Controlled Substance and Legend Drug Diversion: A Law Enforcement and Regulatory Perspective

Phoenix Pharmacy Diversion Awareness Conference
National Association of Boards of Pharmacy (NABP)
Arizona Board of Pharmacy
Drug Enforcement Administration

Marriott Renaissance Phoenix Downtown
Phoenix, Arizona

Joseph Rannazzisi
Deputy Assistant Administrator
Office of Diversion Control
I have no financial relationships to disclose and I will not discuss off-label use and/or investigational drug use in my presentation.
Goals and Objectives

- Background of prescription drug and opioid use and abuse – Scope of the problem
- Identify and discuss the pharmacology of commonly diverted and abused pharmaceuticals
- Identify methods of pharmaceutical diversion and discuss how the pharmacist can prevent diversion in the retail setting
- Discuss law enforcement role in preventing abuse and trafficking
- Discuss disposal regulations
Responding to America’s Prescription Drug Abuse Crisis

“When Two Addictions Collide”

Pharmaceuticals

Money - Greed
Primum non nocere
Prescription Drug Abuse is driven by Indiscriminate Prescribing Criminal Activity
What is the Societal Damage of Prescription Controlled Substance and Legend Drug Abuse?
In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes.

Of this number, 22,134 of these deaths were attributed to Prescription Drugs (16,651 attributed to opioid overdoses/ 75.2 %).

Prescription drug abuse is the fastest growing drug problem in the United States.

Source: CDC Drug Overdose Deaths in the United States, 2010 (October 2012)
Consequences

In 2011, approximately 41,340 unintentional drug overdose deaths occurred in the United States, one death every 12.45 minutes. (increased for 12\textsuperscript{th} consecutive year)\textsuperscript{1}

Of this number, 22,810 deaths were attributed to Prescription Drugs (16,917 attributed to opioid overdoses/ (74.165%).

Prescription drug abuse is the fastest growing drug problem in the United States.

\textsuperscript{1}SOURCE: CDC National Center for Health Statistics/National Vital Statistics Report; June 2014
CDC Vital Signs: Opioid Painkiller Prescribing; July 2014
Drug-Induced Deaths vs. Other Injury Deaths (1999–2009)

Causes of death attributable to drugs include accidental or intentional poisonings by drugs and deaths from medical conditions resulting from chronic drug use. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Not all injury cause categories are mutually exclusive.

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<th>2011 Current Users (Past Month)</th>
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<td>Source: 2011 &amp; 2012 NSDUH</td>
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Prescription Drug Abuse

More Americans abuse prescription drugs than the number of:

Cocaine, Hallucinogen, Heroin, and Inhalant abusers

COMBINED!!!
Scope and Extent of Problem:
Past Month Illicit Drug Use among Persons
Aged 12 or Older

Percentage of Past Month Nonmedical Use of Psychotherapeutics by Age, 2003-2011

Source: 2011 National Survey on Drug Use and Health
Emergency Room Data 2004-2011

- **Increase of 148%**: ER visits attributable to pharmaceutical(s) alone (i.e., with no other type of illicit drug or alcohol) (336,753 to 835,275)
  - No Statistically Significant Change: ER visits attributable to cocaine, heroin, or methamphetamine; 62% increase in marijuana (502,864 to 656,025 – increase of 38%)

- **Increase of 128%**: ER visits attributable to pharmaceuticals alone, plus pharmaceutical(s) in combination with illicit drug(s) and/or alcohol (628,474 to 1,430,156)

- **Rx Drugs most frequently implicated**: Opiates/Opioids pain relievers (+183%)
  - Oxycodone products 262% increase
  - Hydrocodone products 107% increase

- **Emergency room data 2004 – 2011**
  - Fentanyl products 104% increase
  - Zolpidem 136% increase
  - Alprazolam 166% increase
  - Clonazepam 117% increase
  - Carisoprodol no statistically significant change

- For patients aged 20 and younger misuse/abuse of pharmaceuticals increased 45.4%
- For patients aged 20 and older the increase was 111%

Past Year Initiates 2012 – Ages 12 and Older

Figure 7.2 Specific Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2012

- Marijuana: 4,304
- Pain Relievers: 2,056
- Cocaine: 1,119
- Tranquilizers: 629
- Stimulants: 535
- Heroin: 467
- Hallucinogens: 331
- Inhalants: 164
- Sedatives: 135

Numbers in Thousands

SOURCE: 2012 National Survey on Drug Use and Health (NSDUH) published September 2013 by the Dept of HHS/ Substance Abuse and Mental Health Services Administration (SAMHSA)
Questions to Discuss

According to the National Survey on Drug Use and Health (NSDUH), in 2012 there were 6.8 million persons aged 12 and older who used prescription-type psychotherapeutic drugs non-medically in the last month. Which class of pharmaceutical had the highest level of non-medical use?

A) Stimulants  
B) Sedatives  
C) Pain relievers  
D) Tranquilizers
Drug Overdose Mortality Rates per 100,000 People 1999

Drug Overdose Mortality Rates per 100,000 People 2010

Poisoning Deaths: Opioid Analgesics

Source: CDC/NCHS, National Vital Statistics System
Naloxone
The U.S. Population Grows at a Rate of Less Than 1% Per Year!

Source: U.S. Census Bureau
Why are these statistics outpacing population growth?

We all want to feel good and prescription drug use/abuse is an accepted method of curing whatever ails you. There is a pill for everything and medication use is encouraged in society.

Our children are following our lead.
Rush Limbaugh Arrested On Drug Charges

Rush Limbaugh and prosecutors in the long-running prescription fraud case against him have reached a deal. Conservative commentator to be dropped without a guilty plea if he continues treatment, his attorney said Friday.

Limbaugh turned himself in to authorities on a warrant filed Friday charging him with fraud to conceal informing Barbara, a spokeswoman for the Palm Beach County Jail. He and his attorney Roy Black left about an hour and were fingerprinted and he posted $3,000 bail, Barbara said.

Prosecutors' three-year investigation of Limbaugh began after he publicly acknowledged being addicted to a rehabilitation program. They accused Limbaugh of "doctor shopping," or illegally deceiving multiple doctors learning that he received about 2,000 pills, prescribed by four doctors in six months, at a pharmacy near his home.

Limbaugh, who pleaded not guilty Friday, has steadfastly denied doctor shopping. Black said the charge will comply with court guidelines.

Rangers’ Boogaard died of alcohol, oxycodone mix

Updated 6/20/2011 11:09 PM

MINNEAPOLIS (AP) — The death of New York Rangers enforcer Derek Boogaard was an accident, due to a toxic mix of alcohol and the powerful painkiller oxycodone.

The Hennepin County Medical Examiner announced Boogaard's cause of death Friday, saying it was unclear exactly when the 28-year-old died. Boogaard was found in his passion for the game, his teammates, and his community work was unstoppable."

Experts say mixing alcohol and medicines can cause dangerous reactions. Drinking alcohol while taking strong painkillers like oxycodone can result in breathing problems and increase the risk of an overdose, according to the National Institute on Alcohol Abuse and Alcoholism.

The family thanked the Rangers, Minnesota Wild, the NHL and the NHLPA for "supporting Derek's continued efforts in his battle."

"Regardless of the cause, Derek's passing is a tragedy," NHL spokesman Frank Brown said in an email. The Rangers and Wild had no comment.

Coheed and Cambria Bassist Arrested Before Gig

Originally posted Jul 10th 2011 5:18 PM PDT by TMZ Staff

Michael Todd, the bassist for the band Coheed and Cambria, was arrested for armed robbery after he allegedly held up a Walgreens by claiming he had a bomb ... and this all went down right before they played a show!

Jack Camp, Senior Federal Judge, Arrested On Drug, Gun Charges

ATLANTA — A veteran federal judge faces drug and firearms charges after an exotic dancer at an Atlanta strip club told authorities he used cocaine, marijuana and other illegal drugs with her.

Senior U.S. District Judge Jack T. Camp was arrested Friday minutes after he handed an undercover law enforcement agent $160 for cocaine and Roxycodone, a narcotic pain medication, that he intended to use with the exotic dancer, authorities said in a court document released Monday. They said they also found two firearms in the front seat of his vehicle.

Camp, 67, who has presided over some high-profile cases, was released Monday on a $50,000 bond. His attorney, William Morrison, said after a brief hearing that the judge intends to plead not guilty. Morrison said Camp would probably take a leave of absence and would not preside over any more cases until the charges are resolved.

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In Florida two Westchase teachers learn a lesson: Say 'no' to mints in pill bottles

The drug bottles were made more realistic with labels that read in part: “Watson’s Whiz Kid Pharmacy. Take 1 tablet by mouth EVERY 5 MINUTES to cure FCAT jitters. Repeated use may cause craft to spontaneously ooze from pores. No refills. Ms. Falcon’s authorization required.”

The teachers' unusual calming tactic was discovered by Sandy Young, who was greeted with the sight of a pill bottle on each student's desk when she visited her grandson's classroom. The teacher assured her that the pills were fake and just a lighthearted attempt at reducing the stress of the test-taking students.
Violence
# Pharmacy Armed Robberies

## Rankings by State

January 1 thru December 31, 2011  (691)

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Source: DEA Drug Theft & Loss Database as of 03/18/2014
## Pharmacy Armed Robberies Rankings by State

**January 1 thru December 31, 2012**  
*(780)*

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Source: DEA Drug Theft & Loss Database as of 03/18/2014
### Pharmacy Armed Robberies
#### Rankings by State

**January 1 thru December 31, 2013 (702)**

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Source: DEA Drug Theft & Loss Database as of 05/15/2014
Pharmacy Armed Robberies
Rankings by State
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Source: DEA Drug Theft & Loss Database as of 08/18/2014

U.S. Drug Enforcement Administration
Office of Diversion Control
Armed Robbery

- Keep calm – Do as directed
- Do not challenge the bad actor – give him what he wants
- Let him leave the store without any intervention.
- As soon as he clears the store lock the door, call 911 and check on your customers/patients
- Write down any observations (clothing, height, weight, distinguishing features) while it is fresh in your mind
- Armed Robbery is an act of desperation. No amount of drug loss is worth your life or the life of your patients
Violence Related to Controlled Substance Pharmaceuticals

ASSASSIN

Chilling anatomy of drugstore massacre

DRUGSTORE MASSACRE

Husband and wife busted in Rx-slay horror

PAIN KILLER

U.S. Drug Enforcement Administration
Office of Diversion Control
LANSING — Michael Addo, known as a friendly Rite Aid pharmacist with a "million dollar smile," had a toddler and wife in Ghana, where he hoped to return after working in the U.S., police said.

RITÉ AID AND EAST LANSING SHOOTING CASE
Pharmacist slain in Beach robbery was much beloved

By Stacy Parker
The Virginian-Pilot
© April 15, 2014

VIRGINIA BEACH

When pharmacist David Kilgore left Rite Aid three-plus years ago, customers transferred their prescriptions to his new, small independent business.

They admired the way he connected with them on a personal level.

Monday, they placed flowers at his pharmacy's doorstep after learning the 46-year-old was shot during a morning robbery and later died.

"It was always, 'Hey Pete, how you doing?'" said Peter Carlson, who dropped off a colorful bouquet at Beach Pharmacy on Monday evening.

Related: Suspect identified, charged with murder

The pharmacist was working at Rite Aid on Laskin Road near the Oceanfront when development...
Prescription drug epidemic?
How did we get to this point?
Laudanum is no more dangerous than many of the preparations sold as soothing syrups; it has the saving grace of the “poison” label. (By courtesy of the Committee on Interstate and Foreign Commerce.)
The 1960s/70s/80s

Uppers - Amphetamines

Downers - Barbiturates

Quaalude

Hydromorphone

Meprobamate

Oxycodone/APAP

“Ts and Blues”

“Fours and Doors”
The 1990s

OxyContin® Tablets
(oxycodone hydrochloride controlled-release)
Inadequate Pain Control
We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.
The Fifth Vital Sign?

1. Temperature
2. Heart Rate
3. Blood Pressure
4. Respiration
5. Pain?
Wong-Baker FACES Pain Rating Scale

- No Pain
- Sin dolor
- Không Đau
- Tsis Mob
- Отсутствие боли

- Mild Pain
- Dolor leve
- Hơi Đau
- Mob Me Ntsis
- Слабая боль

- Moderate Pain
- Dolor moderado
- Đau Vừa Phải
- Mob Hauj Sim
- Умеренная боль

- Severe Pain
- Dolor agudo
- Rát Đau
- Mob Heev
- Сильная боль

Experts call for balance in addressing under treated pain and drug abuse

Healthcare decisions must remain in the hands of healthcare professionals for the sake of patients

A balance must be struck between physicians’ responsibility to treat chronic pain and the Drug Enforcement Administration’s (DEA) duty to combat drug abuse, according to a series of seven commentaries by national thoughtleaders published today in the February Issue of Pain Medicine.

The commentaries explore the current state of the use of pain medicine from a variety of perspectives, with an emphasis on the tension between physicians treating legitimate pain and the DEA. Pain Medicine is the Journal of the American Academy of Pain Medicine (AAPM).

According to the American Pain Foundation, chronic pain affects more than 50 million Americans. People suffering from chronic pain may need pain medicine to lead normal lives, such as being able to work and to participate in family life. Many patients with chronic pain have lost access to appropriate medical care due to tension between regulatory/legislative bodies and the medical community.

The lead commentary describing current DEA policy on pain care with controlled substances was written by Howard A. Heit, MD, a pain and addiction medicine specialist who has collaborated with the DEA. AAPM President Scott M. Fishman, MD, presents the collision of the war on drugs with efforts to improve pain care. Jennifer Bolen, JD, Former Assistant US Attorney with the United States Department of Justice, makes a compelling case that current DEA policies are founded on erroneous and inappropriate positions. Edward Convington, MD, Steven Pawlik, PhD, and Ben A. Rich, JD, PhD, add additional dimensions to the current perceived state of imbalance, while Will Rowe, Executive Director of the American Pain Foundation, a patient advocacy organization, provides perspective on patients’ rights.

Victories and Defeats in Pain Care

Dr. Heit and others worked with the DEA to develop the August 2004 Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel, which the DEA subsequently disavowed causing “confusion and consternation” among physicians who treat pain.

“It is now apparent to me that the spirit of cooperation that existed between the DEA and the pain community to achieve the goal of balance has broken down. The DEA seems to have ignored the input and needs of the healthcare professionals and pain patients who actually prescribe, dispense and use controlled substances,” Dr. Heit states in his commentary.

“It is essential that we resume dialogue between the DEA and healthcare professionals for the benefit of our patients and society,” continues Dr. Heit. “The DEA and the healthcare professionals treating pain both have an important job to do in ensuring that patients who need [controlled substances] for pain receive them while preventing misuse and diversion. Only through dialogue based on mutual trust and respect can this balance be restored.”

Other government initiatives have challenged the line between health policy and law enforcement. This includes Congress’s empowerment of the DEA allowing the agency authority in reviewing new drugs, a role previously held only by the Food and Drug Administration, according to Dr. Fishman. On Nov. 4, 2005, Congress reversed itself and rescinded the DEA’s new authority.

As healthcare’s regulatory authority shifts from health agencies to law enforcement agencies, the DEA and Federal prosecutors have used the courts to bypass state medical boards when scrutinizing physician practices. Dr. Fishman says that the recently passed national law, National All Schedules Prescription Electronic Reporting Act (NASPERS), which institutes a national prescription monitoring program, may offer some steps forward, but it also carries the potential to impede optimal prescribing and create even perpetuate aberrant prescribing that may facilitate abuse. While this new law is presented to the public as a clinical tool to improve patient care and safety, “...profound inadequacies suggest that this law may be intended less as a clinical tool than as a physician mouse trap,” Dr. Fishman states.

“Healthcare decisions, including those involving legitimate use of analgesics, must remain in the hands of healthcare professionals,” comments Dr. Fishman. “The DEA should be required to work with health agencies and healthcare professionals in finding common ground and reaching the rational position of balance that is in the public’s best interest. Healthcare oversight must remain within agencies whose primary responsibility is to improve public health and continue to insist that drug abuse can be curbed without undermining patients in pain and striving for such policies is in the best interest of society. The least we can do is to make sure that the casualties of illegitimate deserve relief.”

Freedom to Care for Pain Patients Critical

Reluctance to prescribe powerful pain medicine among the medical community for fear of retribution has led to the needless suffering of countless people in pain.

The Department of Justice must “stop the abuse and diversion of prescription medicines without harming access to these medicines for people affected by pain,” states Will Rowe, Executive Director. American commentaries to a failure on the part of the DEA in not abiding by its commitment to the pain community to pursue a balance between the war on drugs and the rights of pain patients, and also cite the more comprehensive command.

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About the American Academy of Pain Medicine

Founded in 1983 as the American Academy of Algology, the American Academy of Pain Medicine (AAPM) has evolved as the primary organization for physicians practicing the specialty of Pain Medicine in total, a defined body of knowledge and scope of practice have emerged, and today, Pain Medicine is recognized as a discrete specialty by the American Medical Association (AMA). AAPM is the only pain Medicine Delegates. The Journal Pain Medicine is published six times a year by Blackwell Science, Inc. For more information, visit www.painmed.org.

About the American Pain Foundation

Founded in 1997, the American Pain Foundation is an independent nonprofit 501(c)(3) organization serving people with pain through information, advocacy, and support. Our mission is to provide the quality pain awareness, providing practical information, promoting research, and advocating to remove barriers and increase access to effective pain management. For more information, visit www.painfoundation.org
The chilling effect

Experts call for balance in addressing under treated pain and drug abuse

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The chilling effect

Victories and defeats in pain care

Dr. Fishman and others worked with the DEA to develop the August 2004 “Questions, Guidelines and Answers for Health Care Providers and Pain Management Persons,” which the authors say have caused confusion and continuous problems for physicians who treat pain.

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Risks to Care for Pain Patients Critical

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The Department of Justice must “stop the abuse and diversion of prescription medicines without harming access to these medicines for people affected by pain,” states Will Rowe, Executive Director, American Pain Foundation, commenting on a failure on the part of the DEA. In not abiding by its commitment to the pain community in the pursuit of a balance between the war on drugs and the rights of pain patients, and also cites the message to counter the assert the more comprehensive command.

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American Pain Foundation Shuts Down as Senators Launch Investigation of Prescription Narcotics
For Immediate Release
May 08, 2012

Baucus, Grassley Seek Answers about Opioid Manufacturers' Ties to Medical Groups

Finance Leaders Investigate Whether Pharmaceutical Companies Encouraged Non-Profit Beneficiaries to Promote Misleading Information about Narcotic Painkillers

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) and senior Committee member Chuck Grassley (R-Iowa) initiated an investigation today into the connections of drug manufacturers Purdue Pharma, Endo Pharmaceuticals, and Johnson & Johnson with medical groups and physicians who have advocated the increased use of narcotic painkillers, or opioids. The Senators also asked seven other medical groups to produce information about their financial ties and collaborations with opioid manufacturers. In letters sent to each yesterday, Baucus and Grassley requested documents and financial information from the companies and noted that deaths resulting from opioid overdoses have recently skyrocketed, growing nearly 400 percent between 1999 and 2008, the most recent year data was available. They also highlighted news reports suggesting the increase may be driven by misinformation and dubious marketing practices used by the pharmaceutical companies and the medical organizations they fund.

“Overdoses on narcotic painkillers have become an epidemic, and it’s becoming clear that patients aren’t getting a full and clear picture of the risks posed by their medications,” Baucus said. “When it comes to these highly-addictive painkillers, improper relationships between pharmaceutical companies and the medical groups that promote their use are still prevalent. The purpose of this letter is to ensure the public and the Committee are informed of and have access to pertinent information about the ties between the companies and their potential role in misinforming the public and medical professionals about the use of these narcotics.”
“Recent investigative reporting from the Milwaukee Journal Sentinel/Medpage Today and ProPublica revealed extensive ties between companies that manufacture opioids and non-profit organizations such as the American Pain Foundation....and the Joint Commission.”
Bioethics think tank’s ties to pain pill industry studied

BY ALAN DAVLEY
The Kansas City Star

A U.S. Senate committee is examining a Kansas City-based bioethics think tank’s financial ties to the pain pill industry.

The inquiry is part of a sweeping investigation by the Senate Finance Committee of connections between pain drug manufacturers and organizations and physicians who have advocated for increased use of narcotic — also known as opioid — painkillers.

Abuse of these potentially addictive pain medications has become a national epidemic and accounts for more overdose deaths than heroin and cocaine combined. About 5 million people had used the drugs recently without a prescription, a federal survey found.

The Center for Practical Bioethics is one of seven organizations that received letters this week from the Senate committee asking them for information about their financial ties and collaborations with opioid manufacturers.

The other organizations are the American Pain Foundation, the American Academy of Pain Medicine, the American Pain Society, the Wisconsin Pain and Policy Study Group, the Joint Commission of Accreditation of Healthcare Organizations and the Federation of State Medical Boards.

Recent investigations by news organizations have found that some of these groups, such as the American Pain Foundation, a patient advocacy group, are funded largely by the drug industry.

The Senate committee is seeking to determine whether any of the groups promoted misleading information about the risks and benefits of opioids while receiving financial support from manufacturers of the drugs.

A Senate aide told The Kansas City Star that the investigation may bring into question guidelines for pain management, or the legitimacy of some of the organizations under scrutiny.

One of the organizations, the American Pain Foundation, disbanded last week, citing “irreparable economic circumstances.”
Now, Dr. Portenoy and other pain doctors who promoted the drugs say they erred by overstating the drugs’ benefits and glossing over risks. “Did I teach about pain management, specifically about opioid therapy, in a way that reflects misinformation? We, against the standards of 2012, I guess I did,” Dr. Portenoy said in an interview with The Wall Street Journal. “We didn’t know then what we know now.”
Commonly Abused Controlled Pharmaceuticals

- Carisoprodol
- CYCLOBENZAPRINE (FLEXERIL)
- Hydrocodone
- OxyContin 80mg
- Oxycodone HCL ER
- Oxymorphone
- Oxycodone 30 mg
- Alprazolam
The Holy Trinity

- **Oxycodone**
- **Carisoprodol** (Muscle Relaxant)
- **Alprazolam** (Benzodiazepine)

**Opiate**
Direct to Consumer Advertising
YOU SHOULD TRY FLYAGRA, TIM. IT CHANGED MY LIFE.
Questions to Discuss

What combination of drugs is referred to as the “trinity”?

A) Hydrocodone, alprazolam, and carisoprodol

B) Promethazine with codeine, methylphenidate and carisoprodol

C) Hydromorphone, carisoprodol and buprenorphine

D) Methadone, diazepam and tramadol
We will not arrest our way out of this problem!!!!!

Enforcement is just as important as....

Prevention/Education

Treatment
Drug Education

or not
Teen Prescription Drug Misuse & Abuse

- **23%** report having abused RX medications at least once in their lifetime.

- **31%** believe “it’s okay to use prescription drugs that were not prescribed to them to deal with an injury or pain, as long as they are not getting high.”

- **22%** say their parents don’t care as much if they are caught using RX drugs without a prescription, compared to getting caught with illegal drugs.

Date Prepared/ Source: 2013 Partnership Attitude Tracking Study, published 7/23/14
Education

➢ Children/Teens

Information from the Internet or their peers

Following parents
What are kids listening to… Eminem?

➢ Rap star Eminem has a Vicodin® (Hydrocodone) tattoo on his arm and a picture of a Vicodin® tablet on one of his CDs.
Where do kids get their information from?

www.EROWID.org
Bluelight Remembers Ryan Haight, Launch of the Recovery forums

by Sebastians_ghost Published on 12-02-2013 06:45

Dear Bluelighters,

As some of you may remember, February 12th is the twelfth anniversary of the passing of one of our own. To most it will be remembered as the first day "Bluelight went black." To those of us who knew Ryan Haight (a.k.a Quicksilver) it is also the day we lost a friend.

The impact of Ryan's life and untimely death have echoed forward in the passage of the Ryan Haight Internet Pharmacy Consumer Protection Act of 2008, signed into law by President G.W. Bush in October of the same year. In honor of Ryan, Bluelight is proud to announce the launch of a new collection of recovery forums designed to support sober living, and provide help to those struggling with drug addiction.
Ok---- so here is my current experiment status' so far.

1.) Milling / Grinding OP 80 - I have found the best way to crush OP80 with the use of a foot file / nail file. Hoseclamp did not work good. Using the file, I was able to get it to a powder around 20% thicker than the old DC.

2.) Experiment 1: Fail - My first experiment was to mill the OP80 and I left it overnight in a mixture of apple cider vinegar and lemon juice. 8-9 hours later, I drank it and received minimal if any effects except a horrible case of acid stomach. I suspect all the acid may have killed the alkaloids or something, or just failed to extract it completely.

3.) Experiment 2: Fail - Grinding up and parachuting - despite milling these OPs down, they still retain substantial time release. I found this to be a failure and it released the oxy slowly over the course of many hours.

4.) M.L.K - I read that if you put M.L.K drops (a popular, common solvent) in a spoon to saturate some milled OP 80, then let it evaporate, it dissolves the plastic and leaves a snortable powder that does not Gai. Many people report success with this, but I did not. Perhaps I did not use enough M.L.K or let it dissolve for long enough.

I posted this in the other thread, but I find this information useful and suggest you all read it here in case you missed it:

From the Purdue website, here is a summary of the info I found:
http://www.fda.gov/ohrms/dockets/ac/05-05-Purdue.pdf

Besides the obvious Simple, Medium, and Complex solvent thing that has everyone confused---- here is some information you guys should consider in ur investigations:

1.) At room temperature, using commonly found solvents, the best they could do was extracting 50% of the oxycodone for SHORT DURATION Shaking Extractions at room temperature.

2.) At room temperature with some less readily available solvents, extraction was as high as 70% during a "SHORT DURATION" shaking extraction at room temp.

3.) When we are dealing with EXTENDED extraction times at ROOM temperature--- some SIMPLE HOUSEHOLD solvents extracted up to 78% of the oxycodone! That might mean if we leave oxycodone soaked in acetone, M.E.K, or Ether for some time we can get almost 80% of the OC cut. How long is an extended duration, I wonder? 1 hour, 2 hour, 4 hours-- shaking and stirring it. In the end, I would assume we would filter out the gunk, evaporate the solvent, and be left with pure oxycodone residue. The 22% or so that wasn't extracted would remain in the gunk we filter and we could eat them or something. There was one simple solvent they listed, however, that only got 2-9% out--- in otherwords destroying the alkaloid entirely. Not sure which one that is but maybe we can research solvents known to destroy oxycodone molecules. The Medium and Complex solvents all removed most of the oxycodone when leaving them at room temperature for extended periods of time.
Months ago, maybe even a year ago now, a friend introduced me to Xanax because we had been on a meth bender and sleeping had become impossible for me and I needed sleep bad. I took quarter of a 2 mg brick and it knocked me out and I loved it, the refreshing sleep. I’ve taken it around 10 times since then, every now and then when I really need to get to sleep and never more than 1-2 mg. So I definitely don’t have a high tolerance to the stuff or anything.

I haven’t had them for months now though. I had been smoking meth today and wanted to sleep. So well over 5 hours ago now, I took quarter of a 2 mg brick. 45 minutes later it hadn’t done a thing, so I took another quarter. So I’d had 1 mg. Half an hour later, still nothing. Waited a bit then swallowed the other half of the brick, 2 mg still would do anything at all other than make me feel slightly relaxed. Swallowed another half a brick or 1 mg, waited 40 minutes, still nothing. Swallowed another whole brick, bringing the total dose up to 5 mg about half an hour ago and still I am wide awake.

They aren’t fake Xanax. So what is up with this? 😐 a few days before this I was taking a couple 25mg serenquel per night for about a week if that makes a difference, haven’t had any for a few days though.

Does anybody know what’s up with this?

Xanax doesn’t do anything of value for me, except make me pass out if I take too much.

Ativan on the other hand does wonders. Lorazepam is a highly effective benzo for putting one to sleep, in fact I have never heard of a doctor prescribing Xanax for sleep, however it is common with lorazepam. Actually Xanax is downright destructive for sleep, do some research.

Perhaps your Xanax is old? Otherwise, join the club. Xanax fucking sucks for me. Ativan is the wonder benzo, not that I have a need for benzos anymore.

Maybe one should lay off the meth if they feel a need to take meds to go to sleep? How about a big hot meal with lots of vegetables and some chelated magnesium and lots of water? Get your body back in balance, meth will wreck your CNS if you aren’t being a careful user.

If you insist on using a prescription medication to help come down off meth and get to sleep, I would use lorazepam or ambien. But you’re just wreaking more havoc to your body by taking all those drugs...
Hydromethomine  
Bluelighter  

Join Date: Mar 2014  
Location: Ohio  
Posts: 78

07-04-2014 22:40

I have only been up to 25mg, and it has worked plenty fine for me. 10 gives me a slightly euphoric feeling. Could I use a certain *potentiator*, or maybe use a certain method? I only have this one 5/500 pill left. Thanks.

danolaa420  
Greenlighter  

Join Date: Mar 2014  
Posts: 12

Yesterday 00:38

Crush it into fine powder and grab a pitch at a time and put it in ur rear end or put the powder in a capsule and stick it up should dissolve

Hydromethomine  
Bluelighter  

Join Date: Mar 2014  
Location: Ohio  
Posts: 78

Yesterday 00:45

Would snorting help at all? I know some people have different reactions to snorting it. I know the acetaminophen isn't nice on the nose, but still.
GET INVOLVED

TEACH
DEA Web-based Resources

www.DEA.gov
Community Coalitions and Advocacy Groups
**Completed PDACs**

**FY-2011**
1. Cincinnati, OH 9/17-18/11  75

**FY-2012**
2. WPB, FL 3/17-18/12  1,192
3. Atlanta, GA 6/2-3/12  328
4. Houston, TX 9/8-9/12  518
5. Long Island, NY 9/15-16/12  391

**FY-2011 Total Attendance** 75

**FY-2012 Total Attendance** 2,429

**FY-2013**
6. Indianapolis, IN 12/8-9/12  137
7. Albuquerque, NM 3/2-3/13  284
8. Detroit, MI 5/4-5/13  643
9. Chicago, IL 6/22-23/13  321
10. Portland, OR 7/13-14/13  242
11. Baton Rouge, LA 8/3-4/13  259
12A. San Diego, CA 8/16-17/13  353
12B. San Jose, CA 8/18-19/13  434

**FY-2013 Total Attendance** 2,948

**FY-2014**
14. Louisville, KY 11/16-17/13  149
15. Charlotte, NC 2/8-9/14  513
17. St. Louis, MO 4/5-6/14  224
18. Philadelphia, PA 7/12-13/14  276

**FY-2014 Attendance To Date** 1,582

**Total Attendance To Date** 7,034

**Scheduled PDACs**

**Proposed FY-2015 PDACs**
22. Las Vegas, NV February 2015
23. Birmingham, AL April 2015
24. Richmond, VA May 2015
25. Oklahoma City, OK June 2015
27. Seattle, WA August 2015
28. Milwaukee, WI September 2015
29. Billings, MT (MT, WY, ND, SD) TBD
Most Frequent Method of Obtaining a Pharmaceutical Controlled Substance for Non-Medical Use

Friends and Family...For Free!!
The Medicine Cabinet and the Problem of Pharmaceutical Controlled Substance Disposal
The Problem – Easy Access
More than half of teens (73%) indicate that it’s easy to get prescription drugs from their parent’s medicine cabinet.

Half of parents (55%) say anyone can access their medicine cabinet.

Almost four in 10 teens (38%) who have misused or abused a prescription drug obtained it from their parent’s medicine cabinet.
So Many Drugs in the Household – Why?

- Unreasonable quantities being prescribed
- Insurance rules
National Take Back Initiative
September 27, 2014

10:00 AM – 2:00 PM

Got Drugs?
Turn in your unused or expired medication for safe disposal
Saturday

Click here for a collection site near you.

September 27, 2014
Nationwide Take-back Initiative
Over 3.4 million pounds (1,733 tons) collected

- On September 30, 2010, approximately 122 tons
- On April 30, 2011, approximately 188 tons
- On October 29, 2011, approximately 189 tons
- On April 28, 2012, approximately 276 tons
- On September 29, 2012, approximately 244 tons
- On April 27, 2013, approximately 376 tons
- On October 26, 2013, approximately 324 tons
- On April 26, 2014, approximately 390 tons
National Take Back Day: April 26, 2014
Total Weight Collected (pounds): 780,158 (390 Tons)
Notice of Proposed Rulemaking
PROZAC® (fluoxetine HCl) FISH (?)
Medicines Recommended for Disposal by Flushing
Listed by Medicine and Active Ingredient

This list from FDA tells you what expired, unwanted, or unused medicines you should flush down the sink or toilet to help prevent danger to *people and pets in the home*.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Active Ingredient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstral, tablets (sublingual)</td>
<td>Fentanyl</td>
</tr>
<tr>
<td>Actiq, oral transmucosal lozenge</td>
<td>Fentanyl Citrate</td>
</tr>
<tr>
<td>Avinza, capsules (extended release)</td>
<td>Morphine Sulfate</td>
</tr>
<tr>
<td>Buprenorphine Hydrochloride, tablets (sublingual)</td>
<td>Buprenorphine Hydrochloride</td>
</tr>
<tr>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride, tablets (sublingual)</td>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
</tr>
<tr>
<td>Butrans, transdermal patch system</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>Daytrana, transdermal patch system</td>
<td>Methadone Methadone Hydrochloride</td>
</tr>
<tr>
<td>Demerol, tablets</td>
<td>Meperidine Hydrochloride</td>
</tr>
<tr>
<td>Diastan/Diastat Acudial, rectal gel</td>
<td>Diazepam</td>
</tr>
<tr>
<td>Dilaudid, tablets</td>
<td>Hydromorphone Hydrochloride</td>
</tr>
<tr>
<td>Dilaudid, oral liquid</td>
<td>Hydromorphone Hydrochloride</td>
</tr>
<tr>
<td>Dolophine Hydrochloride, tablets</td>
<td>Methadone Hydrochloride</td>
</tr>
<tr>
<td>Duragesic, patch (extended-release)</td>
<td>Fentanyl</td>
</tr>
<tr>
<td>Embeda, capsules (extended release)</td>
<td>Morphine Sulfate; Naloxone Hydrochloride</td>
</tr>
<tr>
<td>Exalgo, tablets (extended release)</td>
<td>Hydromorphone Hydrochloride</td>
</tr>
<tr>
<td>Fentanyl, tablets (buccal)</td>
<td>Fentanyl Citrate</td>
</tr>
<tr>
<td>Kadian, capsules (extended release)</td>
<td>Morphine Sulfate</td>
</tr>
<tr>
<td>Methadone Hydrochloride, oral solution</td>
<td>Methadone Hydrochloride</td>
</tr>
<tr>
<td>Methadone, tablets</td>
<td>Methadone Hydrochloride</td>
</tr>
<tr>
<td>Morphine Sulfate, tablets (immediate release)</td>
<td>Morphine Sulfate</td>
</tr>
<tr>
<td>Morphine Sulfate, oral solution</td>
<td>Morphine Sulfate</td>
</tr>
<tr>
<td>MS Contin, tablets (extended release)</td>
<td>Morphine Sulfate</td>
</tr>
<tr>
<td>Nucynta ER, tablets (extended release)</td>
<td>Tapentadol</td>
</tr>
<tr>
<td>Omepril, soluble film (buccal)</td>
<td>Fentanyl Citrate</td>
</tr>
<tr>
<td>Opana, tablets (immediate release)</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Opana ER, tablets (extended release)</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Oxecta, tablets (immediate release)</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Oxycodone Hydrochloride, capsules</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Oxycodone Hydrochloride, oral solution</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Oxycodone Hydrochloride, tablets (immediate release)</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Percocet, tablets</td>
<td>Aspirin; Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Percodan, tablets</td>
<td>Aspirin; Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Sufentanil, film (sublingual)</td>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
</tr>
<tr>
<td>Xyrem, oral solution</td>
<td>Sodium Oxybate</td>
</tr>
<tr>
<td>Xyrem, tablets (sublingual)</td>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen; Oxydode Hydrochloride</td>
<td>Percocet, tablets (sublingual)</td>
</tr>
<tr>
<td>Aspirin; Oxydode Hydrochloride</td>
<td>Percodan, tablets (sublingual)</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Butrans, transdermal patch (extended-release)</td>
</tr>
<tr>
<td>Buprenorphine Hydrochloride</td>
<td>Buprenorphine Hydrochloride, tablets (sublingual)</td>
</tr>
<tr>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
</tr>
<tr>
<td>Suboxone, film (sublingual)</td>
<td>Suboxone, film (sublingual)</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Diastan/Diastat Acudial, rectal gel</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Abstral, tablets (sublingual)</td>
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<td>Fentanyl Citrate</td>
<td>Actiq, oral transmucosal lozenge</td>
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<td>Morphine Sulfate</td>
<td>Morphine Sulfate, tablets (immediate release)</td>
</tr>
<tr>
<td>Morphine Sulfate, oral solution</td>
<td>Morphine Sulfate, oral solution</td>
</tr>
<tr>
<td>Morphine Sulfate, tablets (extended release)</td>
<td>Morphine Sulfate, tablets (immediate release)</td>
</tr>
<tr>
<td>Morphine Sulfate, Naloxone Hydrochloride</td>
<td>Morphine Sulfate, oral solution</td>
</tr>
<tr>
<td>Morphine Sulfate, Naloxone Hydrochloride</td>
<td>Oxycodone Hydrochloride, oral solution</td>
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<tr>
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<tr>
<td>Morphine Sulfate, Naloxone Hydrochloride</td>
<td>Oxycodone Hydrochloride, oral solution</td>
</tr>
</tbody>
</table>
According to the National Survey on Drug Use and Health (NSDUH), in 2012, participants identified the most frequent method of obtaining a prescription-type psychotherapeutic drug that they most recently non-medically used as:

A) Internet  
B) From a friend or relative for free  
C) Purchased from a friend or relative  
D) Purchased from stranger/drug dealer
Pharmaceuticals
Legend Drugs v. Controlled Substances
Legend Pharmaceuticals
Non-Controlled Substances

- **Analgesic:**
  - Tramadol (Ultram®, Ultracet®)
  - Schedule IV in CSA as of August 18, 2014

- **Muscle Relaxant:**
  - Cyclobenzaprine (Flexeril®)
# NFLIS Tramadol Reports and Percentage of Total Narcotic Analgesics

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Reports</th>
<th>% of Total Narcotic Analgesics</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>1,093</td>
<td>1.13%</td>
</tr>
<tr>
<td>2009</td>
<td>1,112</td>
<td>0.98%</td>
</tr>
<tr>
<td>2010</td>
<td>1,395</td>
<td>1.01%</td>
</tr>
<tr>
<td>2011</td>
<td>1,549</td>
<td>1.19%</td>
</tr>
<tr>
<td>2012</td>
<td>1,918</td>
<td>1.51%</td>
</tr>
<tr>
<td>2013</td>
<td>2,335</td>
<td>1.94%</td>
</tr>
</tbody>
</table>

Controlled Pharmaceuticals
# Prescription Requirements

<table>
<thead>
<tr>
<th></th>
<th>Schedule II</th>
<th>Schedule III</th>
<th>Schedule IV</th>
<th>Schedule V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Oral</td>
<td>Emergency Only*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Facsimile</td>
<td>Yes**</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Refills</td>
<td>No</td>
<td>Yes#</td>
<td>Yes#</td>
<td>Yes#</td>
</tr>
<tr>
<td>Partial Fills</td>
<td>Yes***</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Must be reduced in writing, and followed by sign, hard copy of the prescription.
** A signed, hard copy of the prescription must be presented before the medication is dispensed.
*** 72 hour time limitation.
# With medical authorization, up to 5 in 6 months.
Opiates
Papaver

Somniferum

Poppy

Codeine

Morphine

Thebaine

Hydrocodone

Hydromorphone

Oxycodone
Most commonly prescribed prescription medicine?

Hydrocodone/acetaminophen
Worldwide Hydrocodone Use

- **67 Countries** reported an estimated need requirement for hydrocodone to the International Narcotics Control Board.
- **20 countries** reported an estimated need of 1 kilogram or greater.
- **4 countries** reported an estimated need between 500 grams and 999 grams.
- **10 countries** reported an estimated need between 100 grams and 499 grams.
- **6 countries** reported a need between 25 grams and 99 grams.
- **27 countries** reported a need of less than 25 grams.


U.S. Drug Enforcement Administration Office of Diversion Control
Worldwide Hydrocodone Use

- Of the 20 Countries that reported an estimated needs requirement for hydrocodone at one kilogram or more

- 8 countries reported an estimated need of 1 kilogram to 5 kilograms

- 4 countries reported an estimated need over 5 kilograms to 10 kilograms

- 8 countries reported an estimated need over 10 kilograms

Top 10 List

- **10** Guatemala  10 kilograms
- **09** India  10 kilograms
- **08** Vietnam  20 kilograms
- **07** China  20 kilograms
- **06** Denmark  25.5 kilograms
- **05** Columbia  30 kilograms
- **04** Syrian Republic  50 kilograms
- **03** Canada  115.5 kilograms
- **02** United Kingdom  200 kilograms
- **01** United States  **79,700 kilograms  99.3%**


U.S. Drug Enforcement Administration
Office of Diversion Control
INCB: Availability of opioids* for pain management (2010-2012 average)

(Consumption in defined daily doses for statistical purposes (S-DDD) per million inhabitants per day)

*Codeine, дихропропоксифене, dihydrocodeine, fentanyl, hydromorphone, ketobemidone, morphine, oxycodone, pethidine, tilidine and tramadol.
Hydrocodone
Aggregate Production Quota History

(in kilograms)

- 1998: 16,314
- 1999: 20,208
- 2000: 21,417
- 2001: 23,825
- 2002: 25,702
- 2003: 30,622
- 2004: 34,000
- 2005: 37,604
- 2006: 42,000
- 2007: 46,000
- 2008: 55,000
- 2009: 55,500
- 2010: 55,000
- 2011: 59,000
- 2012: 79,700
- 2013: 99,652
- 2014: 99,625

U.S. Drug Enforcement Administration
Office of Diversion Control

Date Prepared/ Source: 04/14/2014, ODQ
Revised APQ
State Ranking* - Hydrocodone
January – December 2013

<table>
<thead>
<tr>
<th>RANK</th>
<th>STATE</th>
<th>TOTAL</th>
<th>RANK</th>
<th>STATE</th>
<th>TOTAL</th>
<th>RANK</th>
<th>STATE</th>
<th>TOTAL</th>
<th>RANK</th>
<th>STATE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CA</td>
<td>28,774,533</td>
<td>12</td>
<td>TX</td>
<td>898,281</td>
<td>23</td>
<td>WA</td>
<td>403,596</td>
<td>34</td>
<td>WV</td>
<td>139,222</td>
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<tr>
<td>2</td>
<td>VA</td>
<td>4,457,905</td>
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<td>CO</td>
<td>799,972</td>
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<td>OH</td>
<td>394,758</td>
<td>35</td>
<td>AR</td>
<td>138,262</td>
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<tr>
<td>3</td>
<td>MD</td>
<td>3,285,370</td>
<td>14</td>
<td>HI</td>
<td>726,532</td>
<td>25</td>
<td>CT</td>
<td>384,584</td>
<td>36</td>
<td>VT</td>
<td>132,800</td>
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<tr>
<td>4</td>
<td>IL</td>
<td>2,941,699</td>
<td>15</td>
<td>IN</td>
<td>679,249</td>
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<td>ID</td>
<td>314,675</td>
<td>37</td>
<td>AK</td>
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<tr>
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<td>GA</td>
<td>2,819,902</td>
<td>16</td>
<td>NV</td>
<td>663,745</td>
<td>27</td>
<td>MS</td>
<td>275,033</td>
<td>38</td>
<td>ND</td>
<td>120,630</td>
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<tr>
<td>6</td>
<td>PA</td>
<td>2,589,438</td>
<td>17</td>
<td>MO</td>
<td>582,549</td>
<td>28</td>
<td>WI</td>
<td>272,985</td>
<td>39</td>
<td>MA</td>
<td>107,280</td>
</tr>
<tr>
<td>7</td>
<td>TN</td>
<td>1,583,792</td>
<td>18</td>
<td>OK</td>
<td>542,220</td>
<td>29</td>
<td>LA</td>
<td>249,230</td>
<td>40</td>
<td>KS</td>
<td>107,195</td>
</tr>
<tr>
<td>8</td>
<td>AL</td>
<td>1,381,772</td>
<td>19</td>
<td>NC</td>
<td>534,746</td>
<td>30</td>
<td>OR</td>
<td>232,470</td>
<td>41</td>
<td>NM</td>
<td>106,471</td>
</tr>
<tr>
<td>9</td>
<td>FL</td>
<td>1,353,701</td>
<td>20</td>
<td>NY</td>
<td>512,374</td>
<td>31</td>
<td>MN</td>
<td>185,255</td>
<td>42</td>
<td>UT</td>
<td>103,700</td>
</tr>
<tr>
<td>10</td>
<td>MI</td>
<td>1,251,007</td>
<td>21</td>
<td>NJ</td>
<td>423,465</td>
<td>32</td>
<td>KY</td>
<td>170,442</td>
<td>43</td>
<td>WY</td>
<td>89,332</td>
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<tr>
<td>11</td>
<td>AZ</td>
<td>1,237,287</td>
<td>22</td>
<td>SC</td>
<td>405,412</td>
<td>33</td>
<td>IA</td>
<td>164,520</td>
<td>44</td>
<td>NE</td>
<td>86,912</td>
</tr>
</tbody>
</table>

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit
Most current ARCOS information as of April 1, 2014

* Business Activity - Practitioners
## State Ranking* - Hydrocodone

January – December 2013

<table>
<thead>
<tr>
<th>RANK</th>
<th>STATE</th>
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<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CA</td>
<td>982,753,220</td>
<td>12</td>
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* Business Activity – Retail Pharmacies

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit
Most current ARCOS information as of April 1, 2014
Currently, the CSA defines hydrocodone substance as Schedule II, while its combination products as Schedule III.

On October 6, 2014, all hydrocodone products will be placed in schedule II.

(see 79FR49661 dated August 22, 2014)
Schedule II

- The drug or other substance has a high potential for abuse
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions
- Abuse of the drug or other substance may lead to severe psychological or physical dependence

Schedule III

- The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I or II
- The drug or other substance has a currently accepted medical use in treatment in the United States
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence

21 USC 812(b)(2),(3)
# Dosing Data for Clinically Employed Opioid Analgesics

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<th>APPROXIMATE EQUI-ANALGESIC</th>
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<td>Morphine</td>
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<td>Codeine</td>
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<td>Meperidine (DEMEROL)</td>
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<td>50–100 mg</td>
<td>50–100 mg q6h</td>
<td>50–100 mg q6h</td>
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Opioid Agonist–Antagonists or Partial Agonists

| Buprenorphine (BUPRENEX) | Not available | 0.3–0.4 mg q6–8h | Not available | 0.4 mg q6–8h | Not available | 0.004 mg/kg q6–8h | Not recommended |
| Butorphanol (STADOL) | Not available | 2 mg q3–4h | Not available | 2 mg q3–4h | Not available | Not recommended | Not recommended |
| Naltrexone (NUBAIN) | Not available | 10 mg q3–4h | Not available | 10 mg q3–4h | Not available | 0.1 mg/kg q3–4h | Not recommended |

Source: Goodman and Gilman's *The Pharmacological Basis of Therapeutics, 12th edition*
Approval of Single Entity
Extended Release Hydrocodone
Manufactured by Alkermes Gainesville LLC for Zogenix, Inc. (San Diego, CA)

FDA Approval October 2013

Anticipated Launch March 2014
Thread: Zohydro's Here: Our New Problem Child? (HOLY LORD IN HEAVEN)

**bigzip44**  
Greenlighter  
Join Date: Aug 2009  
Location: Seattle  
Posts: 36

18-02-2014 01:19

Zohydro ER (hydrocodone bitartrate), created by Zogenix, which also makes needle-free sumatriptan injections, is to be released next month (March). They will be releasing this drug in 10, 15, 20, 30, 40, and 50 milligram CAPSULES, which I assume will be filled with a pure hydrocodone powder, despite the 11-2 panel of experts the FDA created to vote on the approval of the drug. This drug is now in production, obviously.

I was badly addicted to OxyContin for many years and I remain on buprenorphine to this day. This "new" drug, made from the same compound that first triggered my addiction to opioids (which I found in vicodin, of course) is to be released in EXACTLY the same way careless way that OXYCONTIN was released by Purdue Pharma except in a presumably even more abusable form, a powder within a capsule. Zogenix and Zohydro's proponents have even gone so far as to reject claims that the new Tylenol-free formulation should be required to have a similar abuse preventative formulation that Purdue Pharma was finally forced into creating so as to continue selling their pure-formulation OxyCodone which is now, of course, the new, very unsexy OP.

Ah, now down to business. This drug is making my scrotum stir with anticipation; I cannot see a future where Zohydro exists where I also do not get high on it. What the fuck do you guys think about this new thing? Could this be the gnarliest opiate "epidemic" since, well, morphine? I want thoughts, information, experience, opinion, conjecture or speculation any of you professionals have on this new drug.

In my opinion, this is going to change history.

(FYI, this thread was moved from Other Drugs)
22-02-2014 16:02

I like hydrocodone but it always took too long for me to really enjoy vicodin. Not really a huge fan of the capsule approach either but people also produce fake Oxycodone pills so it always comes down to where you're getting them from.

I'm just interested to see how hard these are pushed onto current pain patients vs how many people just stick with their regular hydro pills. Still though, any drug in an ER version that's abuse proof is cool in my book.

---

25-02-2014 00:29

The good news (for us) is that it uses Spheroidal Oral Drug Absorption System. Similar to Adderall XR, you can mash up the little beads and release the goodness 😊

---

25-02-2014 00:44

Originally Posted by shimazu

are more people using opiates now on average or are there just more people period and more ways to get in trouble for it?

rhetorical question really, but I tend to think a lot of famous "eccentric" people back in the day were really just huge drug addicts

I think the consensus is that more people are using opioids nowadays, especially in the last 5 years, which is why it's starting to be recognized as a problem again. Everything I've read says that all markers of opioid use are up, and anecdotally people are seeing a lot more problems than they used to as well.
- Treatment centers/prisons are seeing more upper-middle-class white males using heroin and strong opiates than they ever have before (and more of that population on MMT or bup as well)
- Opiate OD has become a major COD for middle-aged women
- Heroin is stronger (in 😞 than it's ever been since the passage of the CSA (and cheaper)
StealYourFace

18-02-2014 16:40

Looking at the product sheet on the mfg website, it looks as if the time release system is similar to Adderal XR/Dex Spansules with the little time release balls inside. If this is true, these would be awesome. I've never sniffed hydrocodone before for obvious reasons, but this would make it very easy.

"Crosses fingers"

Whosajiggawa...a

18-02-2014 18:09

I have never tried hydrocodone only oxy and almost every other opioid. Sort of amped.
Jackie Jones

20-02-2014 15:32

A spoonful of sugar helps the medicine go down.

Zohydro ER
(hydrocodone bitartrate)

1st Oral, Extended Release Hydrocodone without Acetaminophen for Treating Chronic Pain

FDA Date March 1, 2013

Bigfanofthemdrugs

Moderator
Drug Culture
Cannabis Discussion

20-02-2014 20:20

Idk what you guys are tripping about, I'm stoked to get in on some of that, hydrocodone is one of my favorite opioids. It's just as euphoric as oxy IMD.
State Ranking* - Oxycodone
January – December 2013

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* Business Activity - Practitioners

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit
Most current ARCOS information as of March 18, 2014
### State Ranking* - Oxycodone
#### January – December 2013

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*Business Activity - Retail Pharmacies*

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit

Most current ARCOS information as of March 18, 2014

U.S. Drug Enforcement Administration
Office of Diversion Control
Oxycodone HCL CR
(OxyContin®) Reformulation
well just got ours and they suck! when snorted the pill balls up in your nose and gets stuck, so i tried sucking on one and it did ok, but tastes nasty. No way you can shoot them as mentioned in a previous post. havent tried smoking it yet, kinda in a hole money wise, it cost me over $700.00 to get my 80s filled and i probably wont even get half my money back 😞

* if anyone has tried to smoke this new formulated shit, please post! thanks

---

ya my friend has tried to smoke the new ones... said its very harsh on the lungs and throat...

so far the only way ive been able to beat the time release, is use a hose clamp to grind it very fine, and snort it... it doesn't gel up like you would think (doesn't gel up like the football shaped generic 40's do anyways) it just kinda turns snotty... but if you can get it down fast it seems to work ok

---

Originally Posted by stalk
I've come to the conclusion it's because these psychedelic visions are simply vibrating on a higher, or different, spectrum of frequencies that normally the monkey does not perceive.
Oxycodone 15mg/30mg
Immediate Release
Other Oxycodone Products

Percodan

Tylox

Percocet

Roxicodone
The US Food and Drug Administration (FDA) has approved an abuse-deterrent extended-release formulation of oxycodone (Targiniq ER, Purdue Pharma LP), a combination of oxycodone hydrochloride and naloxone hydrochloride, the agency announced today.

The new formulation is approved to treat pain severe enough to require daily, around-the-clock, long-term opioid treatment, for which alternative treatment options are inadequate.

It is the second extended-release/long acting (ER/LA) opioid with FDA-approved labeling describing its abuse-deterrent properties "consistent with the FDA's 2013 draft guidance for industry, Abuse-Deterrent Opioids -- Evaluation and Labeling," a statement from the FDA notes.

"The FDA is committed to combating the misuse and abuse of all opioids, and the development of opioids that are harder to abuse is needed in order to help address the public health crisis of prescription drug abuse in the US," said Sharon Hertz, MD, deputy director of the Division of Anesthesia, Analgesia, and Addiction Products in the FDA's Center for Drug Evaluation and Research. "Encouraging the development of opioids with abuse-deterrent properties is just one component of a broader approach to reducing abuse and misuse, and will better enable the FDA to balance addressing this problem with meeting the needs of the millions of people in this country suffering from pain."
Oxymorphone Extended Release
Opana ER® (Schedule II)

- Opana ER® - (Schedule II)
  - Treats constant, around the clock, moderate to severe pain
  - Becoming popular and is abused in similar fashion to oxycodone; August 2010 (Los Angeles FD TDS)
  - Slang: Blues, Mrs. O, Octagons, Stop Signs, Panda Bears
  - Street: $10.00 – $80.00
### State Ranking* - Oxymorphone
#### January – December 2013

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*Business Activity - Practitioners*

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit
Most current ARCOS information as of March 18, 2014
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*Business Activity - Retail Pharmacies*

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit
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January – December 2013

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* Business Activity - Practitioners

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit.  
Most current ARCOS information as of March 18, 2014
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</table>

* Business Activity - Retail Pharmacies

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit
Most current ARCOS information as of March 18, 2014
Other Opiates of Interest

Trade Name: MS Contin
Controlled Ingredient: morphine sulfate, 100 mg

Trade Name: MS Contin
Controlled Ingredient: morphine sulfate, 15 mg

Trade Name: MS Contin
Controlled Ingredient: morphine sulfate, 10 mg

Trade Name: Oramorph SR
Controlled Ingredient: morphine sulfate, 30 mg

Trade Name: Oramorph SR
Controlled Ingredient: morphine sulfate, 100 mg

Trade Name: Oramorph SR
Controlled Ingredient: morphine sulfate, 60 mg

Trade Name: Dilaudid
Controlled Ingredient: hydromorphone hydrochloride, 2 mg

Trade Name: Dilaudid
Controlled Ingredient: hydromorphone hydrochloride, 4 mg
Fentanyl

- Fentanyl Patches
- Fentanyl Citrate dispensed in a berry flavored lollipop-type unit
- Fentanyl is 100 times more potent than morphine
- Intended to be used for chronic cancer pain & only for people who are tolerant to prescription opioid (narcotic) pain medicines
- Abused for its intense euphoric effects

Actiq®

U.S. Drug Enforcement Administration
Office of Diversion Control
Dextromethorphan (DXM)

- Cough suppressant in over 125 OTC medications (e.g. Robitussin and Coricidin)
- Bulk form on the Internet
- At high doses, has Ketamine- and PCP-like effects
- Produces physical and psychological dependence
- Deaths associated with DXM abuse
Cough Syrup Cocktails

- “Syrup and Soda”
- “Seven and Syrup”
- “Purple Drank”
Opiates v. Heroin
Papaver

Poppy

Codeine

Morphine

Thebaine

Hydromorphone

Oxycodone

Hydrocodone

U.S. Drug Enforcement Administration
Office of Diversion Control
U.S. Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, 1999-2010

Source: National Vital Statistics System (NVSS), DEA’s Automation of Reports and Consolidated Orders System, SAMHSA’s Treatment Episode Data Set

U.S. Drug Enforcement Administration Office of Diversion Control
Circle of Addiction & the Next Generation

- Hydrocodone (Lorcet®)
  - $5-$7/tab

- Oxycodone Combinations
  - Percocet®
  - $7-$10/tab

- OxyContin®
  - $80/tab

- Heroin
  - $10/bag

- Roxicodone®
  - Oxycodone IR
  - 15mg, 30mg
  - $30-$40/tab

U.S. Drug Enforcement Administration
Office of Diversion Control
Heroin use spikes in area suburbs
Pill addicts risk deadly drug
More people died from heroin overdoses in New York City last year than any year since 2003

The number of people who died from unintentional heroin overdoses in New York City last year was the highest toll the city has seen in a decade, according to data released Thursday by the city’s Department of Health and Mental Hygiene.

In New York, where the overall rate of drug overdose deaths has dramatically risen since 2010, there is a national problem playing out across the city’s streets. The number of overdoses involving heroin in the city has significantly increased since 2010, accounting for more than half of New York City’s overdoses last year. And more than three-quarters of the overdoses in the city involved an opioid of some kind.

This information comes amid a pair of national epidemics operating in tandem: A surge in heroin usage nationwide has been accompanied by a much larger opioid epidemic, with drugs such as oxycodone and methadone now making up a large share of the nation’s overdose deaths.
### HEROIN CASES and EXHIBITS
National Forensic Laboratory Information System

<table>
<thead>
<tr>
<th>Year</th>
<th># Exhibits</th>
<th># Cases</th>
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<td>2009</td>
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<td>2012</td>
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<td>101,512</td>
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<td>2013</td>
<td>142,433</td>
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</table>
Community Impact?

Heroin trafficking organizations relocating to areas where prescription drug abuse is on the rise

Heroin traffickers pave the way for increasing crime and violence

Law enforcement and prosecutors eventually fighting the problem on two fronts (prescription opiate diversion and heroin distribution) further depleting resources

Communities suffer
Acetylfentanyl

• Chemically-modified derivative of the powerful prescription painkiller Fentanyl
• is reportedly “50 times more potent than heroin and 100 times stronger than morphine
• May 2013 - 10,000 pills of “Desmethyl Fentanyl” intercepted in Montreal— hidden inside a microwave oven and a toaster destined for Colorado
  – Additional 1,500 kilograms of various raw materials; enough to make an additional 3 million pills seized
Acetylfentanyl

• RI Medical Examiner's Office regarding twelve (12) overdose deaths in March/April 2013
  • Preliminary Lab/Toxicology reports attribute OD deaths to Acetylfentanyl
    – 5 of 12 overdose deaths occurred in Woonsocket, RI
    – May 16, 2013 two individuals arrested in Woonsocket, RI in possession of 28 grams of suspected Acetyl fentanyl
  • Attempts will be made to confirm link to OD deaths
• Synthetic Opioid
• Mimics heroin
• 21 overdose deaths associated in Europe
• Relatively new in US market
  Seized in Reno, NV
• Dealer attempting to get a substance that is “not an analogue”
• This is marketed as “badger repellant”
W-15 (Synthetic Opioid)

Noticed a few vendors stocking W-15 recently. Seriously little info available on it, but I thought there might be a few people here interested. Apparently it's about 5x more potent than morphine. That's all I've really found out, so here's some pics!

Looks like this:

![W-15 molecule](image)

Hopefully a few knowledgeable people will have some insight. 😊


According to that, doesn't look very promising :/
W-18 (Synthetic Opioid)

- $(4\text{-Nitrophenylethyl})piperidylidene$-$2$(4-chlorophenyl)sulfonamide (W-18) is a potent $\mu$-opioid agonist with a distinctive chemical structure which is not closely related to other established families of opioid drugs.

- This compound was found to be around $10,000x$ more potent than morphine in animal studies, however due to its structural differences from other opioid drugs it would be difficult to represent as being "substantially similar in chemical structure" to any controlled drugs. This makes it likely that it would not be illegalized under drug analog laws.
# State Ranking* - Methadone
## January – December 2013

<table>
<thead>
<tr>
<th>RANK</th>
<th>STATE</th>
<th>TOTAL</th>
<th>RANK</th>
<th>STATE</th>
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*Business Activity - Retail Pharmacies*

Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit. Most current ARCOS information as of 09/10/2014.
Treatment of Narcotic Addiction
WHY IS IT ALSO USED AS AN ANALGESIC?

Cheapest narcotic pain reliever – synthetic

Insurance companies

What’s the problem?
Overdose...Why?

- Patients not taking the drug as directed
- Physicians not properly prescribing the drug
- Non medical users ingesting with other substances
- Opiate naive
Florida Deaths Per 100,000 Prescriptions 2008-2011

Sources:
- Death Data: Florida Department of Law Enforcement, “Drugs Identified in Deceased Persons by Florida Medical Examiners”
- Prescription Data: IMS Exponent, State Level: Florida Retail Prescription Data
The Methadone Poisoning by Jonathan J. Lipman, Ph.D.

Death and morbidity associated with methadone treatment has increased dramatically in recent years, largely in the population prescribed this drug for pain control rather than addiction maintenance. Inadvertent overdose is becoming increasingly common, likely in part because the drug's acute pain-relieving effect lasts only 4 to 6 hours, yet it has a very long and variable plasma half-life of 24 to 56 (in some studies 13 to 55) hours, is stored in body tissues, and toxic accumulation occurs with too-frequent consumption. Adverse effects are most common in patients treated with methadone in combination with other drugs. Both cardiac and respiratory systems are vulnerable targets for the drug's toxic actions, and other co-administered drugs can interactively increase the risk of death through a variety of mechanisms including direct central nervous system depression of respiration, idiosyncratic respiratory vulnerabilities, and lethal cardiac arrhythmias. Idiosyncratic factors also play a part in methadone's cardiac toxicity, and risk factors are well characterized, though perhaps not sufficiently widely known and understood by key stakeholders. The recent change in FDA labeling requirements for the drug—and the November 2006 posting of a government warning regarding its use in pain treatment—has not yet reduced morbidity and mortality associated with methadone as reported in the MedWatch database for the first quarter of 2007.
Other FDA Approved Drugs for Narcotic Addiction Treatment

- **Schedule III**
  - Buprenorphine – Drug Code 9064
    - Subutex (sublingual, single entity tablet)
    - Suboxone (sublingual, buprenorphine/naloxone tablet)
Current DATA-Waived (DW) Practitioners and Narcotic Treatment Programs (NTP), by State

Key: 1st number = DW 30 (17,333)
2nd number = DW 100 (7,169)
3rd number = NTP (1,344)

Source: RICS, 02/07/2014
Buprenorphine
Federal, State and Local Laboratory Exhibits
(Sources: NFLIS and STRIDE)

NFLIS and STRIDE Query Date 08/22/2014

U.S. Drug Enforcement Administration
Office of Diversion Control
# States With the Highest Number of Buprenorphine Laboratory Exhibits

(Source: NFLIS - State and Local Forensic Laboratories)

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NFLIS Query Date: 08/22/2014
Alprazolam (Schedule IV)

- Brand name formulation of *Xanax®*

- Anti-anxiety agent used primarily for short-term relief of mild to moderate anxiety

- Part of the class of drugs called benzodiazepines, more commonly referred to as ‘benzos’

- Extremely addictive
  - Once dependence has occurred, Xanax makes it markedly more difficult for individuals to successfully self-detox than other benzodiazepines
  
  $2.00-$2.50 for 2mg dosage unit.
Drug abusers often prefer alprazolam due to its rapid onset and longer duration of action.

Alprazolam was ranked third in the number of prescriptions for controlled substances in 2003, 2004, 2005 and 2006*

For all sales of generic pharmaceuticals, alprazolam was ranked 7th**

* Source IMS Health
** Source Verispan VONA
Stimulants

Amphetamine Salts C-II

➤ Adderall ® C-II

Methylphenidate C-II

➤ Ritalin®

➤ Concerta®
Ritalin® / Concerta® / Adderall

Used legitimately to treat ADHD

Used non-medically to get high and as an academic “performance-enhancer” to improve memory and improve concentration – gain the edge

Higher GPA

Higher SAT / ACT score

Get that scholarship
Parents’ Lax Attitudes and Permissiveness

Approximately 29% of parents surveyed say they believe ADHD medication can improve a child’s academic or testing performance, even if the teen does not have ADHD.

Teen Attitudes

✓ **31%** believe prescription drugs (Ritalin or Adderall) can be used as study aids.

✓ **29%** believe taking a larger dose than prescribed to them is okay as long as they are not getting high.

Date Prepared/ Source: 2013 Partnership Attitude Tracking Study, published 7/23/14
ADHD Drugs

- Used legitimately to treat ADHD
- Abuse prevalent among college students; can be snorted, injected or smoked; nicknamed “College Crack”
- $5.00 to $10.00 per pill on illicit market
- Adderall® Abusers are 5 times more likely to also abuse prescription pain relievers, 8 times more likely to abuse Benzodiazepines

Source: NSDUH Report; Non-Medical Use of Adderall Among Full-Time College Students, published April 2009
Trends in Abuse of Ritalin/Adderall

- One in eight teens (about 2.7 million) now reports having misused or abused these prescription stimulants at least once in their lifetime.

- 9% of teens (about 1.9 million) report having misused or abused these prescription stimulants in the past year (up from 6% in 2008).

- 6% of teens (about 1.3 million) report abuse of these prescription stimulants in the past month (up from 4% in 2008).

- One in four teens (26%) believes that prescription drugs can be used as a study aid.

- More than one in five teens (22%) says there is little or no risk in using Ritalin/Adderall without a prescription.

Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the Predominantly Inattentive Type (Criterion B).

- Fails to give close attention to details...makes careless mistakes in schoolwork, work
- Difficulty sustaining attention in tasks
- Does not seem to listen when spoken to
- Does not follow through on instructions
- Difficulty organizing tasks
- Often loses things necessary for tasks
- Easily distracted
- Forgetful

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

- Fidgets
- Can’t remain seated
- Restlessness
- Difficulty awaiting turn
- Often interrupts or intrudes

(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
There are no laboratory tests, neurological assessments, or attentional assessments that have been established as diagnostic in the clinical assessment of Attention-Deficit/Hyperactivity Disorder.
Methods of Diversion

- Practitioners / Pharmacists
  - Illegal distribution
  - Self abuse
  - Trading drugs for sex

- Employee pilferage
  - Hospitals
  - Practitioners’ offices
  - Nursing homes
  - Retail pharmacies
  - Manufacturing / distribution facilities

- Pharmacy / Other Theft
  - Armed robbery
  - Burglary (Night Break-ins)
  - In Transit Loss (Hijacking)
  - Smurfing

- Patients / Drug Seekers
  - Drug rings
  - Doctor-shopping
  - Forged / fraudulent / altered prescriptions

- The medicine cabinet / obituaries
- The Internet
- Pain Clinics

U.S. Drug Enforcement Administration
Office of Diversion Control
Where are the Pharmaceuticals Coming From?

- Friends and Family for Free
- Medicine Cabinet
- Doctor Shopping
- Internet
- Pain Clinics
Prescription Fraud

- **Fake prescriptions**
  - Highly organized
  - Use real physician name and DEA Registrant Number
    - Contact Information false or “fake office”
      - (change locations often to avoid detection)
  - Prescription printing services utilized
    - Not required to ask questions or verify information printed

- **Stolen prescriptions**
  - Forged
  - “Smurfed” to a large number of different pharmacies
Criminal Activity
Doctor Shopping
Prescription Drug Monitoring Programs
Mandatory PDMP review before prescribing CS?
Pharmacist access to PDMP
Standard of Care
National Association of Boards of Pharmacy
Diversion via the Internet
1. Consumer in Montana orders hydrocodone on the Internet

2. Request goes through Website Server in San Antonio, TX

3. Web Company (located in Miami, FL) adds request to queue for Physician approval

4. Order is approved by Physician in New Jersey and returned to Web Company

5. Approved order then sent by Web Company to an affiliated Pharmacy

6. Pharmacy in Iowa fills order and ships to Consumer via Shipper

Domestic ‘Rx’ Flow
New Felony Offense Internet Trafficking - 10/15/2008

- 21 USC 841(h)(1): It shall be unlawful for any person to knowingly or intentionally:

  (A) deliver, distribute, or dispense a controlled substance by means of the Internet, except as authorized by this title; or

  (B) aid or abet any violation in (A)

What has been the reaction????
Per Se Violations

Automatic Violation of the CSA if any of the following occurs:

- No in-person medical evaluation by prescribing practitioner

- Online pharmacy not properly registered with modified registration.

- Website fails to display required information
# Current CSA Registrant Population

**Total Population: 1,522,913**

- Practitioner: 1,177,306
- Mid-Level Practitioner: 246,443
- Pharmacy: 69,794
- Hospital/Clinic: 16,045
- Teaching Institution: 312
- Manufacturer: 543
- Distributor: 839
- Researcher: 7,336
- Analytical Labs: 1,524
- NTP: 1,365
- Importer/Exporter: 476
- ADS Machine: 755
- Chemicals: 1,005

As of 03/20/14
SOOOO…How many have applied for registration for Internet Pharmacy Operations?????

43 applications filed
23 withdrawn
7 applications filed in error
12 pending
NONE APPROVED

As of February 28, 2014

U.S. Drug Enforcement Administration
Office of Diversion Control
What took the place of Internet Medical Care and Internet CS pharmaceutical Distribution
Pain Clinics
As of June 4, 2010, Florida has received 1,118 applications and has approved 1026

*As of May 14, 2010, Broward 142; Miami-Dade 79; Palm Beach 111
### NFLIS – Federal, State, and local cases reported

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<th>Year</th>
<th>Hydrocodone</th>
<th>Oxycodone</th>
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<td>9,715</td>
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<td>16,401</td>
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<td>30,637</td>
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<td>2011</td>
<td>37,483</td>
<td>46,906</td>
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<td>2012</td>
<td>35,140</td>
<td>42,869</td>
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<td>2013*</td>
<td>26,844</td>
<td>31,897</td>
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</table>

**NFLIS Query Date:** 02/24/14
Many of these clinics are prescription/dispensing mills

Minimal practitioner/patient interaction
Increased Law Enforcement Pressure

- Clinics migrating north and west
- Funded by owners in Florida
MIGRATION OF PAIN CLINICS

U.S. Drug Enforcement Administration
Office of Diversion Control
MIGRATION OF PAIN CLINICS

U.S. Drug Enforcement Administration
Office of Diversion Control
MIGRATION OF PAIN CLINICS

U.S. Drug Enforcement Administration
Office of Diversion Control
MIGRATION OF PAIN CLINICS

U.S. Drug Enforcement Administration
Office of Diversion Control
‘The Florida Migration’

- Vast majority of ‘patients’ visiting Florida “pain clinics” come from out-of-state:
  - Georgia
  - Kentucky
  - Tennessee
  - Ohio
  - Massachusetts
  - New Jersey
  - North and South Carolina
  - Virginia
  - West Virginia
THE MIGRATION

Johns Hopkins University Hospital

U.S. Drug Enforcement Administration
Office of Diversion Control
THE MIGRATION
Georgetown University Medical Center
INOVA

U.S. Drug Enforcement Administration
Office of Diversion Control
THE MIGRATION

Wake Forrest Baptist Medical Center

U.S. Drug Enforcement Administration
Office of Diversion Control
THE MIGRATION

Medical University of South Carolina

U.S. Drug Enforcement Administration
Office of Diversion Control
THE MIGRATION

Emory University Hospital

U.S. Drug Enforcement Administration
Office of Diversion Control
THE MIGRATION

Mayo Clinic of Jacksonville

U.S. Drug Enforcement Administration
Office of Diversion Control
MRI DONE TODAY
SAME DAY REPORTS GUARANTEED!
ALL WALK-INS WELCOME!!
NO APPOINTMENT NEEDED
All Reports Are Read With A Board Certified Radiologist For The Best Diagnostic Results.
$240 CASH OR CREDIT ONLY

No Insurance Accepted
“short waits or we will pay you”

“earn $$$ for patient referals” (sic)
Chronic Pain?
Stop Hurting & Start Living!

Established • Professional • Dedicated

Utilizing FDA Approved Medications
Outpatient Detox Available

ACCEPTING NEW PATIENTS
DON'T DELAY! CALL TODAY!
OUTPATIENT DETOX

Get Back The Life You Once Knew

Confidential * Proven * Dedicated

CALL TODAY!
Drugs Prescribed

- A ‘cocktail’ of oxycodone and alprazolam (Xanax®)
- An average ‘patient’ receives prescriptions or medications in combination

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<th>Schedule II</th>
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<td>Oxycodone 15mg, 30mg</td>
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<td>Tylenol #3 (codeine)</td>
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<tr>
<td>Methadone</td>
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</table>
Average Charges for a Clinic Visit

- Price varies if medication is dispensed or if customers receive prescriptions.
- Some clinics advertise in alternative newspapers citing discounts for new patients such as 'buy one get one free' or “50% off with this ad”
- Typically, initial office visit is $250 or more; each subsequent visit may exceed $200
- Prescriptions average 120-180 30mg oxycodone tablets per visit
Cost of Drugs

- According to medical experts, most clinics do not require sufficient medical history and tests for proper prescribing of Schedule II substances.

- Oxycodone 30mg immediate release tablets cost approximately $30.00 to $40.00 per tablet on the street depending on the sale location in the U.S. ($1 per mg or more).
State of Florida Legislative Actions

Effective October 1, 2010

- Pain clinics are banned from advertising that they sell narcotics
- They can only dispense 72-hour supply of narcotics
- Prohibits the registration of pain clinics unless they are owned by physicians or licensed by non-physicians as a health care clinic

Effective July 1, 2011

- Clinics must turn over their supply of C-II and C-III controlled substances
- Clinics are no longer able to dispense these drugs
- Clinics cannot have ANY affiliation with a doctor that has lost a DEA number
Reaction

- Shift from dispensing physicians to prescribing physicians

- New pharmacy applications in Florida increased dramatically in 2010
Clinic response to the Florida legislation prohibiting the sale of CS from pain clinics?

Buy Pharmacies!
Who is Applying?

- An individual who is tied to Organized Crime
- An individual who works at Boston Market
- An individual whose father owns a pain clinic
- An individual whose mother works at a pain clinic
- An individual whose father is a doctor at a pain clinic
- An individual who is a bartender/exotic dancer
- An individual who is a truck driver
- An individual who is retired from the dry wall business
- An individual who is a secretary at a pain clinic
- An individual who runs a lawn care business
Alexandria, Va. – The National Association of Chain Drug Stores (NACDS) joined pain care advocacy and other healthcare organizations in urging Members of Congress to help address the problem of prescription drug diversion and abuse.

In a letter to the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee, U.S. Judiciary Committee, U.S. House Committee on Judiciary and the U.S. House Energy and Commerce Committee, the organizations urged Congress to create a commission or advisory group to bring together all government agency stakeholders to address the problem. The groups wrote, “[We] are committed to partnering with law enforcement agencies, policymakers, and others to work on viable strategies to solve the problems of prescription drug diversion and abuse. Although numerous groups and state and federal entities are working to reduce these problems, success remains difficult to achieve. One challenge is that many of these groups and entities are not working in a coordinated manner.”

The letter emphasized the importance of reducing prescription drug diversion and abuse without negatively impacting legitimate patient access and care.

“While appropriate policies must empower law enforcement officials to act aggressively against individuals and entities actually engaging in diversion or abuse, diversion/abuse control actions must be balanced against the needs of healthcare providers to provide care to legitimate patients. We must ensure that legitimate patients receive critical medicines without interruption,” the groups stated in the letter.

In addition to NACDS, the following organizations signed the letter: American Academy of Pain Management (AAPM); American Society for Pain Management Nursing (ASPMN); Center for Practical Bioethics; Inflexxion, Inc.; International Nurses Society on Addictions (IntNSA); National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC); National Fibromyalgia & Chronic Pain Association; Pain Treatment Topics; Purdue Pharma L.P.; U.S. Pain Foundation, Virginia Cancer Pain Initiative Inc.

These groups are committed to ensuring patient access to medications they need to help manage their pain, ranging from a variety of health-related issues and diseases. This letter to Congress further stresses the need to find a solution for this problem – and to do so expeditiously. “Due to the urgent nature of the problems associated with prescription drug diversion and abuse, the advisory group’s recommendations should be provided to Congress within one year of its creation or enactment,” the groups concluded in the letter.
The Controlled Substances Act

21 United States Code
Congressional Findings and declarations: Controlled Substances

Many of the drugs included within subchapter have a useful and legitimate purpose and are necessary to maintain health and general welfare.

The illegal importation, manufacture, distribution and possession and improper use of a CS has a substantial detrimental effect on the health and welfare of the American People.

Major portion of the traffic in controlled substances flows through interstate and foreign commerce.

Local distribution and possession of CSs contribute to the swelling of interstate trafficking of such substances.

CSs manufactured and distributed intrastate cannot be differentiated from those distributed interstate.

Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic.

U.S. is party to international conventions designed to establish effective controls over CS trafficking.
Probably the most important section of the Controlled Substances Act ("CSA") and also the least read and understood.

Provides definitions of words and terms used in the statutory construction of the CSA that will give the reader a better understanding of the true meaning of sections and provisions within of the CSA.
CSA Registrant Population

Current Number of DEA Registrants.......................... 1,523,712

March 20, 2014

Provisional registrations in effect at the time CSA was passed (relative to the Harrison Narcotics Act of 1914)

480,000

1973

U.S. Drug Enforcement Administration
Office of Diversion Control
1,532,161 (06/04/2014)
Practitioners: 1,182,465
Retail Pharmacies: 70,115
Hospital/Clinics: 16,047

Law: 21 USC 822 (a) (1) Persons Required to Register:
“Every person who manufactures or distributes any Controlled Substance or List I Chemical or who proposes to engage in ..”

Law: 21 USC 822 (a) (2) Persons Required to Register:
“Every person who dispenses, or who proposes to dispense any controlled substance ...”
Closed System of Distribution

Cyclic Investigations

Recordkeeping Requirements

Security Requirements

ARCOS Reporting

Established Schedules

Registration

Established Quotas
Cutting off the Source of Supply
Diversion via the Internet
Domestic ‘Rx’ Flow

1. Consumer in Montana orders hydrocodone on the Internet

2. Request goes through Website Server in San Antonio, TX

3. Web Company (located in Miami, FL) adds request to queue for Physician approval

4. Order is approved by Physician in New Jersey and returned to Web Company

5. Approved order then sent by Web Company to an affiliated Pharmacy

6. Pharmacy in Iowa fills order and ships to Consumer via Shipper
# Purchases of hydrocodone by Known and Suspected Rogue Internet Pharmacies

**January 1, 2006 – December 31, 2006**

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**Total Purchases:** 98,566,711

**Source:** ARCOS

**Date Prepared:** 03/07/2007
Checks and Balances of the CSA and the Regulatory Scheme

- **Distributors** of controlled substances

“The registrant shall design and operate a system to disclose to the registrant suspicious orders of controlled substances…Suspicious orders include orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency.” (21 CFR § 1301.74)
DEA Distributor Initiative

➢ Purpose and format:

➢ Educate and inform distributors/manufacturers of their due diligence responsibilities under the CSA by discussing their Suspicious Order Monitoring System, reviewing their ARCOS data for sales and purchases of Schedules II and III controlled substances, and discussing national trends involving the abuse of prescription controlled substances

➢ August 2005 – Present:

  Briefings to 83 firms with 276 locations

Examples of civil action against distributors:

  Cardinal Health, $34 million civil fine
  McKesson, $13.25 million civil fine
  Harvard, $6 million civil fine

Examples of suspension, surrender or revocation of DEA registration

  Keysource, loss of DEA registration
  Sunrise, loss of DEA registration
Checks and Balances
Under the CSA

• Practitioners

“A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice.” (21 CFR § 1306.04(a))

United States v Moore 423 US 122 (1975)
The Controlled Substances Act
Illegal Distribution

21 U.S.C. § 841 (a) Unlawful acts:

Except as authorized by this subchapter, it shall be unlawful for any person to knowingly or intentionally

(1) to manufacture, distribute or dispense, or possess with intent to manufacture, distribute or dispense, a controlled substance; or
Perfunctory initial physical exam...return visits no exam

Physical exam included needle mark checks...some were simulated

Patient received quantity of drugs requested...were charged based on quantity

Unsupervised urinalysis – results did not matter

Accurate records not kept – quantity dispensed not recorded

Practitioner not authorized to conduct methadone maintenance;

Patient directed prescribing;
Rosen was a 68 yo physician who had a practice that was focused on obesity. He dispensed large quantities of stimulants to undercover officers outside the scope and not for a legitimate purpose.

The 5th circuit had to address whether the medication was dispensed “for a legitimate medical purpose and in the course of the doctor's professional practice.” In its analysis, the court stated, “We are however, able to glean from reported cases, certain recurring concomitance of condemned behavior, examples of which include the following:

An inordinately large quantity of controlled substances prescribed

Large numbers of prescriptions were issued

No physical exam given

The physician warned the patient to fill prescriptions at different drug stores
Rosen Factors (Red Flags)

The physician issued prescriptions to a patient known to be delivering the drugs to others.

The physician prescribed controlled drugs at intervals inconsistent with legitimate medical treatment.

The physician involved used street slang rather than medical terminology for the drugs prescribed.

There was no logical relationship between the drug prescribed and treatment of the condition allegedly existing.

The physician wrote more than one prescription on occasions in order to spread them out.
Other Factors (not all-inclusive)

Patients receiving the same combination of prescriptions; cocktail

Patients receiving the same strength of controlled substances; no individualized dosing: multiple prescriptions for the strongest dose

Majority of patients paying cash for their prescriptions

Patient asking for drugs in street slang

Patient directed prescribing

Early refills

No specialized training in pain management;

Individuals driving long distances to visit physicians and/or to fill prescriptions

No records/patient contracts/ urinalysis
True or False...

For a controlled substance prescription to be effective, it must be, “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice.”

➢ A) True
➢ B) False
Pharmacists have a responsibility to protect patients, as well as the public, from the abuse, misuse and diversion of prescription drugs.

2014 AACP Program Material
Pharmacists – The Last Line of Defense

“The responsibility for the proper prescribing and dispensing of controlled substances is upon the practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.”
(21 CFR § 1306.04(a))

U.S v. Hayes 595 F. 2d 258 (5th Cir 1979)
U.S. v. Leal 75 F. 3d 219 (6th Cir 1996)
U.S. v. Birbragher 603 F. 3d 478 (8th Cir 2010)
East Main Street Pharmacy 75 Fed. Reg. 66149 (Oct. 27, 2010)
Pharmacists – The Last Line of Defense

“An order purporting to be a prescription issued not in the course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the act (21 USC 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.” (21 CFR § 1306.04(a))

U.S v. Hayes 595 F. 2d 258 (5th Cir 1979)
U.S. v. Leal 75 F. 3d 219 (6th Cir 1996)
U.S. v. Birbragher 603 F. 3d 478 (8th Cir 2010)
East Main Street Pharmacy 75 Fed. Reg. 66149 (Oct. 27, 2010)
The Last Line of Defense

U.S. Drug Enforcement Administration
Office of Diversion Control
When prescriptions are clearly not issued for legitimate medical purposes, a pharmacist may not intentionally close his eyes and thereby avoid [actual] knowledge of the real purpose of the prescriptions.

(Ralph J. Bertolino, 55 FR 4729, 4730 (1990)),

Corresponding Responsibility
Corresponding Responsibility Cases

East Main Street Pharmacy; Affirmance of Suspension Order
[Federal Register (Volume 75, Number 207) October 27, 2010
pages 66149-66165]; see also Paul H. Volkman 73 FR 30630, 30642 (2008)

Holiday CVS, L.L.C, d/b/a CVS/Pharmacy Nos. 219 and 5195; Decision
and order
[Federal Register Volume 77, Number 198 (Friday October 12, 2012) pages 62315-62346]
Potential Red Flags

Many customers receiving the same combination of prescriptions; cocktail

Many customers receiving the same strength of controlled substances; no individualized dosing: multiple prescriptions for the strongest dose

Many customers paying cash for their prescriptions

Early refills

Many customers with the same diagnosis codes written on their prescriptions;

Individuals driving long distances to visit physicians and/or to fill prescriptions;
Potential Red Flags continued

Customers coming into the pharmacy in groups, each with the same prescriptions issued by the same physician; and

Customers with prescriptions for controlled substances written by physicians not associated with pain management (i.e., pediatricians, gynecologists, ophthalmologists, etc.).

Overwhelming proportion of prescriptions filled by pharmacy are controlled substances

Pharmacist did not reach out to other pharmacists to determine why they were not filling a particular doctor’s prescription

Verification of legitimacy not satisfied by a call to the doctors office
Red Flag?

What happens next?

You attempt to resolve...
Resolution is comprised of many factors

- Verification of a valid practitioner DEA number is required! It is not, however, the end of the pharmacist’s duty. Invalid DEA number = Invalid RX
- Resolution cannot be based solely on patient ID and prescriber verification.
- You must use your professional judgment, training and experience...we all make mistakes
- Knowledge and history with the patient
- Circumstances of prescription presentation
- Experience with the prescribing practitioner
- It does not require a call to the practitioner for every CS RX
- This is not an all-inclusive list...
Who do I call to report a practitioner?

- State Board of Pharmacy/Medicine/Nursing/Dental
- State/County/Local Police
- DEA local office and Tactical Diversion Squad
- Health department
- HHS OIG if Medicare/Medicaid fraud
Practical Application of the Controlled Substances Act to the Current Rogue Pain Clinic Situation
CVS Florida

Ronald Lynch MD
Lake Murray, FL
Registration Revoked 01/18/2011
Filled CS RXs until 09/2011
5 Miles

Anthony Wicks MD
Winter Springs, FL
Registration Expired 05/31/2011
CVS 219: 38 CS RXs June–July 2011, oxycodone 30 mg
CVS 5195: 17 CS RXs June–July 2011, oxycodone 30 mg
10 Miles

Carlos Gonzales MD
West Palm Beach, FL
184 Miles

Jack Danton DO
Pompano Beach, FL
216 Miles

U.S. Drug Enforcement Administration
Office of Diversion Control
During 2011, Cardinal Lakeland supplied 6 of the sixteen pharmacies with DEA registrations within the city limits of Sanford, FL, with approximately 3,144,120 units of oxycodone.

Sanford Population – 53,570
58 units per resident

Of the 3,144,120 units
3,012,500 units (96%) went to CVS #5195 and #219

CVS #5195, Sanford, FL
1.2 million units in 2011
1 chain store within 2 miles purchased 25,700 units for 2011

CVS #219, Sanford, FL
1.8 million units in 2011
Two chain stores within 1 mile collectively purchased 207,000 units
Other Cardinal Issues

- Didn’t follow its own suspicious monitoring program – sales visits based on red flag trigger

- No on-site visits to chain retailers even though it was part of their suspicious ordering monitoring policies

- Low numbers of suspicious orders reported – none for either CVS pharmacy except for 1 report filed for CVS 219 after an AIW was served at the Cardinal Lakeland facility

- Comparison of the 2008 ISO and 2011 ISO revealed the same concerns. Different drugs involved, but the same story…high volume sales without appropriate due diligence

- Cardinal Lakeland customers received, on average, 5,364 units per month between 10/01/08 and 12/31/2011. In contrast, CVS 5195 received 58,223 units per month; Caremed received 59,264 units per month; Gulf Coast received 96,644 units per month and CVS 219 received 137,994 units per month
Are you involved in prescribing or dispensing in violation of the CSA?

What happens next?
DEA Legal Recourse

- Administrative
  - Immediate Suspension Order (ISO)
  - Memorandum of Agreement (MOA)
  - Order to Show Cause (OTSC)

- Civil
  - Fines

- Criminal
  - Tactical Diversion Squads
The Order to Show Cause Process
21 USC § 824

a) Grounds –
1. Falsification of Application
2. Felony Conviction
3. State License or Registration suspended, revoked or denied – no longer authorized by State law
4. Inconsistent with Public Interest
5. Excluded from participation in Title 42 USC § 1320a-7(a) program

b) AG discretion, may suspend any registration simultaneously with Order to Show Cause upon a finding of Imminent Danger to Public Health and Safety
Questions to Discuss

- The Attorney General can immediately suspend a DEA registration based on the determination that the continued registration poses an imminent danger to public health or safety;

A) True  
B) False
HR 4709
What can happen when these checks and balances collapse and diversion occurs?
Purchases of Oxycodone 30mg

- In 2009, 44% of all oxycodone 30mg products were distributed to Florida

- In 2010, 43% of all oxycodone 30mg products were distributed to Florida
Nationwide Distribution of Oxycodone
30mg
January – December, 2012

Remaining States
593,625,290 dosage units

Florida
94,923,484 dosage units

Source: ARCOS
Date Prepared: 01/30/2014
U.S. Drug Enforcement Administration
Office of Diversion Control
Paul Volkman, Chicago Doctor, Gets 4 Life Terms In Drug Overdose Case

ANDREW WELSH-HUGGINS  02/14/12 06:45 PM ET Associated Press
COLUMBUS, Ohio — A Chicago doctor who prosecutors say dispensed more of the powerful painkiller oxycodone from 2003 to 2005 than any other physician in the country was sentenced Tuesday to four life terms in the overdose deaths of four patients.

Dr. Paul Volkman made weekly trips from Chicago to three locations in Portsmouth in southern Ohio and one in Chillicothe in central Ohio before federal investigators shut down the operations in 2006, prosecutors said. He was sentenced in federal court in Cincinnati.

"This criminal conduct had devastating consequences to the community Volkman was supposed to serve," Assistant U.S. Attorneys Adam Wright and Tim Oakley said in a court filing ahead of Tuesday's hearing.

"Volkman's actions created and prolonged debilitating addictions; distributed countless drugs to be sold on the street; and took the lives of numerous individuals who died just days after visiting him," they said.

The 64-year-old Volkman fired his attorneys earlier this month and said he acted at all times as a doctor, not a drug dealer.

"The typical drug dealer does not care how much drugs a client buys, how often he buys, or what he does with his drugs," Volkman said in a 28-page handwritten court filing Monday, maintaining that he did all those things and more for his patients.
Why is this happening?
What’s the Profit?

- May 20, 2010, Tampa, Florida
- Owner/operator of pain clinic dispensing oxycodone
- $5,822,604.00 cash seized
What’s the Profit?

- One case in Florida owner/operator of pain clinic allegedly generated $40 million in drug proceeds
- Houston investigation $41.5 million in assets
Another case in Florida - pain clinic operation paid his doctors (in 2009):

- $861,550
- $989,975
- $1,031,975
- $1,049,032
- $1,225,775
# Deaths Associated with Rx Drugs in Florida

## Reports of Rx Drugs Detected in Deceased Persons and Cause of Death

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<tbody>
<tr>
<td>Methadone</td>
<td>620</td>
<td>716</td>
<td>785</td>
<td>693</td>
<td>720</td>
<td>694</td>
<td>691</td>
<td>512</td>
<td>-17%</td>
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<tr>
<td>Oxycodone</td>
<td>340</td>
<td>496</td>
<td>705</td>
<td>941</td>
<td>1,185</td>
<td>1,516</td>
<td>1,247</td>
<td>735</td>
<td>116%</td>
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<tr>
<td>Hydrocodone</td>
<td>221</td>
<td>236</td>
<td>264</td>
<td>270</td>
<td>265</td>
<td>315</td>
<td>307</td>
<td>244</td>
<td>10%</td>
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<tr>
<td>Benzodiazepines</td>
<td>574</td>
<td>553</td>
<td>743</td>
<td>929</td>
<td>1,099</td>
<td>1,304</td>
<td>1,950*</td>
<td>1,337</td>
<td>133%</td>
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<tr>
<td>Morphine</td>
<td>247</td>
<td>229</td>
<td>255</td>
<td>300</td>
<td>302</td>
<td>262</td>
<td>345</td>
<td>415</td>
<td>68%</td>
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<tr>
<td>TOTAL</td>
<td>2,002</td>
<td>2,230</td>
<td>2,752</td>
<td>3,133</td>
<td>3,571</td>
<td>4,091</td>
<td>6,551</td>
<td>5,255</td>
<td>162%</td>
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* Many of the deaths were found to have several drugs contributing to the cause of death, thus, the count of specific drugs is greater than the number of cases. In report years 2010 and earlier, drug categories as a whole had included the total number of deaths per category, as well as total deaths per each specific drug. For example, in 2010, benzodiazepines were the cause of death in 1,304 cases. However, benzodiazepines were present 1,726 times in those 1,304 deaths (i.e., a single death could have been caused by multiple benzodiazepines). Report year 2011 does not provide a total per category (i.e., cause vs present).

SOURCE: Florida Medical Examiner’s Commission
Thank You!