Instructions for Filling Out the Prescription Monitoring Program Questionnaire

Completion of this questionnaire is voluntary. If you choose to do so, please complete all applicable questions on the questionnaire. Return the completed survey to DEA by [insert date]. Completed surveys maybe returned via e-mail to mandy.a.healy@usdoj.gov, fax at (202) 353-1079, or US mail – DEA, 600 Army Navy Drive, Room E-6377, Arlington, VA, 22202.

Electronic copies of the survey are available through DEA. Should you have any questions regarding this survey, or would like to obtain an electronic version, please contact Program Analyst, Mandy Healy, via e-mail mandy.a.healy@usdoj.gov or phone (202) 307-7286.

Privacy Act Information

Authority: 21 U.S.C. 872(a)(5) and 873(a)(6)(B)
Purpose: Data received from these questionnaires will be used to compile a comprehensive document on the status of PMPs nationwide that will be available to interested parties when appropriate.
Routine Uses: Disclosures of information from this system are made to the following categories of users for the purposes stated.

A. Other Federal law enforcement and regulatory agencies for law enforcement and regulatory purposes
B. State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes.
C. State Prescription Monitoring Programs.

Under the Paperwork Reduction Act, a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 hours per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Drug Enforcement Administration, FOI and Records Management Section, Washington, D.C. 20537; and to the Office of Management and Budget, Paperwork Reduction Project no. 1117-0037, Washington, D.C. 20503.

OMB 1117-0037 Approval Expires 01/31/2006

PRESCRIPTION MONITORING PROGRAM QUESTIONNAIRE

STATE: _____
POPULATION (http://factfinder.census.gov):_____

AGENCY NAME: _____

AGENCY CONTACT PERSON: Name: _____

Address: _____

Telephone # _____ Fax # _____ E-Mail: _____

AGENCY TYPE: Law Enforcement ____ Regulatory Board _____
Public Health _____ Other (Please specify) _____

DOES YOUR STATE HAVE A STATE OPERATED PRESCRIPTION MONITORING PROGRAM? YES_____ NO_____

IF YES, HOW LONG HAS THE PROGRAM BEEN OPERATIONAL AND WHAT METHODS WERE UTILIZED TO PASS THE APPROPRIATE LEGISLATION THROUGH THE LEGISLATURE?_____

_____

_____

IF NO, IS YOUR STATE CONSIDERING CREATING OR IN THE PROCESS OF PROMULGATING REGULATIONS TO ESTABLISH A PRESCRITPION MONITORING PROGRAM?_____

_____

_____

MONITORING PROGRAM: Electronic Data Transfer:_____ State-issued forms: _____
Both: _____

Please specify type of form used: Single ____ Duplicate _____ Triplicate _____
Serialized (which schedules):_____

PRACTITIONER INFORMATION

Number of Practitioners (def 21 CFR 1300.01 (17)): _____

Separate State Controlled Substance Registration: Yes: _____ No: _____

If Yes, what is the fee? $_____

Number of Pharmacies: _____

PROGRAM INFORMATION

Operating Budget (please attach an itemized budget, if available) $_____

Program Staff includes the following (number of employees and their function):
_____

_____

_____

Cost of state-issued prescription forms (if used): $ _____

What is the program's funding source? If funding comes from multiple sources, please specify percentage from each source. _____

_____

PROGRAM DATA

Number of prescriptions processed in FY 2004. _____

Cost for data processing per month (including collecting data, filing, data entry, analysis, and storage fees): $_____

Number of Actions Taken Using PMP Information (including investigations initiated, requests from practitioners and/or pharmacists): _____

Of the cases generated, how many cases were generated for the following reasons:

Forgery:_____
Theft:_____
Doctor Shopping:_____
Illegal Prescription Sales:_____

DRUG DATA COLLECTED: Please indicate all that apply.

Federal Schedule II _____ Schedule III _____ Schedule IV _____ Schedule V _____

Please list additional drugs or classes of drugs: _____

_____

Please list any exemptions/exceptions to reporting requirements:_____

_____

DATA COLLECTION FORMATS.

If you are using the American Society of Automation in Pharmacy (ASAP) format, which version are you using? ASAP 95_____; ASAP 97_____; ASAP 99_____

Pharmacies send data in the following formats (fill in the percentage of prescriptions sent in each format that applies – should total to 100%)

Electronic Transfer --	_____%	Disk --	_____%
Tape --	_____%	Universal Claim Forms --	_____%
Other --	_____%	State-issued Prescription Forms --	_____%

If other, please describe: _____

_____

Do you anticipate any changes to the percentages provided above? If so, please explain:

_____

_____

CURRENT DATA COLLECTION METHOD. Pharmacies send prescription data to:

Our state agency _____ Our contractor, who is _____

Do you anticipate any changes to the collection method described? If so, please explain:

_____

How often are pharmacies required to submit data? _____

_____

CONFIDENTIALITY/ACCESS TO PMP DATA. The following individuals/entities are authorized to access data collected by PMP (Check all that apply) :

State Licensing Boards: _____

State/Local Law Enforcement: _____

DEA Investigators: _____

Other (specify): _____

Prescribers for bona fide patients: _____

Dispensers for bona fide patients: _____

Researcher (If yes, are there any restrictions?) _____

PMP SUPPORT PROGRAMS. Please describe programs in place or anticipated that are designed to enhance the effectiveness of your prescription monitoring program, including:

Educational Programs: _____

_____

_____

Treatment programs:_____

_____

_____

Other State Laws that Complement PMP (i.e., use of safety prescriptions, criminalization of doctor shopping, prohibition against self-prescribing). Please include statute citation.

_____

_____

_____

INTERSTATE PRESCRIPTION TRANSACTIONS

Do mail-service and/or internet pharmacies operate within your state? Yes: _____ No: _____

Does your state require the registration/licensure of mail-order and/or

Internet pharmacies filling prescriptions for individuals in your state? Yes: _____ No: _____

Does your PMP have the capability of providing reports to other states? regarding prescription activity of out-of-state prescribers or patients? Yes: _____ No: _____

If yes to above, are these reports routinely disseminated? Yes: _____ No: _____

If no to above, what obstacles exist that inhibit the dissemination of information to other states?

_____

_____

_____

Program Highlights

Please describe any highlights of your program that occurred over the past two years._____

_____

_____

_____

STATUTES & REGULATONS – Please provide a website reference for state statutes and regulations regarding your prescription drug monitoring program.

_____

_____

WEBSITE – Please provide the website where program information on your state PMP can be located if applicable.

_____

RESPONDENT FEEDBACK – In developing this questionnaire we attempted to be as thorough as possible without being overly burdensome. How did we do? Please provide your comments. _____

_____

_____

SUBMIT COMPLETED FORM TO: E-mail: mandy.a.healy@usdoj.gov

Physical Address: Mandy Healy
Drug Enforcement Administration
600 Army Navy Dr. ODL
Arlington, VA 22202