



ASAM American Society of
Addiction Medicine

Public Policy Statement on Prescription Drug Monitoring Programs (PDMPs)

Background

Prescription Drug Monitoring Programs (PDMPs) are statewide electronic databases that collect designated data from pharmacies and medical offices that dispense controlled substances in the state. PDMPs are maintained at the state level and housed in various statewide regulatory, administrative, or law enforcement agencies. The overseeing agency provides access to the data to individuals who are authorized under state law to receive the information for purposes of their profession, mainly prescribers and dispensers.

PDMPs can be a useful tool to support safer prescribing and dispensing practices for scheduled medications. An American Medical Association survey found that 87% of responding physicians supported PDMPs because they help prescribers become more informed about a patient's prescription history.¹ PDMPs may also be a helpful tool to identify patients who merit an assessment for a substance use disorder (SUD).

The concept of a PDMP was originally developed by the Department of Justice to assist in prosecutions of criminal violations of the Controlled Substances Act. Over time, they became recognized as a useful decision support tool for prescribers when considering whether to prescribe a controlled substance or a medication that could have harmful drug-drug interactions with a controlled substance prescribed or dispensed by another party. Many newer state PDMPs allow access only to healthcare professionals and block access to the data by criminal investigators and prosecutors in the absence of a court order; others allow both healthcare professionals and law enforcement personnel to query a PDMP database.

It is important to note that each state PDMP is set up differently, in terms of which classes of medications are included, who has access to the data, timeliness and accuracy of the data, automatic reporting functions, and use requirements. Best practices for PDMP design and use include enacting and implementing interstate data sharing among PDMPs, integrating PDMP data with health information exchanges and electronic health records, mandating enrollment and utilization, improving data timeliness, allowing delegate access, and conducting user education.² An 'ideal' PDMP would also include peer to peer messaging (in compliance with HIPAA and 42 CFR Part 2) and provider peer review. One study suggests that more robust PDMP programs are associated with greater reductions in prescription opioid overdose.³

A notable gap in PDMP data is the absence of information about methadone or buprenorphine dispensed by opioid treatment programs (OTPs), as reporting such information would violate the federal confidentiality law that protects addiction treatment records (42 CFR Part 2). In a 2011 guidance letter, SAMHSA encouraged OTP staff to use PDMPs “as an additional resource to maximize safety of patient care” but explained that OTPs must comply with 42 CFR Part 2 and therefore, “disclosures of patient-identifying information by such programs to State PDMPs are not permitted unless an exception applies consistent with the federal confidentiality regulations.”⁴ However, thinking about the continued utility and desirability of the heightened privacy protections offered by 42 CFR Part 2 is evolving, and there have been several legislative and administrative efforts to modernize the law since the 2011 letter was issued. Many advocates believe the confidentiality law continues to be a necessary extra protection for patients seeking and receiving treatment for addiction, while others argue that segregating addiction treatment records contributes to stigma and denies patients the clinical benefits of PDMPs. While logistical barriers to reporting methadone and buprenorphine dispensed daily will remain, it is possible that the confidentiality law’s legal barrier to reporting may be soon removed. It is within this evolving policy environment that ASAM offers the recommendations below.

Recommendations:

The American Society of Addiction Medicine (ASAM) makes the following recommendations regarding Prescription Drug Monitoring Programs.

1. Prescribers and dispensers should be required to enroll in and query the state’s PDMP, either directly or by delegating access to office staff, when initiating a prescription for any controlled substance and at least every 3 months (quarterly) thereafter as treatment continues, consistent with the Centers for Disease Control and Prevention prescribing guidelines.
 - a. Mandates should be implemented in conjunction with education about how to engage patients whose PDMP report suggests potential substance misuse and the risks of abruptly discontinuing chronic, prescribed opioid or benzodiazepine therapy.
 - b. States should consider educational rather than punitive approaches to support prescribers and dispensers who do not enroll in or regularly query the PDMP as mandated.
2. States should ensure that PDMPs are functional, efficient, timely, user-friendly, and integrated into clinical work-flow by integrating them as much as possible with electronic health records and pharmacy dispensation systems.
3. State PDMP data should be accessible only for clinical treatment and/or evaluation (including consultations by clinicians who are not treating the patient) and for public health purposes by authorized clinicians and researchers, including for ongoing public health analysis that can critically evaluate the impact of any interventions on prescribing practices. On a case-by-case basis, law enforcement officials can be allowed access to PDMP data through subpoena and within a tightly regulated process.

4. The Department of Veterans Affairs (VA), the Indian Health Services (IHS), and similar federal healthcare agencies should report and transmit data to state PDMPs.
5. States should expand the medications reportable to the PDMP to include methadone and buprenorphine from OTPs, and cannabis obtained through a prescriber recommendation.
6. PDMPs that report total opioid morphine milligram equivalents (MME) should not include buprenorphine or methadone used to treat addiction involving opioid use in the calculation of MME; instead these should be reported separately. Without clinical context, a patient's total opioid dosage as measured by MME can be misleading^a and lead to abrupt and inappropriate cessation of medically necessary treatment.

Adopted by the ASAM Board of Directors April 11, 2018

© Copyright 2018. American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to lists, or other uses of this material require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only without editing or paraphrasing, and with proper attribution to the society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.

American Society of Addiction Medicine

11400 Rockville Pike, Suite 200, Rockville, MD 20852

Phone: 301.656.3920 | Fax: 301.656.3815

www.ASAM.org

^a See ASAM Public Policy Statement on Morphine Equivalent Units/Morphine Milligram Equivalents. Available at: <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2016/10/11/public-policy-statement-on-morphine-equivalent-units-morphine-milligram-equivalents>

¹ Survey: Physicians support PDMPs, face limits with non-opioid therapy [press release]. Chicago, IL: AMA News Room; February 18, 2016. <https://www.ama-assn.org/content/national-survey-finds-physicians-support-pdmps-encounter-barriers-providing-non-opioid>

² Clark T, Eadie J, Kreiner P, and Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. September 20, 2012. Available at: http://www.pewtrusts.org/~media/assets/0001/pdmp_update_1312013.pdf

³ Pardo B. Do more robust prescription drug monitoring programs reduce prescription opioid overdose? *Addiction*. 2017 Oct ; 112(10):1773-1783.

⁴ Clark HW. Dear Colleague letter. September 27, 2011. Available at: <http://atforum.com/documents/dearColl-pmp2011.pdf>