DEA Trends & Update
Honolulu, HI Pharmacy Diversion Awareness Conference
January 22-23, 2017
Goals and Objectives

- Public Health Epidemic
- Impact on Society
- Criminal Activity
- The Controlled Substances Act: Checks & Balances
- Drugs of Abuse
- Legal obligations: DEA registrant
- The DEA Response
- Disposal
Public Health Epidemic
“Primum non nocere”
On an average Day in the U.S.:

- More than **650,000 opioid prescriptions** dispensed\(^1\)
- **3,900 people** initiate nonmedical use of prescription opioids\(^2\)
- **580 people** initiate heroin use\(^2\)

1. **Source**: IMS Health National Prescription Audit\(^1\)
2. SAMHSA National Survey on Drug Use and Health\(^2\)
3. CDC National Vital Statistics System\(^3\)
2000-2015

Over **550,000** unintentional drug overdose deaths in the US

2015

**52,404** drug-related overdose deaths

- **143** deaths every 24 hours (**129** in ’14)
- 1 death every 10.07 minutes (**11.16** minutes ’14)

**33,091** deaths involved opioids, including heroin (**91**)

* **17,536** deaths involved opioid pain relievers (**48**)

*Opioid Pain relievers (other than synthetic opioids) ICD-10 codes (T40.2, T40.3, & T40.6) excluding the category predominated by illicit fentanyl

CDC National Center for Health Statistics/Morbidity and Morality Weekly Report (MMWR); December 30, 2016

U.S. Drug Enforcement Administration
Office of Diversion Control
2014 Comparison

Figure 1. Drug overdose death rates* compared to motor vehicle-related death rates, Hawaii residents, 1999-2014 (Lines show age-adjusted death rates (per 100,000 residents), while actual number of fatalities is indicated by bar and label.)

Released October, 2015
Opioid Pain Relievers contributed to 35% of Drug Overdose Deaths

Table 1. Drug overdose deaths: Demographic characteristics, Hawaii residents, 2010-2014

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average annual number</th>
<th>Percent</th>
<th>Average annual rate per 100,000 residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>51</td>
<td>33%</td>
<td>8.6</td>
</tr>
<tr>
<td>Male</td>
<td>104</td>
<td>67%</td>
<td>16.6</td>
</tr>
<tr>
<td>Age (in years)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>8</td>
<td>5%</td>
<td>4.1</td>
</tr>
<tr>
<td>25-44</td>
<td>53</td>
<td>33%</td>
<td>14.0</td>
</tr>
<tr>
<td>45-54</td>
<td>48</td>
<td>32%</td>
<td>25.8</td>
</tr>
<tr>
<td>55 and older</td>
<td></td>
<td>31%</td>
<td>12.1</td>
</tr>
<tr>
<td>County of residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>20</td>
<td>14%</td>
<td>12.0</td>
</tr>
<tr>
<td>Honolulu</td>
<td>105</td>
<td>65%</td>
<td>12.2</td>
</tr>
<tr>
<td>Kauai</td>
<td>5</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>Maui</td>
<td>26</td>
<td>18%</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Released October, 2015

Between 2006 - 2014: Hawaii’s overdose rate has increased 83%---double the national average of 37% during that time period
Opioid involvement in benzodiazepine overdose

Source: National Center for Health Statistics, CDC Wonder
Prescription Opiates  v.  Heroin
Circle of Addiction & the Next Generation

Oxycodone Combinations
Percocet®
$7-$10/tab

Hydrocodone
Lorcet®
$5-$7/tab

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

Heroin
$15/bag

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

Heroin
$15/bag

OxyContin®
$80/tab

U.S. Drug Enforcement Administration
Office of Diversion Control
CDC (2016):

Heroin deaths **more than triple** between 2010-2014

“This increase . . . has been shown to be closely tied to opioid pain reliever misuse and dependence.”

Source: National Center for Health Statistics, CDC Wonder
Overdoses in 2014

Overdose Deaths by Age in 2014 per 100,000 people

**HEROIN**
- 15-24 years: 3.3
- 25-34 years: 8
- 35-44 years: 5.9
- 45-54 years: 4.7
- 55-64 years: 2.7
- 65-74 years: 0.5

**OPIOIDS**
- 15-24 years: 3.1
- 25-34 years: 9
- 35-44 years: 10.3
- 45-54 years: 11.7
- 55-64 years: 8.5
- 65-74 years: 2.7

Source: CDC
Data: CDC
Everyone is Impacted

Overdose Deaths by Race in 2014 per 100,000 people

<table>
<thead>
<tr>
<th></th>
<th>HEROIN</th>
<th>OPIOIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4.4</td>
<td>7.9</td>
</tr>
<tr>
<td>Black</td>
<td>2.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>1.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Native American</td>
<td>3.7</td>
<td>8.4</td>
</tr>
<tr>
<td>Asian</td>
<td>0.3</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Data: CDC

Source: CDC
Heroin use spikes in area suburbs

Pill addicts risk deadly drug
Community Impact?

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

Heroin traffickers pave the way for increasing crime and violence

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

Communities suffer
Violence
Violence Related to Controlled Substance Pharmaceuticals

NEW YORK POST
Page Six

ASSASSIN

Chilling anatomy of drugstore massacre

DRUGSTORE MASSACRE

Husband and wife busted in Rx-slay horror

PAIN KILLER

PAGE 4-5
The 1960s/70s/80s

Uppers - Amphetamines

Downers - Barbiturates

Quaalude

Hydromorphone

Meprobamate

Oxycodone/APAP

“Ts and Blues”

“Fours and Doors”
Rx Drug Ads on TV – Educational or Influential?

Overweight? Suffering from anxiety or erectile dysfunction? Well, relief is just a prescription pill away according to the endless television ads promoting prescription drugs.
The 1990s

OxyContin® Tablets
(oxycodeone hydrochloride controlled-release)
1st Oral, Extended Release Hydrocodone without Acetaminophen for Treating Chronic Pain

FDA Approval Date: March 1, 2013

jimmy jones
Bluelight Crew

Join Date: Jul 2006
Location: A spoonful of sugar helps the medicine go down.
Posts: 5,589

Bigfanofthemdrugs
Moderator
Drug Culture
Cannabis Discussion

Join Date: Mar 2012
Location: The Limbic System

20-02-2014 20:20

Idk what you guys are tripping about, I'm stoked to get in on some of that, hydrocodone is one of my favorite opioids. It's just as euphoric as oxy IMD.
Prescription Drug Abuse is driven by

Indiscriminate Prescribing

Criminal Activity
Most Frequent Method of Obtaining a Pharmaceutical Controlled Substance for Non Medical Use

Friends and Family... For Free!!
Patients Often Prescribed Extra Painkillers, Many Share Them

Two new U.S. studies shed light on opioid epidemic

**John Hopkins Study:**
+60% had leftover opioids they hung on for “future use”
  20% shared their medications
  8% likely will share w/ friend
  14% likely will share w/ relative
-10% securely lock their medication


**University of Pennsylvania Dental School Study:**
More than half of the narcotics prescribed for wisdom teeth removal go unused...findings suggest that more than 100 million pills prescribed go unused...leaving the door open for possible misuse or abuse.

Survey of Long-Term Painkiller Users

• Majority say their doctor talked about possibility of addiction or dependence – 61% say there was no discussion about plan to get them off.

• Majority say the use the drugs to relieve pain. Other major reasons for taking them:
  – 20% - ‘for fun or get high”
  – 14% - “to deal with day-to-day stress”
  – 10% - “ro relax or relieve tension”

• Other Findings:
  – 34% admit being dependent or addicted
  – 17% have taken painkillers that were not specifically prescribed for them
  – 14% have given their painkillers to a family member or friend
  – 20% know or suspect someone was using, taking or selling their painkillers

Where else do our kids get their information from?

www.erowid.org
Where do kids get their information from?

www.bluelight.org
Criminal Activity
Egregious Activity
(Not on the fringes)
Dr. Yee primarily met with his “patients” in Starbucks cafes throughout Orange County, California.

He would see up to a dozen patients each night between 7:00 and 11:00 p.m. and wrote these “patients” prescriptions, primarily for opiates, in exchange for cash.

Yee pled guilty to distributing millions of dollars in oxycodone, oxymorphone, hydrocodone, hydromorphone, Adderall® and alprazolam outside the course of professional practice and without a legitimate medical purpose.
During a one-year time period, Yee wrote prescriptions for a total of 876,222 dosage units of all medications combined.

52% of all prescriptions (458,056 dosage units) written by Yee were for oxycodone (92%-30mg) during the one-year period.

96% - oxycodone, hydrocodone, alprazolam, hydromorphone, and oxymorphone.

Almost half of Yee’s patients were 25 and under.
The Controlled Substances Act: Checks & Balances
The mission of the Office of Diversion Control is to prevent, detect, and investigate the diversion of pharmaceutical controlled substances and listed chemicals from legitimate channels of distribution while … ensuring an adequate and uninterrupted supply of controlled substances to meet legitimate medical, commercial, and scientific needs.
Closed System of Distribution

1,677,537 (1/18/2017)

- Practitioners: 1,253,249
- Mid Level Practitioner: 319,280
- Retail Pharmacies: 72,126
- Hospital/Clinics: 17,674
Closed System of Distribution

Cyclic Investigations

Established Schedules

Record Keeping Requirements

Security Requirements

Established Quotas

ARCOS

Drug Enforcement Administration
Office of Diversion Control
The DEA is responsible for:

- the **oversight** of the system
- the **integrity** of the system
- the **protection** of the public health and safety
Most commonly prescribed prescription medicine?

Hydrocodone/acetaminophen
Hydrocodone

- Hydrocodone / Acetaminophen (toxicity)

- Similarities:
  - Structurally related to codeine
  - Equal to morphine in producing opiate-like effects

- Brand Names: Vicodin®, Lortab®, Lorcet®

- October 6, 2014 moved to SCHEDULE II

- “Cocktail” or “Trinity”
  - Hydrocodone
  - Soma ® / carisoprodol
  - Alprazolam / Xanax®

Street prices: $2 to $10+ per tablet depending on strength & region

U.S. Drug Enforcement Administration
Office of Diversion Control
Oxycodone

- OxyContin controlled release formulation of Schedule II oxycodone
  - The controlled release method of delivery allowed for a longer duration of drug action so it contained much larger doses of oxycodone
  - Abusers easily compromised the controlled release formulation by crushing the tablets for a powerful morphine-like high
  - 10, 15, 20, 30, 40, 60, 80mg available

- Effects:
  - Similar to morphine in effects and potential for abuse/dependence
  - Sold in “Cocktails” or the “Holy Trinity”
    - Oxycodone, Soma® / Xanax®

- Street price: Approx. $80 per 80mg tablet

NOTE: New formulation introduced into the marketplace in 2010 that is more difficult to circumvent for insufflation (snorting) or injection. Does nothing to prevent oral abuse.
Oxycodone HCL CR (OxyContin®) Reformulation
New OxyContin® OP

08-27-2010, 01:11 AM

mz.mary420
Member

Join Date: May 2010
Location: down south
Posts: 6

well just got ours and they suck! when snorted the pill balls up in your nose and gets stuck, so i tried sucking on one and it did ok, but tastes nasty. No way you can shoot them as mentioned in a previous post. havent tried smoking it yet, kinda in a hole money wise, it cost me over $700.00 to get my 80s filled and i probably wont even get half my money back 😞 * if anyone has tried to smoke this new formulated shit, please post! thanks

08-27-2010, 06:09 AM

mephisto00
Member

Join Date: Apr 2008
Location: NY
Age: 25
Posts: 628

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

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

Quote:

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.
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

U.S. Drug Enforcement Administration
Office of Diversion Control
Other Opiates of Interest

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

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

Trade Name: MS Contin
Controlled Ingredient: morphine sulfate, 30 mg

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

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

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

Fentora®
(tetany buccal tablet)

DURAGESIC®
(Fentanyl Transdermal System)

75 µg/h

Suboxone®
Hydrochloride and naltrexone

U.S. Drug Enforcement Administration
Office of Diversion Control
Legal Obligations: DEA Registrant
Effective Controls

All applicants and registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances.

In order to determine whether a registrant has provided effective controls against diversion, the Administrator shall use the security requirements set forth in §§ 1301.72-1301.76 as standards for the physical security controls and operating procedures necessary to prevent diversion.

21 CFR § 1301.71(a)
Non-practitioners 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(b)
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)
Clinical Reminders:

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

Use immediate-release opioids when starting

Start low and go slow

When opioids are needed for acute pain, prescribe no more than needed

Do not prescribe ER/LA opioids for acute pain

Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

Evaluate risk factors for opioid-related harms

Check PDMP for higher dosages and prescriptions from other providers

Use urine drug testing to identify prescribed substances and undisclosed use

Avoid concurrent benzodiazepine and opioid prescribing

Arrange treatment for opioid use disorder if needed

The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.

21 CFR § 1306.04(a)
A pharmacist, by law, has a corresponding responsibility to ensure that prescriptions are legitimate.

When a prescription is presented by a patient or demanded to be filled for a patient by a doctor’s office, a pharmacist is not obligated to fill the prescription!!!
The Last Line of Defense
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;
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
www.nabp.net
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
The DEA Response
360 Degree Strategy
DEA recognizes we cannot arrest our way out of the drug problem – our goal is lasting success in the communities we serve.

Education and Prevention are key elements for a true 360 Strategy.

Law enforcement operations provide an opportunity for community empowerment and a jumping off point for education and prevention efforts.
Distributor Initiative

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

Briefings to 99 firms with 309 registrations
This conference is designed to educate pharmacists, pharmacy technicians, and pharmacy loss prevention personnel on ways to address and respond to potential diversion activity.
**Completed PDACs**

**FY-2011**
1. Cincinnati, OH 9/17-18/11 75
2. WPB, FL 3/17-18/12 1,192
3. Atlanta, GA 6/2-3/12 328
4. Houston, TX 9/8-9/12 518
5. Long Island, NY 9/15-16/12 391

Total Attendance FY-2011: 75

**FY-2012**
1. WPB, FL 3/17-18/12 1,192
2. Atlanta, GA 6/2-3/12 328
3. Houston, TX 9/8-9/12 518
4. Long Island, NY 9/15-16/12 391
5. Indianapolis, IN 12/8-9/12 137
6. Albuquerque, NM 3/2-3/13 284
7. Detroit, MI 5/4-5/13 643
8. Denver, CO 8/2-3/14 174
9. Portland, OR 7/13-14/13 242
10. Baton Rouge, LA 8/3-4/13 259
11. San Diego, CA 8/16-17/13 353
12. San Jose, CA 8/18-19/13 434

Total Attendance FY-2012: 2,429

**FY-2013**
1. WPB, FL 3/17-18/12 1,192
2. Atlanta, GA 6/2-3/12 328
3. Houston, TX 9/8-9/12 518
4. Long Island, NY 9/15-16/12 391
5. Indianapolis, IN 12/8-9/12 137
6. Albuquerque, NM 3/2-3/13 284
7. Detroit, MI 5/4-5/13 643
8. Denver, CO 8/2-3/14 174
9. Portland, OR 7/13-14/13 242
10. Baton Rouge, LA 8/3-4/13 259
11. San Diego, CA 8/16-17/13 353
12. San Jose, CA 8/18-19/13 434

Total Attendance FY-2013: 2,948

**FY-2014**
1. WPB, FL 3/17-18/12 1,192
2. Atlanta, GA 6/2-3/12 328
3. Houston, TX 9/8-9/12 518
4. Long Island, NY 9/15-16/12 391
5. Indianapolis, IN 12/8-9/12 137
6. Albuquerque, NM 3/2-3/13 284
7. Detroit, MI 5/4-5/13 643
8. Denver, CO 8/2-3/14 174
9. Portland, OR 7/13-14/13 242
10. Baton Rouge, LA 8/3-4/13 259
11. San Diego, CA 8/16-17/13 353
12. San Jose, CA 8/18-19/13 434

Total Attendance FY-2014: 2,196

**FY-2015**
1. WPB, FL 3/17-18/12 1,192
2. Atlanta, GA 6/2-3/12 328
3. Houston, TX 9/8-9/12 518
4. Long Island, NY 9/15-16/12 391
5. Indianapolis, IN 12/8-9/12 137
6. Albuquerque, NM 3/2-3/13 284
7. Detroit, MI 5/4-5/13 643
8. Denver, CO 8/2-3/14 174
9. Portland, OR 7/13-14/13 242
10. Baton Rouge, LA 8/3-4/13 259
11. San Diego, CA 8/16-17/13 353
12. San Jose, CA 8/18-19/13 434

Total Attendance FY-2015: 1,570

**FY-2016**
1. WPB, FL 3/17-18/12 1,192
2. Atlanta, GA 6/2-3/12 328
3. Houston, TX 9/8-9/12 518
4. Long Island, NY 9/15-16/12 391
5. Indianapolis, IN 12/8-9/12 137
6. Albuquerque, NM 3/2-3/13 284
7. Detroit, MI 5/4-5/13 643
8. Denver, CO 8/2-3/14 174
9. Portland, OR 7/13-14/13 242
10. Baton Rouge, LA 8/3-4/13 259
11. San Diego, CA 8/16-17/13 353
12. San Jose, CA 8/18-19/13 434

Total Attendance FY-2016: 1,020

**Total Attendance To Date:** 12,030

---

**Proposed PDACs**

**FY-2017 PDACs**
- 43-Alaska – February 10, 2017
- 44-Kansas – March 11 & 12, 2017
- 45-Puerto Rico – March, 2017 (Date TBD)
- 46-South Dakota (Possibly combined w/IA & NE) – Spring 2017 (Date TBD)
- 47-Vermont/New Hampshire – Spring 2017 (Date TBD)
- 48-Connecticut/Rhode Island – May 2017 (Date TBD)
- 49-Nebraska – June 2017 (Date TBD)
- 50-Iowa – July 2017 (Date TBD)
- 51-Idaho/Montana/Wyoming – TBD

**37 STATES** (incl. the D.C.) **82 PDAC CONFERENCES**
The Federation of State Medical Boards (FSMB) promotes excellence in medical practice, licensure, and regulation on behalf of 70 state medical and osteopathic Boards across the country in their protection of the public.

DEA and FSMB are currently working on developing strategies to work more effectively and jointly on indiscriminate prescriber investigations in order to facilitate the administrative process to take action against those that are a threat to the public health and welfare quickly, and at the same time not jeopardize a criminal investigation.
“Stakeholders’ Challenges and Red Flag Warning Signs Related to Prescribing and Dispensing Controlled Substances”

- Represents the medical, pharmacist, and supply chain spectrum highlighting the challenges and “red flag” warning signs related to prescribing and dispensing controlled substance prescriptions.

- The goal was to provide health care practitioners with an understanding of their shared responsibility to ensure that all controlled substances are prescribed and dispensed for a legitimate medical purpose, as well as to provide guidance on which red flag warning signs warrant further scrutiny.

- NABP along with 10 national associations and 6 major pharmaceutical firms were the coalition of stakeholders of this document.
Scheduled Investigations

- Increase in the number of DEA registrants that are required to be investigated to ensure compliance with the Controlled Substances Act and its implementing regulations

- Increase in the frequency of the regulatory investigations

- Verification investigations of customers and suppliers
Since 2011, Eleven States have Passed Legislation Mandating Prescriber Education

- Nevada (NV)
- Utah (UT)
- New Mexico (NM)
- Iowa (IA)
- Ohio (OH)
- West Virginia (WV)
- Kentucky (KY)
- Tennessee (TN)
Maine

- Second State to Mandate Electronic Prescribing
- Prescribers are required to undergo addiction training every 2 years
- Set cap on daily strength for opioid prescribing:
  - Acute pain – 7 days
  - Chronic pain – 30 days
- To begin January 2017
National Take Back Initiative

10:00 AM – 2:00 PM

U.S. Drug Enforcement Administration
Office of Diversion Control
National Take Back I-XII Totals:

Total Weight Collected (pounds): 7,202,977 (3601 Tons)

Drug Enforcement Administration
Diversion Control Program

Overseas: 25
Secure and Responsible Drug Disposal Act of 2010
**Ultimate user** means as “a person who has lawfully obtained, and who possesses, a controlled substance for his own use or for the use of a member of his household or for an animal owned by him or a member of his household.”

21 USC § 802(27)

**Ultimate user** methods of destruction prior to Disposal rule:
- Disposal in Trash (ONDCP method); or
- Flushing (FDA opioids and select CSs)
- National Take-back Event (DEA)
- Transfer to Law Enforcement
- (Police Station Receptacles or local Take-back events)
- DEA
Secure and Responsible Drug Disposal Act of 2010

- CSA amended to provide ultimate users and LTCF with additional methods to dispose of unused, unwanted or expired controlled substance medication in a secure, safe and responsible manner
  
  21 USC § 822(f) & (g)

- Participation is voluntary
  
  21 USC § 822(g)(2)

- Registrants authorized to collect:
  - Manufacturers
  - Distributors
  - Reverse Distributors
  - Narcotic Treatment Programs
  - Hospitals/clinics with an on-site pharmacy
  - Retail Pharmacies
  
  21 CFR § 1317.40

Authorized collectors, as registrants, are readily familiar with the security procedures and other requirements to handle controlled substances.
Law Enforcement may continue to conduct take-back events.

Any person may partner with Law Enforcement.

Law Enforcement shall maintain control and custody of collected substances until secure transfer, storage, or destruction has occurred.

Authorized collection receptacles and inner liners “should” be used.

21 CFR § 1317.35 and 1317.65
Collection
Collection **means to receive a controlled substance for the purpose of destruction from an:**

- Ultimate user,
- Person lawfully entitled to dispose of an ultimate user decedent’s property, or
- LTCF on behalf of an ultimate user who resides or has resided at the facility.

21 USC § 822(g)(3) & (4) and 21 CFR § 1300.01(b)
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.

Outer container must display a sign stating only Schedule II-V and non-controlled substances are acceptable substances.

Schedule I controlled substances are not permitted to be collected.

21 CFR § 1317.75(e)
Collection Receptacle Inner Liner

- Waterproof, tamper-evident, and tear-resistant.

- Removable and sealable upon removal without emptying or touching contents.

- Contents shall not be viewable from the outside when sealed (i.e., can’t be transparent).

- Size shall be clearly marked on the outside of the liner (e.g., 5-gallon, 10-gallon, etc.).

- Outside of liner shall have permanent, unique ID number.

21 CFR § 1317.60(a)
Ultimate users shall put the 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 or inventory in collection receptacles.

21 CFR § 1317.75(b) and (c)
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

- Must have method of on-site destruction

21 CFR § 1317.70 (b)

DEA Registrant who sells mail-back packages for another registrant is NOT required to modify registration as a collector
Registrant Disposal
Registrant Disposal - Inventory

Practitioner & Non-Practitioner may dispose of inventory

- Prompt on-site destruction
- Prompt delivery to reverse distributor by common or contract carrier or reverse distributor pick-up
- Return and recall: Prompt delivery by common or contract carrier or pick-up at the registered location

Practitioner may also request assistance from the SAC
Non-Practitioner may also transport by its own means

21 CFR § 1317.05(a) and (b)
Form 41 shall be used to record the **destruction of all controlled substances, including controlled substances acquired from collectors.**

- The Form 41 shall include the names and signatures of the two employees who witnessed the destruction.
- Exceptions for DEA Form 41:
  - Destruction of a controlled substance dispensed by a practitioner for immediate administration at the practitioner’s registered location, when the substance is not fully exhausted (i.e. wastage) shall be properly recorded in accordance with § 1304.22(c), and such record **need not** be maintained on a Form 41.
  - Transfers by registrant to a reverse distributor must be recorded in accordance with § 1304.22(c), and such record **need not** be maintained on a Form 41.

21 CFR § 1304.21(e)
Abandoned Controlled Substances

• Circumstances when there is no authorized person to dispose of controlled substances
  ſ School
  ſ Summer camp
  ſ Hospital

• Return to ultimate user is not feasible

• Options
  ſ Contact law enforcement or DEA
  ſ Destroy on-site

79 FR 53546 (Disposal Final Rule)
Pharmaceutical Wastage
Pharmaceutical Wastage

Not subject to 21 CFR Part 1317
- Destruction does not have to be “non-retrievable”
- DEA Form 41 must not be utilized

Dispensing must be recorded as a record
21 CFR § 1304.22(c)

Clarification memorandum on DEA website at www.deaDiversion.usdoj.gov
Miscellaneous Pharmacy Topics
Multiple Prescriptions
Schedule II Controlled Substances

- Individual practitioner may issue multiple prescriptions which authorizes patient to receive 90-day supply of C-II

β Each separate prescription is for legitimate medical purpose issued by practitioner acting in usual court of professional practice
β Written instructions on each prescription indicating earliest date it can be filled
β Doesn’t cause undue risk of diversion by patient
β Compliance with all other elements of CSA and state laws
Faxed Prescription vs. EPCS

- True electronic prescriptions are transmitted as **electronic data files** to the pharmacy, whose application imports the data file into its database.

- A system that allows the prescriber to “sign” his/her name does **NOT** conform to EPCS regulations.

- A facsimile with a written signature is **NOT** an electronic Rx.

21 CFR § 1306.05(d)
Hospice & LTCF Prescriptions

Schedule II narcotic substances may be transmitted by the practitioner or the practitioner's agent to the dispensing pharmacy by facsimile

- Practitioner (or agent) must note it is hospice patient
- Facsimile serves as original written prescription

21 CFR § 1306.11(f), (g) & 1306.13(b)

Schedule III-V prescription

- Written prescription signed by a practitioner, or
- Facsimile of a written, signed prescription transmitted by the practitioner (or agent)
Distribution by Pharmacy to Practitioner

- Practitioner registered to dispense may distribute a quantity of such substance to another practitioner for general dispensing
  - Purchaser must be registered with DEA
  - Schedule III-V - records by purchaser and receiver must conform to 21 CFR § 1304.22(c)
  - Schedule I or II - an order form must be used and must conform to 21 CFR § 1305
  - Total number of controlled substances **dispensed cannot exceed 5%** of total controlled substances dispensed

21 CFR § 1307.11(a)(1)
Repackaging by Pharmacy

- Practitioner can prepare, compound, package, or label in the course of his professional practice
  21 CFR § 1300.01(b)

- Pharmacy can **NOT** repackage drugs (ie 100 ct bottle packaged in smaller size bottles) and sell the drugs in the form of a distribution to any DEA Registrant - including practitioner office.

- Violation of DEA and FDA regulations
Questions?

Luis.A.Carrion@usdoj.gov