

On-Line With Industry is a publication of the Drug Enforcement Administration (DEA), Office of Diversion Control. It is intended to facilitate communication between the DEA and the controlled drug and regulated chemical industries. Information presented in this newsletter shall not be construed as authorizing or permitting any person to perform any act which is not authorized or permitted under federal or state laws. Any conflicts between information presented in this newsletter and existing laws or regulations must be resolved in favor of the law.

Laura M. Nagel

Deputy Assistant Administrator
Office of Diversion Control

Patricia M. Good

Chief, Liaison and Policy Section

Mary Johnson-Rochée

Editor



TABLE OF CONTENTS



Editor’s Note Page 2



News from Inside The Office of Diversion Control Page 2



Industry Update. Page 13



Information Resources/Important Web Sites Page 17



Conferences, Meetings, and Training Page 18



Letters to the Editor Page 20

Editor's Note

This edition of *On-Line With Industry* marks a turning point for the Office of Diversion Control's primary publication geared to industry. *On-Line With Industry* is delivered to its readers with a new name, a new face and a new editor. It is hoped that readers find it full of information of interest and use to both the pharmaceutical and regulated chemical industries. It is the editor's intent to empower our readers with useful information and provide a front row seat to what is taking place in DEA and within industry. One of the primary missions of the Liaison and Policy Section is to foster communication between the DEA and the industries that it regulates. This publication will serve to inform our readers with regard to what the DEA's key issues and changing priorities are, as well as, to highlight for our readership issues emerging in industry which have direct bearing upon industry's compliance activities and overall progress. *On-Line With Industry* is specifically directed at the controlled substances and regulated chemical industries. This period is one marked with milestones and major steps in newer directions for the Office of Diversion Control. This publication is yet another step.
Editor

News from Inside

The Office of Diversion Control

Drug and Chemical Evaluation Section

In the Spotlight: Carisoprodol

Introduction

Carisoprodol is a non-controlled prescription drug. It is prescribed as an adjunct to rest, physical therapy and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions. Wallace Laboratories (Cranbury, NJ) introduced it into the United States pharmaceutical market in 1959 under the trade name Soma®. It is currently available from several pharmaceutical companies in tablet form for oral administration. The tablets contain either 350-mg carisoprodol or 200-mg carisoprodol in combination with codeine and/or aspirin.

Chemically, carisoprodol is N-isopropyl-2-methyl-2-propyl-1,3-propanediol dicarbamate. It is a white crystalline powder with a mild, characteristic odor and a bitter taste. Pharmacologically, it is classified as a centrally acting skeletal muscle relaxant. The exact pharmacological mechanism of carisoprodol action has not been established. Carisoprodol is thought to produce muscle relaxation in animals by blocking interneuronal activity in the brain stem and spinal cord.

Carisoprodol Diversion

Analysis of data obtained from DEA's System to Retrieve Information from Drug Evidence (STRIDE¹) for the period of 1980 to 2001 indicates that there were 368 exhibits for a total of about 109,077 dosage units of carisoprodol analyzed by DEA throughout the country. Seizures during the execution of federal search warrants at residences, offices or pharmacies accounted for more than half of the total encounters. Undercover purchases from dealers or from pharmacies accounted for about a quarter of the total encounters. When carisoprodol was seized, it was often encountered along with controlled substances such as diazepam or propoxyphene. Carisoprodol has also been found with other drugs of abuse such as cocaine, heroin, methamphetamine, anabolic steroids, marijuana, LSD and/or MDMA. Carisoprodol seizures have ranged from one pill to many thousands at a time. It is not clear from the STRIDE reports as to how most individuals diverting carisoprodol are obtaining the drug. However, it is evident that carisoprodol prescriptions for non-legitimate use do occur. There are instances of patients making phone calls to pharmacies, submitting phony prescriptions and obtaining carisoprodol through mail-order pharmacies without prescriptions. Street prices for carisoprodol range from \$1-\$12/tablet depending on location and quantity purchased. Federal investigative reports suggest that carisoprodol is being diverted from hospitals, pharmacies and nursing homes. The DEA is aware of some instances where carisoprodol has

¹ STRIDE – A database of drug evidence submitted to DEA laboratories

been used to make counterfeit drug products.

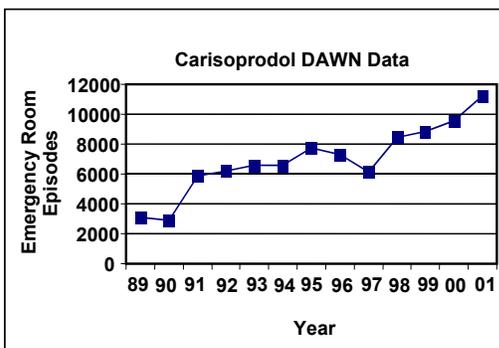
Carisoprodol Abuse Patterns

Carisoprodol is abused typically by poly-drug abusers. However, several published clinical reports indicate that carisoprodol also can be the sole drug of abuse. A recent study² suggests that some patients, especially those with a history of substance abuse and on carisoprodol prescription medication for over three months, may be particularly prone to abuse this drug. Carisoprodol has been used to prolong the duration and to increase the efficacy of the primary drugs of abuse such as alcohol or narcotics. It is also used to achieve the same effect with a smaller amount of primary drugs of abuse. Carisoprodol is used as a calming drug to take the edge off the jittery feeling associated with cocaine abuse. Some individuals abused the combination of carisoprodol and tramadol, a non-controlled analgesic, and reported profound relaxation and euphoria. Carisoprodol has been frequently detected in blood specimens of impaired driving cases. The daily consumption of carisoprodol by some drug abusers may be as high as 30-50 tablets. A recent study suggests that about 80 percent of the physicians are not aware that carisoprodol is metabolized into meprobamate, a Schedule IV controlled substance. About 60 percent of the physicians are not familiar with the abuse potential of carisoprodol.

² Reeves R.R., Carter O.S., Pinkofsky H.B., Struve F.A., Bennett D.M., Carisoprodol (Soma): Abuse potential and Physician Unawareness. J. Addictive Diseases 18: 51-56, 1999.

Carisoprodol Abuse Trends – DAWN data

The abuse trend for carisoprodol from 1989 through 2000 is shown in the figure given below. It is based on estimated emergency episodes from the Drug Abuse Warning Network (DAWN). There has been a clear increase in the number of emergency room episodes for the period of 1989 to 2000. Unlike carisoprodol, there were no increases in emergency room episodes for other muscle relaxants such as methocarbamol and diazepam during the period of 1994 to 2000. The majority of the persons reporting to the emergency rooms for carisoprodol-related injuries were between the ages of 25-45. The major reason people reported to the emergency rooms after taking carisoprodol was due to overdose. The major motive for taking carisoprodol was suicide. The other motives for taking carisoprodol were dependency and psychological effects. Medical Examiners' data reveals that the number of deaths associated with carisoprodol use increased from 13 in 1989 to 70 in 1996. Carisoprodol was commonly detected in combination with several other drugs of abuse such as opioid analgesics and non-steroidal analgesics, benzodiazepines, alcohol and barbiturates.



Carisoprodol Abuse: Pharmacological and Toxic Effects

The subjective effects of carisoprodol are considered to be similar to that of barbiturates. Meprobamate, a major metabolite of carisoprodol in humans, is well known to cause dependence and tolerance and it is a Schedule IV controlled drug. The degree of abuse potential of meprobamate is considered equal to or greater than that of benzodiazepines. Flumazenil, a benzodiazepine antagonist, readily reverses the acute intoxication associated with overdose of either meprobamate or carisoprodol. Thus, the conversion of carisoprodol to meprobamate in humans may presumably be the basis for its abuse. Further, the DAWN data indicate that both meprobamate and carisoprodol are similar in their profiles and patterns of abuse. Women abuse these drugs more frequently than men. The abusers are typically between 25-45 years of age and are most often Caucasians. The reason for seeking treatment is due to overdose. The reason for taking the drug was frequently for the purpose of attempting suicide. Further, there is some preliminary evidence that the withdrawal symptoms observed in carisoprodol-dependent subjects are similar to those seen in meprobamate-dependent subjects. These symptoms may include anxiety, insomnia, disorientation, tremors, and hallucinations. A tapering dose schedule of meprobamate substitution readily resolves these symptoms.

It has been reported that carisoprodol overdose produces vertigo, dizziness, headache, drowsiness, altered state of consciousness, amnesia, stupor, coma and death.

Carisoprodol Regulation

Carisoprodol is currently not a controlled drug. The DEA conducted an eight-factor analysis on the actual abuse of carisoprodol and its metabolic conversion to meprobamate. The DEA sent this analysis report to the Department of Health and Human Services (DHHS) in 1996 for scientific and medical evaluation. The Food and Drug Administration (FDA) convened the Drug Abuse Advisory Committee in February 1997 and the data were reviewed. The Committee concluded that the data on carisoprodol abuse and its metabolic conversion to meprobamate were insufficient. Thus, there was no control recommendation from the DHHS.

Carisoprodol (Soma®) - Request for Information

Carisoprodol (Soma®) is the recommended international non-proprietary name of a drug prescribed as an adjunct for the relief of pain, muscle spasm and limited mobility associated with painful skeletal muscular conditions. Currently, it is not controlled under the Controlled Substance Act (CSA) and is available therapeutically by prescription. Carisoprodol is currently controlled by some states. Carisoprodol is being reviewed again by the DEA after receiving information from medical professionals, state regulatory authorities and law enforcement personnel indicating that the drug is being diverted, trafficked and abused. Federal, state and local sources of information indicate that carisoprodol abuse is significant, widespread and increasing. Analysis of STRIDE data obtained for the period 1980-2001 revealed that carisoprodol has been encountered by law enforcement

personnel in several states and the District of Columbia. These encounters involved seizures, undercover purchases or “gifts” of carisoprodol. Carisoprodol has been shown to produce barbiturate or alcohol-type effects. Carisoprodol abuse has resulted in injury (seizures, coma) and death. Carisoprodol has often been abused in combination with benzodiazepines and/or narcotic analgesics. The DEA’s Office of Diversion Control continues to gather information on the abuse, diversion and trafficking of carisoprodol. Reports of actual abuse are extremely important factors in establishing the abuse potential of a substance for control under the CSA. **Please contact Dr. Srihari R. Tella at the address given below for further information or to report an encounter with carisoprodol.**

Drug and Chemical Evaluation
Section
Office of Diversion Control
Drug Enforcement Administration
Washington, D.C. 20537
Phone: (202) 307-7175
Fax: (202) 353-1263
Email: stella@dialup.usdoj.gov

The Emergence of Illicit Use of Two Piperazine Derivatives and the phenethylamine 2,5-Dimethoxy-4-(n)-propylthiophenethylamine Piperazine Derivatives.

Introduction

There is increasing evidence that two piperazine derivatives, benzylpiperazine (BZP) and 1,3-trifluoromethylphenylpiperazine

(TFMPP), are becoming popular drugs of abuse in the United States. BZP and TFMPP are N-monosubstituted piperazine derivatives.

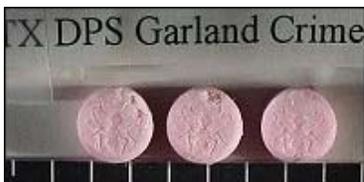
Benzylpiperazine was first synthesized in 1944 as a potential anti-parasitic agent. To date, neither BZP nor TFMPP has an accepted medical use in treatment in the United States. Thus, the safety of use has never been determined or accepted. They are available as bulk chemicals that are primarily used as chemical intermediates.



Bull's Head



Dolphin



Fly



No Markings

Scope of Abuse

Increasing encounters by law enforcement and discussions on websites popular with recreational drug users have provided evidence that the abuse of the piperazines BZP and TFMPP is becoming a growing problem in the United States. BZP and TFMPP are showing up in similar venues as the popular club drug 3,4-methylenedioxymethamphetamine (MDMA or "ecstasy"). On the Internet websites, there is much discussion on the effects of these piperazine derivatives alone and in combination. According to these websites, the co-abuse of BZP and TFMPP mimic the effects of MDMA. These piperazines are being promoted as a legal alternative to MDMA. BZP and TFMPP are sometimes sold as "ecstasy," or as "BZP," "A2," "legal E" or "legal X." These piperazines are being purchased from Internet chemical supply houses and formulated into tablets with intent for human consumption.

Crime laboratories in Florida, Texas, Illinois, Louisiana, Wisconsin, Rhode Island, Las Vegas, Nevada, and Connecticut have reported exhibits containing BZP and/or TFMPP. In some of the cases, the piperazines were being trafficked and sold as MDMA. Some of the seized tablets actually resembled MDMA tablets; similar in color and bearing logos commonly seen on MDMA tablets. Law enforcement encounters have mainly been tablets containing both BZP and TFMPP or BZP only. The tablets seized have varied in color: pink, white, off-white, purple, orange, tan, and mottle orange-brown tablets have been encountered. Some of the tablets also bore imprints commonly seen on MDMA tablets; a

bull's head (Taurus zodiac sign), housefly, heart, crown, and smiley face logos have been observed on some of the seized tablets. Powder containing BZP only has also been encountered.

2,5-Dimethoxy-4-(n)-propylthiophenethylamine (2C-T-7).

Introduction

2C-T-7, a phenethylamine, has appeared in the illicit drug traffic. 2C-T-7 is structurally related to the Schedule I phenethylamine 4-bromo-2,5-dimethoxyphenethylamine (2C-B), and other hallucinogens (e.g., 2,5-dimethoxy-4-methylamphetamine (DOM), and 1-(4-bromo-2,5-dimethoxyphenyl)-2-aminopropane (DOB)). 2C-T-7 is a sulfur analogue of 2C-B. Based on the structural similarities, 2C-T-7 is likely to have the same pharmacological profile as 2C-B and other Schedule I hallucinogens. 2C-T-7 has never been developed as a pharmaceutical product for medical use. As a consequence, no scientific data is available on its pharmacological effects in animals or humans. Hence, the safety of uses of this substance has never been determined or accepted.

Scope of Abuse

Encounters by law enforcement and discussions on websites popular with recreational drug users have provided evidence that the abuse of the 2C-T-7 is becoming a growing problem in the United States. Information gathered by the DEA indicates that 2C-T-7 is being purchased over the Internet. It is being sold under the "street names" Blue

Mystic, T7, Beautiful, Tweety-Bird Mescaline or Tripstay.

The DEA became aware of the possible illicit use of 2C-T-7 in the fall of 2000 when it was reported that a young healthy male had overdosed on 2C-T-7 following intranasal administration. Post-mortem evaluation detected only 2C-T-7 in the victim's blood and urine; alcohol and other drugs of abuse were not detected. Since this confirmed 2C-T-7-related death, two deaths reported in April 2001 were also linked to 2C-T-7.

Law enforcement encounters with 2C-T-7 have been encountered at the state level. Forensic laboratories from Texas and Wisconsin have reported exhibits containing 2C-T-7. One exhibit analyzed by the Wisconsin State Crime Lab was shown to be a mixture of 2C-T-7 and N,N-dipropyltryptamine (DPT). These exhibits indicated that 2C-T-7 was being distributed as a powder.

The interest in the abuse of 2C-T-7 by young adults is evident by the discussion on drug websites and the purchase from an Internet company. The information being discussed on these websites includes the route of administration, recommended doses, and narrative from individuals describing their experiences and effects after self-administering 2C-T-7.

2C-T-7 is being abused orally or intranasally. Information posted on these websites has indicated that it is co-abused with other drugs such as MDMA, ketamine and cannabis. Its subjective effects have been described as being similar to those of 2C-B. Its effects include visual hallucinations, mood lifting, sense of well-being, emotionality

volatility, increased appreciation of music, and psychedelic ideation. Consistent with the known long duration (6 – 8 hours) of effects of 2C-B, individuals are posting that 2C-T-7's effects last 5 to 7 hours after oral ingestion.

In response to this apparent growing problem, the DEA issued a final rule to temporarily place 2,5-dimethoxy-4(n)-propylthiophenethylamine, benzylpiperazine and 1,3-trifluoromethylphenylpiperazine into Schedule I of the CSA pursuant to the temporary scheduling provisions of the CSA. The final rule for 2C-T-7 (67 FR 59163) and the piperazines (67 FR 59160) was published on September 20, 2002. As a result of the final rule, the criminal sanctions and regulatory controls of Schedule I substances under the CSA will be applicable to the manufacture, distribution, and possession of 2C-T-7. The DEA will continue to actively monitor the scope, patterns of abuse, and the public health risk that these compounds pose. The Drug and Chemical Evaluation Section within the Office of Diversion Control is collecting information to support the final scheduling actions for these substances. We would appreciate any information that one can provide to support the Federal Government's effort in monitoring the abuse trend of these piperazines and 2C-T-7. Contact Dr. BeLinda A. Hayes, Drug Science Specialist at (202) 307-4594 with any information pertaining to 2C-T-7. Information pertaining to the piperazines BZP and TFMPP should be directed to Ms. Liqun Wong, Chemist, at (202) 307-7176. Information may be faxed to (202) 353-1263.

Diversion Planning and Resources Section

Career Opportunities

The Office of Diversion Control is currently authorized 524 Diversion Investigator (DI) positions. These positions are assigned to more than 80 offices throughout the United States and overseas. We envision an increase in that number for FY 2004. A Diversion Investigator is a highly trained specialist responsible for addressing the problem of diversion of pharmaceuticals and regulated chemicals from the legitimate channels in which they are manufactured, distributed and dispensed. The mission of the program is to aid the pharmaceutical and chemical industries in complying with the CSA, other pertinent Acts, as well as international treaties and conventions. When non-compliance is identified, DIs conduct in-depth investigations to uncover and investigate suspected sources of diversion and take appropriate criminal, civil and/or administrative actions.

General qualifications for a DI state that you must be a U.S. citizen and possess a valid driver's license. There are certain physical requirements you must meet. Candidates must have a Bachelor's degree (any major) and meet certain Superior Academic Achievement Provisions.

Typically, DIs are recruited through competitive or merit promotion procedures. However, the following additional programs are also being utilized.

- Veterans' Readjustment Appointment (VRA). Eligibility

for this program requires an honorable discharge from the Armed Forces within the last 10 years. A candidate for this appointment must have also served on active duty (not active duty for training or active duty as a Reservist) for more than 180 days. Candidates need to submit a detailed resume or application (OF-612), copies of college transcripts and a DD-214, Certificate of Release or Discharge from Active Duty (Member 4 copy).

- Federal Career Intern Program (FCIP). In December, 2002, the new FCIP was implemented within DEA. The FCIP is a two-year training program, open to all ages, offering federal benefits as well as promotion opportunity. Employees will be eligible for conversion to career-conditional status upon completion of the two-year program.

Mobility is a condition of employment as a DI. Candidates must also successfully complete a 12-week training program. To gain more information and knowledge regarding the additional conditions of employment as well as additional qualification requirements, please contact the Diversion Investigator Recruitment and Hiring Center at (202) 307-8846 or by mail at DEA Headquarters, ATTN: ODAS, (DI Hiring), Washington, D.C. 20537. You can also log onto www.dea.gov or www.DEAdiversion.usdoj.gov.

Liaison and Policy Section

The Pharmacy Theft Prevention Program

Over the past two years, as the abuse of narcotics escalated in the United States, so did the incidence of retail pharmacy thefts and robberies. The growing illicit demand for narcotics and the significantly high street dollar value for these drugs resulted in an overwhelming number of pharmacy robberies where narcotics were specifically sought. Review by the DEA of reported pharmacy theft data indicates that by and large, Florida, Massachusetts, Ohio, Kentucky, Alabama and Pennsylvania are documented hot spots for pharmacy theft and robbery related incidents. While these states stand out in terms of the reported number of incidents per state, pharmacy theft and robberies are a problem in many areas nationwide.

The DEA's Office of Diversion Control, Liaison and Policy Section is responding to this problem by developing a Pharmacy Theft Prevention Program. This initiative is envisioned as a major liaison effort on the part of the Liaison and Policy Section. The Pharmacy Theft Prevention Program will enlist the partnership of the pharmaceutical industry, state and federal regulatory and law enforcement counterparts, the DEA field offices nation-wide, the media and the public. The mission of the program will be to deter criminals from attempting pharmacy related crimes and to make these crimes as risky and unproductive as possible, without jeopardizing the lives of innocent people.

DEA Headquarters will serve as the focal point for this program. The program will include major outreach and education components. Critical to the program will be the establishment of networking and alert systems. The program will be implemented at the field level.

As an added component of the Pharmacy Theft initiative, the Liaison and Policy Section is generating publicity documents. The list of documents planned thus far includes a Pharmacy Theft Prevention Booklet, warning posters and decals. These documents will be disseminated primarily to representatives of industry, regulatory and law enforcement counterparts and DEA field offices nationwide. The Booklet will serve as a guide intended to provide pharmacists with insight on how to deter would be diverters, thieves and robbers, as well as how to better safeguard their controlled substances stocks and maintain a safe working environment. The warning posters and decals will be posted in pharmacies and will serve a deterrent effect as well.

At this writing, the Pharmacy Theft Prevention Program is in its very early developmental phase. During the week of September 22, 2002, Liaison and Policy staff participated in the Annual Fall Conference sponsored by the National Association of Chain Drug Stores (NACDS). The DEA's Pharmacy Theft initiative was presented at this meeting to NACDS and the overall response was quite favorable. The NACDS is being requested to review the Pharmacy Theft Prevention Booklet. Endorsement of the publication by NACDS is being requested as well. The Liaison and Policy Section looks

forward to working with NACDS on this very worthwhile project.

Registration and Program Support Section

THE GROWTH OF THE DEA REGISTRANT POPULATION

By Sharon Lick, Staff Coordinator
DEA Headquarters, Registration Unit

The CSA, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, is the legal foundation of the U.S. Government's fight against drug abuse, which includes both pharmaceutical and illicit controlled substances. Subsequent to 1970, Congress enacted Title 21 CFR, Section 1300 to end to provide regulations for handlers of pharmaceutical controlled substances, including the DEA registration process.

Since the enactment of the CSA and Title 21 CFR, Section 1300 to end, the DEA registrant population has doubled and new registration categories have been created. The purpose of this article is to show the growth of the DEA's registrant population and explain the addition of new registration categories.

In 1971, DEA registrations were issued to Type A and Type B registrants. Type A registrants included retail pharmacies, hospital/clinics, practitioners and teaching institutions. Type B registrants included controlled substance manufacturers, distributors, researchers, analytical laboratories, importers, exporters and narcotic treatment programs.

Review of DEA records reveals the following Fiscal Year approximations of Type A and Type B registrants:

1974 – 495,000
1975 – 509,000
1976 – 530,000
1977 – 561,000
1978 – 580,000
1979 – 604,000
1980 – 624,000
1981 – 646,000
1982 – 664,000
1983 – 685,000
1984 – 712,000
1985 – 728,000
1986 – 749,000
1987 – 761,000
1988 – 779,000
1989 – 805,000
1990 – 831,000
1991 – 850,000
1992 – 868,000
1993 – 890,000
1994 – 897,000
1995 – 910,000
1996 – 930,000
1997 – 959,000
1998 – 980,000
1999 – 1,010,000
2000 – 1,037,000
2001 – 1,076,000

The DEA's records indicate that the registration population, as of September 16, 2002, included 1,092,293 Type A registrants and 11,304 Type B registrants, totaling 1,103,597 registrants.

In 1988, the Chemical Diversion and Trafficking Act was enacted by Congress. With this legislation, a new registration category was created for handlers of List 1 chemicals, which can be used to manufacture illicit controlled

substances. As of September 16, 2002, there were 3,297 chemical handlers registered with DEA. These registrations include 213 manufacturers, 2,727 distributors, 13 retail distributors, 177 importers and 167 exporters.

In 1991, DEA registrations were issued to companies to legally dispose of pharmaceutical controlled substances. These companies, referred to as reverse distributors, are now included with Type B registrants.

In 1993, separate DEA registrations were issued for mid-level practitioners, also categorized as Type A registrants. Based on state authorization, DEA mid-level practitioner registrations are issued to Physician Assistants, Nurse Practitioners, Optometrists, Ambulance Services, Animal Shelters, Euthanasia Technicians, Registered Veterinary Technicians, Nursing Homes, Homeopathic Physicians, Registered Pharmacists, Naturopathic Physicians and Doctors of Oriental Medicine.

We have seen DEA registrations double since the 1970s and the emergence of new registration categories. These numbers and categories will continue to change. The DEA anticipates the continued growth in the number of registrants and the complexity of issues relating to registration.

Industry Update

Clarification of the Exemption of Sales by Distributors of Pseudoephedrine and Phenylpropanolamine Products

This clarification is meant to resolve the misconceptions regarding the exemption of sales by retail distributors of pseudoephedrine and phenylpropanolamine products packaged in blister packs from regulated transactions. Some retail distributors believe that this exemption is absolute—that a retailer may, without regulation, sell any amount of product packaged in blister packs to any person for any purpose, as often as that person wishes to make a retail purchase. It is not. By definition, sales by retail distributors are to be almost exclusively below-threshold amounts to individuals for legitimate medical use. Transactions that significantly exceed the threshold for retail distributors do not fit within this definition and thus are not exempt.

The Comprehensive Methamphetamine Control Act of 1996 (MCA) created the safe harbor exemption for sales by retailers of “ordinary over-the-counter pseudoephedrine or phenylpropanolamine products.” (Ephedrine and combination ephedrine products were not included in this safe harbor.) The MCA defined ordinary over-the-counter pseudoephedrine and phenylpropanolamine products as follows [emphasis added]:

The term **ordinary over-the-counter pseudoephedrine or phenylpropanolamine product** means any product containing pseudoephedrine

or phenylpropanolamine that is—**regulated** ... and ... sold in package sizes of **not more than 3.0 grams** of pseudoephedrine base or 3.0 grams of phenylpropanolamine base, and that is packaged in **blister packs**, each blister containing **not more than two dosage units**, or where the use of blister packs is technically infeasible, that is packaged in unit dose packets or pouches;..... (21 U.S.C. 802(45))

To fully understand the exemption of sales by retail distributors of ordinary over-the-counter pseudoephedrine and phenylpropanolamine products from a regulated transaction, it is necessary to clearly understand the definition of a regulated transaction [emphasis added]:

The term **regulated transaction** means—a distribution, receipt, **sale**, importation, or exportation of ... a listed chemical, or if the Attorney General establishes a **threshold amount** for a **specific listed chemical**, a threshold amount, including a cumulative threshold amount for multiple transactions ... of a listed chemical, except that such term does not include-- ...

- **[not a regulated transaction]** any transaction in a listed chemical that is contained in a drug that may be marketed or distributed lawfully in the United States under the Federal Food, Drug, and Cosmetic Act ... unless—
- **[regulated transaction]** the drug contains **ephedrine** or its salts, optical isomers, or salts of optical isomers, **pseudoephedrine** or its salts, optical isomers, or salts of optical isomers, or **phenylpropanolamine** or its salts, optical isomers, or salts of optical isomers ... except
- **[Not a regulated transaction]** that any **sale of ordinary over-the-counter pseudoephedrine or phenylpropanolamine products by retail distributors** shall not be a regulated transaction... (21 U.S.C. 802(39))

It is also necessary to understand the definition of a retail distributor as it relates to pseudoephedrine or phenylpropanolamine products. A retail distributor of pseudoephedrine and

phenylpropanolamine products is defined as follows [emphasis added]:

The term “retail distributor” means...a[n] ... entity or person whose activities as a distributor relating to pseudoephedrine or phenylpropanolamine products are limited almost exclusively to sales for personal use, both in number of sales and volume of sales, either directly to walk-in customers or in face-to-face transactions by direct sales. ... Sale for personal use means the sale of below-threshold quantities in a single transaction to an individual for legitimate medical use. (21 U.S.C. 802(46))

This definition of the activities of a retail distributor makes no distinction about the packaging of pseudoephedrine or phenylpropanolamine products. All retail sales of these products—both ordinary over-the-counter pseudoephedrine or phenylpropanolamine products (safe harbor blister packs) and pseudoephedrine or phenylpropanolamine products packaged in other ways (such as in bottles)—are almost exclusively to be in amounts below the retail threshold to an individual for legitimate medical use.

Therefore, when all of the above definitions and conditions are taken as a whole, the exemption of sales of ordinary over-the-counter pseudoephedrine or phenylpropanolamine products (blister packs) by a retail distributor from being a regulated transaction must be read as follows:

Any sale of **ordinary over-the-counter pseudoephedrine or phenylpropanolamine products** by [a] person whose activities as a distributor relating to **pseudoephedrine or phenylpropanolamine products** are limited almost exclusively to sales for personal use, both in number of sales and volume of sales, either directly to walk-in customers or in face-to-face transactions by direct sales shall not be a regulated transaction. **Sale for personal use**

means the sale of **below-threshold** quantities in a **single transaction** to an **individual** for **legitimate medical use**.

The threshold for pseudoephedrine and phenylpropanolamine products for retail distributors is defined as follows:

The threshold for any sale of products containing pseudoephedrine or phenylpropanolamine products by retail distributors ... shall be 9 grams of pseudoephedrine or 9 grams of phenylpropanolamine in a single transaction and sold in packages of not more than 3 grams of pseudo-ephedrine base or 3 grams of phenylpropanolamine base; (21 U.S.C. 802(39)(a)(ii)(IV))

Thus, below-threshold retail sales of ordinary over-the-counter pseudoephedrine or phenylpropanolamine products (blister packs) are to be almost exclusively less than 9 grams in a single transaction.

The DEA recognizes that there may be occasional sales of ordinary over-the-counter pseudoephedrine or phenylpropanolamine products (blister packs) which exceed the 9-gram per transaction threshold. Such a situation might occur when a whole family is sick or suffering from allergies, or the person comes from a long distance, such as in a rural area. Such an occasional sale is permitted, and does not disqualify the retail distributor from the blister pack exemption. In instances where a retail distributor conducts an occasional transaction involving an amount greater than 9 grams, the retail distributor is not subject to the requirements of a regulated transaction.

However, a significant number of sales to an individual or a significant volume of sales in a single transaction (above the threshold) to an individual of

pseudoephedrine or phenylpropanolamine products would not fall within the definition of sale for personal use. Sale for personal use is defined as “below-threshold quantities in a single transaction to an individual for legitimate medical use.” Additional sales to the same individual would not be expected to occur until the product the individual had bought would be consumed.

If sales of ordinary over-the-counter pseudoephedrine or phenylpropanolamine drug products by a retail distributor exceed “almost exclusively below threshold” amounts either in number of sales or volume of sales, the retailer must register with DEA as a distributor of List I chemicals (21 CFR 1309). A registered distributor must meet the security requirements for List I chemicals (21 CFR 1309.71) and for every sale of threshold or greater amounts must meet the requirements for regulated transactions. This includes the requirements for customer identification; recordkeeping and reporting described in 21 CFR 1310.

Conclusion

The definition of the activities of a retail distributor relating to pseudoephedrine or phenylpropanolamine products makes no distinction about the packaging of pseudoephedrine or phenylpropanolamine products. All sales of these products by a retail distributor—both ordinary over-the-counter pseudoephedrine or phenylpropanolamine products (safe harbor blister packs) and pseudoephedrine or phenylpropanolamine products packaged in other ways (such as in bottles)—are almost exclusively to be in amounts

below the retail threshold for a single transaction to an individual for legitimate medical use. Products must be sold to walk-in customers or must be sold in face-to-face transactions. Sales of significant amounts of product over the threshold by a retail distributor to an individual in a single transaction or a significantly large number of sales of product to an individual are inconsistent with activities defined for a retail distributor. An occasional sale above the retail threshold is allowed and does not disqualify the retailer from retaining the blister pack exemption. More than occasional sales that do not fit within the parameters of this exemption require the retailer to obtain a DEA registration as a distributor and meet all the requirements for a distributor, including, but not limited to, security requirements for storing List I chemicals and all the requirements for any sales that are regulated transactions.

National Forensic Laboratory Information System

National Forensic Laboratory Information System (NFLIS) is a DEA – sponsored project that systematically collects results from solid dosage drug analyses conducted by state and local forensic laboratories across the country. The NFLIS is a unique source of information for monitoring and understanding drug abuse and trafficking in the United States, including the diversion of legally manufactured drugs into illegal markets. Findings from NFLIS can also supplement existing drug data sources including information from demand-side survey and drug testing programs. The NFLIS presents

laboratory results, which are validated by chemical analysis, and have the highest degree of validity. As such, there are tremendous benefits associated with NFLIS, a national drug forensic laboratory reporting system that provides timely and detailed analytic results of drug seizures.

Started in September 1997, NFLIS has become a fully operational system and is moving toward full national coverage. As of August 2002, 32 state lab systems and 45 local lab systems representing 174 individual labs, were participating in NFLIS. In 2001, a total of 848,713 analyzed drug items were reported to NFLIS. Generalized or summary data from the NFLIS can serve multiple audiences, including forensic laboratories, policymakers, local, state, and federal law enforcement personnel, and researchers. Participating labs will receive regular report (quarterly and annual) summarizing data from their specific lab, as well as regional and national data. These reports provide statistically representative national and regional estimates for the most frequently analyzed drug items. National case-level estimates for the most common drugs analyzed are also presented in the reports. These reports also include findings on major drug categories such as narcotic analgesics, benzodiazepines, club drugs, anabolic steroids, and stimulants. In addition, the reports also provide summary on commonly reported drug combinations, drug purity reported among selected labs, and drugs identified by labs in border point-of-entry locations.

NFLIS is enhancing DEA resources for carrying out its core mission. NFLIS will improve our ability to track national,

regional, and local drug patterns, including providing timely and geographically specific information on emerging drug problems. Over the next several years, the DEA will seek to expand the NFLIS project to include all state, local, and federal laboratories that perform solid dosage drug analyses.

Contact Us

Drug Enforcement Administration
Office of Diversion Control
Drug & Chemical Evaluation Section
Washington, D.C. 20537
Attention: Liqueun Wong, Project Officer
Phone: (202) 307-7176
Fax: (202) 353-1263
E-mail: lwong@dialup.usdoj.gov

Final Rule Published Placing Xyrem® into Schedule III

On March 13, 2000, the DEA published a final rule (65 FR 13235) placing Gamma-hydroxybutyric Acid (GHB), its salts, isomers and salts of isomers into Schedule I of the CSA pursuant to the "Hillary J. Farias and Samantha Reid Date-Rape Drug Prohibition Act of 2000" (PL106-172), with the exception that all FDA approved drug products containing GHB are to be automatically placed in Schedule III upon approval.

On July 17, 2002, the FDA approved a GHB containing drug, Xyrem® (sodium oxybate, GHB). Xyrem® is indicated for the treatment of cataplexy associated with narcolepsy. The drug, GHB, is also a popular drug of abuse among teens and young adults at "rave" parties and night clubs. This drug is abused for its euphoric and alleged hallucinogenic

effects. It can produce drowsiness, dizziness, nausea, and visual disturbances at low doses. At higher doses, GHB produces unconsciousness, seizures, severe respiratory depression and coma.

What is Xyrem®

Xyrem®, a central nervous system depressant, is a FDA-approved drug containing GHB with Orphan Drug Status. It is approved to reduce the incidence of cataplexy (weak or paralyzed muscles) and to improve daytime sleepiness in patients with narcolepsy. The FDA approved Xyrem® for marketing and distribution in the United States under Section 505 of the Food, Drug, and Cosmetic Act. As provided for in Title 21, CFR, Section 1308.13(c)(5), any drug containing gamma-hydroxybuturate for which an application is approved under Section 505 of the Federal Food, Drug, and Cosmetic Act, is a Schedule III controlled substance. As such, any authorized persons manufacturing, distributing or dispensing GHB-containing FDA-approved drug products must register in Schedule III, maintain Schedule III security, comply with the labeling requirements of 21 CFR 1302.03-1302.07, comply with all inventory and recordkeeping requirements and comply with all Schedule III prescription requirements.

While Xyrem® is a Schedule III controlled substance, GHB, including its salts, isomers, and salts of isomers, remains a Schedule I drug. Abuse of Xyrem® will be subject to Schedule I criminal sanctions per the “Hillory J. Farias and Samantha Reid Date-Rape Drug Prohibition Act of 2000” (PL106-

172). Thus, any person who sells, distributes, or gives Xyrem® to someone else, or who uses Xyrem® for purposes other than what it is prescribed for, may be punished under the federal and state law.

The DEA requests that you forward this information to all of your members. For further information on Xyrem® or its Rules and Regulations, please contact this office at (202) 307-7297.

Information Resources/Important Websites

Drug Enforcement Administration
Office of Diversion Control
<http://www.DEAdiversion.usdoj.gov>

Office of National Drug Control
Policy
<http://www.whitehousedrugpolicy.gov>

U.S. Food and Drug
Administration
<http://www.FDA.gov>

National Association of Chain
Drug Stores
<http://www.nacds.org>

National Association of Boards of
Pharmacy
<http://www.nabp.net>

Bureau of Justice Statistics
<http://www.ojp.usdoj.gov.bjs>

National Association of Drug
Diversion Investigators (NADDI)
<http://www.naddi.org>
Pharmacy Associations
<http://www.rxwebportal.com>

National Criminal Justice
Reference Service (NCJRS)
<http://www.ncjrs.org>

National Household Survey on
Drug Abuse
<http://www.icpse.umich.edu/SAMHSA/nhsac.html>

Drug Abuse Warning Network
(DAWN)
<http://www.health.org/pubs/dawn/dwnfiles.html>

National Institute of Justice
<http://www.ojp.usdoj.gov/nij>

National Institute on Drug Abuse
(NIDA)
<http://www.nida.nih.gov> or
<http://www.drugabuse.gov>

DID YOU KNOW??

The DEA Headquarters' Registration Section has upgraded the services available through their toll-free number, 1-800-882-9539.

By accessing the 800 number, mail boxes are now available to process computer generated **requests** for DEA Order Forms, Renewal Applications and Duplicate Registration Certificates. The system provides instructions to the registrant regarding address change procedures. NOTE: Any address changes need to be **processed** by DEA

prior to requesting DEA Order Forms, Renewal Applications and Duplicate Registration Certificates. These changes provide more efficient service to our registrants.

Conferences, Meetings, and Trainings

DEA Hosts Chemical Industry Conference

The DEA hosted a three-day "Chemical Industry Conference" in Charleston, South Carolina, on September 10-12, 2002. Representatives from 25 industry firms (including their affiliated associations) were in attendance.

Laura M. Nagel, Deputy Assistant Administrator for the DEA's Office of Diversion Control, opened the conference and set the tone for the ongoing presentations and discussions. The Office of Diversion Control directs the DEA's worldwide chemical regulatory and control initiatives. Ms. Nagel emphasized that attendees, both in and out of government, should not lose sight of the "end game," which is the elimination of drug trafficking and abuse. Precursors and essential chemicals are the "points of origin" for the manufacture of major illicit drugs such as cocaine, methamphetamine and others. Regulations, initiatives and operations should be continually viewed and reviewed in light of this larger standard.

In fact, "the Chemical Industry" is many industries, which do not share uniform business models and markets. The DEA

programs reflect this reality conceptually and operationally. Domestic initiatives have continued to focus on methamphetamine trafficking, which is clearly attached to the availability of pseudoephedrine and similar chemicals. The DEA has learned through investigations such as Operation Mountain Express, that regulatory controls affecting the use of pseudoephedrine are weak and that some businesses are wittingly or unwittingly, supporting the illegal production of methamphetamine. This has resulted in an aggressive application of administrative sanctions, including show cause proceedings, to limit registrations to firms that provide assurances that their business practices will not become part of the drug abuse problem. There is no doubt that these initiatives have had an impact on the methamphetamine problem.

On the international scene, Canada is a major source for pseudoephedrine used to illegally manufacture methamphetamine and it is harder and harder for marginal companies, the so-called "bad actors," to make a go of it. Nevertheless, methamphetamine remains one of the high profile drugs on the abuse scene. The DEA anticipates continued pressure on the Canadians to develop adequate controls and continued intensive investigative efforts to eliminate the domestic sources

The DEA also works with the International Narcotics Control Board, which is attached to the United Nations.

Two programs, known as Operation Purple and Operation Topaz, are major strategic efforts to identify, track and disrupt the illegal international movement of potassium permanganate and acetic anhydride. Potassium permanganate is an oxidizing agent used to remove impurities from cocaine base. Acetic anhydride is a chemical used in the production of heroin. The tracking of the potassium permanganate has been far easier due to the smaller number of manufacturers and a smaller universe of nations which export it. Both programs have been successful in developing intelligence information and disrupting trafficker operations. A third program, known as Project Prism, is being developed to target the amphetamine type stimulant chemicals.

Cooperation between the DEA and industry was mentioned time and again by DEA executives and staff. If there was ever a time to lay aside personal and professional agendas and perspectives, it was on Wednesday, September 11th. The conference planners prepared a short slide show to honor the heroes and remember the victims of the terrorist attacks on the World Trade Center and the Pentagon. Terrance W. Woodworth, Deputy Director, DEA's Office of Diversion Control, using FDR's famous phrase, describing the attack as a "day of infamy," led the attendees through a recitation of the Pledge of Allegiance after the slide show. It was a powerful reminder of our common heritage and way of life.

Upcoming Meetings

Start Date	End Date	Association	City, State	Contact Information
04/13	04/16/ 2003	2003 American Association of the Treatment of Opioid Dependence (AATOD) Conference	Wash., DC	www.aatod.org
04/26	04/30/ 2003	National Association of Chain Drug Stores (NACDS) Annual Conference	Palm Beach, FL	www.nacds.org
05/12	05/16/ 2003	DEA National Conference/DPM Conference	Philadelphia, PA	www.deadiversion.usdoj.gov
05/14	05/16/ 2003	American Society of Consultant Pharmacists	Tampa, FL	www.ascp.com
06/10	06/13/ 2003	Healthcare Distribution Management Association	Orlando, FL	www.hdmanet.org

contact the Editor, Mary Johnson-Rochee.

*L*etters to the Editor

HOW TO REACH US

Letters To The Editor

Our fax number is (202)353-1079.
Letters should be addressed to:
DEA/ODLL
2401 Jefferson-Davis Highway
Alexandria, VA 22301

Letters should include the author(s) full name(s), affiliation and include a statement authorizing publication of the materials. Submissions may be edited for purposes of clarity and space.

We welcome your suggestions, topics of interest and article submissions. If you would like to be on our distribution list to receive this publication, you may