-.09
Alaska	§ 17.30.200	
Arizona	§§ 23-1062.02, 32-1501, 36-2606	
Arkansas	§ 20-7-615, 20-7-604	007.07.4-VII, 060.00.1-2, 060.00.1-19, 067.00.4-VIII, 067.00.4-XII, 069.00.1-V-IX1
California	Health & Safety Code § 11165.4	
Colorado		Tit. 2 § 502-1:21.320.3, Tit. 7 § 1101-3.18
Connecticut	§ 21a-254	
Delaware	16 § 4798	
Florida	§ 381.986	
Georgia	§ 16-13-63	360-8-.02
Illinois	720 § 570/314.5	
Indiana	§§ 35-48-7-12.1, 12-23-18-5.3	
Kentucky	§ 218A.172	201 KAR 8:540, 201 KAR 9:016, 201 KAR 9:260, 201 KAR 20:057, 201 KAR 25:090, 902 KAR 20:430
Louisiana	§§ 40:978, 40:1046	Tit. 48, Pt. I § 7831 Tit. 46, Pt. XLV § 7717
Maine	22 § 7253	14-118-11 § 5 02-373-2 § 5
Maryland	Health-General § 21-2A-04.2	

Massachusetts	94C § 24A	105 CMR 700.012, 105 CMR 725.010, 234 CMR 5.06, 244 CMR 4.07, 247 CMR 9.04, 249 CMR 4.02, 263 CMR 5.07
Michigan		§ 418.101008a
Minnesota	§§ 245A.192, 256B.0638	
Mississippi		§ 30-17-2640:1.15
Nevada	§§ 453.164, 639.23507	
New Hampshire	§ 318-B:41	Den. 503.06, Med. 502.06, Nat. 501.06, Nur. 502.06
New Jersey	§§ 45:1-46.1, 24:21-15.2	§ 13:45A-35.9
New Mexico	§ 26-1-16.1	§§ 16.5.57, 16.10.14, 16.11.2, 16.12.9, 16.16.15, 16.17.5, 16.19.4, 16.21.9
New York	Public Health Law § 3343-a	Tit. 10 § 80.63 Tit. 14 § 822.16
North Carolina	§§ 90-113.74C and 90-113.74D	
North Dakota		61-12-01-04, 75-09.1-10-10, 54-05-03.1-10, 20-02-01-12, 20-02-01-13
Ohio	§§ 4731.055, 4715.302, 4723.487, 4730.53, 3796.08, 4731.30	4731-11-11, 4715-6-01, 4723-9-12, 4730-2-10, 4729-5-20, 4123-6-21.4, 4725-16-04
Oklahoma	63 § 2-302, 63 § 2-309D	
Pennsylvania	35 § 872.8, 35 § 10231.403, 35 § 873.5	
Rhode Island	§ 21-28-3.20	31-2-6 § 4.4, 46-1-13 § 45.0
South Carolina	§ 44-53-1645	
Tennessee	§ 53-10-310	1140-11-.07, 1200-34-01-.10, 0940-05-42-.07, 0940-05-42-.15, 0940-05-42-.17
Texas	§§ 481.0764, 481.0765	22 ADC § 111.2
Utah	§§ 58-37f-304, 58-31b-803	
Vermont	18 § 4289, 18 § 4290	12-5-21 § 6.0, 12-5-53 § 4.0, 12-5-53 § 6.0, 12-5-53 § 8.0, 12-5-102 § 7.0, 12-7-5 § 7502, 12-5-21 § 5.0
Virginia	§ 54.1-2522.1	
Washington		296-20-03035, 296-20-03056, 388-377B-0440
West Virginia	§§ 16-5H-4, 60A-9-5a, 16A-4-3, 16A-5-2	§§ 5-10-3, 11-10-3, 19-14-3, 24-7-3, 69-7-27, 69-7-42
Wisconsin	§ 961.385	

Mandatory Registration Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama	§ 34-24-604	540-X-4-.03, 540-X-12-.05, 540-X-18-.05, 540-X-19-.03, 540-X-19-.04, 540-X-19-.05, 540-X-20-.04
Alaska	§§ 17.30.200, 08.36.070, 08.64.101, 08.68.100, 08.72.060, 08.80.030	
Arizona	§§ 36-2606, 32-3219	
Arkansas	§ 20-7-615	007.07.4-VII, 060.00.1-2, 060.00.1-19, 069.00.1-V-IX1
California	Health & Safety Code § 11165.1	
Colorado	§ 12-42.5-403	Tit. 3 § 709-1:IX
Connecticut	§ 21a-317	§§ 21a-408-2 and 21a-408-38
Delaware	16 § 4798	
Georgia		360-8-.02
Hawaii	§ 329-101	
Idaho	§§ 37-2726 and 37-2716	
Illinois	720 §§ 570/314.5 and 570/318	
Kentucky	§ 218A.202	201 KAR 5:130, 201 KAR 9:230, 201 KAR 25:011, 201 KAR 25:021
Louisiana	§ 40:973	
Maine	LD 1840 (2016)	
Maryland	Health-Gen. § 21-2A-04.1	
Massachusetts	94C § 7A	
Minnesota	§ 152.126	
Mississippi	§ 73-21-127	§§ 30-17-2640:1.15, 30-20-3001:IV, 30-20-3001:XLIII
Nevada	§ 453.164	
New Hampshire	§ 318-B:33	
New Jersey	§ 45:1-46	
New Mexico		§§ 16.5.57, 16.10.14, 16.16.15, 16.17.5, 16.19.20, 16.21.9
North Carolina	§ 90-113.74B	
Ohio	§§ 4715.14, 4723.486, 4725.16, 4729.12, 4730.49, 4731.281	
Rhode Island	§ 21-28-3.32	31-2-6 § 4.5
South Dakota	§ 34-20E-2.1	
Tennessee	§ 53-10-305	
Texas	Health & Safety Code § 481.0763	
Utah	§ 58-37f-401	
Vermont	18 § 4289	12-5-21 § 5.0, 12-5-21 § 6.0, 12-5-102 § 2
Virginia	§§ 54.1-2522.1 and 54.1-2522.2	
West Virginia	§ 60A-9-5a	§§ 5-10-3, 11-10-3, 19-14-3, 24-7-3

Data Collection Frequency, Data Fields Collected, and Substances Monitored Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama	§ 20-2-213	420-7-2-.12
Alaska	§ 17.30.200	12 AAC 52.865
Arizona	§§ 36-2602 and 36-2608	R4-23-502
Arkansas	§ 20-7-604	007.07.4-IV
California	Health and Safety Code § 11165	
Colorado	§ 12-42.5-40	719-1:23.00.00
Connecticut	§ 21a-254	21a-254-4
D.C.	§§ 48-853.01, 48-853.03	17 DCMR §§ 10301, 10302, 10303, 10304
Delaware	16 § 4798	
Florida	§ 893.055	64K-1.004
Georgia	§ 16-13-59	
Hawaii	§ 329-101	§ 23-200-17
Idaho		27.01.01.204
Illinois	720 § 570/316	77 ADC 2080.100, 2080.230
Indiana	§ 35-48-7-8.1	856 IAC 6-1-3
Iowa	§ 124.552	657-37.3
Kansas	§ 65-1683	68-21-2, 68-21-7
Kentucky	§ 218A.202	902 KAR 55:110
Louisiana	§ 40:1006	46, Part LIII §§ 2911 and 2913
Maine	22 §§ 7246, 7249	14-118 CMR Ch. 11, § 5
Maryland	Health-Gen. §§ 21-2A-02, 21-2A-03, 21-2A-04	COMAR 10.47.07.03
Massachusetts	94C § 24A	105 CMR 700.012
Michigan	§ 333.7333a	R 338.3056, 338.3162b, 338.3162c, 338.3162d, 338.3162e
Minnesota	§ 152.126	
Mississippi	§ 73-21-127	30-20-3011:XLIII
Missouri (St. Louis Co.)	602.802	
Montana	§ 37-7-1503	24.174.1702, 24.174.1704
Nebraska	§ 71-2454	
Nevada	§§ 453.162, 453.163	NAC 639.926
New Hampshire	§§ 318-B:32, 318-B:33	Ph. 1504.01
New Jersey	§§ 45:1-44, 45:1-45	13:45A-35.3, 13:45A-35.5
New Mexico		16.19.29
New York	Public Health Law § 3343-a	10 NYCRR 80.71, 80.73
North Carolina	§ 90-113.73	10A NCAC 26E.0603
North Dakota	§ 19-03.5-02	NDAC 61-12-01-02
Ohio	§§ 4729.75, 4729.79	OAC 4729-37-02, 4729-37-04, 4729-37-07
Oklahoma	62 § 2-309C	475:45-1-2, 475:45-1-3, 475:45-1-4, 475:45-1-5
Oregon	§§ 431A.855, 431A.860	OAR 333-023-0810
Pennsylvania	35 §§ 872.6, 872.7	
Rhode Island	§§ 21-38-3.18, 21-38-3.32	31-2-1:2.0, 31-2-1:3.0

South Carolina	§ 44-53-1640	
South Dakota	§§ 34-20E-2, 34-20E-3, 34-20E-4	20:51:32:02, 20:51:32:03
Tennessee	§§ 53-10-304, 53-10-305	1140-11-.04, 1140-11-.05
Texas	Health & Safety Code §§ 481.074, 481.075	
Utah	§§ 58-37f-201, 58-37f-203	R156-37f
Vermont	18 § 4283	12-5-21:4.0
Virginia	§§ 54.1-2521, 54.1-2522, 54.1-3456.1	18 VAC 76-20-20, 76-20-30, 76-20-40
Washington	§ 70.225.020	246-470-020, 246-470-030, 246-470-035
West Virginia	§§ 60A-9-3, 60A-9-4	§§ 15-8-3, 15-8-4
Wisconsin	§ 961.385	CSB 4.03, 4.04, 4.05, 4.06, 4.08
Wyoming	§ 35-7-1060	AI PDSC Ch. 8 § 4

Data Transmitters Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama	§ 20-2-213	420-7-2-.12
Alaska	§ 17.30.200	12 AAC 52.865
Arizona	§§ 36-2602, 36-2608	R4-23-502
Arkansas	§ 20-7-604	007.07.4-IV
California	Health & Safety Code § 11165	
Colorado	§ 12-42.5-407	3 CCR 719-1:23.00.00
Connecticut	§ 21a-254	21a-254-4
D.C.	§§ 48-853.01, 48-853.03	17 DCMR § 10301
Delaware	16 § 4798	
Florida	§ 893.055	64K-1.004
Georgia	§ 16-13-59	
Hawaii		§ 23-200-17
Idaho		27.01.01.204
Illinois	720 § 570/102, 720 § 570/313	77 ADC 2080.20, 2080.30, 2080.100
Indiana	§§ 35-48-7-2.9, 35-48-7-8.1	856 IAC 6-1-1, 6-1-3
Iowa	§ 124.552	657-37.3
Kansas		68-21-2, 68-21-7
Kentucky	§ 218A.202	902 KAR 55:110
Louisiana	§ 40:1003	46, Part LIII § 2901
Maine	22 §§ 7246, 7249	14-118 CMR Ch. 11, §§ 3, 5
Maryland	Health-General §§ 21-2A-01, 21-2A-03	10.47.07.02, 10.47.07.03
Massachusetts	94C § 24A	105 CMR 700.012
Michigan	§ 333.7333a	R. 338.3056, R. 338.3162b, R. 338.3162d, R. 338.3162e
Minnesota	§ 152.126	
Mississippi	§ 73-21-127	30-20-3001:XLIII
Missouri (St. Louis Co.)	602.801, 602.802	
Montana	§§ 37-7-1503	24.174.1702

Nebraska	§ 71-2454	
Nevada	§§ 453.162, 453.163	NAC 639.926
New Hampshire	§§ 318-B:31, 318-B:33	Ph. 1502.01, Ph. 1504.01
New Jersey	§§ 45:1-44, 45:1-45	13:45A-35.2, 13:45A-35.3
New Mexico	§ 30-31-16	16.19.29
New York	Public Health Law §§ 3333, 3343-a	10 NYCRR 80.71, 10 NYCRR 80.73
North Carolina	§§ 90-113.72, 90-113.73	10 NCAC 26E.0603
North Dakota	§§ 19-03.5-01, 19-03.5-02	61-12-01-01, 61-12-01-02
Ohio	§§ 4729.01, 4729.77, 4729.78, 4729.79	4729-37-01, 4729-37-03
Oklahoma	63 §§ 2-309B, 2-309C	475:45-1-2
Oregon	§§ 431A.850, 431A.860	333-023-0805, 333-023-0810
Pennsylvania	35 §§ 872.3, 872.7	
Rhode Island	§ 21-28-3.18	31-2-1:1.0, 31-2-1:2.0, 31-2-1:3.0
South Carolina	§§ 44-53-1630, 44-53-1640	
South Dakota	§§ 34-20E-1, 34-20E-3	20:51:32:02
Tennessee	§§ 53-10-302, 53-10-304, 53-10-305	1140-11-.01, 1140-11-.05
Texas	§§ 481.074, 481.075	
Utah	§ 58-37f-203	R156-37f
Vermont	18 §§ 4282, 4283	12-5-21:3.0, 12-5-21:4.0
Virginia	§§ 54.1-2519, 54.1-2521, 54.1-2522	18 VAC 76-20-10, 76-20-40
Washington	§§ 70.225.010, 70.225.020	246-470-010, 246-470-030, 246-47-035
West Virginia	§ 60A-9-4	§§ 15-8-2, 15-8-3
Wisconsin	§ 961.385	CSB 4.02, CSB 4.04, CSB 4.05, CSB 4.08
Wyoming	§ 35-7-1060	AI PDSC Ch. 8 § 4

Data Retention Statutes and Regulations[1]		
State	**Statutes**	**Regulations**
Alabama	N/A	N/A
Alaska	§ 17.30.200(k)	
Arizona	N/A	N/A
Arkansas	§ 20-7-607	007.07.4-VII
California	N/A	N/A
Colorado	N/A	N/A
Connecticut		21a-254-7
D.C.		17 DCMR § 10300
Delaware	N/A	N/A
Florida		64K-1.004
Georgia	§ 16-13-59	
Hawaii	§ 329-104	
Idaho	§ 37-2726	
Illinois		
Indiana	N/A	N/A

[1] States designated "N/A" may have an internal data retention policy that is not set out in statute or regulation.

Iowa	§ 124.553	657-37.6
Kansas	§ 65-1687	
Kentucky		902 KAR 55:110
Louisiana	N/A	N/A
Maine	22 § 7250	14-118 CMR Ch. 11 § 8
Maryland	Health-General § 21-2A-04	10.47.07.09
Massachusetts	N/A	N/A
Michigan	N/A	N/A
Minnesota	§ 152.126(5)(e)	
Mississippi	N/A	N/A
Missouri	N/A	N/A
Montana	§ 37-7-1508	24.179.1709
Nebraska	N/A	N/A
Nevada	N/A	N/A
New Hampshire	§ 318-B:32	
New Jersey	N/A	N/A
New Mexico	N/A	N/A
New York	Public Health Law § 3343-a	
North Carolina	§ 90-113.74	
North Dakota	N/A	N/A
Ohio	§ 4729.82	
Oklahoma	N/A	N/A
Oregon	§ 431A.865	
Pennsylvania	35 § 872.6	
Rhode Island	§ 21-28-3.32	31-2-1:3.0
South Carolina	N/A	N/A
South Dakota		20:51:32:11
Tennessee	N/A	N/A
Texas	Health & Safety § 481.076	
Utah	N/A	N/A
Vermont	18 § 4283	
Virginia	N/A	N/A
Washington	N/A	N/A
West Virginia	§ 60A-9-5	
Wisconsin	N/A	N/A
Wyoming	N/A	N/A

Authorized Recipients of PMP Information Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama	§ 20-2-214	420-7-2-.13
Alaska	§ 17.30.200	12 AAC 52.855, 12 AAC 52.875
Arizona	§ 36-2604	R4-23-503
Arkansas	§§ 12-18-622, 20-7-606, 20-7-607	007.07.4-VI, 007.07.4-VII
California	Health & Safety §§ 11165, 11165.1	
Colorado	§ 12-42.5-404	3 CCR 719-1:23.00.00
Connecticut	§ 21a-254	21a-254-6
D.C.	§§ 48-853.04, 48-853.05	17 DCMR §§ 10306, 10307, 10308
Delaware	16 § 4798	
Florida	§§ 893.055, 893.0551	64K-1.003
Georgia	§ 16-13-60	
Hawaii	§ 329-104	
Idaho	§§ 37-2726, 37-2730A	27.01.01.204
Illinois	720 § 570/318	77 ADC 2080.200, 77 ADC 2080.210
Indiana	§ 35-48-7-11.1	
Iowa	§ 124.553	657-37.4
Kansas	§ 65-1685	68-21-5
Kentucky	§ 218A.202	902 KAR 55:110
Louisiana	§ 40:1007	Tit. 46, Pt. LIII §§ 2917, 2921
Maine	22 § 7250	14-118 CMR Ch. 11 § 7
Maryland	§ 21-2A-06	10.47.07.05
Massachusetts	94C § 24A	105 CMR 700.012
Michigan	§ 333.7333a	
Minnesota	§ 152.126	
Mississippi	§ 73-21-127	30-20-3001:XLIII
Missouri (St. Louis Co.)	602.806	
Montana	§ 37-7-1506	24.174.1708
Nebraska	§§ 71-2454, 71-2455	
Nevada	§§ 453.164, 453.165	
New Hampshire	§ 318-B:35	Ph. 1505.01, Ph. 1505.02, Ph. 1505.03, Ph. 1505.04, Ph. 1505.05
New Jersey	§ 45:1-46	13:45A-35:6
New Mexico		16.19.29
New York	Public Health Law §§ 3343-a, 3371, 3371-a	10 NYCRR 80.107
North Carolina	§ 90-113.74	
North Dakota	§ 19-03.5-03	
Ohio	§ 4729.80	4729-37-08
Oklahoma	63 § 2-309D	
Oregon	§ 431A.865	333-023-0820
Pennsylvania	35 § 872.9	
Rhode Island	§ 21-28-3.32	31-2-1:3.0
South Carolina	§ 44-53-1650	

South Dakota	§ 34-20E-7	20:51:32:05, 20:51:32:06, 20:51:32:07, 20:51:32:08, 20:51:32:09, 20:51:32:10
Tennessee	§§ 53-10-306, 53-10-308	1140-11-.02
Texas	§ 481.076	
Utah	§§ 58-37f-301, 58-37f-303	R156-37f
Vermont	18 § 4284	12-5-21:7.0, 12-5-21:8.0
Virginia	§ 54.1-2523	18 VAC 76-20-50, 76-20-60
Washington	§ 70.225.040	246-470-040, 246-470-050, 246-470-060, 246-470-070, 246-470-080
West Virginia	§ 60A-9-5	§ 15-8-7
Wisconsin	§ 961.385	CSB 4.09, 4.11
Wyoming	§ 35-7-1060	AI PDSC Ch. 8, § 5

Law Enforcement Access to PDMP Information Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama	§ 20-2-214	420-7-2-.13
Alaska	§ 17.30.200	12 AAC 52.855, 12 AAC 52.875
Arizona	§ 36-2604	R4-23-503
Arkansas	§§ 12-18-622, 20-7-606, 20-7-607	007.07.4-VI, 007.07.4-VII
California	Health & Safety §§ 11165, 11165.1	
Colorado	§ 12-42.5-404	3 CCR 719-1:23.00.00
Connecticut	§ 21a-254	21a-254-6
D.C.	§§ 48-853.04, 48-853.05	17 DCMR §§ 10306, 10307, 10308
Delaware	16 § 4798	
Florida	§§ 893.055, 893.0551	64K-1.003
Georgia	§ 16-13-60	
Hawaii	§ 329-104	
Idaho	§§ 37-2726, 37-2730A	27.01.01.204
Illinois	720 § 570/318	77 ADC 2080.200, 77 ADC 2080.210
Indiana	§ 35-48-7-11.1	
Iowa	§ 124.553	657-37.4
Kansas	§ 65-1685	68-21-5
Kentucky	§ 218A.202	902 KAR 55:110
Louisiana	§ 40:1007	Tit. 46, Pt. LIII §§ 2917, 2921
Maine	22 § 7250	14-118 CMR Ch. 11 § 7
Maryland	§ 21-2A-06	10.47.07.05
Massachusetts	94C § 24A	105 CMR 700.012
Michigan	§ 333.7333a	
Minnesota	§ 152.126	
Mississippi	§ 73-21-127	30-20-3001:XLIII
Missouri	602.806	
Montana	§ 37-7-1506	24.174.1708
Nebraska	§§ 71-2454, 71-2455	
Nevada	§§ 453.164, 453.165	

New Hampshire	§ 318-B:35	Ph. 1505.01, Ph. 1505.02, Ph. 1505.03, Ph. 1505.04, Ph. 1505.05
New Jersey	§ 45:1-46	13:45A-35:6
New Mexico		16.19.29
New York	Public Health Law §§ 3343-a, 3371, 3371-a	10 NYCRR 80.107
North Carolina	§ 90-113.74	
North Dakota	§ 19-03.5-03	
Ohio	§ 4729.80	4729-37-08
Oklahoma	63 § 2-309D	
Oregon	§ 431A.865	333-023-0820
Pennsylvania	35 § 872.9	
Rhode Island	§ 21-28-3.32	31-2-1:3.0
South Carolina	§ 44-53-1650	
South Dakota	§ 34-20E-7	20:51:32:05, 20:51:32:06, 20:51:32:07, 20:51:32:08, 20:51:32:09, 20:51:32:10
Tennessee	§§ 53-10-306, 53-10-308	1140-11-.02
Texas	§ 481.076	
Utah	§§ 58-37f-301, 58-37f-303	R156-37f
Vermont	18 § 4284	12-5-21:7.0, 12-5-21:8.0
Virginia	§ 54.1-2523	18 VAC 76-20-50, 76-20-60
Washington	§ 70.225.040	246-470-040, 246-470-050, 246-470-060, 246-470-070, 246-470-080
West Virginia	§ 60A-9-5	§ 15-8-7
Wisconsin	§ 961.385	CSB 4.09, 4.11
Wyoming	§ 35-7-1060	AI PDSC Ch. 8, § 5

Penalties for Unauthorized Use or Disclosure of PDMP Data Statutes and Regulations		
State	**Statutes**	**Regulations**
Alabama	§ 20-2-216	
Alaska	§ 17.30.200	
Arizona	§ 36-2610	
Arkansas	§ 20-7-611	
California	Health & Safety Code §§ 11165.1, 11165.2	
Colorado	§ 12-42.5-406	
Connecticut	§ 21a-254	
D.C.	§ 48-853.09	
Delaware	16 § 4798	
Florida	§ 893.0551	
Georgia	§ 16-13-64	
Hawaii	§ 329-104	
Idaho	§ 37-2726	
Illinois	720 § 570/406	
Indiana	§ 35-48-7-14	

Iowa	§ 124.558	657-37.9
Kansas	§ 65-1693	
Kentucky	§ 218A.202	
Louisiana	§ 40:1009	
Maine	22 § 7251	
Maryland	Health-General § 21-2A-09	10.47.07.07
Massachusetts		105 ADC 700.012
Michigan		
Minnesota	§ 152.126	
Mississippi	§§ 73-21-97, 73-21-103, and 73-21-127	30-20-3001:XLIII
Missouri	St. Louis Co. Ord. 602.808	
Montana	§ 37-7-1513	
Nebraska		
Nevada	§§ 639.310 and 639.23507	
New Hampshire	§ 318-B:36	
New Jersey	§ 45:1-49	
New Mexico		16.19.29
New York	Public Health Law §§ 12-b, 3396	
North Carolina	§ 90-113.75	
North Dakota	§ 19-03.5-10	
Ohio	§§ 4729.86, 4729.99	
Oklahoma	63 § 2-309D	
Oregon	§ 431A.900	
Pennsylvania	35 § 872.10	
Rhode Island	§ 21-28-3.32	31-2-1:4.0
South Carolina	§ 44-53-1680	
South Dakota	§ 34-20E-19	
Tennessee	§ 53-10-306	
Texas	Health & Safety § 481.127	
Utah	§ 58-37f-601	
Vermont	18 § 4284	12-5-21:5
Virginia	§ 54.1-2525	
Washington	§ 70.225.060	
West Virginia	§ 60A-9-7	
Wisconsin	§ 961.385	CSB 4.13
Wyoming	§ 35-7-1060	

Appendix C – PDMP Vendor User Manuals

State	Data Upload Manual	User Account Manual
Alabama	http://www.alabamapublichealth.gov/PDMP/dispenser-packets.html	http://www.alabamapublichealth.gov/PDMP/assets/ALPDMP_TrainingGuidePractitionersPharmacists.pdf
Alaska	https://www.commerce.alaska.gov/web/portals/5/pub/PHA_AWARxE_DispenserGuide.pdf	https://www.commerce.alaska.gov/web/portals/5/pub/PHA_Howpatientsearch_2016.pdf
Arizona	https://pharmacypmp.az.gov/sites/default/files/documents/files/AZ%20Data%20Submission%20Dispenser%20Guide_0.pdf	https://pharmacypmp.az.gov/sites/default/files/documents/files/aware_user_guide_0.pdf
Arkansas	http://www.arkansaspmp.com//files/2017/AR_Data_Submission_Dispenser_Guide.pdf	http://www.arkansaspmp.com//files/2017/AR_PMP_AWARxE_Requestor_User_Support_Manual.pdf
California	https://oag.ca.gov/cures/publications	https://oag.ca.gov/cures/publications
Colorado	http://rxsentry.net/assets/files/copdmp/aware/Colorado_Data_Submission_Dispenser_Guide_v1.3.pdf	http://rxsentry.net/assets/files/copdmp/aware/CO_PDMP_AWARxE_Requestor_User_Support_Manual.pdf
Connecticut	http://www.ct.gov/dcp/lib/dcp/drug_control/pmp/pdf/cpmrs_data_reporting_manual_2014.pdf	http://www.ct.gov/dcp/lib/dcp/drug_control/pmp/pdf/cpmrs_awarxe_user_support_manual.pdf
Delaware	https://cdn2.hubspot.net/hubfs/2881008/PDF%20Documents/DE%20PDMP%20Data%20Submission%20Dispenser%20Guide_V1-3-1.pdf	https://d1b1sdx6nwlphm.cloudfront.net/aware/default/updated_patient_rx_request_tutorial.pdf
District of Columbia	https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20PMP%20AWARxE%20Dispenser%20Guide_Final.pdf	https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20PDMP%20AWARxE%20User%20Support%20Manual_Final_9.20.16%20%283%29.pdf
Florida	http://hidesigns.com/assets/files/flpdms/2015/FL_RxSentry_Dispensers_Implementation_Guide_ASAP_4.2.pdf	http://hidesigns.com/assets/files/flpdms/2016/Training_Guide_for_Florida_Practitioners_and_Pharmacists_-_Designee_Update_Final.pdf
Georgia	https://dph.georgia.gov/sites/dph.georgia.gov/files/GA%20PDMP%20Dispenser%20Guidev1.2.pdf	https://dph.georgia.gov/sites/dph.georgia.gov/files/Georgia%20AWARxE%20User%20Support%20Manual.pdf
Guam		
Hawaii	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&uact=8&ved=0ahUKEwiu0e7KyNfXAhVCc98KHa6PDTcQFghJMAY&url=https%3A%2F%2Fdps.hawaii.gov%2Fwp-content%2Fuploads%2F2016%2F12%2FHI-PDMP-Data-Submission-DISPENSER-Guide.pdf&usg=AOvVaw2esKZ9U06AtH1DudFoq2iH	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0ahUKEwiu0e7KyNfXAhVCc98KHa6PDTcQFgg-MAQ&url=https%3A%2F%2Fdps.hawaii.gov%2Fwp-content%2Fuploads%2F2016%2F12%2FHI-PDMP-AWARxE-Requestor-USER-Guide.pdf&usg=AOvVaw0wFmFt4l9o03rQCNzUuQjn

Idaho	https://bop.idaho.gov/pmp/2014-11-20_IdahoPMP-AWARxE-Interface-Specification-Data-Submission-Printed-Guide.pdf	https://bop.idaho.gov/pmp/2017.11.02_Idaho_PMP%20AWARxE_Requestor_User_Support_Guide.pdf
Illinois	https://www.ilpmp.org/PMPVideos.php	https://www.ilpmp.org/PMPVideos.php
Indiana	https://www.in.gov/pla/inspect/files/IN%20Data%20Submission%20Dispenser%20Guide.pdf	https://indiana.pmpaware.net/login
Iowa	https://pharmacy.iowa.gov/sites/default/files/documents/2016/03/iowa_data-collection_manual_8-2014_appriss.pdf	https://pharmacy.iowa.gov/document/pmp-web-center-user-guide
Kansas	http://www.pharmacy.ks.gov/docs/default-source/KTRACS/ks-ktracs-data-submission-guide5024c1317d2763409daeff0000e61470.pdf?sfvrsn=0	http://www.pharmacy.ks.gov/docs/default-source/KTRACS/k-tracs_requestor_guide.pdf?sfvrsn=0
Kentucky	http://www.chfs.ky.gov/NR/rdonlyres/6335B91E-AEA2-4A3F-838C-CB62D29B4FBA/0/KASPERControlledSubstanceReportingGuideVersion13.pdf	
Louisiana	http://www.pharmacy.la.gov/assets/docs/PMP/LA-DispenserGuide_2016-0503.pdf	http://www.pharmacy.la.gov/assets/docs/PMP/AWARxE-UserSupportManual_2017-0101.pdf
Maine	http://trk.appriss.com/CP000y0tj07U0Od03002Q00	http://trk.appriss.com/iAeU0OP2G9j00d000i73Q0a
Maryland	https://mdpdmpreporting.hidinc.com/	
Massachusetts	http://www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/alerts/pmp-data-submission-guide.pdf	https://www.youtube.com/embed/xeNLxVkieJY
Michigan	http://www.michigan.gov/documents/lara/MI_Data_Submission_Dispenser_Guide_576262_7.pdf	http://www.michigan.gov/documents/lara/2b-Michigan_PMP_AWARxE_Requestor_User_Support_Manual_556541_7.pdf
Minnesota	http://www.pmp.pharmacy.state.mn.us/assets/files/new/MNPDMP_DispensersImplementationGuide_ASAP%204.2_05162017.pdf	http://www.pmp.pharmacy.state.mn.us/assets/files/documents/MNPDMP_Query_and_Reports_Tutorial.pdf
Mississippi	_	
Missouri (St Louis County)	http://www.stlouisco.com/Portals/8/docs/document%20library/PDMP/MO_PMP_Data_Submission_Guide_v1_1.pdf	https://youtu.be/gFDU8vbiWBY
Montana	https://app.mt.gov/Pdr/Content/Pdf/MPDRReportingGuideForPharmacies2016.pdf	http://boards.bsd.dli.mt.gov/Portals/133/Documents/pha/mpdr/dli-bsd-mpdr016.pdf
Nebraska	https://nehii.org/images/stories/videos/docs/Nebraska-PDMP-Dispensers-Implementation-Guide_v3.3.pdf	http://nehii.org/index.php?option=com_docman&view=download&alias=164-pdmp-prescriber-training-materials&category_slug=forms-documents&Itemid=53

Nevada	http://bop.nv.gov/uploadedFiles/bopnvgov/content/Links/Nevada%20PMP%20Dispenser%20Guide%20August%202016.pdf	http://bop.nv.gov/uploadedFiles/bopnvgov/content/Links/PMPApprissUserSupportManual.doc
New Hampshire	https://www.oplc.nh.gov/pharmacy/documents/nh-pdmp-data-submission-dispenser-guide.pdf	https://www.oplc.nh.gov/pharmacy/documents/nh-pdmp-awarxe-requestor-user-support-manual.pdf
New Jersey	http://www.njconsumeraffairs.gov/pmp/Documents/NJPMP-Data-Submission-Dispenser-Guide.pdf	
New Mexico	http://www.nmpmp.org/Documents/NM%20PMP%20Data%20Submission%20Dispenser%20Guide.pdf	http://www.nmpmp.org/Documents/NM%20PMP%20AWARxE%20User%20Support%20Manual.pdf
New York	https://www.health.ny.gov/professionals/narcotic/electronic_data_transmission/docs/submitter_guide.pdf	
North Carolina	https://files.nc.gov/ncdhhs/documents/files/pdmp-dispensersimplementationguide10-13.pdf	
North Dakota	https://www.nodakpharmacy.com/pdfs/AWARxEmanual.pdf	https://www.nodakpharmacy.com/pdfs/ND_QuickReferenceGuide_HowtoRunaPatientSearch.pdf
Ohio	https://www.ohiopmp.gov/Documents/General/PHARMACIES_PRESCRIBERS/Ohio%20PMP%20Handbook%20(ASAP%204.2A)%20-%20Instructions%20for%20reporting%20dispensed%20drugs%20to%20OARRS.pdf	https://www.ohiopmp.gov/Documents/General/PHARMACIES_PRESCRIBERS/OARRS%20User%20Manual.pdf
Oklahoma	http://elclwd.xara.hosting/index_htm_files/OK%20PMP%20Dispenser%20Guide_v1.2.pdf	http://elclwd.xara.hosting/index_htm_files/OK%20PMP%20AWARxE%20User%20Support%20Manual%20v5.docx
Oregon	http://www.orpdmp.com//assets/files/2017/Oregon_PDMP_Data_Submission_Dispenser_Guide.pdf	http://www.orpdmp.com/assets/files/2017/OR_PMP_AWARxE_Requestor_User_Support_Manual.pdf
Pennsylvania	http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP_DispenserGuide_v4.pdf	http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-PatientRecordQueryandWarningSigns.pdf
Rhode Island	http://go.appriss.com/rs/768-UPQ-075/images/RI%20PDMP%20AWARxE%20Dispenser%20Guide.pdf?mkt_tok=3RkMMJWWfF9wsRons63MZKXonjHpfsX%2B6egtUKWg38431UFwdcjKPmjr1YEBTMJ0aPyQAgobGp5I5FEPTLjYSbBxt6UKXg%3D%3D	http://health.ri.gov/publications/guides/HowToUseThePDMP.pdf
South Carolina	http://www.scdhec.gov/Health/Docs/sc-dispensers-implementation-guide.pdf	http://www.scdhec.gov/Health/docs/DrugControl/PMP%20Aware%20User%20Support%20Guide.pdf
South Dakota	https://doh.sd.gov/boards/pharmacy/assets/SD-Data-Submitter-Guide.pdf	http://doh.sd.gov/boards/pharmacy/assets/UserSupportGuide.pdf
Tennessee	https://www.tn.gov/assets/entities/health/attachments/TNDataCollectionManual.pdf	

Texas	http://www.pharmacy.texas.gov/files_pdf/TX_PMP_AWARxE_DispenserGuide.pdf	http://www.pharmacy.texas.gov/files_pdf/User_Support_Manual.pdf
Utah		
Vermont	http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_VPMS_Data_Collection_Manual.pdf	http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_AWARxE%20User%20Support%20Manual.pdf
Virginia	https://cdn2.hubspot.net/hubfs/2881008/PMP%20Implementation%20Documents/VA%20PMP%20Dispenser%20Guide%20v_1.4.pdf	http://trk.appriss.com/v0000O680djQU0c2P030000
Washington		
West Virginia		
Wisconsin	https://pdmp.wi.gov/download?fileName=WIPDMPDataSubmitterGuide.pdf	https://youtu.be/hlPUeCJtImU
Wyoming	https://drive.google.com/open?id=0B8cDfZ_Wrtc8eXctdEtKNmY2eW8	

Appendix D – Examples of Frequently Asked Questions (FAQs)

Category	Sample Questions and Answers
General	Am I required to see a driver's license or SSN for the patient identifier field?
	We prefer that you collect driver's license or state issued ID numbers on all patients that you can. If the patient doesn't have either of these, you can use their social security number, you can create an ID by using the patient's first, middle, last initials, 8-digit DOB, and gender, i.e. ADG01191978F (if you can't add the gender to the end, just use initials and DOB), or use their insurance number.
	Can I keep a copy of the PDMP in the patient's file?
	Yes. It is also recommended that you discuss any plans to keep copies of reports with your legal advisor to ensure that your plans meet any other requirements. OR The PDMP recommends that all PDMP History reports be kept in a separate location which is only accessible to authorized personnel. Essentially, the PDMP Patient History Report should not be filed in the patient medical chart. This measure will prevent unauthorized disclosure of the PDMP Patient History Report from being accessed and distributed by unauthorized individuals.
	Do other states have a Prescription Drug Monitoring Program?
	Currently, 49 states, the District of Columbia and one U.S. territory (Guam) have a PDMP that is operational (meaning collecting data from dispensers and reporting information from the database to authorized users). The St. Louis County Dept. of Public Health has partnered with other Missouri jurisdictions to establish a PDMP covering many areas of the state.
	How can the PDMP information help me in my daily practice?
	The PDMP database is most useful for detecting and preventing "doctor-shopping." If your registration is approved, you can log on and view the last 6 months of controlled substance prescriptions for a patient. If you see a pattern of excessive use of controlled substances, you can use more caution in prescribing or dispensing to the patient. Another use for the database is for prescribers to detect pharmacy errors or fraudulent use of their DEA numbers. A prescriber can log in and run a report displaying all schedule drugs reported with their DEA number.
	How is compliance measured with the PDMP?
	The PDMP matches the list of pharmacies who filed a report against the list of pharmacies licensed in the state. Those who failed to report will be contacted. If you have a problem reporting on time, contact the PDMP as soon as possible to arrange a mutually agreeable time to report. The PDMP uses thresholds to measure whether a pharmacy reports all the required data. The PDMP will reject a record that is missing data and is below the threshold. The pharmacy will receive a letter from the PDMP that identifies the rejected records. These prescriptions must be corrected and resubmitted.
	How is this program funded?
	The implementation and initial operation of the program is funded by a grant from the United States Department of Justice – Bureau of Justice Assistance. OR Healthcare providers and pharmacists are the ones paying for the system. Licensees pay a $25 annual fee included in their boards licensing fees. No general state funds are used. The rationale is that this will be a tool used by health care providers and pharmacists to help provide better patient care.

General Cont'd	How long does it take a prescription to appear on a patient's PDPM report after being dispensed?
	Pharmacies are required to report prescription information to the PDMP within one day of the date the drug was dispensed. Taking into account the time required to process that information and prepare it for reporting, the prescription information should be available within a few days of the dispensing date at the latest.
	How often is the data in the PDMP updated?
	All retail pharmacies that dispense schedule drugs are required to report their scripts to the PDMP on a daily basis. We collect the scripts throughout the week and load them into the PDMP on Friday of each week. OR All dispensers must report data weekly. However, if the dispensing pharmacy or practitioner does not have the technology or does not fill any controlled substance prescriptions to patients a waiver may be requested. OR Dispensers are required to submit data to the PDMP within 7 days of dispensing a monitored prescription drug. Dispensers are encouraged to submit data as soon and as often as they like.
	How will the effectiveness of the PDMP be assessed?
	The primary purposes of the PDMP are to improve patient care and safety and to reduce the abuse and diversion of prescription drugs while ensuring patients with a legitimate medical need for the drugs are not adversely affected. With that in mind, there are numerous ways in which "success" may be measured, including: Increase in the number of healthcare professionals using the PDMP; Reduction in reported rate of current non-medical users of prescription drugs; Reduction in reported initiation rate of non-medical users of prescription drugs; Reduction in reported rate of prescription drug abuse; Reduction in the rate of ER admissions for prescription drug overdose; Reduction in rate of prescription drug-related deaths
	Is information from other states visible?
	Yes, with direct access to the program prescribers may also request information from other states through the interstate query feature.
	Is the PDMP accessible via the EHR, HIE, or pharmacy software?
	Yes. You can access the PDMP from within the health information network. The report will be limited to the past year and no other state's data is included.
	The report shows a hospital as the prescriber. How do I know who actually wrote the prescription?
	Pharmacies report the DEA number of the prescriber to PDMP. For prescribers who are authorized to use the DEA number of hospital/institution in which they work, the DEA number will correspond to a specific hospital/institution. Contract the dispensing pharmacy to determine the actual prescriber. They are required to maintain that information.
	What are drugs of concern?
	Any product containing all three of these drugs: butalbital, acetaminophen, and caffeine; Tramadol; and Any compound, mixture, or preparation that contains any detectable quantity of ephedrine or pseudoephedrine, its salts or optical isomers, or salts of optical isomers. Any individual who wants to have a drug added to the program for monitoring may submit a written request to the PDMP.

General Cont'd	What are the laws/statutes and regulations?
	Each PDMP's profile has a link to the laws and rules governing the PDMP: http://www.pdmpassist.org/content/state-profiles
	What information is contained in the PDMP?
	The PDMP contains all Schedule 2, 3, 4 and 5 controlled substance prescriptions dispensed by retail pharmacies. OR The following information is reported to the PDMP: The recipient's name; The recipient's or the recipient representative's identification number or the identification number or phrase designated by the central repository; The recipient's date of birth; The national drug code number of the controlled substance dispensed; The date the controlled substance is dispensed; The quantity of the controlled substance dispensed; The number of days of supply dispensed; The dispenser's United States Drug Enforcement Agency registration number; The prescriber's United States Drug Enforcement Agency registration number; Patient address information, including city, state and zip code.
	What is the PDMP? What is the purpose of the PDMP?
	Prescription Drug Monitoring Programs (PDMPs) are highly effective tools utilized by government officials for reducing prescription drug abuse and diversion. PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. The data are used to support states' efforts in education, research, enforcement and abuse prevention. PDMPs are managed under the auspices of a state, district, commonwealth, or territory of the United States. States recognize the medical need for controlled substances and, therefore, PDMPs do not interfere with appropriate, medical use. Prescription data is provided only to entities authorized by state law to access the program, such as health care practitioners, pharmacists, regulatory boards and law enforcement agencies. PDMPs are proactive in safeguarding public health and safety while supporting the legitimate use of controlled substances. PDMPs do not infringe on the legitimate prescribing of a controlled substance by a practitioner acting in good faith and in the course of a professional practice.
	When am I required to request a PDMP report?
	Each board (pharmacy, medical, nursing, dental) has its own rules defining when it is required to obtain a report on a patient.

General Cont'd	Where does the data in the report come from?
	Data contained in the PDMP reports come directly from the dispensing pharmacy locations. All questions on a particular record or records should be directed to the dispensing pharmacy as they have the original, hard copy prescription or phone records on hand.
	Which prescription drugs are monitored?
	The law stipulates that the program is to monitor all schedule II, III, IV and V controlled substances
	Will having this program in our state limit the ability of patient to receive necessary medications?
	No, the PDMP will not interfere with the legitimate use of any medication. The purpose of the program is to promote optimal patient and community health by ensuring the correct use of scheduled medications, and to prevent potential diversion and abuse.
	Will the PDMP offer any kind of referrals to treatment programs?
	The PDMP provides data to healthcare professionals to enable them make more informed decisions about prescribing and dispensing monitored prescription drugs to their patients or potential patients. Healthcare professionals are encouraged to use the data obtained from the PDMP to improve their treatment of patients, including referring patients to substance abuse treatment, if they choose to do so.
Access	How can I reset my password?
	By navigating to the User Profile screen, a user can change their password by selecting Password Reset. A user can reset a forgotten password by clicking the "Forgot My Password" link located on the log in screen.
	How do I change information within my user profile?
	You must email the administrator to change information contained in your user profile.
	How do I register for a PDMP account?
	You must register for an account on the PDMP's vendor's website.

Access Cont'd	How many months/years are in the PDMP available for access?
	Data reported is available to permissible users for a 12-month period beginning the day the data was received. The PDMP program staff and certain authorized individuals may use all data collected for the purposes of administering, operating, and maintaining the prescription monitoring program and conducting trend analyses and other studies necessary to evaluate the effectiveness of the program. Data retained beyond 24 months must be de-identified. Data is retained for a maximum of 4 years.
	Under what circumstances are law enforcement officers permitted to request an Rx report?
	Law enforcement officers are permitted to request Rx History reports on a patient when the patient is the subject of an open investigation involving a drug crime. OR Federal, state, and local law enforcement authorities acting pursuant to a valid search warrant.
	Who can access the PDMP?
	Prescribers and pharmacists with registered accounts; Regulatory boards in the Department of Regulatory Agencies with a valid court order or subpoena; Law enforcement officers with a valid court order or subpoena; Patients can receive a copy of their own information
Use	Can a patient get a copy of their own PDMP report? Can I get a copy of my own PDMP report?
	The only mechanism available for an individual to obtain his or her prescription history report is through the Information Practices Act (IPA). OR An individual may request their own PDMP report by completing an application, having it notarized, and presenting the application to the PDMP Office.
	Can I run a PDMP report for someone else at my office or pharmacy?
	If you also treat the patient, you can request a report on the patient and share the report with others who treat the patient within your office or pharmacy. However, you may not provide a report to someone else solely for their own use. The treating physician/pharmacist should obtain his/her own PDMP account.
	Can I run a PDMP report on a patient who I have treated in the past but am not currently treating?
	State law allows a pharmacist or prescriber to request a Patient Rx History Report solely for the purpose of treatment. If you are no longer treating the patient, you are not authorized to request a PDMP report.

Use Cont'd	Can PDMP reports be generated for pharmacy recordkeeping?
	Yes, however copying or providing this data to an outside entity is strictly prohibited.
	How can practitioners, patients, or anyone else dispute the information about them stored by the PDMP?
	Patients or healthcare professionals who believe they have identified an error should ask the pharmacy or dispenser that submitted the data to correct the error. Only the pharmacy or dispenser that submitted the information can correct the error.
	How should providers use these reports?
	Reports should be used to supplement a patient evaluation or investigation, to confirm a patient's drug history, or document compliance with a therapeutic regimen. The PDMP does not guarantee any report to be wholly accurate or complete. The report is based on the search criteria entered and the data entered by the dispenser. For questions about any record in a PDMP report or to verify a prescription, contact the dispenser directly. If there are any concerns about data provided, please contact the PDMP. Please do not e-mail patient confidential information or redistribute the reports.
	If a problem is found, are we required to explain what we found to the patient?
	No, it is up to the discretion of the provider. A printed copy of the report can be logged in the patient medical record.
	Is registration mandatory?
	Prescribers must submit an application before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later. Registration requirements are not based on dispensing, prescribing, or administering activities but, rather, on possession of a Drug Enforcement Administration Controlled Substance Registration Certificate.

Use Cont'd	Is use mandatory?
	Requirements for use of the PDMP, including the following: 1) when prescribing a patient a controlled substance of more than 30 MME per day, physicians shall query the PDMP for that patient at least two times per year; 2) physicians shall query the PDMP every time a prescription for more than 90 MME per day is written on the same day the prescription is written; 3) for controlled substances totaling 30 MME or less, physicians are expected to use the PDMP in a manner consistent with good clinical practice; Provides exemptions for query requirements including when writing prescriptions for nursing home patients; hospice patients, where the prescription indicates hospice on the physical prescription; when treating a patient for active, malignant pain; or, intra-operative patient care.
	What are patient alerts?
	These messages alert clinicians when their patient's aggregate prescription level exceeds certain thresholds. Alerts are presented at the following therapy thresholds: Patient is currently prescribed more than 100 morphine milligram equivalents per day; Patient has obtained prescriptions from 6 or more prescribers or 6 or more pharmacies during last 6 months; Patient is currently prescribed more than 40 morphine milligram equivalents of methadone daily; Patient is currently prescribed opioids more than 90 consecutive days; Patient is currently prescribed both benzodiazepines and opioids.
	What are the clinical steps in response to concerns raised by a report?
	Talk with your patient. Attempt to determine the reasons for the concerning behavior. Reasons could include: Changing providers because of insurance coverage; Under-treatment of pain; Misunderstanding your pain management rules; Prescription drug abuse; Illegal behavior (diversion, fraud, etc.). Administer a brief intervention. Express concern over behavior patterns; discuss risks of misuse and its negative consequences. Clarify expectations (using one pharmacy, receiving controlled medications from only one provider, etc.). OR Increase patient monitoring and limit-setting.
	What if I suspect my information is accessed or used inappropriately?
	Improper access or disclosure of information should be reported in writing to the PDMP. The notification should include what information you suspect was inappropriately accessed or used, when and by whom, and why the action is considered inappropriate. The PDMP will investigate the matter.
	What information do I need to provide to make a request for a patient PDMP report?
	At a minimum you must provide a patient's first name, last name, and date of birth in order to make a request for a report.

Use Cont'd	What information does a report provide?
	The patient's name, date of birth and address (which the requestor provides); the prescribers name; the dispensers name, city, state and phone number; the drug name & strength, prescription number, days' supply, quantity dispensed and dispensing date
	What kind of flagging system exists?
	Currently the only warning system goes out monthly to the prescribers and dispensers in the form of "unsolicited reports." When the patient meets a certain criteria a report is generated and sent to all the prescribers and dispensers that are seeing that patient.
	What should a prescriber or dispenser do if they think data from the PDMP indicates that a patient is abusing prescription drugs?
	Data obtained from the PDMP may be used to make more informed decisions regarding the care given to a patient. However, data from the PDMP is not 100% accurate and should not be the only source of information considered when determining if a patient may be abusing prescription drugs. It is just one piece of information that should not be used in isolation to determine whether a patient is abusing drugs.
Dispensers	Do dispensing practitioners have to report/Do practitioners need to report to the PDMP if controlled substances are dispensed from an office?
	A pharmacy or dispensing practitioner that never dispenses controlled substances are not required to report to the PDMP and can notify the PDMP in writing that they will not be reporting. OR A pharmacy or dispensing practitioner that never dispenses controlled substances can request permanent exemption from the reporting requirement. Those that dispense controlled substances only occasionally may submit "zero-claim" reports for periods during which they have not dispensed any controlled substances to patients.
	Do I have to transmit zero reports?
	A zero report must be submitted every seven (7) days for a retail pharmacy, or every thirty (30) days for a hospital (Type II) pharmacy The reporting frequency may be subjected to change.
	Do Non-Resident (out-of-state) pharmacies report to the PDMP?
	Non-Resident pharmacies that dispense and send prescriptions to this state's residents are required to report controlled substance prescriptions to the PDMP.

Dispensers Cont'd	How can I manually enter a prescription into the PDMP?
	Prescription data can be manually entered into PDMP using the Universal Claim Form (UCF) option available to data submitters. To submit a UCF a user must register for a PDMP account. Entities that do not have pharmacy software or the ability to create an ASAP file for data submission may submit data via a UCF.
	How can I view the status of files I've submitted to the PDMP?
	The File Status screen displays information extracted from the data files submitted to PDMP. A status column is located at the end of each row displaying the status of the file. If there are errors then the status column will state "Pending Dispensation Error" and the text will be a hyperlink to the view records screen. If a file is unable to be parsed into the PDMP, the appropriate message will display. A new file must be submitted to PDMP. It is not necessary to void a file that failed parsing since it was not successfully submitted to PDMP. If a file has been submitted by sFTP without using a state specific sub-folder, the file will be displayed and the user will be prompted to select a destination PDMP for the data file to be transferred to
	How do I report a compounded prescription?
	You should use all 9's in the NDC field for compounded drugs and then use the fields in the CDI segment. This will allow you to put the NDC numbers that you used to make the compound in the CDI segment. In the NDC field for the DSP segment you will just need 99999999999.
	How often do I have to report to the PDMP?
	All dispensers must report data weekly. However, if the dispensing pharmacy or practitioner does not have the technology or does not fill any controlled substance prescriptions to patients a waiver may be requested.
	Is there an exemption form/waiver?
	To request an exemption from PDMP reporting, send a letter of explanation to the PDMP. Please include your DEA #. If your situation changes and you do dispense a reportable medication, you must report. Exemptions must be renewed with each renewal of the terminal distributor license.
	What options are available for reporting to the PDMP?
	Secure FTP over SSH, PGP encrypted files sent via simple FTP, upload via SSL Web site, and physical media (tape, diskette, CD, DVD), online UCF (universal claims form). All of these methods must adhere to the American Society for Automation in Pharmacy (ASAP) standard. If an automated recordkeeping system capable of producing an electronic report in the ASAP format is not available, dispensers may submit prescription information via paper submission using a specially provided form.

Dispensers Cont'd	Who is required to submit information to PDMP?
	Dispensers are required to submit information about each dispensing of a monitored prescription drug. "Dispenser" means all of the following: A pharmacy from where a pharmacist dispenses a monitored prescription drug and a practitioner who dispenses a monitored prescription drug.
	Who is exempted from reporting?
	Certain types of pharmacies, clinics and practitioners are NOT considered as a dispenser for PDMP purposes and are therefore EXEMPT from reporting to the Program. These include: Licensed hospital pharmacies that only distribute CDS for direct administration to an inpatient of the hospital; Pharmacies that provide pharmaceutical specialty services exclusively to persons living in assisted living facilities, comprehensive care facilities, and developmental disabilities facilities; Opioid maintenance programs; Veterinarians when dispensing controlled substances for animals in the usual course of providing professional services.
	Are there any exceptions to the reporting requirements?
	Certain types of drug delivery are not required to be reported, including: Direct administration of CDS to a patient; Provision of patient drug samples; Inpatient Hospice Dispensing.
Data Errors	Do I have to correct duplicate errors?
	No, if you generate a duplicate error, it means that record is already in the system. You may disregard duplicate errors.
	How do I correct my errors after I've uploaded data into PDMP?
	After viewing your error report, you should go back into your pharmacy's software system and correct each error. Once you have completed your error correction, you may resubmit your records in the same file or as part of your next regular submission.

Data Errors Cont'd	I ran a PDMP report and more than one person showed up on the results. What do I do?
	Occasionally, 2 people will show up on a single PDMP report. This most often occurs when both parties have the same birth date or same street name or when there are multiple pieces of overlapping information and our computer is unable to isolate one unique patient. This is common with twins and when two people in the same household have the same or similar names (father/son Jr., Joan and John, Michelle/Michael). Email the PDMP and provide the name (with proper spelling) and date of birth of the patient, and we will separate the accounts. We prefer this information come from the prescriber or pharmacy, not the patient. We are not able to separate patients from inter-state requests. Each patient will have a state identifier in the name box indicating from which state's PDMP the data was pulled.
	If there is a potential error in the report, who should be contacted?
	Contact the dispensing pharmacy or practitioner to verify the information they reported is correct; the PDMP if there is information missing; or law enforcement if a crime has been committed.
	What does it mean if it says my request returned multiple patient records?
	This means multiple patients were identified as matching the search criteria and the request must be manually consolidated by the administrator to include the correct patient records. Once a particular set of patient records have been consolidated, it will not have to be repeated and the user will not experience a delay the next time this patient report is requested.
	What does it mean if it says no matching patient found?
	That means no patient records in the database matched the search criteria entered or for the time period searched. If you believe this has occurred in error, please contact the PDMP and a ticket will be created for you to receive assistance with this matter.
	What if a patient says the PDMP information is wrong and the information is falsely attributed to them?
	First, review the patient information to ensure there is not more than one individual on the report, and that the report has not combined information on the patient with that of another individual. Secondly, confirm any prescriptions of concern by contacting the dispensing pharmacy. The dispensing pharmacy will have the hard copy record of the original prescription, and should be able to answer questions regarding the prescription. The pharmacy can also verify the patient's information for you. If the patient contests the information on the report and believes that it is an error, have the patient contact the PDMP.

Data Errors Cont'd	What if the report is missing names or numbers?
	The information reported to the PDMP was incomplete and did not contain all required fields when it was transmitted. If possible, you may contact the dispensing pharmacy for more information on that particular prescription record.
	How do I correct errors within submitted files?
	The view records screen provides a deeper view of the records within a selected data file that need correcting. A "Correct" button is displayed at the end of each row that will allow the user to make corrections to the record. The Error Correction screen allows a user to make corrections to data submitted that did not pass the validation rules. A "Corrected Value" column displays the values the user enters to correct the error. The Message column displays the relevant error message for the field explaining why it did not pass the validation rules.
	Why can't I find prescriptions that I know have been written or filled?
	There could be several reasons for this: The dispensing pharmacy is not properly reporting their prescription data to us. If you think that is the situation, please let us know so we can contact the particular pharmacy; There may be a difference in patient name spelling from how you think it is spelled and how it is actually listed in the PDMP; if the prescription had been written and or filled in the last week, it has not yet been reported to the PDMP.
	Why do I see scripts in the PDMP attributed to me that I did not write and what can I do about it?
	The dispensing pharmacy may have erroneously entered into their computer system your name/DEA number as the prescribing physician. And of course there is the possibility that unauthorized prescriptions are being written using your name and DEA number. Regardless, please call the PDMP with the details of the discrepancy so we can determine the circumstances of the situation. We will keep you informed about what we find.
Delegates	Can a person be a delegate for more than one prescriber or pharmacist?
	Yes, so long you are sufficiently competent in the use of the PDMP and you are either employed by, or under contract with, the prescriber or pharmacist, or the same practice or pharmacy.
	Can I authorize a delegate to access the PDMP?
	Yes, as a prescriber or pharmacist, you can authorize up to three delegates to access the PDMP database for your patients.

Delegates Cont'd	How does a delegate enroll in PDMP?
	You may register for a delegate account by creating an account within the PDMP. The registering individual must provide the email address of a supervisor who is previously registered within the PDMP, and delegates can provide email addresses of more than one supervisor. Supervisors must approve the delegate request before the PDMP administrator will be able to approve the account for access.
	How many delegates may a prescriber/dispenser have?
	A prescriber/supervisor may have as many delegates as they are comfortable supervising in the appropriate use of PDMP. A delegate may be a delegate for multiple prescribers/supervisors.
	Who can I choose as a delegate?
	If you are a prescriber, you may authorize a delegate who is sufficiently competent in the use of the PDMP, whom you either employ or have under contract with your practice. If you are a pharmacist, you may authorize a delegate who is sufficiently competent in the use of the PDMP whom you either employ or have under contract with your pharmacy.
Privacy	Can a person request that a PDMP report be sent to a third party?
	Yes, an individual can request data be sent to a 3rd party by filling out an authorization for release form. The form needs to notarized and sent to the PDMP office.
	Can I consult with other prescribers and dispensers listed on the PDMP report without patient authorization?
	According to HIPAA, this type of consultation is permitted because consultation is within the HIPAA definition of "treatment."
	Can reports be printed for office or record keeping purposes?
	Yes, however copying or providing this data to an outside entity is strictly prohibited.

Privacy Cont'd	Can the PDMP report be used in court?
	PDMP reports are not evidence and should not be presented in court. The PDMP was designed to be used as a tool for gathering evidence.
	Can the practitioner show the requested profile to the patient?
	Yes. This is up to the professional judgment of the practitioner.
	How do I know that my private medical information is secure?
	A number of safeguards have been put in place to protect the confidentiality of patient medical information. All authorized users of the system must be registered and approved for access. Even after access to the system has been granted, to ensure confidentiality of patients' medical records, a multitude of statutory restrictions still apply. For instance, a practitioner submitting a request for patient information must be providing medical or pharmaceutical treatment to the patient in question, or must be evaluating the need for such treatment. Likewise, members of the law enforcement community are only allowed to obtain private information in cases where an investigation dealing with controlled substances is already underway.
	How does HIPAA affect the PDMP?
	The disclosures of information to the PDMP by Pharmacies are mandated and not discretionary.
	How is patient privacy protected?
	The PDMP is HIPAA compliant. It has built in security features designed to protect patient information. The HIPAA privacy regulations permit disclosure of protected health information, without authorization or opportunity to agree or object, in certain specified instances. These include disclosures for a covered person's own treatment, payment of claims, and health care operations of the covered entity. In addition, state laws may also address privacy concerns with regard to confidentiality of patient information. In some instances, state law may provide for more stringent restrictions on release of patient information than the HIPAA privacy regulations; in those cases, the state law takes precedence.

Training	How does training occur?
	The tutorials will be available on-demand to train users on how to submit data to and how to obtain information from the PDMP.
	Is PDMP training available?
	Training can be presented at your facility or function by request.
	Is PDMP training mandatory?
	Completion of the tutorials is not required in order for practitioners and dispensers to access data stored by the PDMP.