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

Oklahoma Pharmacy Diversion Awareness Conference
National Association of Boards of Pharmacy (NABP)
Oklahoma Board of Pharmacy
Drug Enforcement Administration
Department of Health and Human Services – Office of Inspector General

Renaissance Hotel and Convention Center
Oklahoma City, Oklahoma
June 27/28, 2015

Joseph Rannazzisi
Deputy Assistant Administrator
Office of Diversion Control
Completed PDACs

FY-2011
1-Cincinnati, OH 9/17-18/11
2-WPB, FL 3/17-18/12
3-Atlanta, GA 6/2-3/12
4-Houston, TX 9/8-9/12
5-Long Island, NY 9/15-16/12

FY-2012 Total Attendance 2,429

FY-2013
6-Indianapolis, IN 12/8-9/12
7-Albuquerque, NM 3/2-3/13
8-Detroit, MI 5/4-5/13
9-Chicago, IL 6/22-23/13
10-Portland, OR 7/13-14/13
11-Baton Rouge, LA 8/3-4/13
12A-San Diego, CA 8/16-17/13
12B-San Jose, CA 8/18-19/13
13-Boston, MA 9/21-22/13

FY-2013 Total Attendance 2,948

FY-2014
14-Louisville, KY 11/16-17/13
15-Charlotte, NC 2/8-9/14
16-Knoxville,TN 3/22-23/14
17-St. Louis, MO 4/5-6/14
18-Philadelphia,PA 7/12-13/14
19-Denver, CO 8/2-3/14
20-SLC, UT 8/23-24/14
21-Phoenix, AZ 9/13-14/14

FY-2014 Total Attendance 2,196

FY-2015
22-Las Vegas, NV 2/7-8/15
23-Birmingham, AL 3/28-29/15
24-Norfolk, VA 5/30-31/15

Total Attendance To Date 8,547

Proposed FY-2015 PDACs
25-Oklahoma City, OK June 27-28, 2015
26-Milwaukee, WI July 25-26, 2015
27-Seattle, WA August 8-9, 2015
28-Portland, ME September 12-13, 2015

Postponed FY-2015 PDAC
Rapid City, SD
I have no financial relationships to disclose and I will not discuss off-label use and/or investigational drug use in my presentation.
Background of prescription drug and opioid use and abuse - scope of the problem and potential solutions

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 the pharmacist and corresponding responsibility

Discuss disposal regulations
According to the National Survey on Drug Use and Health (NSDUH), in 2013 there were 6.5 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
Questions to Discuss

- According to the National Survey on Drug Use and Health (NSDUH), in 2013, 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
In determining whether a prescription is valid, a pharmacist is only required to 1) call the prescribing practitioner to verify that he/she authorized the prescription and 2) check to see if he/she has a valid and current DEA registration prior to dispensing the controlled substance;

A) True
B) False
Questions to Discuss

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
Questions to Discuss

Which of the following statements is false concerning regulations promulgated under the Secure and Responsible Drug Disposal Act of 2010:

A) Regulations do not limit the ways ultimate users may dispose of pharmaceutical controlled substances – they expand them.

B) Any method of pharmaceutical disposal that was valid prior to these regulations continues to be valid.

C) Any DEA registrant may participate as an authorized collector of pharmaceutical controlled substances.

D) DEA may not require any person to establish or operate a disposal program.
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
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 2011, approximately 41,340 unintentional drug overdose deaths occurred in the United States, one death every 12.45 minutes. (increased for 12th consecutive year)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.

2012 Current Users (Past Month) 2013

ANY ILLICIT DRUG: 23.9 million

MARIJUANA: 18.9 million

PSYCHOTHERAPEUTIC DRUGS: 6.8 million

COCAINÉ: 1.6 million

Methamphetamine 440,000

Heroin: 335,000

ANY ILLICIT DRUG: 24.6 million

MARIJUANA: 19.8 million

PSYCHOTHERAPEUTIC DRUGS: 6.5 million

COCAINÉ: 1.5 million

Methamphetamine 595,000

Heroin: 289,000

Source: 2012 & 2013 NSDUH
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


U.S. Drug Enforcement Administration
Office of Diversion Control
Percentage of Past Month Nonmedical Use of Psychotherapeutics by Age, 2003-2012

Source: 2011 National Survey on Drug Use and Health
Drug Overdose Mortality Rates per 100,000 People 2010

Poisoning Deaths: Opioid Analgesics

Source: CDC/NCHS, National Vital Statistics System

U.S. Drug Enforcement Administration
Office of Diversion Control
## Drug-Poisoning Deaths Involving Opioid Analgesics or Heroin in the US, 1999-2013

<table>
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<th>Year</th>
<th>Heroin</th>
<th>Opioid Analgesics</th>
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<tr>
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<tr>
<td>'13</td>
<td>8.3</td>
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</table>

Number of Deaths in Thousands

Date Prepared/ Source: 01/28/15, CDC/NCHS, National Vital Statistics System, Mortality File

U.S. Drug Enforcement Administration
Office of Diversion Control
Naloxone
Naloxone Hydrochloride - Narcan

NARCAN (naloxone) is indicated for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids, including propoxyphene, methadone and certain mixed agonist-antagonist analgesics: nalbuphine, pentazocine, butorphanol, and cyclazocine. NARCAN (naloxone) is also indicated for diagnosis of suspected or known acute opioid overdosage.
Woodbridge police officer saves 2 overdose victims in 5 days using Narcan

WOODBRIDGE — A township police officer who had just undergone training in the use of Narcan saved the lives of two overdose victims over five days, according to police. “The timing could not have been better,” said Woodbridge police Capt. Roy Hoppock.

Narcan, also known as nasal naloxone, is an opioid-reversal drug recently approved for use by law enforcement to help save heroin and opioid users from death by overdose.

The first incident in Woodbridge occurred about 8:45 p.m. on Jan. 21 when police received a 911 call about a 25-year-old woman who had overdosed on narcotics in a home in the Colonia section.

“One officer immediately administered Nasal Naloxone (Narcan) to the victim,” Hoppock said in a statement. “Almost immediately the victim showed signs of regaining consciousness.”

Hoppock identified the officer as Patrolman Christopher McClay. Hoppock said McClay had received training in the use of Narcan just two hours before the 911 call.

At 2:43 a.m. on Jan. 25, police received a 911 call about an unconscious person in a business parking lot in the Iselin section. “As officers arrived, they observed the victim, a male age unknown breathing, but unconscious,” Hoppock said.

The same officer who participated in the Jan. 21 call, McClay, administered Narcan to the victim, Hoppock said. “The victim appeared to regain consciousness,” Hoppock said. “At that point EMS arrived and the victim was transported to JFK Hospital. Hoppock said the Woodbridge Police Department is now in the process of training all patrol officers in the use of Narcan.

The drug has been used by paramedics and emergency room doctors for years. Only recently has it been given to police officers, who are often the first on the scene of drug overdoses.

According to the state Attorney General’s Office, there were 741 heroin-related deaths in New Jersey in 2013, a 160 percent increase since 2010.
Agonist vs. Antagonist

Agonist + Receptor → Pharmacological Response

Antagonist + Receptor → No Pharmacological Response
Opioid Displacement

- Naloxone displaces the opioid from the receptor
- Dependent on mode of administration onset can be apparent within a few minutes
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.
Pharmaceutical Abuse
The personal doctor to a professional wrestler who killed himself, his wife and their 7-year-old son was sentenced to 10 years in prison Tuesday for illegally distributing prescription drugs to patients.

Dr. Phil Astin, 54, had pleaded guilty Jan. 29 to a 175-count federal indictment.

Prosecutors said Astin prescribed painkillers and other drugs to known addicts for years. They said at least two of Astin's patients died because of his lax oversight of what medicines they were taking. However, the indictment was unclear about whether Chris Benoit, a wrestler for Stamford, Conn.-based World Wrestling Entertainment, was one of the two.

"I take full responsibility," Astin told the judge Tuesday. "I am sorry I hurt so many lives. I was thinking that I was looking after my patients."

U.S. District Judge Jack Camp said there was no doubt Astin tried to help hundreds of patients at his western Georgia clinic. But the judge said he could not overlook Astin's misconduct.

"The fact that two people did die outweighs other conditions."
Rush Limbaugh Arrested On Drug Charges

Rush Limbaugh and prosecutors in the long-running prescription fraud case against him have reached a deal: a 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 information. Barbara, a spokeswoman for the Palm Beach County Jail. He and his attorney Roy Black left about an hour and fingerprinted and he posted $3,000 bail. Barbera 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 into thinking he needed 2,000 pills, prescribed by four doctors in six months, at a pharmacy near.

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

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!

Rangers' Boogaard died of alcohol, oxycodone mix

Updated 5/23/2011 11:06 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

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.

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.
Violence
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
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
Slain Lansing Rite Aid pharmacist, father of toddler, may not have known attacker

Michael Nana Baffour Addo was a well-liked pharmacist at Rite Aid in the Frandor Shopping Center in Lansing. (Courtesy photo)

By Melissa Anders | manders@mlive.com
Follow on Twitter
on May 13, 2014 at 4:14 PM, updated May 14, 2014 at 5:38 PM

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 retire and open his own pharmacy.

RITE AID AND EAST LANSING SHOOTING CASE

Source:
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.

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Related: Suspect identified, charged with murder

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The pharmacist was working at Rite Aid on Laskin Road near the Oceanfront when development at the property caused him to leave and pursue his dream of owning his own pharmacy.
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

Quaalude

Downers - Barbiturates

Hydromorphone

Meprobamate

Oxycodone/APAP

“Ts and Blues”

“Fours and Doors”
OxyContin® Tablets
(oxycodone hydrochloride controlled-release)

10 mg
20 mg
40 mg
80 mg
160 mg

The 1990s
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?
Pain Scale

Wong-Baker FACES Pain Rating Scale

No Pain
Sin dolor
Không Đau
Tsis Mob
Отсутствие боли

Mild Pain
Dolor leve
Hội Đau
Mob Me Ntsis
Слабая боль

Moderate Pain
Dolor moderado
Đau Vi ra Phai
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 a series of seven commentaries exploring the role of the DEA in pain medicine, the conflict of interest created by the DEA’s dual roles, and the impact of the DEA on the medical community.

Victrories 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 patients who actually prescribe, disperse and use controlled substances,” Dr. Heit states in his commentary.

“It is essential that we resume dialogue between the DEA and healthcare professions 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 those 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 (NASPHER), which institutes a national prescription monitoring program, may offer some steps forward, but it also carries the potential to impede optimal prescribing and could 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 a 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. We must 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 legitimate narcotic 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 Academy of Pain Medicine. Rowe’s commentary points 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 cites the DEA’s more comprehensive command.

About the American Academy of Pain Medicine

Founded in 1983 as the American Academy of Allogogy, the American Academy of Pain Medicine (AAPM) has evolved as the primary organization for physicians practicing the specialty of Pain Medicine in the US. It is the only national organization representing physicians practicing pain medicine. 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 improve the quality of life for people with pain through information, advocacy, and support. For more information, visit www.painfoundation.org.
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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 need to address and work to improve the tension between the DEA and pain treatment. 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 Covington, MD, Steven Passik, PhD, and Ben A. Rich, JD, PhD, add additional dimensions to the current perceived state of imbalance, while Will Rewo, Executive Director of the American Pain Foundation, a patient advocacy organization, calls for a more comprehensive approach to pain management.

Victims and Experts Argue in Commentaries

Dr. Heit and others who have worked to develop the DEA's guidelines for providing controlled substances for the treatment of chronic pain were often left scratching their heads over allegations of fraud and abuse by doctors who administered controlled substances for the treatment of chronic 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 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 those 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."

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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 recent passage of national laws, National All Schedules Prescription Electronic Reporting Act (NASPER), which institutes a national prescription monitoring program, may offer some steps forward, but it also carries the potential to impede optimal prescribing and could perpetuate. Dr. Fishman adds that these initiatives may facilitate abuse. While this new law is presented to the public as a clinical tool to improve patient care and safety, "...this tool is moving forward without adequate discussion of the potential consequences for patients and the public health."

"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 healthcare agencies and healthcare professionals in finding a 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. If we 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 will not legitimate relief in the community.

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 Rewo, Executive Director, American Pain Foundation. "It's not about enlarging the problem by committing to the pain community to pursue a balance between the war on drugs and the rights of pain patients, and also calls for a more comprehensive approach to pain management."

About the American Academy of Pain Medicine

Founded in 1983 as the American Academy of Allogery, the American Academy of Pain Medicine (AAPM) has evolved as the primary organization for physicians practicing the specialty of Pain Medicine in growth, 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 specialty organization in the United States.

The Journal Pain Medicine is published six times a year by Blackwell Science, Inc. For more information, visit www.painmed.org.

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

Contact: Communications Office (Baucus), 202-224-4515
Jill Gerber (Grassley), 202-224-6522

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 professionals that prescribe them can result in deadly side effects. The public has a right to know about these relationships and conflicts of interest.”
“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 BAVLEY
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? Well, 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.”

A Pain-Drug Champion Has Second Thoughts

By Thomas Catan and Evan Perez

It has been his life’s work. Now, Russell Portenoy appears to be having second thoughts.

Two decades ago, the prominent New York pain-care specialist drove a movement to help people with chronic pain. He campaigned to rehabilitate a group of painkillers derived from the opium poppy that were long shunned by physicians because of their addictiveness.

Dr. Portenoy’s message was wildly successful. Today, drugs containing opioids like Vicodin, OxyContin and Percocet are among the most widely prescribed pharmaceuticals in America.

Opioids are also behind the country’s deadliest drug epidemic. More than 16,500 people die of overdoses annually, more than all illegal drugs combined.

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? Well, 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.”

Recent research suggests a significantly higher risk of addiction than previously thought, and questions whether opioids are effective against long-term chronic pain.

The change of heart among former champions of opioid use has happened quietly, largely beyond the notice of many doctors. New York psychiatrist Joseph Carr and said he was “shocked” after attending a recent lecture outlining the latest findings on opioid risk.

“‘It goes in the face of everything you’ve learned,’” he said. “‘You saw other doctors come around to it and saying, ‘Oh my God, what are we doing?’”

Because doctors feared they were dangerous and addictive, opioids were long reserved mainly for cancer patients. But Dr. Portenoy argued that they could be also safely be taken for months or years by people suffering from chronic pain. Among the assertions he and his fellows made in the 1990s: Less than 1% of opioid users became addicted, the drugs
Commonly Abused Controlled Pharmaceuticals

Carisoprodol
C-IV as of 1/11/2012

CYCLOBENZAPRINE (FLEXERIL)

OxyContin 80mg
Oxycodone HCL ER

Hydrocodone

Oxycodone 30 mg

Oxymorphone

Alprazolam

Oxycodone

Xanax (Alprazolam)
The Holy Trinity

- **Oxycodone**: Opiate
- **Carisoprodol**: Muscle Relaxant
- **Alprazolam**: Benzodiazepine

C-IV as of 1/11/2012
Direct to Consumer Advertising
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.

*U.S. Drug Enforcement Administration Office of Diversion Control*
Education

➢ Children/Teens

Information from the Internet or their peers

Following parents
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 forums designed to support sober living, awareness, and to help to those struggling with drug and alcohol 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 OC.

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 those 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 gel. 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 u missed it:

From the Purdue website, here is a summary of the info I found:
http://www.fda.gov/ohrms/dockets/ac/...-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 out. 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 other words 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.
5 mg alprazolam has done nothing

04-04-2014 14:14

looneytoon7

Greenlighter

Join Date: Jan 2014
Posts: 5

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 wtf is up with this!? 😳 a few days before this I was taking a couple 25mg seroquel for about a week if that made a difference, haven't had any for a few days though. Does anybody know wtf is up with this?

04-04-2014 22:39

deerman

Greenlighter

Join Date: Apr 2014
Location: Dragon Mountains
Posts: 18

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...
Is there any way to get high off of just 5mg of hydrocodone?

Hydromethonine

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.

danola420

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

Hydromethonine

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.
Dr. Deception: ok so me and my friend have 3 0.25 mg alprazolam tablets now. i've been doing some research about this drug, but i still need to know more before we do them. some info about us im 5'5" and weigh 130lbs has 6'1" i think and around 140-150 i believe. neither of us have any tolerance to this drug, but we're not newbies to drugs. we've both used cannabis, hydrocodone, alcohol, and we've dabbled a little in the methyphenidate ring but not too much. so getting back to the point, i would like to know how much to take each to feel a "high" feeling or however your supposed to feel when you take it recreationally. i also want to know what's the best way to take it like snorting it, orally take it, parachuting it? plus how long does it take to feel effects, and how long they last, so if you could get back to me on this info it would be greatly appreciated. thank you.

Su77en: I'm trying to process everything now. Can you come across with more for me? Put a pen in it and get back 2 me. Su77en

Dr. Deception: im sorry, but how do you mean? i just want an answer to my questions if you don't know them thats ok im sure someone else on this forum does.
Pimp Lazy  
07-09-2005 23:58
Flexeril and cannabis has one of the most pleasant body buzzes I've ever had. Smoked opium comes close to that. I imagine the first item might be useful on the come down. Peace.

liquid arcadia  
09-09-2005 01:17
Flexeril works GREAT for me, i ate one 10 mg and it knocked me the fuck out after eating a strong meth infected pill...after i woke up i was very lethargic, as it wore off i could feel the meth take over again and had some trouble sleeping that night...amazing stuff...works great!

Psilocyte  
09-09-2005 05:11
^ really? hmm, i wonder why it does nothing for me. I've taken it in the same situation (meth laced pills). I ended up taking 60mg that night and nothing worked. As soon as i took 2 temazepam i was finally relaxed though
Soma and Klonopin.

Brian242 15-01-2012 00:56
Bluelighter

Ok so we all (or most) know that Soma potentiate opiates very well, but I was wondering about taking 1-2mg Clonazepam with 1-2 350mg Soma's. Has this been done and is it safe?

Violenza666 15-01-2012 01:05
Bluelighter

Soma potentiates everything for me. However for the Benzo and Soma non tolerant it's likely a knockout... lol I am prescribed both...

Try half a Soma with 1mg klonopin... or try a whole soma with .5 klonopin.... Valium makes me less noddly when I mix it with Soma... but sometimes I'll be sitting there relaxing and ill fall asleep for hours... I am a stay at home mom so my rule is I don't take my Soma when I am home alone and that way I don't nod out and fall asleep.

How often do you use Klonopin? How tolerant are you? It is safe for some people... for some they can die... all I can tell you... Be careful!

Brian242 15-01-2012 01:20
Bluelighter

Originally Posted by Violenza666

Soma potentiates everything for me. However for the Benzo and Soma non tolerant it's likely a knockout... lol I am prescribed both...
Dear Drugs-Forum readers: We are a small non-profit that runs one of the most read drug information & addiction help websites in the world. We serve over 3 million readers per month, and have costs like all popular websites: servers, hosting, licenses and software. To protect our independence we do not run ads. We take no government funds. We run on donations which average $25. If everyone reading this would donate $5 then this fund raiser would be done in an hour. If Drugs-Forum is useful to you, take one minute to keep it online another year by donating whatever you can today. Donations are currently not sufficient to pay our bills and keep the sites up. Your help is most welcome. Thank you.
Dear Drugs-Forum readers: We are a small non-profit that runs one of the most read drug information & addiction help websites in the world. We serve over 3 million readers per month, and have costs like all popular websites: servers, hosting, licenses and software. To protect our independence we do not run ads. We take no government funds. We run on donations which average $25. If everyone reading this would donate $5 then this fund raiser would be done in an hour. If Drugs-Forum is useful to you, take one minute to keep it online another year by donating whatever you can today. Donations are currently not sufficient to pay our bills and keep the site up. Your help is most welcome. Thank you.

PLEASE HELP

Why Drugs-Forum is so addictive...

Since starting this site 11 years ago DF has evolved so much. In the beginning it was a cosy group of peeps posting crap and having fun. Hell, I remember that I used to call up members to confront them about soliciting on the site. That all has changed. What was clear from the start was that we are onto something good. Something with meaning. Something that will grow big and influential. Back then we already knew that this site was going to make a difference. This has not changed.

The site has already made significant impact. With 35 million+ readers per year it affects the world. It's one of the main go-to places on the net. It affects what people know about drugs and how people perceive drugs. Drug Policy Organisations attribute a lot to DF.

The site has changed lives and saved lives. Lives we...

Getting addicted to oplates full time..

After I received that first packet of Oxy's everything changed pretty rapidly. They were a step up from the other pain killers I had been taking in terms of strength and the euphoria was incredible, it allowed me to be really confident again and go out to clubs even dancing for hours again like if I had been taking ecstasy still. If you crash up Oxycontin, and snort it, you get the effects instantly and it hits you harder, I had started swallowing one then carrying others crushed up into a powder in a bag with me, I just snorted in pub toilets like people take ecstasy but it was opiates for me. I loved it so much I just didn't care about anything else, I budgeted all my monthly outings around ordering a big parcel from Mexico or Serbia or wherever I could get them sent from dodgy online pharmacies.

It was around the initial...

addiction
alexander
andrew

Recent Entries
Best Entries
Top Stories

Getting addicted to oplates full time. (JonnyBside)
[Summary]
JonnyBside 17-01-2015

Jumped (GrainOfSalt)
[Summary]
GrainOfSalt 02-03-2015

Education system failure, illegal drugs, and新股主义 (SiddoID)
[Summary]
SiddoID 26-12-2015

There Are No Losers...Only Those Who Quit Trying (The Flying Pan-Things Always Get Hit In Here)
[Summary]
St. Dismas Monastery 22-02-2015

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[Summary]
GET INVOLVED

TEACH
DEA Web-based Resources

www.DEA.gov
Community Coalitions and Advocacy Groups
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
Medicine Cabinets: 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.

Date Prepared/ Source: 2013 Partnership Attitude Tracking Study, published 7/23/14
So Many Drugs in the Household – Why?

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

Got Drugs?
Turn in your unused or expired medication for safe disposal Saturday
September 27, 2014

10:00 AM – 2:00 PM
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
- On September 27, 2014, approximately 309 tons
Secure and Responsible Drug Disposal Act of 2010

- Legislation that provides ultimate users and long-term care facilities (LTCFs) with additional methods to dispose of unused, unwanted, or expired controlled pharmaceuticals in a secure, safe, and responsible manner.

- Authorized DEA to promulgate regulations that allow ultimate users to transfer pharmaceutical controlled substances to authorized entities for disposal.
  - Specific language in the regulation continues to allow Federal, State, tribal, and local law enforcement to maintain collection receptacles at the law enforcement’s physical location; and either independently or in partnership with private entities or community groups, to voluntarily hold take-back events and administer mail-back programs.

- Created an exception for LTCFs to transfer pharmaceutical controlled substances for disposal on behalf of patients who reside or have resided at that facility.
Secure and Responsible Drug Disposal Act of 2010

- Regulations do not limit the ways ultimate users may dispose of pharmaceutical controlled substances – they expand them.
- Any method of pharmaceutical disposal that was valid prior to these regulations continues to be valid.
- Participation is voluntary.
- DEA may not require any person to establish or operate a disposal program.
Disposal of Controlled Substances, Final Rule

- Ultimate users will now have more locations where they can securely, safely, responsibly, and conveniently dispose of their unwanted pharmaceutical controlled substances.

- Expected benefit to the public by:
  - Decreasing the supply of pharmaceutical controlled substances available for misuse, abuse, diversion, and accidental ingestion; and
  - Protecting the environment from potentially harmful contaminants by providing alternate means of disposal for ultimate users.
Authorized to Collect

- The following persons are authorized to collect from ultimate user and other non-registrants for destruction:
  - Any DEA registrant authorized pursuant to § 1317.40
  - Federal, State, tribal, or local law enforcement when in the course of official duties and pursuant to § 1317.35

Registrants authorized to collect:
- Manufacturers
- Distributors
- Reverse Distributors
- Narcotic Treatment Programs
- Hospitals/clinics with an on-site pharmacy
- Retail Pharmacies

Authorized collectors, as registrants, are readily familiar with the security procedures and other requirements to handle controlled substances.

21 CFR § 1317.40
How does a registrant become a collector?

• Authorized registrant must be registered to handle schedule II controlled substances

• Request a modification in writing to the DEA or on-line at www.DEAdiversion.usdoj.gov

• Request must contain:
  – Registrant’s name, address, and DEA number
  – The method(s) of collection:
    o Collection receptacle and/or mail-back program
    – Authorized signature per § 1301.13(j)

• No fee is required for this modification request

21 CFR §§ 1301.51(b) and (c)
New Authorized Methods of Collection

- Collection receptacles
- Mail-back programs
Collection Receptacles

• Only ultimate users *shall* put the controlled substances directly into the collection receptacle.

• Controlled and non-controlled substances may be comingled.

• Collected substances shall not be counted, sorted, inventoried, or otherwise individually handled.

• Registrants shall not dispose of stock/inventory in collection receptacles.

21 CFR § 1317.75(b) and (c)
Design of Collection Receptacle

- Securely fastened to a permanent structure.
- Securely locked, substantially constructed container with permanent outer container and removable inner liner.
- Outer container must have small opening that allows for contents to be added but does not allow for removal of contents.

21 CFR § 1317.75(e)
Collection Receptacle Location

• Must be securely placed and maintained:
  • Inside collector’s registered location
  • Inside law enforcement’s physical location, or
  • Inside an authorized LTCF
Collection Receptacle Location

- **Registered location** – immediate proximity of designated area where controlled substances are stored and at which an employee is present.

- **LTCF** – located in secure area regularly monitored by LTCF employees.

- **Hospital/clinic** – located in an area regularly monitored by employees, **not** in proximity of where emergency or urgent care is provided.

- **NTP** – located in a room that does not contain any other controlled substances and is securely locked with controlled access.

*21 CFR § 1317.75(d)*
Mail-Back Program

Requirements of mail-back program

• Only lawfully possessed schedules II-V controlled substances may be collected

• Controlled and non-controlled substances may be collected together

21 CFR § 1317.70 (b)
Mail-back Program:
Who is Authorized to Operate?

Any authorized collector that has and utilizes at its registered location (on-site) a method of destruction consistent with § 1317.90

21 CFR § 1317.70
Mail-Back Packaging Specifications

- Packages may be made available for sale or free of charge;
- Any person may partner with a collector or law enforcement to make packages available to the public;
- Nondescript and no markings that indicate it contains controlled substances;
- Water- and spill-proof, tamper-evident, tear-resistant, and sealable;
- Pre-addressed with the collector’s registered address;
- Pre-paid postage;
- Unique ID number so package can be tracked; and
- Instructions for mailing.

21 CFR § 1317.70 (c)
PhRMA v. County of Alameda
Cert. denied (5/26/2015)

2012 Ordinance requiring manufacturers and distributors to be responsible for costs of disposal of unused medicines

District court found that the Ordinance serves a legitimate public health and safety interest at a relatively modest cost.
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>
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<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>Methyldione</td>
</tr>
<tr>
<td>Demerol, tablets</td>
<td>Meperidine Hydrochloride</td>
</tr>
<tr>
<td>Demerol, oral solution</td>
<td>Meperidine Hydrochloride</td>
</tr>
<tr>
<td>Diastat/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; Naltrexone Hydrochloride</td>
</tr>
<tr>
<td>Exalgo, tablets (extended release)</td>
<td>Hydromorphone Hydrochloride</td>
</tr>
<tr>
<td>Fentora, 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>Orosol, soluble film (buccal)</td>
<td>Fentanyl Citrate</td>
</tr>
<tr>
<td>Opana, tablets (immediate release)</td>
<td>Oxymorphone Hydrochloride</td>
</tr>
<tr>
<td>Opana ER, tablets (extended release)</td>
<td>Oxymorphone 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, extended release</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Percocet, tablets</td>
<td>Acetaminophen; Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Percocet, tablets</td>
<td>Acetaminophen; Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Suboxone, film (sublingual)</td>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
</tr>
<tr>
<td>Xyrem, oral solution</td>
<td>Sodium Oxybate</td>
</tr>
<tr>
<td>Zubsolv, tablets (sublingual)</td>
<td>Buprenorphine Hydrochloride; Naloxone Hydrochloride</td>
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</table>

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Medicine</th>
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<tr>
<td>Acetaminophen; Oxycodone Hydrochloride</td>
<td>Percocet, tablets</td>
</tr>
<tr>
<td>Aspirin; Oxycodone Hydrochloride</td>
<td>Percodan, tablets</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Buprenorphine Hydrochloride, tablets (sublingual)</td>
</tr>
<tr>
<td>Buprenorphine Hydrochloride, Naloxone Hydrochloride</td>
<td>Buprenorphine Hydrochloride, tablets (sublingual)</td>
</tr>
<tr>
<td>Butrans, transdermal patch (extended release)</td>
<td>Butrans, transdermal patch (extended release)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Fentanyl</td>
</tr>
<tr>
<td>Fentanyl Citrate</td>
<td>Actiq, oral transmucosal lozenge</td>
</tr>
<tr>
<td>Fentora, tablets (buccal)</td>
<td>Fentora, tablets (buccal)</td>
</tr>
<tr>
<td>Orosol, soluble film (buccal)</td>
<td>Orosol, soluble film (buccal)</td>
</tr>
<tr>
<td>Dilaudid, tablets</td>
<td>Dilaudid, tablets</td>
</tr>
<tr>
<td>Hydromorphone Hydrochloride</td>
<td>Hydromorphone Hydrochloride</td>
</tr>
<tr>
<td>Methadone Hydrochloride</td>
<td>Methadone Hydrochloride</td>
</tr>
<tr>
<td>Methadone, tablets</td>
<td>Methadone, tablets</td>
</tr>
<tr>
<td>Methadone Hydrochloride, extended release</td>
<td>Methadone Hydrochloride, extended release</td>
</tr>
<tr>
<td>Nalbutrex, tablets</td>
<td>Nalbutrex, tablets</td>
</tr>
<tr>
<td>Nucynta ER, tablets (extended release)</td>
<td>Nucynta ER, tablets (extended release)</td>
</tr>
<tr>
<td>Oxycontin, tablets (extended release)</td>
<td>Oxycontin, tablets (extended release)</td>
</tr>
<tr>
<td>Oxycodone Hydrochloride</td>
<td>Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>Oxycodone Hydrochloride, capsules</td>
<td>Oxycodone Hydrochloride, capsules</td>
</tr>
<tr>
<td>Oxycodone Hydrochloride, extended release</td>
<td>Oxycodone Hydrochloride, extended release</td>
</tr>
<tr>
<td>Opana, tablets (immediate release)</td>
<td>Opana, tablets (immediate release)</td>
</tr>
<tr>
<td>Opana ER, tablets (extended release)</td>
<td>Opana ER, tablets (extended release)</td>
</tr>
</tbody>
</table>

FDA continually evaluates medicines for safety risks and will update the list as needed. Please visit the **Disposal of Unused Medicines: What You Should Know** page at [www.fda.gov](http://www.fda.gov) for more information.
Pharmaceuticals
Legend Drugs v. Controlled Substances
Legend Pharmaceuticals
Non-Controlled Substances

➤ Muscle Relaxant:
  – Cyclobenzaprine (Flexeril®)
Gabapentin

- Structurally related to $\gamma$-amino-butyric acid (GABA), an inhibitor of neurotransmission

- Precise mechanism of action producing analgesic and anti-epileptic actions is unknown

- Approved for clinical and veterinary use as a prescription only medication

- Gabapentin is not named or defined under the CSA

- Anecdotal reports of misuse and abuse
Gabapentin Therapeutic Use

• FDA-approved treatment with multiple off-label uses
  – Approved for the treatment of seizures and various pain states
  – Believed to have many advantages over other available medications and a first-line agent in the treatment of neuropathic pain

• Therapeutic category: anticonvulsant; analgesic

• Products: GABAPENTIN, GRALISE, HORIZANT, NEUROTIN

• Effective dose for the treatment of neuropathic pain varies but is similar to the doses effective for seizure treatment ranging from 300 mg/day to over 3600 mg/day
Gabapentin Abuse and Misuse

• Effects vary with user, dosage, past experience, psychiatric history, and expectations

• Abused alone or used as a cutting agent

• Range of experiences have been reported in relation to abuse: euphoria, sociability, marijuana-like high, zombie-like effects, sedation, and hallucinations

• Withdrawal symptoms reported:
  – Per Kruszewski et al. (2009), dependence and abuse involved toxic delirium, intense cravings, and prolonged post-withdrawal confusional state reminiscent of benzodiazepine withdrawal

• Two studies reporting concomitant abuse:
  – Used with cannabis, alcohol, SSRIs, LSD, amphetamine, and GHB (Psychother Psychosom, 2011)
  – Misuse to potentiate the ‘high’ obtain from methadone (Eur Addict Res, 2014)
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><strong>Written</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Oral</strong></td>
<td>Emergency Only*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Facsimile</strong></td>
<td>Yes**</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Refills</strong></td>
<td>No</td>
<td>Yes#</td>
<td>Yes#</td>
<td>Yes#</td>
</tr>
<tr>
<td><strong>Partial Fills</strong></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.
New Controlled Substances (Recently Scheduled)

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

Poppy

Somniferum

Codeine

Morphine

Thebaine

Hydrocodone

Hydromorphone

Oxycodone

Hydrocodone

U.S. Drug Enforcement Administration
Office of Diversion Control
Narcotic Drugs
Stupéfiants
Estupefacientes
2013

Estimated World Requirements for 2014
Statistics for 2012
Évaluations des besoins du monde pour 2014
Statistiques pour 2012
Previsiones de las necesidades mundiales para 2014
Estadísticas de 2012
U.S. was the country with the highest consumption of Hydrocodone (approximately 45.5 tons or 99% of global consumption)

U.S. was the country with the highest consumption of Oxycodone (approximately 77.8 tons or 82% of global consumption)

U.S. was the country with the highest consumption of Morphine (approximately 24.9 tons or 57% of global consumption)

U.S. was the country with the highest consumption of Methadone (approximately 15.2 tons or 49% of global consumption)

U.S. was the country with the highest consumption of hydromorphone (approximately 1.42 tons or 42% of global consumption)

U.S. was the country with the highest consumption of fentanyl (approximately .48 tons or 37% of global consumption)
Most commonly prescribed prescription medicine?

Hydrocodone/acetaminophen
<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Kilograms</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Guatemala</td>
<td>10</td>
</tr>
<tr>
<td>09</td>
<td>India</td>
<td>10</td>
</tr>
<tr>
<td>08</td>
<td>Vietnam</td>
<td>20</td>
</tr>
<tr>
<td>07</td>
<td>China</td>
<td>20</td>
</tr>
<tr>
<td>06</td>
<td>Denmark</td>
<td>25.5</td>
</tr>
<tr>
<td>05</td>
<td>Columbia</td>
<td>30</td>
</tr>
<tr>
<td>04</td>
<td>Syrian Republic</td>
<td>50</td>
</tr>
<tr>
<td>03</td>
<td>Canada</td>
<td>115.5</td>
</tr>
<tr>
<td>02</td>
<td>United Kingdom</td>
<td>200</td>
</tr>
<tr>
<td>01</td>
<td>United States</td>
<td>79,700</td>
</tr>
</tbody>
</table>

Hydrocodone
Aggregate Production Quota History

Year | Production Quota (in kilograms)
--- | ---
1998 | 16,314
1999 | 20,208
2000 | 21,817
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

Date Prepared/ Source: 04/14/2014, ODQ
Revised APQ
Currently, the CSA defines hydrocodone substance as Schedule II, while its combination products as Schedule III.

On October 6, 2014, all hydrocodone products were 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
## Dosing Data for Clinically Employed Opioid Analgesics

<table>
<thead>
<tr>
<th>DRUG</th>
<th>APPROXIMATE EQUI-ANALGESIC (\text{ORAL DOSE}^a)</th>
<th>APPROXIMATE EQUI-ANALGESIC (\text{PARENTERAL DOSE}^a)</th>
<th>RECOMMENDED STARTING DOSE (\text{ADULTS} &gt;50\text{ KG})</th>
<th>RECOMMENDED STARTING DOSE (\text{CHILDREN AND ADULTS} &lt;50\text{ KG})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid Agonists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>30 mg q3–4h (around-the-clock dosing)</td>
<td>10 mg q3–4h</td>
<td>15 mg q3–4h</td>
<td>5 mg q3–4h</td>
</tr>
<tr>
<td></td>
<td>60 mg q3–4h (single dose or intermittent dosing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>130 mg q3–4h</td>
<td>75 mg q3–4h</td>
<td>30 mg q3–4h</td>
<td>30 mg q2h (IM/SC)</td>
</tr>
<tr>
<td>Hydromorphone (DILAUDID)</td>
<td>7.5 mg q3–4h</td>
<td>1.5 mg q3–4h</td>
<td>4 mg q3–4h</td>
<td>1 mg q3–4h</td>
</tr>
<tr>
<td>Hydrocodone (in LORCET, LORTAB, VICODIN, others, typically with acetaminophen)</td>
<td>30 mg q3–4h</td>
<td>Not available</td>
<td>5 mg q3–4h</td>
<td><strong>Not available</strong></td>
</tr>
<tr>
<td>Levorphanol</td>
<td>4 mg q6–8h</td>
<td>2 mg q6–8h</td>
<td>2 mg q6–8h</td>
<td>1 mg q6–8h</td>
</tr>
<tr>
<td>Meperidine (DEMEROL)</td>
<td>300 mg q2–3h</td>
<td>100 mg q3h</td>
<td><strong>Not recommended</strong></td>
<td>50 mg q3h</td>
</tr>
<tr>
<td>Methadone (DOLOPHINE, others)</td>
<td>20 mg q6–8h</td>
<td>10 mg q6–8h</td>
<td>2.5 mg q12h</td>
<td>2.5 mg q12h</td>
</tr>
<tr>
<td>Oxycodone (REXICODONE, OXYCONTIN, also in PERCOCET, PERCODAN, TYLOX, others)</td>
<td>30 mg q3–4h</td>
<td>Not available</td>
<td>5 mg q3–4h</td>
<td><strong>Not available</strong></td>
</tr>
<tr>
<td>Oxymorphone (NUMORPHAN)</td>
<td>Not available</td>
<td>1 mg q3–4h</td>
<td>Not available</td>
<td>1 mg q3–4h</td>
</tr>
<tr>
<td>Propoxyphene (DARVON)</td>
<td>130 mg(^b)</td>
<td>Not available</td>
<td>65 mg q4–6h</td>
<td><strong>Not available</strong></td>
</tr>
<tr>
<td>Tramadol (ULTRAM)</td>
<td>100 mg(^b)</td>
<td>100 mg</td>
<td>50–100 mg q6h(^b)</td>
<td>50–100 mg q6h(^b)</td>
</tr>
<tr>
<td><strong>Opioid Agonist–Antagonists or Partial Agonists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine (BUPRENEX)</td>
<td>Not available</td>
<td>0.3–0.4 mg q6–8h</td>
<td>Not available</td>
<td>0.4 mg q6–8h</td>
</tr>
<tr>
<td>Butorphanol (STADOL)</td>
<td>Not available</td>
<td>2 mg q3–4h</td>
<td>Not available</td>
<td>2 mg q3–4h</td>
</tr>
<tr>
<td>Nalbuphine (NUBAIN)</td>
<td>Not available</td>
<td>10 mg q3–4h</td>
<td>Not available</td>
<td>10 mg q3–4h</td>
</tr>
</tbody>
</table>

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
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 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)
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 isn't abuse proof is cool in my book.

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

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 anecdotaly 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've 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)

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

Orially Posted by shimazu 🙄
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 Adderall 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"

Whosajiggawaaa 18-02-2014 18:09

I have never tried hydrocodone only oxy and almost every other opiod. Sort of amped.
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.
Hysingla™ ER
(hydrocodone bitartrate extended-release tablets)
Oxycodone HCL CR (OxyContin®) Reformulation
New OxyContin® OP

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. haven't tried smoking it yet, kinda in a hole money wise, it cost me over $700.00 to get my 80s filled and I probably won't 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 it's very harsh on the lungs and throat.

so far the only way I've 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
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
Hydromorphone
Other Opiates of Interest

<table>
<thead>
<tr>
<th>Trade Name: MS Contin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Ingredient: morphine sulfate, 100 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trade Name: MS Contin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Ingredient: morphine sulfate, 15 mg</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Trade Name: MS Contin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Ingredient: morphine sulfate, 10 mg</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Trade Name: Oramorph SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Ingredient: morphine sulfate, 30 mg</td>
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<td>Controlled Ingredient: hydromorphone hydrochloride, 2 mg</td>
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<th>Trade Name: Dilaudid</th>
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<tbody>
<tr>
<td>Controlled Ingredient: hydromorphone hydrochloride, 4 mg</td>
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</table>
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
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
Teen OTC Cough Medicine Misuse and Abuse

Prevalence of Teen OTC Cough Medicine Abuse
% Used at Least Once (n=3705)

- Lifetime
- Annual
- Monthly

17% ACD
12% CDE
8%
6%
5%
4%
3%
2%
1%
0%

2009 (A)
2010 (B)
2011 (C)
2012 (D)
2013 (E)

“In your lifetime/in the past 12 months/in the past 30 days, how many times have you taken a non-prescription cough or cold medicine to get high?”
A-E indicates a significant difference at the 95% confidence level.

Date Prepared/ Source: 2013 Partnership Attitude Tracking Study, published 7/23/14
Cough Syrup Cocktails

- “Syrup and Soda”
- “Seven and Syrup”
- “Purple Drank”
Opioids v. Heroin
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
Circle of Addiction & the Next Generation

Hydrocodone
Lorcet®
$5-$7/tab

Oxycodone
Combinations
Percocet®
$7-$10/tab

Heroin
$10/bag

OxyContin®
$80/tab

Roxicodone®
Oxycodone IR
15mg, 30mg
$30-$40/tab
Heroin use spikes in area suburbs
Pill addicts risk deadly drug
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
Clandestinely Produced Synthetic Opioids
What is a synthetic designer drug and why is law enforcement struggling to keep up with these compounds?
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
• 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
Acetylfentanyl
(N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide)

Introduction:
Acetylfentanyl, similar to the Schedule II opioid fentanyl, is a potent opioid analgesic. Recently, it has been linked to a number of overdose deaths in the northeastern part of the U.S. Acetylfentanyl is not a part of most illicit drug screens and remained undetected in many of these cases. Upon being identified in one death, secondary analyses were performed to confirm the presence of acetylfentanyl in numerous jurisdictions.

Chemistry:
The chemical structure of acetylfentanyl and the Schedule II substance fentanyl are shown below.

![Chemical Structures of Acetylfentanyl and Fentanyl](image)

Acetylfentanyl and fentanyl are both synthetic opioids and have similar structures. With one less methyl group attached to the amide group, acetylfentanyl is the N-acetyl version of fentanyl.

Pharmacology:
Acetylfentanyl (EC50 = 676 nM), similar to morphine (EC50 = 23.5 nM), has been shown to bind to μ-opioid receptors in rat cerebrum membrane preparations. Acetylfentanyl, similar to morphine, has been shown to inhibit the twitch response in electrically stimulated vas deferens preparation. A pharmacology study using acetic acid writhing test showed that acetylfentanyl produces analgesic response in mice 15.7-fold more potent than that of morphine. Potency of acetylfentanyl was about 3-fold less than that of fentanyl in this assay. The ED50 (the dose at which 50% of test animals had met the criterion for analgesic response) dose for acetylfentanyl, fentanyl and morphine were 0.021, 0.0061, and 0.33 mg/kg, respectively. Similarly, in another study using tail flick and phenytoin writhing tests, acetylfentanyl produced analgesic response in mice. Acetylfentanyl has been shown to completely suppress the signs of withdrawal in morphine-dependent monkeys.

Besides analgesia, fentanyl-like substances, similar to other opioid analgesics, produce a variety of pharmacological effects including alteration in mood, euphoria, drowsiness, respiratory depression, suppression of cough reflex, constriction of pupils (miosis), and impaired gastrointestinal motility. Clinical studies evaluating pharmacological effects of acetylfentanyl in humans have not been reported in the scientific literature.

In acute toxicity studies in mice, the LD50 (the dose causing death of 50% of test animals) of acetylfentanyl and fentanyl are 9.3 mg/kg and 82 mg/kg, respectively. Significant bleeding in the small intestines of mice was observed in acetylfentanyl-administered mice.

Licit Uses:
There are no published studies as to the safety of acetylfentanyl for human use. There are no commercial or medical uses for this substance.

Illicit Uses:
As a μ-opioid receptor agonist, acetylfentanyl may serve as a direct substitute for heroin or other μ-opioid receptor agonist substances in opioid dependent individuals.

Recently, the Centers for Disease Control and Prevention (CDC) issued a health alert to report that between March 2013 and May 2013, 14 overdose deaths related to injected acetylfentanyl had occurred among intravenous drug users (ages between 19 and 57 years) in Rhode Island.

After confirming five overdoses in one county, including a fatality, Pennsylvania asked coroners and medical examiners across the state to screen for acetylfentanyl. This request led to 50 confirmed fatalities and five non-fatal overdoses statewide in 2013.

Control Status:
Acetylfentanyl is not currently scheduled under the Controlled Substance Act (CSA). However, if intended for human consumption, acetylfentanyl may be treated as a “controlled substance analogue” under the CSA pursuant to 21 U.S.C §§802(32)(A) and 813.

Comments and additional information are welcomed by the Drug and Chemical Evaluation Section; Fax 202-353-1263, telephone 202-307-7183, or E-mail ODE@usdoj.gov.
Acetyl Fentanyl Deaths

- Most recent: September 2014, Bend, OR, confirmed by M.E. toxicology
- **14** overdose deaths in RI; March-May 2013, reported by CDC
- Approximately **50** overdose deaths in PA; 2013, (caused by fentanyl or acetyl fentanyl) reported by PA Dept. of Drug and Alcohol Programs
- **3** overdose deaths in NC; February 2014, Reported by NC Dept. of Health and Human Services
- **5** overdose deaths in LA; October 2013, reported by the media

Likely that the prevalence of acetyl fentanyl in opioid-related emergency room admissions and deaths are under-reported. Since standard radioimmunoassays (e.g. ELISA) detect presence of fentanyl and its analogues, **confirmatory GC/MS is necessary.**

- DEA monitoring Acetyl fentanyl deaths for possible scheduling
- Total number of fentanyl and acetyl fentanyl deaths unknown without old DAWN system.
Other Fentanyl-Related Compounds Include:

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Synthetic Opioid
AH-7921

- 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:

![Chemical Structure](image)

Hopefully a few knowledgeable people will have some insight.

UPDATE: Found an experience report whilst searching. It's on reddit: [http://www.reddit.com/r/opiates/comments/5wq5w/w_rc_opi](http://www.reddit.com/r/opiates/comments/5wq5w/w_rc_opi)

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

- (4-Nitrophenylethyl)piperidylidene-2-(4-chlorophenyl)sulfonamide (W-18) is a potent μ-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.

- Nitrophenylethyl)piperidylidene-2-(4-chlorophenyl)sulfonamide
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
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 36 (in some studies 12 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 subdued morbidity and mortality associated with methadone as reported in the MedWatch database for the first quarter of 2007.
Prescription Opioid Trafficking Trends
DATA-2000 Physicians
Other FDA Approved Drugs for Narcotic Addiction Treatment

- Schedule III
  - Buprenorphine – Drug Code 9064
    - Subutex (sublingual, single entity tablet)
    - Suboxone (sublingual, buprenorphine/naloxone tablet)
Benzodiazepines
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.
Alprazolam Xanax® (Z-bars)

- 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’ Relaxed 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.
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.


U.S. Drug Enforcement Administration
Office of Diversion Control
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

(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 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

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
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
Egregious Activity
(Not on the fringes)
Doctor Shopping
Mandatory PDMP review before prescribing CS?
Pharmacist access to PDMP
Standard of Care
National Association of Boards of Pharmacy
Diversion via the Internet
Pain Clinics
Explosion of South Florida Pain Clinics

As of June 4, 2010, Florida has received 1,118 applications and has approved 1,026

*As of May 14, 2010, Broward 142; Miami-Dade 79; Palm Beach 111

U.S. Drug Enforcement Administration
Office of Diversion Control
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
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

U.S. Drug Enforcement Administration
Office of Diversion Control
“short waits or we will pay you”

“earn $$$ for patient referrals” (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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<td>Methadone</td>
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</table>
The Controlled Substances Act

21 United States Code
CSA Registrant Population

Current Number of DEA Registrants: 1,582,633

Provisional registrations in effect at the time CSA was passed (relative to the Harrison Narcotics Act of 1914): 480,000

June 12, 2015

1973
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

1,582,633 (06/12/15)
Practitioners: 1,207,876
Retail Pharmacies: 71,110
Hospital/Clinics: 16,411
Closed System of Distribution

- Cyclic Investigations
- Established Schedules
- Recordkeeping Requirements
- Registration
- Security Requirements
- Established Quotas
- ARCOS Reporting

U.S. Drug Enforcement Administration
Office of Diversion Control
The Controlled Substances Act

Checks and Balances
The Flow of Pharmaceuticals

Raw Material

Importers

Manufacturers

Dosage Form Manufacturers

Import - Manufacturers

Dosage Form Manufacturers

Imp - Manufacturers

Dosage Form Manufacturers

Wholesalers

Distributors

Smaller Distributors

Hospitals

Pharmacies

Physicians (Rx and drugs)

NTPs

Patients

21 CFR 1306.04

21 USC 823(c)(1)
21 USC 823(d)(1)
21 CFR 1301.74
(Suspicious Orders)

21 USC 823(b)(1)
21 USC 823(e)(1)
21 CFR 1301.71

U.S. Drug Enforcement Administration
Office of Diversion Control
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
# Purchases of Hydrocodone by Known and Suspected Rogue Internet Pharmacies

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

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<td>FLORIDA</td>
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**Total Purchases:** 98,566,711
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)
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)
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;
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
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
Checks and Balances
Under the CSA

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
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 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! 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
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
Drug Dealers Masquerading as Doctors

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?
Florida Pain Clinic Raid
**Deaths Associated with Rx Drugs in Florida**

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

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<td>Benzodiazepines</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, benzodiazepenes were the cause of death in 1,304 cases. However, benzodiazepenes were present 1,726 times in those 1,304 deaths (i.e., a single death could have been caused by multiple benzodiazepenes). Report year 2011 does not provide a total per category (i.e., cause vs present).

SOURCE: Florida Medical Examiner’s Commission
19 Manatees Rescued From Storm Drain in Satellite Beach, Florida

A group of 19 manatees was freed after being trapped in a 36-inch storm drain, officials said early Tuesday.
Questions
Thank You!