

STATE OF MINNESOTA

OPIOIDS

Preventing and Addressing Prescription Drug Abuse



OFFICE OF MINNESOTA ATTORNEY GENERAL
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ACKNOWLEDGEMENT

People are dying from prescription drug overdoses at record levels. The most recent data reflect more than 18,000 deaths in a year in the United States alone.¹ Another 10,000 died from heroin overdoses.² Since 1999 the amount of prescription opioids sold in the United States quadrupled, and the fatality rate of opioid painkiller overdoses has similarly quadrupled.³ The epicenter of the epidemic is the United States, where less than five percent of the world's population consumes 80% of the global opioid supply. Recent surveys indicate that more than half of the people who abused prescription drugs got them for free from a family member.⁴ Other research similarly indicates that the vast majority of heroin users initially used prescription opioid pain relievers.⁵

This Report relies on a multitude of interviews and contributions from health care professionals, emergency room personnel, government officials, and victims of the opioid epidemic. The Report is a compilation of recommendations that can be taken in Minnesota in relatively short order to strengthen efforts to address this crisis.

There are many different approaches to the prescription drug epidemic. Some focus on medical providers, some on pharmaceutical manufacturers, some on treatment and rehabilitation, some on prevention, and some on the criminal justice system. The proposals vary by state and by the impact of the epidemic on a particular community, and there will no doubt be continuing debate as to the most effective approach to the crisis.

This Report does not claim that its recommendations will solve the prescription opioid epidemic. At best, it is hoped that it marks the beginning steps of proposals to build on efforts to address this crisis in Minnesota.

SECTION 1. INTRODUCTION.

You do not have to look further than the daily news to see the devastating effect that opioid abuse is having across the country and in Minnesota. The misuse of opioids, both legally prescribed and illicitly obtained, has become a public health epidemic nationally and in Minnesota. The United States uses 80% of the world’s painkillers, despite having less than 5% of the world’s population. Opioid-related overdoses are the leading cause of drug-related deaths in Minnesota, with prescription opioids contributing to more deaths than heroin. Nationally, 78 people die of an opioid-related overdose every day. More than 40 people die every day from a prescription-opioid overdose.

While illicit drugs like heroin, carfentanil, and synthetic substances are also being used and taking lives at alarming rates, this report focuses on prescription opioids. In many cases, users of illicit substances began by abusing prescription opioids before switching to street drugs that were cheaper and more attainable. Overdose fatalities related to prescription opioids now surpass those from heroin and cocaine combined.

The opioid crisis involves many stakeholders: those struggling with addiction and their friends and families, employers, health care providers, pharmacists, insurers and third-party payors, professional-licensing boards, law enforcement, and the criminal justice system. Federal and state lawmakers have taken steps in recent years to acknowledge and address the growing problems related to opioids. But gaps in the law remain. This Office has met with professionals in the field, consulted with other state attorneys general and government regulators, and communicated with families affected by the opioid crisis. This report provides background on how the opioid crisis evolved; outlines the current state of the problem; discusses federal and state laws, initiatives, and resources related to prescription-opioid abuse; and makes recommendations for further reforms to prevent and address prescription-opioid abuse.

RECENT HEADLINES

“Heroin Fells Six in a Day in Anoka”—*Star Tribune*,
October 23, 2016

“The Pill Makers Next Door”—*Wall Street Journal*,
October 6, 2016

“Parents Get Their Drug Fix, Even When Children Watch”—*New York Times*,
September 28, 2016

SECTION 2. OPIOID OVERVIEW.

Section 2.1. What Are Opioids? Opioids can be traced to the discovery of opium, which was first discovered and labeled the “plant of joy” by the Sumerians around 3400 B.C.⁶ Opium may have been first used for euphoria in religious rituals before eventually spreading throughout the ancient world to every major civilization, where it would be used to treat pain and other ailments.⁷

Opioids are compounds that bind to and stimulate widely distributed receptors in the central nervous system, the peripheral nervous system, and the immune system.⁸ Opioids encompass both naturally occurring substances, derived from opium, and synthetic and semisynthetic compounds that, like naturally occurring opioids, act primarily on opioid receptors in the body.⁹ Their primary clinical use is as painkillers, where they reduce the intensity of the pain signals that reach the brain.¹⁰ Opioids are susceptible to addiction and abuse because, in addition to reducing pain, they trigger chemical processes in the brain that create intense feelings of pleasure.¹¹ Commonly known opioids include both illegal substances like heroin and prescription painkillers like hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin and Percocet), morphine, and codeine.

Section 2.2. Opioid Prescriptions Began Increasing in the Late 1990s. Most of the common prescription-opioid painkillers are schedule II drugs. Any doctor may prescribe an opioid painkiller in the ordinary course of a medical practice when the painkiller is prescribed to treat pain.¹² Prescribing controlled substances requires a registration from the U.S. Drug Enforcement Agency (DEA), which is attainable by completing a simple application form.¹³ For most of the 20th century, medical professionals in the United States considered long-term use of opioids to be “contraindicated by the risk of addiction, increased disability, and lack of efficacy over time.”¹⁴ Because doctors generally perceived prescription opioids as dangerously addictive, doctors reserved their long-term use for patients with cancer or other terminal illnesses.¹⁵ A series of studies in the late 1970s and early 1980s explored the effect of opioid treatment on patients with chronic pain, including non-cancer pain.¹⁶ These studies concluded that opioid treatment for chronic pain was largely a safe practice and generated a discussion in the 1990s about prioritizing pain treatment for all patients.¹⁷ One of the more salient elements of the campaign to enhance pain treatment was to describe pain as the fifth vital sign.¹⁸

Pharmaceutical companies played a significant part in advancing the campaign to prioritize pain treatment as companies aggressively promoted expanded opioid usage. Beginning in 1996, Purdue Pharma began promoting the use of opioids for non-malignant pain in conjunction with the release of its opioid painkiller, OxyContin.¹⁹ “We do not want to niche OxyContin just for cancer pain,” a marketing executive told employees in 1995.²⁰ In its promotional campaign, Purdue claimed that the risk of addiction from OxyContin was extremely small: Purdue even trained its sales representatives to convey to providers that the risk of addiction to OxyContin was less than one percent.²¹ The company promised that one dose could

“[T]wo major facts can no longer be questioned. First, opioid analgesics are widely diverted and improperly used, and the widespread use of the drugs has resulted in a national epidemic of opioid overdose deaths and addictions. . . . Second, the major source of diverted opioids is physician prescriptions.”—Drs. Nora D. Volkow and A. Thomas McLellan

relieve pain for 12 hours.²² As the *L.A. Times* noted, “[o]n the strength of that promise, OxyContin became America’s bestselling painkiller, and Purdue reaped \$31 billion in revenue.”²³

In 2012, 259 million painkiller prescriptions were issued, enough for every adult in the country to have a bottle of pills.

The push for better pain treatment coincided with an exponential increase in opioid prescriptions. Sales of opioid painkillers quadrupled between 1999 and 2010.²⁴ The Center for Disease Control and Prevention (CDC) estimates that 20% of patients who have pain-related diagnoses or pain unrelated to cancer receive an opioid prescription.²⁵ Each year between 2000 and 2010 saw a six-percent increase in the likelihood of an individual receiving an opioid prescription.²⁶ These trends culminated in 259 million prescriptions in 2012, “enough for every adult in the United States to have a bottle of pills.”²⁷ In 2016, the American Medical Association recommended removing pain as a vital sign.²⁸

Section 2.3. More Prescriptions Result in More Drug Diversion. The proliferation of opioid prescriptions has fueled increased opportunities for people to divert the painkillers for non-medical uses. According to the John Hopkins Bloomberg School of Public Health, research data strongly indicate that most prescription-drug abuse stems from diversion of legitimate prescriptions.²⁹ The most common form of diversion involves patients with legitimate opioid prescriptions transferring the drugs to family members or friends trying to self-medicate.³⁰ According to at least one study, approximately 70% of people who report non-medical use of a prescription opioid obtained the drug from a friend or family member.³¹ Given these patterns, it is unsurprising that “many physicians admit that they are not confident about how to prescribe opioids safely, how to detect abuse or emerging addiction, or even how to discuss these issues with their patients.”³²

Section 2.4. The Addictive Qualities of Opioids. The representations from the 1990s and Purdue Pharma’s marketing campaign about the risk of opioid addiction were eventually proved to be false. In 2007, a Purdue affiliate and three company executives pleaded guilty to criminal charges related to their false representations about the risks of OxyContin. Evidence established that clinical trials conducted before the drug hit the market revealed that, not only did it not provide relief for the promised duration, it was addictive.³³ The company and executives paid nearly \$635 million in fines.³⁴

While opioids are prescribed to relieve pain, they simultaneously activate the brain’s reward systems that trigger the release of dopamine, leading to feelings of intense pleasure.³⁵ This chemical interaction mimics the same biochemical effect that occurs when people engage in other rewarding life activities, like eating or having sex.³⁶ The pleasure induced by opioids has been described as being a few hundred times better than the pleasure produced by eating or having sex.³⁷ Accordingly, in the early stages of opioid abuse, stimulating the brain’s reward system is a primary reason for using opioids in excess.³⁸ But the compulsion to take opioids evolves with greater exposure and builds with time.³⁹

The first clinically significant change in compulsion is opioid tolerance.⁴⁰ Over time, increasingly higher dosages are necessary to produce the same amount of dopamine and achieve the same effect because brain cells with opioid receptors become less responsive to opioid stimulation.⁴¹ An increasing tolerance can also lead to withdrawal symptoms that manifest through reduced dopamine releases that previously occurred in response to normally rewarding activities like eating.⁴² These withdrawal symptoms exacerbate the compulsion to take opioids.⁴³

The second clinically significant change in the transition to opioid addiction is opioid dependence.⁴⁴ Typically, opioids initially suppress neurons that stimulate wakefulness and general alertness, resulting in drowsiness, low blood pressure, and slowed breathing.⁴⁵ After repeated exposure to opioids, the neurons in the brain that typically stimulate alertness, breathing, and blood pressure adjust by becoming more active.⁴⁶ As a result, when opioids are present, their mitigating effect on these neurons is offset by the neurons' increased activity.⁴⁷ But when opioids are absent, the increased activity of these neurons triggers withdrawal symptoms like jitters, anxiety, muscle cramps, and diarrhea.⁴⁸ In other words, repeated exposure to opioids alters or "hijacks" the brain so that it functions normally when opioids are present and abnormally when they are not.⁴⁹ These brain changes underlie the compulsive drug-seeking behavior associated with opioid addiction. "Chemistry, not moral failing, accounts for the brain's unwinding."⁵⁰

Withdrawal itself is not fatal. But its effects have been described as so overwhelming that a relapse is likely if the withdrawal is not addressed immediately. *The Pioneer Press* once described that individuals in withdrawal "feel like their bones are breaking and fluids leak from every orifice."⁵¹ A

former drug user has stated that, when users are in withdrawal, "They can't eat. They can't stand up. They have stomach cramps. They have muscle aches. They can't think. All they know is what they need to stop the pain."⁵² The director of a treatment program put it more bluntly: "You don't die from withdrawal. You just wish you would have."⁵³

*"You don't die from withdrawal.
You just wish you would have."*—
Treatment program director

The structural changes in brain activity associated with opioid addiction and withdrawal symptoms help explain the danger posed by repeated exposure to opioids. By virtue of the effect that opioids have on the brain, greater exposure leads to craving higher dosages to achieve the same effect experienced at lower dosages and to stave off withdrawal symptoms.⁵⁴ At the same time, significantly higher risks of overdose are associated with exposure to higher dosages of opioids, with one study finding that the risk of overdose was nine times higher for individuals who received prescribed opioid dosages of at least 100 milligrams compared to individuals receiving lower dosages.⁵⁵ Part of this effect is explained by the asymmetry in individuals' development of tolerance to different effects of opioids. An article in *The New England Journal of Medicine* noted that tolerance to analgesic (pain-relief) and euphoric effects of opioids develops quickly, while tolerance to other opioid effects, like respiratory depression, develops more slowly.⁵⁶ Accordingly, increasing dosages to maintain the painkilling effects of the opioid exacerbate a patient's risk of overdose.⁵⁷ The U.S. Surgeon General recently explained that, "addiction is not a character flaw—it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer."⁵⁸

No single factor determines who will become addicted to opioids.⁵⁹ Community-, family-, and individual-level factors may all affect individuals' risk levels.⁶⁰ The Surgeon General has stated that factors may include access to substances, family conflict, family history of substance-use disorders, low involvement in school, a history of abuse or neglect, and a history of substance use during adolescence.⁶¹ Adolescence and young adulthood are particularly critical times for being at risk of developing a substance use problem or disorder.⁶² Research has indicated that high school students who receive and take a legitimately prescribed opioid are one-third more likely to abuse the drug by age 23 than students who have not taken a prescription.⁶³ Some recent research has also suggested that the personality traits that make someone most susceptible to addiction are sensation-seeking, impulsiveness, anxiety sensitivity, and hopelessness.⁶⁴

Section 2.5. Opioid Use Disorder. The recent deluge of prescription opioids for pain relief, coupled with opioids' powerful inducements toward compulsive and addictive behavior, has resulted in an astounding rate of opioid addiction, affecting approximately 2.5 million adults in 2014, with approximately 1.9 million specifically addicted to prescription painkillers.⁶⁵ Further, 12.5 million Americans ages 12 and older reported misusing a prescription painkiller in the past year.⁶⁶ The *Diagnostic and Statistical Manual of Mental Disorders* recognizes opioid use disorder as a subset of substance use disorder.⁶⁷ The symptoms of opioid use disorder include a strong desire for opioids, the inability to control or reduce use despite interference with other obligations, use of increasing dosages, spending a significant time obtaining and using opioids, and experiencing withdrawal symptoms when reducing use.⁶⁸

In 2014, approximately 2.5 million adults met the criteria for an opioid use disorder, with approximately 1.9 million specifically addicted to prescription painkillers.

Section 2.6. Treating Opioid Dependence. One of the common and effective forms of treating opioid dependency is medication-assisted treatment, which generally consists of a medication in addition to other psychosocial counseling and support.⁶⁹ While methadone remains one form of medication-assisted treatment, since 2002 buprenorphine has been one of the more prevalent forms of medication-assisted treatment. Buprenorphine is a schedule III drug that is a partial agonist, whereas methadone is a full agonist like heroin.⁷⁰ An agonist is a chemical that binds to a receptor on a nerve cell and produces a response.⁷¹ Subutex consists only of buprenorphine, but one of the more common medications used is Suboxone, which is a combination of buprenorphine and naloxone.⁷² Naloxone is primarily used to counteract the effects of an opioid overdose in emergency situations.⁷³ Unlike buprenorphine, naloxone is not susceptible to abuse because it does not mimic the effects of opioids or address withdrawal symptoms.⁷⁴ Other buprenorphine-based drugs that the FDA has approved for treating opioid dependence include Bunavail and Zubsolv.⁷⁵ In May 2016, the FDA approved the first buprenorphine implant, Probuphine.⁷⁶ Common brands of naloxone include Narcan and Evzio.⁷⁷

Because buprenorphine is only a partial agonist and because it can be combined with naloxone, drugs like Suboxone generally present a lower risk of abuse or overdose.⁷⁸ Moreover,

a patient can fill a buprenorphine prescription at a pharmacy and take it at home as opposed to frequently traveling to a methadone clinic—that may be far away—to receive methadone.⁷⁹ Research has found that buprenorphine is effective in treating opioid dependence.⁸⁰ Because medication-assisted treatment involves using a medication to treat addiction, some providers are resistant to using it even though some research suggests that abstinence-based treatment has difficulty in successfully treating opioid dependence.⁸¹ Physicians with first-hand experience prescribing buprenorphine tend to have a more optimistic view of its efficacy than physicians who have not prescribed it.⁸² For example, in a survey of rural Washington state physicians who were currently prescribing buprenorphine, all reported that they were generally satisfied with the effectiveness of buprenorphine for treating opioid addiction, and 95% said they would recommend the use of buprenorphine to their colleagues.⁸³

Whereas any doctor can prescribe schedule II opioid painkillers to treat pain, the DEA more strictly regulates distribution of buprenorphine to treat opioid dependence. As discussed in more detail in Section 4 of this report, only physicians who obtain a waiver from the DEA are authorized to prescribe buprenorphine, and most then face strict patient limits. And, as discussed in Sections 5 and 6, barriers to accessing buprenorphine can accumulate due to the limited number of authorized prescribers and to roadblocks imposed by insurers.

Treatment not only benefits the individual with a substance use problem, it makes economic sense. Every dollar spent on treatment for a substance use disorder saves \$4 in health care costs and \$7 in criminal-justice costs.⁸⁴

SECTION 3. THE CURRENT OPIOID CRISIS.

The United States is facing an unprecedented drug overdose epidemic, driven by the increased availability of prescription opioids. Despite constituting only 4.6% of the world's population, Americans consume 80% of the global opioid supply.⁸⁵ In 2014, a record number of people died from drug overdoses in the United States, and opioids accounted for most of these deaths.⁸⁶

Section 3.1. The National Devastating Toll of Opioid Abuse. According to the American Society of Addiction Medicine, drug overdoses are the leading cause of accidental death in the United States, with 47,055 lethal drug overdoses occurring in 2014.⁸⁷ Since 2009, deaths from overdoses have exceeded those from car accidents.⁸⁸ Between 2000 and 2014, nearly one-half million people died in the United States from drug overdoses.⁸⁹

“The bottom line is that [the prescription opioid epidemic] is one of the very few health problems in this country that’s getting worse.”—Dr. Tom Frieden, CDC director

“Our heroin addicts are now 20-year-old kids. . . . Today’s addicts, many don’t look like your Keith Richards stereotype. They look like your prom queen.”—Minneapolis DEA Agent

As illustrated by the CDC in Figure 1, opioids account for a significant part of the drug overdose epidemic. In 2014, 61% of all drug overdoses involved an opioid.⁹⁰ That year, 28,647 people—about 78 people a day—died from an opioid-related drug overdose.⁹¹ In 1999, opioids accounted for just 35% of all drug overdose deaths, and an average of 16 people a day died from an opioid-related overdose.⁹² While the death rate for drug overdoses in general has increased by 137% since 2000, the death rate for opioid-related overdoses increased by 200%.⁹³

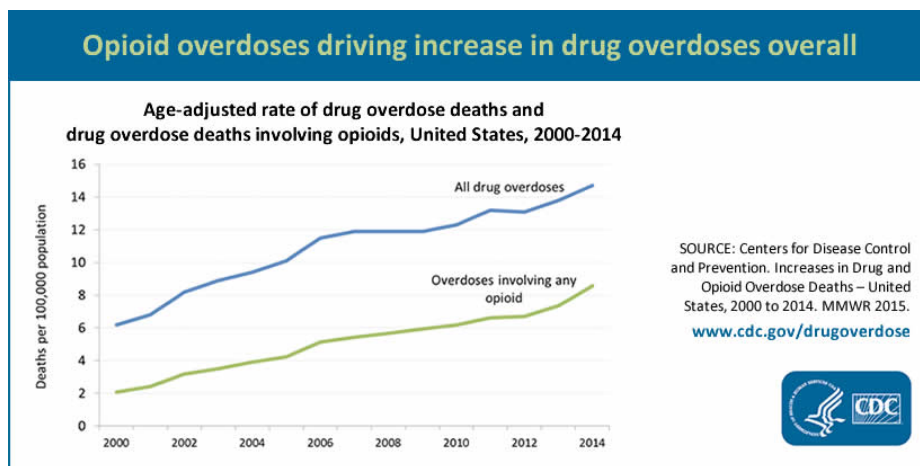


Figure 1. Opioid Overdoses Compared to Drug Overdoses.

Section 3.2. The Devastating Toll of Opioid Abuse in Minnesota. Minnesota is not immune from these trends. Between 1999 and 2014, the state had 3,262 opioid-related fatalities; 1,767 of these deaths related to prescription opioids, 348 related to heroin, and 1,147 related to other opioids.⁹⁴ In 2015, 572 people in Minnesota died from drug overdoses; 216 of the deaths

related to prescription opioids, while 114 related to heroin.⁹⁵ Between 2014 and 2015, deaths in Minnesota related to drug overdoses increased by 11%, and these deaths have quadrupled since 2000.⁹⁶ The starkness of these numbers is underscored when considering that, in 2008, fewer than ten people died from a heroin overdose in Minnesota—a number low enough that the CDC did not report the exact number.⁹⁷

The opioid epidemic stretches across all demographics in Minnesota, but some segments of the population have been hit particularly hard. The opioid-related death rate for Native Americans between 1999 and 2014 was five times higher than that of whites.⁹⁸ The death rate for African Americans was also higher than the rate for whites.⁹⁹ Geographically, the counties with the highest death rates are Anoka, Carlton, Cass, Hennepin, Mille Lacs, and St. Louis Counties.¹⁰⁰ Cass County and Mille Lacs County have been hit the hardest.¹⁰¹ As illustrated by Figure 2, generationally, most opioid-related deaths have occurred in those between ages 45 and 54 (846 deaths), followed by those ages 35 to 44 (750 deaths), those ages 25 to 34 (605 deaths), those ages 55 to 64 (360 deaths), and those ages 15 to 24 (322 deaths).¹⁰²

Minnesota Deaths From Opioid Overdoses, 1999-2014

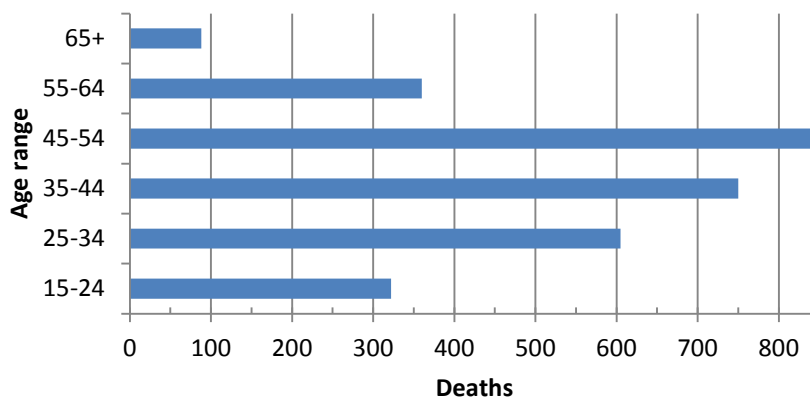


Figure 2. Minnesota Opioid-Related Overdose Fatalities. (Sources MPRNews, CDC)

Section 3.3. Prescription-Drug Abuse is Driving the Opioid Epidemic. In 2012, the CDC described prescription-drug abuse as the fastest growing drug problem in the United States.¹⁰³ Analyzing data from 2000 to 2014, the CDC observed a long-term trend in fatal overdoses involving prescription opioids and a more recent increase in deaths from illicit opioids, primarily heroin.¹⁰⁴

4.3 million people ages 12 or older report currently using prescription painkillers without a prescription or medical need.

As to the increase in overdoses from prescription painkillers, a survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is part of the U.S. Department of Health and Human Services, found that 4.3 million individuals ages 12 or older reported current non-medical use of prescription painkillers in 2014, meaning that they were using prescription painkillers either without a prescription or without a medical need.¹⁰⁵ Between

2003 and 2010, the rate of chronic non-medical use of prescription pain relievers—defined as past-year non-medical use for 200 days or more—increased by 74.6%.¹⁰⁶ Emergency room visits involving misuse or abuse of prescription opioids increased 153% between 2004 and 2011.¹⁰⁷ These trends culminated in nearly 2.5 million Americans ages 12 or older meeting the criteria for a opioid use disorder in 2014, according to SAMHSA.¹⁰⁸

The increasing number of individuals engaging in non-medical use of prescription opioids and the corresponding addiction rates have resulted in an unprecedented increase in overdose deaths caused by prescription opioids. While representing less than 25% of all drug overdose deaths in 1999, prescription opioids now account for 40% of all drug overdose deaths.¹⁰⁹ Since 2003, prescription opioids have resulted in more overdose deaths than heroin and cocaine combined.¹¹⁰ The increasing number of prescription-opioid overdose deaths is troubling, with the number of prescription opioid-related overdoses quadrupling since 1999.¹¹¹ Of the 28,647 opioid-related deaths in 2014, nearly 19,000 were from prescription opioids.¹¹² More than 40 people die in the United States each day from a prescription opioid overdose.¹¹³

Data indicate that the rate of prescription-opioid overdose deaths strongly correlates with increases in prescription-opioid sales and corresponding prescription abuse and addiction. For example, the CDC reports that, between 1999 and 2008, overdose death rates, sales, and substance-abuse-treatment admissions related to opioid painkillers increased in parallel, as illustrated by the following chart created by the CDC:

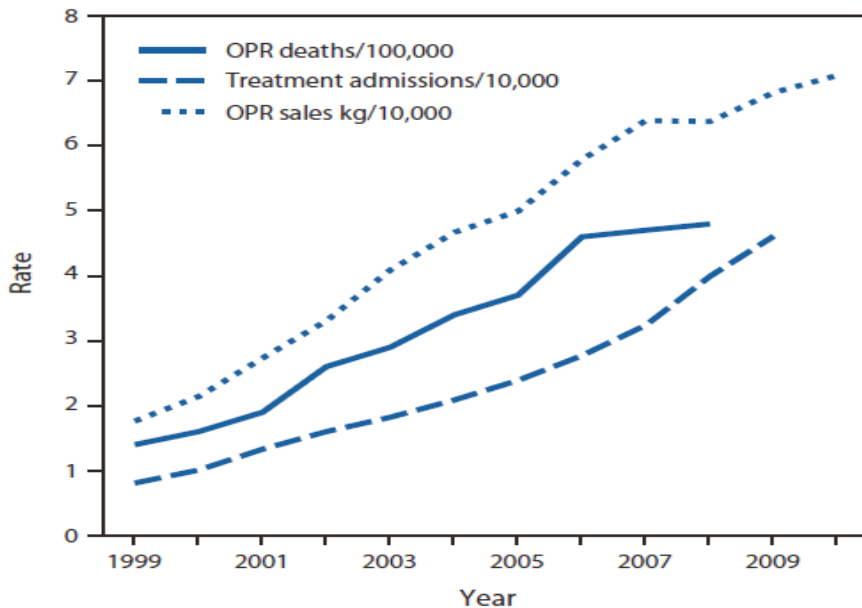


Figure 3. Rates per 10,000 population of opioid pain reliever (OPR) overdose deaths, treatment admissions, and kilograms sold in the United States, 1999-2010. (Source: Ctrs. for Disease Control & Prevention, *Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008*, 60 MORBIDITY & MORTALITY WKLY. REP. 1487, 1491 (2011).)

These trends led the authors of an article published in *The New England Journal of Medicine* to declare in March 2016 that it “can no longer be questioned” that “the widespread use of [prescription opioids] has resulted in a national epidemic of opioid overdose deaths and addictions.”¹¹⁴

“Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use.”—CDC

Prescription-drug abuse is of particular concern because of its role as a gateway to other opioids. “Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use.”¹¹⁵ A review of research in *The New England Journal of Medicine* concluded that nearly 80% of heroin users reported previously engaging in non-medical use of prescription opioids before using heroin.¹¹⁶ Another study from SAMHSA found that the likelihood of using heroin

was 19 times higher among individuals who reported prior non-medical painkiller use.¹¹⁷ Research has additionally shown significant shifts in the patterns of first opioid use among heroin users entering substance-abuse treatment programs. According to a study published in *The Journal of the American Medical Association: Psychiatry*, among people who began using opioids in the 1960s, more than 80% reported that their first opioid was heroin; conversely, in the 2000s, 75% of users initiated opioid use with prescription opioids.¹¹⁸ Many individuals reported resorting to heroin because it is cheaper and more accessible.¹¹⁹

The transition from non-medical use of prescription opioids to illicit synthetic opioids like heroin has significant consequences. First, transitioning to heroin exposes users to a cheaper, more accessible source for their opioid addiction.¹²⁰ Second, once users are in illegal markets, they are exposed to more potent, illicit synthetic opioids. For example, since 2015, the DEA has issued public warnings about the increasing presence of two synthetic opioids, fentanyl and carfentanil, that are often disguised as or combined with heroin.¹²¹ Fentanyl is 50 to 100 times more potent than morphine and 30 to 50 times more potent than heroin.¹²² Carfentanil is 100 times more potent than fentanyl.¹²³ Carfentanil is typically used as a tranquilizing agent for elephants and other large mammals.¹²⁴ Figure 4 reflects the small amounts of carfentanil and fentanyl needed to achieve the same effect as a larger amount of heroin. Even in this figure, the depiction of carfentanil is exaggerated because it would otherwise be imperceptible.

Equivalent Strengths of Heroin, Fentanyl, and Carfentanil

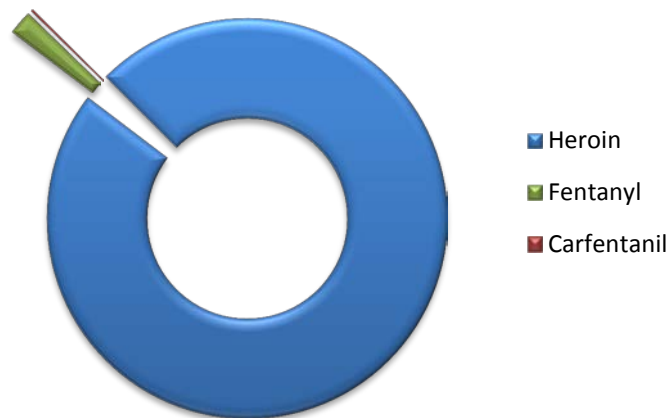


Figure 4. Relative Potency of Heroin, Fentanyl, and Carfentanil. (Source: DEA.)

Carfentanil and fentanyl are particularly dangerous because each can be absorbed through the skin, and a small amount can kill.¹²⁵ Carfentanil is so strong that it is difficult to revive someone who has overdosed, even with multiple doses of naloxone.¹²⁶ While little data exist on the proliferation of carfentanil due to its recent emergence in illicit markets, CDC data show that the number of drug products seized by law enforcement that tested positive for fentanyl increased by 426% from 2013 to 2014.¹²⁷

The increasing number of individuals using illegal opioids has coincided with a recent and steep increase in deaths related to illicit opioids like heroin and fentanyl. The number of deaths from synthetic opioids increased by 79% between 2013 and 2014, and the increase correlated with the increase in drug products testing positive for fentanyl.¹²⁸ Meanwhile, heroin-overdose death rates increased by 26% from 2013 to 2014 and have tripled since 2010.¹²⁹ Despite the relatively recent nature of the data, the increasing levels of abuse of, and addiction to, prescription opioids indicate that prescription-opioid abusers are turning to heroin, which in turn is leading to an increase in deaths from both heroin and other synthetic opioids like fentanyl.¹³⁰ According to a report published by the CDC, these findings indicate that the opioid epidemic is worsening.¹³¹ Consistent with these trends, Minnesota has experienced a wave of overdose deaths related to fentanyl-laced heroin, including a cluster of deaths alleged to be linked to one metro area drug dealer.¹³²

Every 25 minutes, a baby is born suffering from opioid withdrawal.

Every day, more than 1,000 people receive emergency-room treatment for misused prescription opioids.

Every year, prescription-opioid abuse costs about \$25.6 billion in lost workplace productivity.

those unemployed but looking for work.¹³⁹ Some have speculated that the high rate of painkiller use may be connected to being unemployed, as those with few job prospects may be more likely to become depressed and addicted to painkillers.¹⁴⁰

Section 3.4. The Costs of Opioid Abuse. In addition to the rising human and death toll, the opioid crisis imposes significant economic costs on society. Abuse of opioid painkillers costs society billions of dollars each year.¹³³ Estimates range from \$53 to \$72 billion a year, when accounting for medical costs, treatment costs, lost productivity, and costs incurred by the criminal justice system.¹³⁴ The CDC reports that more than 1,000 people receive emergency-room treatment every day for misusing prescription opioids, and the National Institute on Drug Abuse reports that a baby is born suffering from opioid withdrawal every 25 minutes.¹³⁵ Lost workplace productivity alone has been estimated to be about \$25.6 billion a year.¹³⁶ Seven million men between the ages of 25 and 54 (about 11.4% of the age group) are not in the labor force, meaning that they are unemployed and not seeking work.¹³⁷ The percentage has increased from less than 4% in the past two decades.¹³⁸ One recent study found that 44% of these men not in the labor force reported taking painkillers on a daily basis, in contrast to about 20% of employed men and

Household compositions and caretaking responsibilities have also shifted because of the opioid epidemic. In 2015, 2.9 million children were living with grandparents responsible for their care, compared to 2.5 million in 2005.¹⁴¹ More children are now living with their grandparents because their parents have either died from a heroin or prescription-drug overdose or are struggling with an opioid addiction and unable to care for their children.¹⁴² In addition to changing retirement plans for many grandparents, these dynamics create strains related to finances and health. About one-fifth of grandparents caring for grandchildren live below the poverty line, and more than one-quarter have a disability.¹⁴³

SECTION 4. FEDERAL LAWS, INITIATIVES, AND RESOURCES RELATED TO PREVENTING AND COMBATTING OPIOID ABUSE.

The federal Controlled Substances Act was first enacted in 1970, and the distribution and disposal of controlled substances have been heavily regulated. Since approximately 2000, however, there have been several shifts in federal law aimed at increasing safe and timely disposal of prescription drugs, expanding treatment access for those dependent on opioids, and curbing prescription-drug abuse.

“[Previous] restrictions [on drug disposal] resulted in the accumulation of pharmaceutical controlled substances in household medicine cabinets that were available for abuse, misuse, diversion, and accidental digestion.”—DEA

Section 4.1. Proper Disposal of Controlled Substances. Several federal laws affect the disposal of controlled substances. Prompt and safe disposal reduces the risk that prescription drugs will be diverted or otherwise misused.

Section 4.1.a. Federal Controlled Substances Act. The Controlled Substances Act (CSA), 21 U.S.C. §§ 801-971, broadly regulates manufacturing, possessing, using, importing, distributing, and disposing of certain drugs, including opioids approved for medical use. The CSA classifies drugs on one of five schedules depending on whether the drug has an acceptable medical use and whether the drug has the potential for abuse and dependency.¹⁴⁴ Opioids are found in all five of the federal schedules from heroin on schedule I to cough suppressants containing small amounts of codeine on schedule V.¹⁴⁵ Before 2010, the CSA required a person to dispose of a lawfully prescribed controlled substance by either surrendering the medication directly to law enforcement, seeking the DEA’s assistance, or destroying it themselves.¹⁴⁶ The DEA has since recognized that these cumbersome restrictions ultimately deterred safe and timely disposal and led to the accumulation of prescription drugs in medicine cabinets, making them “available for abuse, diversion, and accidental digestion.”¹⁴⁷

Section 4.1.b. Secure and Responsible Drug Disposal Act of 2010. In 2010, Congress enacted the Secure and Responsible Drug Disposal Act of 2010 (Disposal Act), Pub. L. 111-273, 124 Stat. 2858 (codified in 21 U.S.C. §§ 822, 828(b)). The Disposal Act amended the CSA and authorized the DEA to expand the methods for collecting and disposing of controlled substances.¹⁴⁸ This Office joined 40 other state attorneys general to support passage of the Disposal Act, explaining that states lacked adequate mechanisms for citizens to dispose of unused medications, which were contributing to drug diversion.¹⁴⁹

The DEA’s final rules implementing the Disposal Act took effect in October 2014.¹⁵⁰ The rules expanded disposal options by allowing registered pharmacies, manufacturers, distributors, narcotic treatment programs, and hospitals with on-site pharmacies to provide collection receptacles for controlled substances.¹⁵¹ These registered collectors may also conduct “mail-back programs” if the collector has the ability to destroy the substance.¹⁵² Long-term care facilities may collect from residents if the collection receptacle is managed and maintained by a registered pharmacy.¹⁵³ The rules also allow any person to partner with law enforcement to conduct a take-back event and give law enforcement agencies and other collectors the authority to conduct mail-back programs.¹⁵⁴

Section 4.1.c. Other DEA tools and resources. The DEA administers the registration of collection sites for controlled substances under the Disposal Act, and local DEA offices partner with participating law enforcement agencies to host National Prescription Drug Take-Back Days.¹⁵⁵ The DEA also maintains a search tool to assist citizens in finding a disposal location in their area at <https://apps.dea.diversion.usdoj.gov/pubdispsearch/>. The database is searchable by zip code or city and state.

In October 2016, the DEA exercised its authority under the CSA to issue a final order reducing the Aggregate Production Quota (APQ) for several schedule II opioid medications in 2017, including oxycodone, hydrocodone, fentanyl, hydromorphone, and morphine.¹⁵⁶ The DEA defines the “APQ” as “the total amount of a controlled substance necessary to meet the estimated medical, scientific, research, industrial, and export needs for the year and for the maintenance of reserve stocks.”¹⁵⁷ Practically, this means that the DEA serves as a gatekeeper, controlling the amount of opioids legally sold each year in the United States.¹⁵⁸

Section 4.2. Federal Laws Related to Medication-Assisted Treatment. The federal government also plays a significant role in access to medication-assisted treatment because it determines which medications may be used and who may prescribe and administer them.

Section 4.2.a. Drug Addiction Treatment Act. In 2000, Congress enacted the Drug Addiction Treatment Act (DATA) of 2000 as part of the CSA, 21 U.S.C. § 823(g). Before DATA, the only approved medications to treat opioid addiction were methadone and levo-alpha-acetyl-methadol, both schedule II drugs that could be dispensed only through a federally approved opioid treatment program.¹⁵⁹ DATA created a system for some physicians to obtain waivers to prescribe schedule III, IV, and V drugs, including buprenorphine (e.g., Subutex) and buprenorphine/naloxone (e.g., Suboxone), for treating opioid dependence.¹⁶⁰ To qualify for a waiver the physician must generally hold an additional certification in addiction or complete eight hours of training on treating and managing opiate-dependent patients.¹⁶¹ A physician may treat up to 30 patients for the first year of a waiver, and then may seek a waiver to treat up to 100 patients.¹⁶² Effective August 2016, physicians with 100-patient waivers may seek waivers to treat up to 275 patients.¹⁶³

Access to treatment remains a problem because few providers have obtained a waiver to prescribe buprenorphine. Of the approximately 435,000 primary care physicians in the United States, only about 6.9% have a waiver, and only about one-half of that group actually treats opioid use disorders.¹⁶⁴ As illustrated in Figure 5, of Minnesota’s physicians authorized to prescribe buprenorphine, 50 doctors are certified to treat up to 30 patients and 20 are certified to treat up to 100 patients.¹⁶⁵

Minnesota Physicians Authorized to Prescribe Buprenorphine

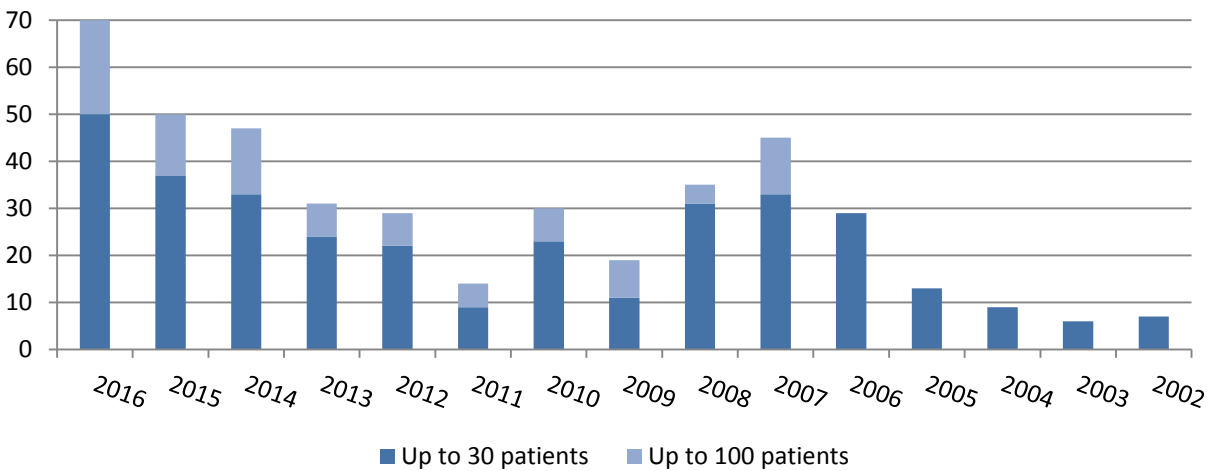


Figure 5. Minnesota Buprenorphine Prescribers by Authorized Patient Caseload. (Source: SAMHSA.)

Patient limits do not apply to providers who dispense buprenorphine on site in an opioid treatment program.¹⁶⁶ SAMHSA data indicate that, overall, only 122 of Minnesota’s 16,804 professionally active physicians are authorized to prescribe buprenorphine.¹⁶⁷ This amounts to about 0.73% of Minnesota’s physicians.

Section 4.2.b. Food and Drug Administration approvals for medication-assisted treatment and opioid antagonists. The U.S. Food and Drug Administration (FDA) is responsible for approving prescription drugs for use. While buprenorphine has been marketed as an injectable painkiller since 1985, the FDA first approved it for treating opioid dependence in 2002 when it approved Subutex (buprenorphine) and Suboxone (buprenorphine/naloxone) tablets.¹⁶⁸ In 2010, the FDA approved Suboxone in a sublingual film form for treating opioid dependence.¹⁶⁹ In 2016, this Office filed an antitrust lawsuit with 41 other states against Indivior, the drug manufacturer that makes Suboxone, based on anticompetitive conduct that has precluded other manufacturers from making competing generic versions of the drug. The FDA approved Bunavail in 2014 and Zubsolv in 2015, both of which are also combinations of buprenorphine and naloxone.¹⁷⁰

The FDA first approved naloxone hydrochloride in 1971 for administration by injection.¹⁷¹ In 2014, the FDA approved Evzio, an auto injector similar to an EpiPen, as the first naloxone injection approved to address the risk of opioid overdose in all settings.¹⁷² In late 2015, the FDA approved a nasal spray form of naloxone called Narcan.¹⁷³ Naloxone remains a prescription drug, but the FDA has announced that it is reconsidering its options for making naloxone more accessible.¹⁷⁴

Section 4.3. Recent Federal Reforms, Proposed Legislation, and Initiatives. Federal agencies have recently taken more aggressive approaches to curbing painkiller abuse. Several recent federal laws and pending bills are also aimed at further addressing the opioid crisis.

Section 4.3.a. New CDC prescribing guidelines. In March 2016, the CDC issued new opioid-prescribing guidelines for primary care physicians, after concluding that further clinician guidance was needed for opioid prescribing.¹⁷⁵ The new guidelines focus on when opioids should be used for chronic pain, how opioids should be selected, how long opioids should be used, and how physicians should assess risks of opioid abuse.¹⁷⁶ The guidelines advise prescribers to be particularly cautious when prescribing the equivalent of more than 50 morphine milligram equivalents (MMEs) per day and to carefully justify prescriptions exceeding 90 MME per day.¹⁷⁷

Section 4.3.b. FDA drug rejections and guidance. In recent years, the FDA has stopped several new opioid painkillers from entering the market and has taken action when drug manufacturers have misrepresented the safety of unapproved opioids. For example, in 2014, the FDA denied approval of Moxduo (morphine and oxycodone), concluding that insufficient evidence established that the drug was safer than morphine or oxycodone used independently.¹⁷⁸ In September 2016, the FDA sent a warning letter to DURECT Corporation and Pain Therapeutics, Inc., based on their online representations suggesting that an experimental new drug—Remoxy ER (oxycodone)—was safe and effective.¹⁷⁹ The FDA also recently encouraged opioid drug manufacturers to include abuse deterrents in drugs.¹⁸⁰

Section 4.3.c. Comprehensive Addiction and Recovery Act of 2016. In 2016, Congress enacted the Comprehensive Addiction and Recovery Act (CARA), Pub. L. No. 114-198. CARA seeks to address the opioid crisis primarily by awarding grants to treat and prevent opioid addiction.¹⁸¹ This Office was part of a coalition of 38 state attorneys general who supported CARA's passage, recognizing the devastating effects of opioid abuse and advocating for a strategy that includes prevention, law enforcement, reduction of overdose deaths, evidence-based treatment, and support for people who are in or seeking recovery.¹⁸² While CARA passed with overwhelming bipartisan support, disagreements remain about the level of funding provided to implement the components of the final act.¹⁸³ Some of CARA's major provisions include:

- Focusing on opioid-abuse prevention and education by creating the Pain Management Best Practices Inter-Agency Task Force, directing the U.S. Department of Health and Human Services to conduct an education and awareness campaign, requiring a closer review of applications for new opioid painkillers and prescription-labeling requirements, and providing grants for community-based coalitions to address local drug crises.¹⁸⁴
- Improving access to overdose treatment by providing grants to health centers and other entities to expand access to overdose drugs such as naloxone and creating grant programs for states to implement strategies for pharmacists to dispense overdose drugs through standing orders.¹⁸⁵
- Improving information available to opioid prescribers by reauthorizing the National All Schedules Prescription Electronic Reporting Act of 2005, which provides grants for states to maintain or improve prescription drug monitoring programs.¹⁸⁶
- Assisting law enforcement through grants for developing and implementing alternative incarceration programs (such as drug courts or diversion programs), for facilitating

coordination between criminal-justice and substance-abuse agencies, for training first responders on administering opioid overdose reversal drugs, for purchasing opioid overdose reversal drugs for use by first responders, and for implementing drug take-back programs.¹⁸⁷

- Expanding funding for medication-assisted treatment by providing grants to state substance abuse agencies, local governments, or nonprofit organizations serving those with high rates of opioid use.¹⁸⁸
- Expanding access to medication-assisted treatment by allowing nurse practitioners and physicians assistants who meet certain requirements to obtain waivers to prescribe buprenorphine.¹⁸⁹
- Providing grants to states for implementing integrated opioid-abuse response initiatives that include educating prescribers, creating or improving comprehensive prescription drug monitoring programs, maintaining opioid- and prescription-drug addiction treatment programs, and preventing overdose deaths.¹⁹⁰
- Overhauling the prescribing practices of opioids in the U.S. Department of Veterans Affairs.¹⁹¹ Among other things, the law directs the Department to ensure that providers are educated on current prescribing practices and have access to state prescription drug monitoring programs.¹⁹²

Section 4.3.d. Public awareness and proposed federal legislation related to opioid addiction and diversion. In 2016, U.S. Surgeon General Dr. Vivek Murthy launched a public awareness campaign about the opioid epidemic. In August 2016, he wrote to 2.3 million health professionals, encouraging them to seek education about safe prescription practices and to screen patients for opioid use disorder and connect them with evidence-based treatment.¹⁹³ He also launched a website, *TurnTheTideRx.org*, that has a variety of resources related to opioids.¹⁹⁴ Additionally, federal legislators have recently proposed additional measures to combat the opioid epidemic, although many of these proposals have yet to be acted on. Some examples include:

- ***Prescription Drug Monitoring Act of 2016 (S. 3209).*** In 2016, U.S. Senator Amy Klobuchar introduced a bill that would require doctors to consult their state’s prescription drug monitoring program before prescribing a controlled substance.¹⁹⁵ The bill would also require states to share program data with other states through a single technology to be established by the U.S. Attorney General in coordination with U.S. Department of Health and Human Services.¹⁹⁶
- ***Promoting Responsible Opioid Prescribing (S. 2758 and H.R. 4499).*** Both the Senate and House of Representatives have pending legislation to remove consideration of pain-related questions on patient surveys from decisions relating to payment from Medicare.¹⁹⁷ Currently, the patient surveys, which are used to calculate Medicare reimbursement rates based on quality measures, ask patients three questions related to pain management, including whether the practitioner did “everything they could to help” with pain.¹⁹⁸ Some doctors report being faced with the choice of either prescribing unnecessary narcotics or

risking low patient satisfaction scores on surveys, resulting in cuts to reimbursement rates.¹⁹⁹ Sponsoring legislators hope that this new law would remove an incentive for hospitals to overprescribe opioids.²⁰⁰

- ***Carl's Law (S. 3298, H.R. 5601)***. Both Senate and House legislators have proposed Carl's Law to amend the Federal Food, Drug, and Cosmetic Act to require labels of prescription opioids to state prominently that the drug contains an opioid and that addiction is possible.²⁰¹ The bill is named after Carl Messinger, a New Hampshire man who, while in recovery for a heroin addiction, was prescribed a cough syrup that contained an opioid. The prescription triggered drug-seeking behavior that eventually led to a fatal overdose.²⁰²

Section 4.3.e. SAMHSA Initiatives and Tools. SAMHSA provides resources and tools to assist people with opioid addictions to seek help by maintaining on its website the Buprenorphine Physician & Treatment Program Locator and the Opioid Treatment Program Directory.²⁰³ SAMHSA also offers trainings for physicians on opioid prescribing and medication-assisted treatment.²⁰⁴

SECTION 5. MINNESOTA AND OTHER STATE LAWS AND INITIATIVES RELATED TO OPIOID ABUSE.

Section 5.1. Minnesota Laws. Since about 2013, Minnesota has enacted legislation specifically related to opioid abuse and treatment. The result of these legislative efforts can be seen in Minnesota’s prescription drug monitoring program and its Opioid Prescribing Improvement Program, as well as in laws relating to prescribing practices, treatment and overdose prevention, and controlled substances disposal. The Minnesota Board of Pharmacy has adopted rules to increase opportunities for intervention in opioid addiction and to help prevent controlled substances diversion. In 2016, the State amended many criminal laws to increase penalties for drug dealers, reduce criminal penalties for individuals with addictions, and facilitate treatment opportunities.

“Health officials and the public were slow to realize the extent of the danger presented by opioids until the problem became widespread enough that it was difficult to turn aside.”—Minnesota Public Radio

Section 5.1.a. Prescription drug monitoring program. Minnesota’s prescription drug monitoring program, administered by the Minnesota Board of Pharmacy, is a tool for prescribers and pharmacists to manage patient care and to identify individuals who may be abusing or diverting controlled substances.²⁰⁵ All dispensers of controlled substances, including pharmacies and practitioners who dispense from their office, are required to submit data about controlled-substance prescriptions to the prescription drug monitoring database. Effective July 1, 2017, prescribers and pharmacists will be required to register and maintain a prescription drug monitoring program user account.²⁰⁶ They are not required, however, to actually check or review the database before issuing or filling a controlled-substance prescription.²⁰⁷ One exception when the prescription drug monitoring system must be accessed and reviewed is before a client is ordered a controlled substance while enrolled in an opioid addiction treatment program licensed by the Minnesota Department of Human Services (DHS).²⁰⁸

Dispensers are required to report data about controlled-substance prescriptions into the prescription drug monitoring system daily.²⁰⁹ Minnesota law requires dispensers to report 14 types of data, including the names of the prescriber and dispenser; patient information, including the patient’s name, address, and date of birth; and information about the prescribed controlled substance, including the medication’s name, strength, and quantity, and the duration of the prescription.²¹⁰ The Board of Pharmacy may require dispensers to collect additional data, beyond those listed in the statute.²¹¹ For example, the Board requires dispensers to report the prescriber’s and dispenser’s phone numbers, the patient’s gender, and the patient’s payment method.²¹²

The data submitted to the prescription drug monitoring database are classified as private data and not subject to public disclosure.²¹³ Multiple permissible users may access the data, including prescribers, dispensers, the individual to whom the controlled substance is prescribed, and federal, state, and local law enforcement agencies with a valid search warrant.²¹⁴

The Board of Pharmacy is allowed by statute to participate in an interstate prescription monitoring data exchange system.²¹⁵ Currently, Minnesota exchanges data with 26 other states.²¹⁶

Section 5.1.b. Prescribing practices. In 2015, the Minnesota Legislature established the Opioid Prescribing Improvement Program (OPIP) with the goal of reducing opioid dependency by improving opioid prescribing practices by providers who serve Medical Assistance patients.²¹⁷ OPIP requires DHS and the Minnesota Department of Health to establish a work group to recommend prescribing protocols for all phases of the prescribing cycle and to develop sentinel measures and educational resources for providers to discuss opioids with their patients.²¹⁸ As part of OPIP, DHS is supposed to collect data measuring the prescribing patterns of the prescribers in the program and compares their patterns to those of their anonymized peers. Abnormal patterns can lead to implementation of an improvement plan and ultimately termination from the Minnesota Health Care Program. All prescribers who prescribe opioids to program enrollees are required to participate, but other prescribers may participate voluntarily.²¹⁹

“A lot of people who become dependent on these drugs didn’t do so on purpose and they did so legally.”—

Professor, Department of
Pharmaceutical Care & Health
Systems

When ordering an opioid prescription, all Minnesota practitioners, regardless of whether they are serving Medical Assistance patients, must establish that the prescription drug order was initially based on a patient examination.²²⁰ When a controlled substance is not covered, in whole or in part, by a health plan company or third-party payor, the person purchasing the drug must present valid photo identification, unless that person is known to the dispenser.²²¹

The Minnesota Board of Pharmacy has also promulgated rules to assist with recognizing and intervening in opioid addiction and preventing diversion. For example, upon receiving a prescription drug order, a pharmacist must review the patient’s medication, and verify that the patient is receiving the correct medication in the correct strength and dosage form.²²² Labels on drugs administered as controlled substances must include the phrase: “Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.”²²³ Additionally, in an effort to prevent and detect diversion through improper dispensation and theft, each pharmacy must maintain a perpetual inventory system for schedule II controlled substances.²²⁴ The Board also requires all prescriptions to be filled within one year of issuance.²²⁵

Section 5.1.c. Treatment. All substance-abuse programs licensed by DHS must provide educational information about medication-assisted treatment options.²²⁶ DHS is required by statute to establish a pilot program for treating pregnant women with substance use disorders within limits of federal funds available for such a program, and providers in DHS-licensed opioid treatment and withdrawal-management programs must provide educational information about opioids, including opioid tolerance and overdose risks.²²⁷ To reduce diversion, in addition to other requirements, patients receiving DHS-licensed treatment services who receive more than 24 milligrams of buprenorphine daily must meet face-to-face with a prescribing physician.²²⁸ Minnesota’s Medicaid program does not require preauthorization for Suboxone (buprenorphine/naloxone) film. But preauthorization is required for buprenorphine/naloxone tablets and other forms of buprenorphine like Zubsolv.²²⁹

Section 5.1.d. Prior authorizations. After hearing from a range of providers—including doctors, nurses, pharmacists, and counselors—this Office reached out to the major private third-party payors in Minnesota to determine their preauthorization practices and asked that they remove any preauthorization requirements for buprenorphine when prescribed to treat opioid dependence.²³⁰ HealthPartners and PreferredOne reported that neither required preauthorization.²³¹ Medica and Blue Cross Blue Shield of Minnesota each reported that it had preauthorization requirements, but both agreed to remove their preauthorization requirements.²³² Only UnitedHealth Group, which is not licensed as an insurer or HMO in Minnesota, refused to alter its policy of requiring preauthorization for all buprenorphine prescriptions.²³³ UnitedHealth Group is an administrator of self-insured employee health plans, and state regulation of such plans is preempted by federal law under the Employee Retirement Insurance Security Act of 1974 (“ERISA”).

Section 5.1.e. Criminal laws and drug courts. Minnesota’s criminal laws also play a role with respect to possessing and selling opioid medications and other opioids such as heroin. Minnesota lists many opioid medications specifically on drug schedules II to V, while heroin and other opioids not used for medical purposes are listed on schedule I.²³⁴ Schedule II contains many opioid painkillers including codeine, fentanyl, hydrocodone (Vicodin), and oxycodone (OxyContin), while schedule III contains narcotic drugs with certain amounts of codeine, opium, and morphine.²³⁵ Selling or unlawfully possessing opioids can range from a first- to a fifth-degree controlled substance crime.²³⁶ Provisions of Minnesota’s fifth-degree controlled substance law also address doctor-shopping by prohibiting the procurement of controlled substances through fraud, deceit, misrepresentation or subterfuge, or by using a false name.²³⁷

In 2016, the Minnesota Legislature enacted the Drug Reform Act, which revised Minnesota’s drug laws and sentencing guidelines with the intent of increasing penalties for drug dealers and kingpins and reducing penalties for individuals with addictions so they can seek treatment.²³⁸ Aggravating factors that can enhance the class of a crime include the involvement of interstate or international drug transfers, the offender’s position within a drug-distribution hierarchy, and the sale or possession of drugs in three or more counties.²³⁹ The law also reduced some classes of crimes. For example, someone with no prior drug convictions would most likely be charged with fifth-degree possession, which was reduced from a felony to a gross misdemeanor.²⁴⁰ In addition, the law focuses on providing probation and treatment for individuals with an addiction, providing that most cases involving unlawful possession of an opioid painkiller will result in a presumptively-stayed sentence for all but the most recidivistic offenders.²⁴¹ The law also appropriated funds for fiscal year 2017 to the Commissioner of Corrections to establish 70 new chemical-dependency or mental-health treatment beds and to hire two chemical-dependency release planners.²⁴²

Since 2014, the number of treatment courts in Minnesota that focus on specialties like drug addiction has increased. The Minnesota Judicial Branch reports that these courts reduce recidivism and save taxpayers money.²⁴³ As of the date of this report, 57 counties either have an established treatment court or have announced plans to establish one.²⁴⁴ Counties are largely dependent on obtaining grants from other sources to fund these initiatives.²⁴⁵

Recently, Minnesota was approved to design a program, in partnership with Wisconsin, to combat opioid production and trafficking under the federal High Intensity Drug Trafficking Areas (HIDTA) program.²⁴⁶ The HIDTA program provides resources to law enforcement agencies operating in designated drug-trafficking regions.²⁴⁷ Minnesota’s recent HIDTA designation is concentrated in Hennepin, Ramsey, Dakota, Anoka and Washington counties and along the I-35 and I-94 corridors.²⁴⁸

*“Until the night of his death, Steve had never taken an opioid that had not been prescribed to him.”—Steve Rummler
Hope Foundation*

Section 5.1.f. Access to naloxone.

Medical directors of EMTs licensed to provide basic life support may, but are not required to, authorize and allow emergency responders to carry and use naloxone.²⁴⁹ In 2014, Minnesota enacted Steve’s Law, a pair of Good Samaritan laws that allow non-medical professionals to administer naloxone and to seek medical assistance for an overdose without risking criminal prosecution for participating in drug activity. The laws also authorize a licensed health care professional to prescribe, dispense,

distribute, or administer naloxone pursuant to a standing order.²⁵⁰ Steve’s Law is named after Steve Rummler, a Minnesotan whose life as a successful financial advisor was cut short after he became addicted to prescription opioids he received for chronic pain. When his prescriptions ran out, he turned to heroin and overdosed.²⁵¹

Section 5.1.g. Disposal. Minnesota law allows the collection and disposal of controlled substances in a manner consistent with federal law and state environmental regulations and authorizes pharmacies to collect controlled substances for disposal purposes.²⁵² County law enforcement, pharmacies (including those operated by EssentiaHealth, HealthPartners, Park Nicollet, and Walgreens), and Minnesota Indian Tribe communities provide permanent disposal sites at multiple locations throughout Minnesota. A list of current drug-disposal locations in Minnesota is attached in the Appendix to this report.

Section 5.1.h. Other public awareness efforts. In response to an increase in heroin overdoses in its communities, including six in one day, Anoka County recently created a public service announcement to display in movie theaters in the county. These efforts are in conjunction with a toolkit it has made available to the public on the county’s website with information about prevention and treatment.²⁵³

Section 5.2. Other States. Other states are also reacting in varying ways and degrees to the toll of opioid abuse, including mandating use of prescription drug monitoring programs; increasing access to treatment and medication-assisted treatment; increasing access to naloxone; limiting prescribing; encouraging proper disposal of unused opioids; increasing professional continuing education about opioid abuse; and creating public outreach campaigns. Maine, Massachusetts, New York, and Wisconsin recently enacted comprehensive opioid-specific legislative packages in response to increasing opioid abuse and overdose deaths in their states.

Section 5.2.a. Other state prescription drug monitoring programs. All states, with the exception of Missouri, have some form of a prescription drug monitoring program. Not

all states mandate using the program, and those that do have varying requirements, from requiring use for all controlled-substances prescriptions to requiring use under some circumstances. For example, Maine (effective Jan. 1, 2017) and Tennessee require prescribers and dispensers to check the program when initially prescribing an opioid and then at set intervals (Maine, every 90 days; Tennessee, annually) as long as the prescription is renewed.²⁵⁴ Alaska and New Jersey require pharmacists to review their programs before dispensing.²⁵⁵ Effective April 2017, Wisconsin will mandate use and require data entry to be complete within 24 hours of issuing a prescription.²⁵⁶ The following chart summarizes states' requirements:

Circumstances Requiring Mandatory Use of State PDMPs					
State	Every Controlled Substance Prescription*	Initial Prescription or New Episode of Treatment*	Drug Seeking Suspected	Admission or Enrollment in Treatment Program	Other
Alaska	•				
Arizona					•
Arkansas					•
Connecticut	•				
Delaware			•		•
Georgia					•
Indiana		•			
Kentucky	•				
Louisiana		•			
Maine		•			
Massachusetts		•			•
Minnesota				•	
Mississippi				•	
Nevada			•		
New Hampshire		•			
New Jersey	•				
New Mexico		•			•
New York	•				
North Carolina				•	
North Dakota			•	•	•
Ohio	•				
Oklahoma	•				
Pennsylvania		•	•		•
Rhode Island		•		•	•
South Carolina					•
Tennessee		•			
Utah					•
Vermont		•			•
Virginia		•			
Washington				•	•
West Virginia		•	•	•	
Wisconsin	•				

*Exceptions exist.

Table 1. Circumstances Requiring Use of Prescription Drug Monitoring Programs. (Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.)

Like Minnesota, almost all states with prescription drug monitoring programs allow law enforcement some level of access to its database; only Nebraska and Vermont do not.²⁵⁷ In Florida, law enforcement may request indirect access to the database during active criminal investigations.²⁵⁸ Wisconsin law enforcement uploads information into the database when they encounter violations of the law concerning controlled substances.²⁵⁹

Most states with prescription drug monitoring programs share data with other states, but to varying extents. As of October 2016, 38 states engaged in some type of interstate data sharing.²⁶⁰ Minnesota shares data with 26 states.²⁶¹ Eight states are in the process of implementing a process for sharing. Only Hawaii, Oregon, and Wyoming are not engaged in, or in the process of implementing, interstate data sharing.²⁶²

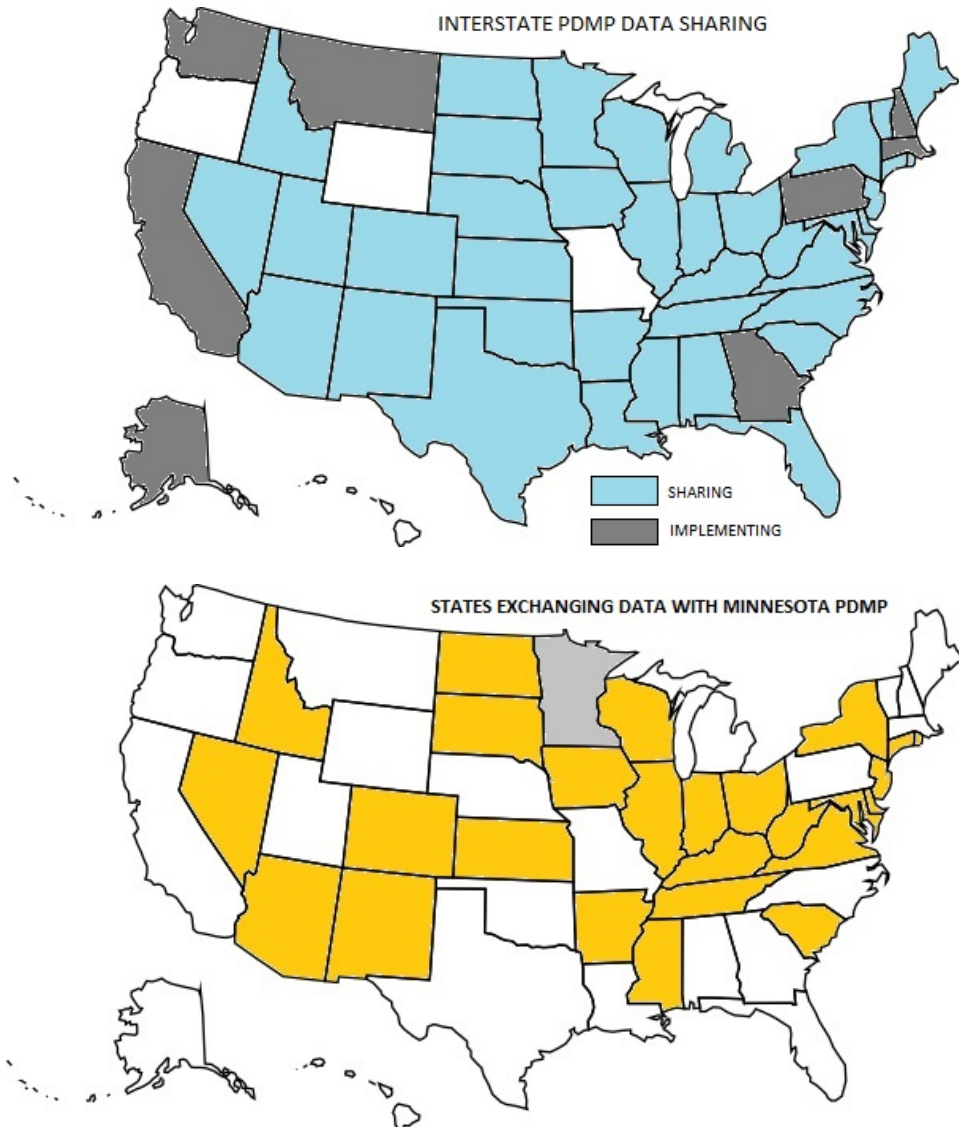


Figure 5. States sharing some PDMP data and States sharing PDMP data with Minnesota.

Section 5.2.b. Prescribing restrictions and guidelines. In recent years some states have restricted opioid prescriptions based on the length of the prescription or on daily

morphine milligram equivalents (MMEs). For example, with some exceptions (such as for cancer treatment or other palliative care), Connecticut limits opioid prescription supplies to seven-days for both minors and first-time adult outpatients, and further requires prescribers to discuss the risks of opioids with minors and their parents before prescribing; Maine prohibits opioid prescriptions exceeding 100 MMEs per day and, effective January 2017, prescriptions will generally be limited to a seven-day supply within seven days, and prescriptions for chronic pain may not exceed a 30-day supply within 30 days; Massachusetts imposes a seven-day limit on first-time opioid prescriptions for adults and on all opioid prescriptions to minors; New York limits opioid prescriptions for acute pain to a seven-day supply; and Rhode Island limits first-time opioid prescriptions to outpatients for acute pain to 30 MMEs per day and to 20 dosages.²⁶³

Other states have issued opioid-prescribing guidelines. For example, the Medical Board of California cautions prescribers to consider referring to a specialist at 80 MMEs per day; earlier this year, the Massachusetts Department of Public Health reduced its suggested limit from 240 MMEs per day to 120 MMEs per day, which had been reduced from 360 MMEs per day in 2014; the Ohio Boards of Medicine, Pharmacy, Dentistry, and Nursing jointly adopted guidelines encouraging prescribers to reevaluate pain management plans that exceed 80 MMEs; the Utah Department of Health advises prescribers to “increase clinical vigilance” at 120 to 200 MMEs per day; and Washington State’s medical directors’ group suggests referring to a specialist at 120 MMEs per day.²⁶⁴

Section 5.2.c. Access to treatment and medication-assisted treatment. The number of certified physicians authorized by the Drug Addiction Treatment Act (DATA) to provide buprenorphine as a medication-assisted treatment option varies widely by state. California has 428 physicians certified to treat up to 30 patients, compared to North Dakota having one, while Pennsylvania has 117 physicians certified to treat up to 100 patients while both North and South Dakota having none.²⁶⁵ The following table identifies the top and bottom five states relative to how many DATA-certified physicians each state has:

Number of Drug Addiction Treatment Act (DATA)-certified Physicians By State			
Top 5 States	DATA-Certified (30)	Top 5 States	DATA-Certified (100)
California	428	Pennsylvania	117
Massachusetts	296	California	107
New York	292	Florida	87
Ohio	224	Massachusetts	82
Washington	206	Ohio	80
Bottom 5 States	DATA-Certified (30)	Bottom 5 States	DATA-Certified (100)
Iowa	9	Iowa	4
Delaware	8	Hawaii / D.C.	3
Montana	7	Alaska / Kansas	2
South Dakota	5	Montana/ Wyoming	1
North Dakota	1	N Dakota / S Dakota	0

Table 2. Top and Bottom States for DATA-Certified Physicians. (Source: SAMHSA.)

Some states are beginning to prioritize removing roadblocks to treatment, especially relating to awareness of, and access to, medication-assisted treatment. For example, Massachusetts requires that patients being discharged from treatment programs receive information on FDA-approved medication-assisted therapies.²⁶⁶ New York requires hospital staff

to provide services to connect patients with treatment options.²⁶⁷ Once an individual has completed treatment in New York, they are provided multiple services, including education and employment resources, legal and social services, and assistance with transportation and childcare services.²⁶⁸ The New York State Department of Health also produced a brochure encouraging physicians to become qualified and obtain DEA authorization to treat opioid dependence.²⁶⁹

Massachusetts and New York are also removing insurance-related barriers to treatment. Massachusetts requires private insurers to pay for substance abuse evaluations without prior authorization, and New York is requiring insurers to abolish prior authorizations for inpatient treatment and for emergency supplies of medications used for treating opioid addiction.²⁷⁰

Section 5.2.d. Access to naloxone. States are expanding access to naloxone (the drug that can reverse an overdose) through standing-order prescriptions and by equipping first responders with the life-saving drug. For example, eight states (Alabama, Indiana, Maryland, New Mexico, North Carolina, Pennsylvania, Vermont, and Wisconsin) have statewide standing orders for naloxone, and a ninth (Iowa) is in the process of implementing one.²⁷¹ Standing orders allow a doctor to issue a general prescription authorizing dispersal of a medication to anyone who satisfies particular criteria without an individual prescription. Statewide standing orders in other states have generally been signed by officials in states' health departments.

In addition to state-specific efforts, as illustrated by the following table, Walgreens makes naloxone available without an individual prescription to more than 2,600 of its pharmacies in 16 states, and CVS has expanded its naloxone access program to 30 states.²⁷²

NATIONAL PHARMACY CHAINS NALOXONE STANDING ORDERS BY STATE					
STATE	CVS	WALGREENS	STATE	CVS	WALGREENS
Alabama		•	New Mexico	•	•
Arkansas	•		New York	•	•
California	•		North Carolina	•	•
Colorado	•		North Dakota	•	
Connecticut	•		Ohio	•	•
Florida	•		Oklahoma		•
Idaho	•	•	Oregon	•	
Indiana	•	•	Pennsylvania	•	•
Kentucky	•		Rhode Island	•	•
Louisiana	•		Tennessee	•	
Maryland	•	•	Texas		•
Massachusetts	•	•	Utah	•	
Minnesota	•		Vermont	•	
Mississippi	•		Virginia	•	
Montana	•		Washington	•	•
New Hampshire	•		Wisconsin	•	•
New Jersey	•	•			

Table 3. National Pharmacy Standing Orders for Naloxone. (Sources: CVS and Walgreens.)

Massachusetts recently authorized law enforcement to establish a training course on drug-related overdoses.²⁷³ Similarly, Wisconsin provides training opportunities for all first responders to administer naloxone.²⁷⁴

Similar to the Minnesota laws discussed in Section 5.1.f., to encourage the use and administration of naloxone, most states have immunity and Good Samaritan laws that limit the liability of a person who administers naloxone in emergency situations and limit exposure to criminal charges for people who seek assistance from law enforcement or medical professionals for another person who has overdosed.²⁷⁵

Section 5.2.e. Disposal. Many states take part in DEA National Take Back Days and hold their own take back events and work with local law enforcement to provide permanent disposal sites. Both CVS and Walgreens have implemented disposal programs. Walgreens has installed disposal kiosks at 288 of its pharmacies throughout 21 states, and CVS has donated more than 600 drug collection containers to law enforcement agencies in 42 states.²⁷⁶

Section 5.2.f. Continuing education. Because most physicians receive little training in medical school regarding pain management and substance abuse disorders, some states are beginning to look for ways to fill these gaps with continuing medical education (CME) requirements specifically focused on controlled substance prescribing.²⁷⁷ Forty-six states and the District of Columbia have general CME requirements for licensed physicians.²⁷⁸ Until recently, however, only eight states (Delaware, Kentucky, Massachusetts, Mississippi, New Mexico, Utah, Vermont, and West Virginia) required all physicians licensed to prescribe or dispense controlled substances to obtain CME hours on the topics of controlled substance prescribing, pain management, or substance abuse disorders.²⁷⁹ In 2016, both Maine and New York added opioid-specific CME requirements, bringing the total number of states to 10.²⁸⁰

Section 5.2.g. Public awareness. Some states have implemented programs to educate the public about the risks associated with opioid abuse. For example, New York requires pharmacists to include educational materials with prescriptions that include information about addiction risks, local treatment services, and proper disposal.²⁸¹ Massachusetts requires that information on opiate use and misuse be distributed at annual head-injury safety programs for high school athletes, that public schools educate students about substance abuse prevention, and that all driver-education programs address addiction.²⁸² Some states have also developed public awareness and outreach campaigns. Indiana, Montana, and Massachusetts, for example, have launched public service campaigns.²⁸³

SECTION 6. BARRIERS TO AND RECOMMENDATIONS FOR ADDRESSING OPIOID ABUSE.

While strides have been made at the federal and state levels in recent years to combat the opioid crisis, gaps in the law remain, and further reforms are needed. Outlined below is a list of some of the areas where further action should be discussed. Not all goals are achievable at the state level. In some cases, Congress should act. And, in others, a cultural shift in how prescription drugs are prescribed and how addiction is treated is necessary.

Reforms will not come easily. Across the country, efforts to tackle factors contributing to the opioid crisis have been met with opposition from the pharmaceutical industry, which devotes significant resources to preventing reform.²⁸⁴ A joint investigation by the Associated Press and the Center for Public Integrity found that, between 2006 and 2015, the pharmaceutical industry and its supporters spent more than \$880 million on lobbying and campaign contributions to oppose stricter regulations.²⁸⁵ This was more than 200 times the amount spent by those seeking reforms.²⁸⁶

Section 6.1. The Legislature Should

Require Health Care Professionals to Use the Prescription Drug Monitoring Program.

Minnesota has a prescription drug monitoring program established in Minn. Stat. § 152.126, but its utility is limited by the program's voluntary nature. Most pharmacies must report to the Minnesota Board of Pharmacy information on controlled substances they dispense each day.²⁸⁷ Neither prescribers nor dispensers are required to check the database before prescribing or dispensing controlled substances. Under current law, the only time they must check the database before issuing or filling a prescription is when they prescribe controlled substances to clients in DHS-licensed opioid-addiction programs.²⁸⁸ Although prescribers and dispensers must *register*

“People are going to doctors, getting scripts, and selling them on the street to survive.”—Jeff, patient in opioid treatment program

for the prescription drug monitoring program beginning in July 2017, they may still prescribe and dispense opioids without verifying the patient's prescription drug history in the database. Data-sharing programs that are meant to prevent doctor-shopping are less effective when prescribers and dispensers do not check them. Research indicates that mandated use of a prescription drug monitoring program is effective in reducing opioid prescriptions.²⁸⁹

“I couldn't save my own son. . . . We are not equipped to handle this epidemic, and thousands of kids need help. . . . [S]omeone needs to help now, [w]e are losing our future generation daily!”—Jennifer, Minnesota mother whose 19-year old son died from a heroin overdose

“The makers of prescription painkillers have adopted a 50-state strategy that includes hundreds of lobbyists and millions in campaign contributions to help kill or weaken measures aimed at stemming the tide of prescription opioids. . . .”—Associated Press and Center for Public Integrity

In some cases, the DEA may revoke a provider's registration to prescribe controlled substances or a health-related licensing board may impose discipline that restricts a provider's

authority to prescribe controlled substances. It appears that this information may not always be readily available to a dispenser, and the information does not appear in the state's prescription drug monitoring program.

Recommendations:

- The Minnesota Legislature should require prescribers and dispensers to review a patient's history in Minnesota's prescription drug monitoring database before prescribing or dispensing controlled substances.
- The Legislature should require prescribers and dispensers to maintain contemporaneous documentation that they checked the program before prescribing or dispensing a controlled substance.
- As an additional safeguard against dispensing unauthorized prescriptions issued by providers who have lost authority to prescribe controlled substances, either because of a DEA or licensing-board restriction, the Legislature should amend Minn. Stat. § 152.126 to require the prescription drug monitoring program to contain a field with information about any restrictions on a prescriber's authority to prescribe controlled substances. This presumably will require the Minnesota Board of Pharmacy to coordinate with the DEA and health-related licensing boards to periodically determine the status of the ability of Minnesota providers to prescribe controlled substances so the information can be included in the database.
- Current law imposes significant restrictions on access to the prescription drug monitoring program database.²⁹⁰ These restrictions may impede the ability of appropriate state boards and agencies to study the data and to proactively identify overprescribing patterns, fraudulent billing of state Medicaid programs, and geographical or demographical areas of concern. The Legislature should consider amending Minn. Stat. § 152.126 to allow the Board of Pharmacy and other appropriate government agencies to access the prescription drug monitoring program's data when they have a legitimate government purpose for accessing the data.

To make prescription drug monitoring programs most effective, all states should be required to share program data. Bills have been introduced in Congress to require all states that have a prescription drug monitoring program to share data, but thus far these measures have not been enacted.

Section 6.2. Continuing Education Requirements Should Address the Risks Associated with Prescription Opioids. Minnesota doctors currently must complete 75 hours of continuing education every three years, dentists must complete 50 hours every two years, and pharmacists must complete 30 hours every two years.²⁹¹ The Board of Medical Practice does not require any specific coursework.²⁹² The Board of Dentistry requires dentists to take two credits in certain “core” subjects, but requires no coursework specific to prescription.²⁹³ Similarly, pharmacists are generally directed to include courses geared toward the “properties and actions of drugs and drug dosage forms,” but are not required to take coursework specifically addressing the risks of prescription opioids.²⁹⁴

Recommendation:

- The Legislature should require opioid prescribers and dispensers—including doctors, dentists, and pharmacists—to take at least two hours of periodic continuing education that addresses proper pain management, the risks associated with prescription opioids, and current evidence-based practices of prescribing and dispensing prescription opioids and identifying opioid use disorder and opioid dependence. Given the established addictive nature of opioids and the role of prescription opioids in the opioid crisis, it is imperative that those involved in prescribing and dispensing these drugs remain up to date on current research and best prescribing and dispensing practices.

Section 6.3. Pharmacists Should Provide Clear and Conspicuous Information About the Proper Use and Disposal of Prescription Opioids.

State law currently requires prescription containers to be labeled with directions for use.²⁹⁵ One of the problems with prescription opioids is that consumers may assume they are safe because a doctor prescribed them. While an opioid painkiller may be appropriate for an individual’s circumstances, no one should be lulled into a sense of safety simply because the medication was legitimately prescribed. The Board of Pharmacy currently requires pharmacists to warn that controlled substances may impair driving abilities and that federal law prohibits transferring the drugs.²⁹⁶ No law, however, requires dispensers to warn of the risks of addiction or to provide information on how to safely dispose of unneeded medications.

“The drug is so physically addicting that I equate it with the devil because it’s that evil of a drug. It steals your values, your morals, your family, and your self-esteem and you become a shell of your yourself.”—PJ, mother of daughter with opioid addiction

Recommendations:

- When opioid prescriptions are filled, the Legislature should require pharmacists to provide clear and conspicuous notice about the risks of opioid abuse and addiction. This information need not be specifically provided on the medication label, but should be provided contemporaneously with the prescription.

- Similarly, greater awareness is needed about how Minnesotans can safely dispose of prescription medications that are no longer needed. The Legislature should require pharmacists to provide information about the proper disposal of prescription medications. Providing this information will aid in increasing awareness about the addictive nature of opioids and the importance of disposing of unneeded medications.
- The Legislature should direct the Board of Pharmacy to develop concise, plain-language materials that dispensers can distribute to comply with these obligations.

Section 6.4. The Minnesota Department of Health Should Issue a Statewide Standing Order for Naloxone. Naloxone, commonly known as Narcan, is an opiate antagonist that can safely reverse an overdose. State law already provides authority for the issuance of “standing orders,” which allow a doctor to issue a general prescription authorizing dispersal of a medication to anyone who satisfies particular criteria without requiring an individual prescription for a particular patient.²⁹⁷ State health officials in at least eight other states have issued standing orders for naloxone. No evidence suggests that access to naloxone increases the prevalence or frequency of opioid use.²⁹⁸

Recommendation:

- A qualified staff member of the Minnesota Department of Health should issue a statewide standing order for naloxone. Given the indisputable effectiveness of naloxone in curbing the death toll associated with the opioid epidemic, the State should take this important step to increase access to this life-saving medication.

Section 6.5. Pharmacists Should be Required to Fill Prescriptions Under Standing Orders Authorizing Them to Dispense Opiate Antagonists. Minnesota law permits pharmacists to dispense medications pursuant to standing orders or other treatment protocol agreements.²⁹⁹ It has been a growing practice to use these tools to authorize pharmacists to dispense naloxone. This Office has nonetheless heard from providers that some pharmacists remain reluctant to dispense naloxone even when a standing order or other prescribing protocol is in place.

Recommendation:

- The Legislature should amend Minn. Stat. § 151.34 to prohibit pharmacists from refusing to dispense an opiate antagonist for which a standing order or other prescribing protocol is in place and the prescribing criteria are satisfied.

Section 6.6. Law Enforcement Agencies and Retail Pharmacies Should Maintain Collection Boxes for Proper Drug Disposal. Proper and timely destruction of prescription medications lowers the risk of those drugs being abused or diverted. As reflected in the Appendix to this report, a couple of counties have no collection boxes and some have only a handful.

Recommendations:

- The Legislature should require each county's law enforcement agency to maintain at least one collection receptacle for controlled-substance drug disposal as allowed by federal law.
- The Legislature should also require retail pharmacies and on-site pharmacies at clinics and hospitals to register as authorized collectors under federal law and to maintain collection receptacles for controlled substances.

Section 6.7. The Time for Filling Opioid Prescriptions Should be Shortened.

Currently, the State's rules provide that a prescription for a controlled substance remains valid for one year.³⁰⁰ Allowing unfilled prescriptions to remain active increases the risk of the prescription being abused or diverted.

Recommendation:

- The Legislature should shorten the timeframe for filling a prescription opioid to 30 days. If an opioid is legitimately prescribed for current pain, presumably the prescription should be filled quickly to address that pain. Shortening the timeframe for filling a prescription would decrease the amount of time a prescription drug can be diverted or abused.

Section 6.8. Minnesota's Medicaid Program Should Eliminate Unnecessary Preauthorization Requirements. As previously discussed, the effects of opioid withdrawal are severe. Any delay in obtaining medications meant to treat opioid dependence increases the chances that the person will instead turn to more painkillers or heroin to fill the void, thereby increasing the risk of a fatal overdose. Buprenorphine and buprenorphine/naloxone (e.g., Suboxone) are the common medications prescribed to assist in treating opioid dependence, and they have been effective. As noted, this Office has received assurances or commitments from Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, and PreferredOne that they either do not or will not impose preauthorization requirements for buprenorphine. Nationally, Cigna also recently agreed to end preauthorization requirements.³⁰¹ Minnesota's Medicaid program requires preauthorization for all forms of buprenorphine except Suboxone film.³⁰²

Recommendation:

- The Legislature should eliminate preauthorization requirements in the Medical Assistance Program for medications containing buprenorphine that are prescribed to treat opioid dependence.

A White House task force recently reminded insurers of their legal obligation to treat drug addiction the same way as other medical conditions, specifically noting that an insurer cannot require prior authorization for buprenorphine if the insurer does not impose similar restrictions on medications prescribed for physical illnesses.³⁰³ Federal law requires parity in these circumstances, but the law is still limited in that preauthorization is prohibited only when the insurer does not impose a similar requirement for treating other conditions. While the State's authority is limited by the federal Employee Retirement Income Security Act of 1974 (ERISA) with respect to the administration of self-funded insurance plans, Congress should eliminate

unnecessary preauthorization requirements in self-funded plans that may delay access to important medications to treat opioid addiction.

Section 6.9. First-Responders and Emergency Medical Technicians Should Carry Naloxone. State law permits an EMT’s medical director to authorize the use of intravenous infusion, including opiate antagonists.³⁰⁴ Naloxone is a proven life-saving tool for reversing opioid overdoses and recent FDA approvals have made it even easier to administer, no longer requiring an injection. Costs can be an impediment to accessing naloxone, both for first responders and for individuals. The cost of naloxone can range from \$20 to \$40 per dose.³⁰⁵ The cost of naloxone has been increasing in recent years, prompting Congress to question drug makers on the pricing.³⁰⁶

Recommendations:

- As an additional tool in fighting the opioid epidemic, the Legislature should require Minnesota’s first responders and EMTs to carry naloxone and receive training on how to administer it.
- If cost is an impediment, the Legislature should consider funding sources to reimburse local governments for the costs of purchasing naloxone.
- The Legislature should also consider funding sources that can assist low-income patients who are not in government health insurance programs to access this life-saving drug.

Section 6.10. The Legislature Should Take Further Measures to Address Overprescribing. One of the contributing factors to the opioid crisis is overprescribers, or so-called “pill mills,” in which doctors irresponsibly and continuously prescribe high quantities and dosages of opioids in a manner that is not medically appropriate. There are impediments in current law that make it difficult to preemptively identify these providers. For example, the current system often relies on a licensing board to receive a complaint about an inappropriate prescriber, but patients who are drug-addicted typically don’t file such complaints. Even when the boards receive a complaint, they often must engage in lengthy proceedings requiring a “battle of the experts” to determine whether the provider inappropriately prescribed medication.

“The only time I touched heroin was whenever I couldn’t find pills. There were times where I did it for a couple days at a time until I found pills, then I would just do the pills. If you were doing painkillers, you’d never be thinking, ‘I’m going to be shoving a needle in my arm.’”—Kevin, Patient in opioid treatment program

In 2015, the Minnesota Legislature directed the creation of the Opioid Prescribing Improvement Program (OPIP), under which DHS is instructed to collect data measuring opioid prescribing patterns, compare prescribers to their anonymized peers, and share abnormal patterns with prescribers. While the Legislature mandated participation by prescribers who prescribe

opioids to *Minnesota Health Care Program* (e.g., Medical Assistance and MinnesotaCare) enrollees, it gave other prescribers the option to voluntarily participate.

Recommendations:

- The Legislature should require all opioid prescribers to participate in the OPIP, regardless of the entity from which the patient receives health coverage. Most doctors treat all patients, including those enrolled in the Minnesota Health Care Program. Some providers, however, do not treat Medical Assistance or MinnesotaCare patients or only accept cash payments. For example, the Kaiser Family Foundation reported that many dentists do not accept insurance and that many who accept insurance do not accept Medical Assistance.³⁰⁷ Requiring prescribers of controlled substances to participate in the OPIP for monitoring purposes will provide all opioid prescribers an opportunity to align their prescribing practices with community standards.
- In its recent legislative report on the OPIP, the Opioid Prescribing Work Group reported that the Minnesota Department of Human Services is about two years away from having a working program.³⁰⁸ It would be helpful for the detection of improper prescribing patterns for the program to be implemented as expeditiously as possible. In designing the OPIP's monitoring program, the Work Group should be cognizant of maintaining patient privacy and design the program to collect data in a way that detects improper prescribing patterns but does not compromise the privacy of patient data.
- As set forth in Section 6.1, allowing appropriate government agencies to access the prescription drug monitoring program database to identify overprescribing patterns would also help in the detection of so-called "pill mill" physicians.
- As noted in Section 5.2.b, a number of states have imposed guidelines for the length and/or the strength of opioid prescriptions. The State should give consideration to adopting such guidelines.

Section 6.11. The Legislature Should Be Responsive to the Judicial Branch's Need for Resources for Drug-Related Cases in the Criminal Justice System. While drug and specialty treatment courts are new in Minnesota, they have shown success. It appears that these specialty courts generally form on a county-by-county basis and that counties are dependent on grants to establish and maintain the courts.

Recommendation:

- The Office defers to the Judicial Branch to determine its needs, but recommends that the Legislature be responsive to its requests for resources to better address drug addiction within the criminal justice system, including through the expansion of drug courts.

Section 6.12. Access to Treatment Needs to Expand, Particularly in Rural Areas.

The opioid crisis reaches all corners of the state, but few doctors in Minnesota are authorized to prescribe buprenorphine and most treatment resources are concentrated in the Twin Cities metropolitan area. For example, of the 122 physicians that SAMHSA identifies as authorized to prescribe buprenorphine in Minnesota, more than one-third are in Hennepin County, and about 64% are in the seven-county metropolitan area.³⁰⁹ Treatment not only aids individuals, it saves money in the long run by reducing health-care and criminal-justice costs.

“I don’t know what to do, I don’t have a place to live, I don’t have a job, I don’t have any money, I don’t have insurance. If you send me out of here I’m going to go to a bridge and jump off.”—Kevin, describing an emergency-room visit

Recommendation:

- The Legislature should review options for expanding treatment resources in greater Minnesota.

“We want people to know that this can happen to anyone. Nobody is immune.”
—Rosemary, mother whose 21-year-old daughter died of an opioid overdose

“I will never let his death be for nothing, there are so many things that need [to] change.”—Jennifer

¹ Nat'l Ctr. for Health Stat., U.S. Dep't of Health & Hum. Servs., *Number and Age-Adjusted Rates of Drug-Poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999-2014*, http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf (last visited Nov. 21, 2016).

² *Id.*

³ Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Hum. Servs., *Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008*, 60 MORBIDITY & MORTALITY WKLY. REP. 1487, 1487 (2011); Nat'l Ctr. for Health Stat., *supra* note 1.

⁴ Nat'l Institute on Drug Abuse, *Drug Facts: Prescription and Over-the-Counter Medications*, <https://www.drugabuse.gov/publications/drugfacts/prescription-over-counter-medications> (last visited Nov. 21, 2016).

⁵ Theodore Cicero et al., *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA PSYCHIATRY 821, 825 (2014); Pradip Muhuri et al., Substance Abuse & Mental Health Servs. Admin, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CBHSQ DATA REVIEW (Aug. 2013), <http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm> (last visited Nov. 9, 2016).

⁶ Michael J. Brownstein, *A Brief History of Opiates, Opioid Peptides, and Opioid Receptors*, 90 PROC. NAT'L ACAD. SCI. 5391, 5391 (1993); Andrew Rosenblum et al., *Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions 2* (Nat'l Inst. Health author manuscript 2009), published in 16 EXPERIMENTAL & CLINICAL PSYCHOPHARMACOLOGY 405 (2008).

⁷ Brownstein, *supra* note 6, at 5391; Rosenblum et al., *supra* note 6, at 2.

⁸ Rosenblum et al., *supra* note 6, at 3.

⁹ *Id.*

¹⁰ Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—Misconceptions and Mitigation Strategies*, 374 NEW ENG. J. MED. 1253, 1254 (2016).

¹¹ *Id.*

¹² *Prescriptions: Question & Answers*, DRUG ENFORCEMENT ADMIN., <https://www.deadiversion.usdoj.gov/faq/prescriptions.htm> (last visited Nov. 6, 2016).

¹³ DRUG ENFORCEMENT ADMIN., U.S. DEP'T OF JUSTICE, *Practitioner's Manual: An Informational Outline of the Controlled Substances Act* 7, 48-51 (2006).

¹⁴ Rosenblum et al., *supra* note 6, at 2.

¹⁵ Harriet Ryan et al., *OxyContin's 12-Hour Problem*, L.A. TIMES, May 5, 2016, at 1.

¹⁶ Sonia Moghe, *Opioid History: From "Wonder Drug" to Abuse Epidemic*, CNN (Oct. 14, 2016, 6:41 a.m.), <http://www.cnn.com/2016/05/12/health/opioid-addiction-history/> (last visited Nov. 6, 2016).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 221-23 (2009).

²⁰ Ryan et al., *supra* note 15.

²¹ Van Zee, *supra* note 19, at 223.

²² Ryan et al., *supra* note 15.

²³ *Id.*

²⁴ Ctrs. for Disease Control & Prevention, *supra* note 3, at 1487.

²⁵ Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Hum. Servs., *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016*, 65 MORBIDITY & MORTALITY WKLY. REP. 1, 1 (2016).

²⁶ Brian D. Sites et al., *Increases in Use of Prescription Opioid Analgesics and the Lack of Improvement in Disability Metrics Among Users 5* (Nat'l Inst. Health author manuscript 2015), *published in* 39 REGIONAL ANESTHESIA & PAIN MED. 6 (2014).

²⁷ Ctrs. for Disease Control & Prevention, *supra* note 25, at 1.

²⁸ Nat'l Council on Alcoholism & Drug Dependence, Inc., *AMA Drops Pain as Vital Sign* (June 30, 2016), <https://www.ncadd.org/blogs/in-the-news/ama-drops-pain-as-vital-sign> (last visited Nov. 6, 2016).

²⁹ JOHN HOPKINS BLOOMBERG SCH. OF PUB. HEALTH, *The Prescription Opioid Epidemic: An Evidence-Based Approach* 36 (2015).

³⁰ *Id.*; *see also* Sean Esteban McCabe et al., *Motives, Diversion, and Routes of Administration Associated with Nonmedical Use of Prescription Opioids 5* (Nat'l Inst. Health author manuscript 2007), *published in* 32 ADDICTIVE BEHAV. 562 (2007).

³¹ Christopher M. Jones et al., *Research Letter*, 174 JAMA INTERNAL MED. 802, 802-03 (2014).

³² Volkow & McLellan, *supra* note 10, at 1253.

³³ Ryan et al., *supra* note 15.

³⁴ Van Zee, *supra* note 19, at 223; Ryan et al., *supra* note 10.

³⁵ Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, 1 SCI. & PRAC. PERSP. 13, 14 (2002).

³⁶ *Id.*

³⁷ Courtland Milloy, *Addiction as Brain Disorder*, WASH. POST, Dec. 15, 2015, at B1.

³⁸ Kosten & George, *supra* note 35, at 14.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* at 15.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.* at 14.

⁴⁵ *Id.* at 15.

⁴⁶ *Id.*

⁴⁷ *Id.*

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²⁹⁷ MINN. STAT. § 151.37, subd. 2(a) (2016).

²⁹⁸ OFF. OF THE SURGEON GEN., *supra* note 49, at 4-12.

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APPENDIX

Drug Disposal Locations in Minnesota by County¹

Anoka County

Anoka County Sheriff's Office // 13301 Hanson Blvd. NE, Andover, MN 55304
Blaine Human Services Center // 1201 89th Ave NE, Blaine, Minnesota 55434
Blaine Police Department // 10801 Town Square Drive NE, Blaine, MN 55449
Centennial Lakes Police Department // 54 North Road, Circle Pines, MN 55014
Columbia Heights Police Department // 825 41st Avenue NE, Columbia Heights, MN 55421
Fridley Police Department // 6431 University Avenue NE, Fridley, MN 55432
Lino Lakes Police Department // 640 Town Center Pkwy, Lino Lakes, MN 55014
Ramsey Police Department // 7550 Sunwood Drive NW, Ramsey, MN 55303
Spring Lake Park Police Department // 1301 81st Avenue NE, Spring Lake Park, MN 55432
St. Francis Police Department // 4058 St. Francis Blvd. NW, St. Francis, MN 55070
Walgreens Pharmacy // 10686 University Ave NW, Coon Rapids, MN

Becker County

Becker County Sheriff's Department // 925 Lake Ave, Detroit Lakes MN 56501
City Of Becker // 12060 Sherburne Ave, Becker, MN, 55308-469
Essentia Health DL Pharmacy // 211 Frazee St E., Detroit Lakes, MN 56501

Beltrami County

Paul Bunyan Drug Task Force // Law Enforcement Center, 613 Minnesota Ave NW, Bemidji, MN

Benton County

Benton County Sheriff's Department // 581 Hwy 23, Foley, MN
City of Rice // 205 Main St E, Rice, MN, 56367-4522
Sauk Rapids Police Department // 250 Summit Ave N, Sauk Rapids, Minnesota 56379

Big Stone County

Sauk Rapids Police Department // Sauk Rapids Government Center, 250 Summit Ave. N, Sauk Rapids, MN

Blue Earth County

Blue Earth County Justice Center // 401 Carver Road, Mankato, MN
Mankato Public Safety Center // 710 S Front St, Mankato, Minnesota 56001
Walgreen Co // 1270 Madison Avenue, Mankato, MN 56001

Brown County

New Ulm Police // 15 S Washington, New Ulm, Minnesota 56073
Sleepy Eye Police Department // 130 2nd Ave NW, Sleepy Eye, Minnesota 56085
Springfield Police Department // 16 N Marshall Ave, Springfield, Minnesota 56087

¹ Information in this appendix was taken from the DEA's searchable online database at <https://apps.deadiversion.usdoj.gov/pubdispsearch/>. The Minnesota Pollution Control Agency also has a searchable list of drug-disposal locations at <https://www.pca.state.mn.us/living-green/managing-unwanted-medications>.

Carlton County

Carlton County Sheriff's Department // 317 Walnut Avenue, Carlton, MN 55718
Cloquet Police Department // 508 Cloquet Ave, Cloquet, Minnesota 55720
Moose Lake Police Department // 600 Highway 73, Moose Lake, MN 55767

Carver County

Carver County Sheriff's Office // 606 E 4th Street, Chaska, MN 55318
Chanhassen City Hall // 7700 Market Blvd, Chanhassen, MN 55317
Waconia City Hall // 201 Vine Street S, Waconia, MN 55387

Cass County

Cass County Sheriff's Department // 300 Minnesota Ave W, Walker, MN 56484
Cass County Sheriff's Department // 330 Second St NW, Cass Lake, Minnesota 56633
Pine River Police Department // 200 Front St, Pine River, Minnesota 56474

Chippewa County

Montevideo Police Department // 103 Canton Ave, Montevideo, Minnesota 56265

Chisago County

Chisago County Sheriff's Department // 313 N Main St, Rm 100, Center City, Minnesota 55012
Chisago County Sheriff's Department // 325 S Eliot, Rush City, Minnesota 55069
North Branch Police Department // 6408 Elm St, North Branch, Minnesota 55056

Clay County

Barnesville Police Department // 101 Front St S, Barnesville, Minnesota 56514
Dilworth Police Department // 500 Center Ave W, Dilworth, Minnesota 56529
Glyndon Police Department // 218 Parke Ave S, Glyndon, Minnesota 56547
Hawley Police Department // 319 8th St, Hawley, Minnesota 56549
Moorhead Police Department // 915 9th Ave N, Moorhead, Minnesota 56560

Clearwater County

Clearwater County Sheriff's Department // 213 Main Ave N, Dept 102, Bagley, Minnesota 56611

Cook County

Cook County Law Enforcement // 143 Gunflint Trail, Grand Marais, Minnesota 55604

Cottonwood County

Cottonwood County Sheriff's Department // 902 5th Ave, Windom, Minnesota 56101
Sterling Long Term Care Pharmacy #32 // 607 10th Street, Worthington, MN 56187

Crow Wing County

Breezy Point Police Department // 8361 Co Rd 11, Breezy Point, Minnesota 56472
City of Nisswa // 5442 City Hall St, Nisswa, MN, 56468-2478
City of Pequot Lakes // 4638 County Road 11, Pequot Lakes, MN, 56472-3385
Crosby Police Department // 2 2nd St SW, Crosby, Minnesota 56441
Crow Wing County Sheriff's Department // 304 Laurel St, Brainerd, Minnesota 56401
Essentia Health Brainerd Pharmacy // 2024 S. 6th Street, Brainerd, MN 56401
Essentia Health Baxter Pharmacy // 13060 Isle Dr., Baxter, MN 56425

Dakota County

Apple Valley Police Department // 7100 147th St. W., Apple Valley, MN
Burnsville Police Department // 100 Civic Center Pkwy., Burnsville, MN
Dakota County Law Enforcement Center (Hastings) // 1580 Highway 55, Hastings, MN
Eagan Police Department // 3830 Pilot Knob Rd., Eagan, MN

Farmington Police Department // 19500 Municipal Drive, Farmington, MN
Farmington Police Department // 3830 Pilot Knob Rd, Eagan, Minnesota 55122
Inver Grove Heights Police Department // 8150 Barbara Ave., Inver Grove Heights, MN
Lakeville Police Department // 9237 183rd St. W., Lakeville, MN
Mendota Heights Police Department // 1101 Victoria Curve, Mendota Heights, MN
Rosemount Police Department // 2875 145th St. W., Rosemount, MN
South St. Paul Police Department // 125 Third Ave. N., South St. Paul, MN
Walgreens Pharmacy // 15250 Cedar Ave, Apple Valley, MN
West St. Paul Police Department // 1616 Humboldt Ave., West St. Paul, MN

Dodge County

Dodge County Sheriff's Office // 22 East 6th Street, Mantorville, MN
Kasson Police Department // 19 E Main Street, Kasson, MN

Douglas County

Alexandria Police Department // 501 3rd Ave W, Alexandria, Minnesota 56308
City of Brandon // 115 E Front St, Brandon, MN, 56315-4502
Pope and Douglas Solid Waste Management (PDSWM) // 2115 Jefferson St, Alexandria, MN, 56308

Faribault County

Faribault County Sheriff's Department // 320 Dr. H. Russ Street, Blue Earth, MN 56013
Wells Police Department // 125 South Broadway, Wells, MN 56097

Fillmore County

Fillmore County Detention Center // 901 Houston Street NW, Preston, MN 55965

Freeborn County

Freeborn Law Enforcement Center // 411 S Broadway, Albert Lea, Minnesota 56007
Curt's Long Term Care Pharmacy // 1615 W Main St, Suite B, Albert Lea, MN 56007

Goodhue County

Cannon Falls Police Department // 918 River Road, Cannon Falls, Minnesota 55009
City of Kenyon // 709 2nd Street, Kenyon, MN, 55946-1339
Goodhue Law Enforcement Center // 430 W 6th St, Red Wing, Minnesota 55066
Goodhue County Sheriff's Department // 401 Main Street, Wanamingo, Minnesota 55983
Goodhue County Sheriff's Department // 430 West 6th Street, Red Wing, Minnesota 55066
Wanamingo City // 401 Main St, Wanamingo, Minnesota 55983
Zumbrota Police Department // 50 West Second Street, Zumbrota, Minnesota 55992

Grant County

Grant County Sheriff's Department // 10 2nd St. NE, Elbow Lake, MN 56531

Hennepin County

Eden Prairie City Center (free medication disposal bags) // 8080 Mitchell Road, Eden Prairie, MN 55344
Golden Valley Police Department // 7800 Golden Valley Rd, Golden Valley, MN 55427
HealthPartners Bloomington Clinic // 8600 Nicollet Ave S, Bloomington, MN 55420-2855
HealthPartners Brooklyn Center Clinic // 6845 Lee Ave N, Brooklyn Center, MN 55429
HealthPartners Riverside Clinic // 2220 Riverside Ave, Minneapolis, MN 55454
HealthPartners West Clinic // 5100 Gamble Drive, Ste 100, St. Louis Park, MN 55416
Hennepin County District Court Brookdale // 6125 Shingle Creek Pkwy, Brooklyn Center, MN 55430
Hennepin County District Court Ridgedale // 12601 Ridgedale Drive, Minnetonka, MN 55305
Hennepin County Library –Southdale // 7001 York Ave. S., Edina, MN 55435
Hennepin County Public Safety Facility // 401 4th Ave. S., Minneapolis, MN 55415
Hennepin County Sheriff's Department // 9401 83rd Ave. N., Brooklyn Park, MN 55445

Maple Grove Police Department // 12800 Arbor Lakes Parkway N, Maple Grove, MN 55369
Osseo Police Department // 415 Central Ave., Osseo, MN 55369
Park Nicollet Clinic-Bloomington // 5320 Hyland Greens Drive, Bloomington, MN 55437
Park Nicollet Brookdale // 6000 Earle Brown Drive, Brooklyn Center, MN 55430
Park Nicollet Clinic-Maple Grove // 9555 Upland Lane N, Maple Grove, MN 55369
Park Nicollet-Minneapolis // 2001 Blaisdell Ave S // Minneapolis, MN 55404
Park Nicollet-Minnetonka // 15111 Twelve Oaks Center Dr, Minnetonka, MN 55305
Park Nicollet- Meadowbrook // 3931 Louisiana Ave S, St. Louis Park, MN 55426
Park Nicollet Clinic-St. Louis Park // 3800, 3850 and 3900 Park Nicollet Blvd, St. Louis Park, MN 55416
Park Nicollet Clinic-Wayzata // 250 Central Ave. N, Wayzata, MN 55391
Rogers Police Department // 21860 Industrial Court, Rogers, MN 55374
St. Louis Park Nicollet Methodist Hospital // 6500 Excelsior Blvd, St. Louis Park, MN 55426
Walgreens Pharmacy // 7700 Brooklyn Blvd, Brooklyn Park, MN
Walgreens Pharmacy // 540 Lake Rd N, Hopkins, MN
Walgreens Pharmacy // 4547 Hiawatha Ave, Minneapolis, MN

Houston County

Houston County Sheriff's Department // 306 S Marshall Street, Caledonia, MN 55921

Hubbard County

Hubbard County Sheriff's Department // 301 Court Ave, Park Rapids, MN 56470

Isanti County

Isanti County Sheriff's Department // 509 18th Avenue SW, Cambridge, MN 55008

Itasca County

Grand Itasca Pharmacy // 1601 Golf Course Road, Grand Rapids, MN 55744
Itasca County Sheriff's Department // 440 1st. Ave. NE, Grand Rapids MN 55744

Jackson County

Jackson County Sheriff's Department // 400 Sherman St, Jackson, MN 56143

Kanabec County

Kanabec County Jail // 100 South Vine, Mora, MN

Kandiyohi County

Kandiyohi County Sheriff's Department // 2201 23rd St. NE, Willmar, MN 55051

Kittson County

None listed

Koochiching County

Essentia Health International Falls Pharmacy // 2501 Keenan Drive, Suite A, International Falls, MN 56649
Koochiching County Law Enforcement Center // 715 4th Street, International Falls, MN 56649

Lac qui Parle County

Lac Qui Parle County Sheriff's Department // 600 6th Street, Madison, Minnesota, 56256

Lake County

Essentia Health Silver Bay Pharmacy // 99 Edison Blvd, Suite L, Silver Bay, MN 55614
Essentia Health Two Harbors Pharmacy // 802 11th Street Suite C, Two Harbors, MN 55616
Lake County Sheriff 's Department // 7 Davis Drive, Silver Bay, Minnesota 55614
Lake County Sheriff 's Department // 613 3rd Ave, Two Harbors, Minnesota 55616

Lake of the Woods County

Lake of the Woods County Law Enforcement Center // 206 8th Ave SE, Suite #300, Baudette, MN 56623

Le Sueur County

Le Sueur County Sheriff's Department // 130 South Park Avenue, Le Center, MN 56057

Lincoln County

None listed.

Lyon County

Lyon County Law Enforcement Center // 611 West Main Street, Marshall, MN 56258

Mahnomen County

Mahnomen County Sheriff's Department // 311 North Main St., Mahnomen, MN 56557

Marshall County

Marshall County Sheriff's Department // 208 E. Colvin Ave. Suite 1, Warren, Minnesota 56762

Martin County

Martin County Law Enforcement Center // 201 Lake Avenue, Fairmont, MN

McLeod County

Hutchinson Police Department // 10 Franklin St. South, Hutchinson , MN 55350
McLeod County Sheriff's Department // 801 East 10th St., Glencoe , MN 55336
Winsted Police Department // 201 1st St. North, Winsted, MN 55395

Meeker County

Meeker County Sheriff 's Department // 460 3rd St S, Dassel, Minnesota 55325
Meeker Law Enforcement Center // 326 N Ramsey Ave, Litchfield, Minnesota 55355

Mille Lacs County

City of Isle // 285 2nd Ave S, Isle, MN, 56342-4594
Mille Lacs Sheriff 's Department // 640 3rd St SE, Milaca, Minnesota 56353
Mille Lacs Sheriff 's Department // 305 21st Ave S, Princeton, Minnesota 56371

Morrison County

Little Falls Police Department // 207 1st Street NE, Little Falls, MN 56345
Pierz Police // 101 Main St S, Morrison, Minnesota 56364
Ramsey Police Department // 7550 Sunwood Drive, Ramsey, Minnesota 55303

Mower County

Mower County Sheriff's Department // 201 1st St NE, Austin, Minnesota 55912

Murray County

Murray County Sheriff's Department // 2500 28th St, Slayton, Minnesota 56172

Nicollet County

City of North Mankato // 1001 Belgrade Ave, Mankato, MN, 56003-3501
Nicollet County Sheriff's Department // 501 S. Minnesota Ave., St. Peter, MN 56082

Nobles County

Nobles County Sheriff's Department // 1530 Airport Rd, Suite 100, Worthington, Minnesota 56187
Sterling LTC Pharmacy // 607 10th Street, Worthington, MN 56187

Norman County

Norman County Sheriff's Department // 15 2nd Avenue East, Ada, MN 56510

Olmstead County

Olmsted County Sheriff's Department // 151 4th St SE, Rochester, Minnesota 55904

Otter Tail County

Battle Lake Police Department // 108 E. Main, Battle Lake, MN
Henning Police Department // 607 2nd Street, Henning, MN
New York Mills Gov't Ctr. // 118 N Main, New York Mills, Minnesota 56567
Ottertail County Sheriff's Department // 417 Court St S, Fergus Falls, Minnesota 56537
Ottertail County Sheriff's Department // 469 Main St W, Ottertail, Minnesota 56571
Parkers Prairie Police Department // 102 N Otter Ave, Parkers Prairie, Minnesota 56361
Pelican Rapids Police Department // 315 N Broadway, Pelican Rapids, Minnesota 56572
Perham Police Department // 525 W Main St, Perham, Minnesota 56573

Pennington County

Thief River Falls Police Department // 102 W First St, Thief River Falls, Minnesota 56701

Pine County

Pine County Sheriff's Department // 106 1st Street SE, Hinkley, MN 55037
Pine County Sheriff's Department // 635 Northridge Dr. NW, Suite 100, Pine City, MN 55063
Pine County Sheriff's Department // 1602 Hwy 23 N, Sandstone, MN 55072

Pipestone County

Pipestone County Sheriff's Department // 416 Hiawatha Ave S, Pipestone, MN 56164

Polk County

Benton County Sheriff's Department // 581 Hwy 23, Foley, MN 56329
Crookston Police Department // 321 W Robert Street, Crookston, MN 56716
East Grand Forks Police Department // 520 Demers Ave, East Grand Forks, MN 56721

Pope County

Pope County Sheriff's Department // 130 E Minnesota Ave, Glenwood, MN 56334

Ramsey County

East Side Family Clinic Pharmacy // 895 East 7th Street, Saint Paul, MN 55106
HealthPartners Arden Hills Clinic // 3930 Northwoods Dr, Arden Hills, MN 55112
HealthPartners Maplewood Clinic // 2165 White Bear Ave N, Maplewood, MN 55109
HealthPartners Como Clinic // 2500 Como Ave, Saint Paul, MN 55108-1494
HealthPartners St. Paul Clinic // 205 S Wabasha St, St. Paul, MN 55107
HealthPartners Specialty Center // 401 Phalen Blvd, St. Paul, MN 55130
HealthPartners Midway Clinic // 451 N Dunlap St, St. Paul, MN 55104
HealthPartners White Bear Lake Clinic // 1430 Hwy 96 E, White Bear Lake, MN 55110
Law Enforcement Center // 425 Grove St., St. Paul, MN

North Saint Paul City Hall // 2400 Margaret Street, North St. Paul, MN
Ramsey County Sheriff's Patrol Station // 1411 Paul Kirkwold Dr., Arden Hills, MN
Regions Hospital // 640 Jackson Street, St. Paul, MN 55101
Walgreens Pharmacy // 1075 Hwy 96 E, St. Paul, MN
Westside Community Health Services Pharmacy // 153 Cesar Chavez St., St Paul, MN 55107

Red Lake County

None listed

Redwood County

Redwood County Sheriff's Department // 303 E 3rd Street, Redwood Falls, MN 56283

Renville County

Buffalo Lake Police Department // 301 N Main St, Buffalo Lake, MN 55314
City of Bird Island // 660 Birch Ave, Bird Island, MN, 55310
City of Morton // Medication Disposal, 220 W 2nd St, Morton, MN, 56270
Fairfax Police Department // 103 2nd Ave NW, Fairfax, MN, 55332
Renville County Sheriff 's Department // 24 SE 2nd Ave, Fairfax, MN 56332
Renville County Sheriff 's Department // 105 S 5th St, Suite 210, Olivia, MN 56277
Renville County Sheriff 's Department // 221 Main St N, Renville, MN 56284

Rice County

Faribault Police Department // 25 4th St. NW, Faribault, MN 55021
Northfield Police Department // 1615 Riverview Drive, Northfield, MN 55057
Northfield Safety Center // 300 5th Street W, Northfield, MN 55057
Rice County Sheriff's Department // 118 NW 3rd St., Faribault, MN 55021

Rock County

Rock County Sheriff's Department // 1000 North Blue Mound Ave., Luverne, MN 56156

Roseau County

City of Roseau // Roseau City Center, 114 2nd St NE, Roseau, MN, 56751-1110
Warroad Police Department // 802 Cheme Dr NW, Warroad, MN 56763

Scott County

Bell Plaine Police Department // 420 E Main St, Belle Plaine, MN 56011
Jordan Police Department // 210 East First St, Jordan, MN 55352
New Prague Police Department // 118 Central, Ave N, New Prague, MN 56071
Prior Lake Police Department // 4649 Dakota St SE, Prior Lake, MN 55372
Savage Police Department // 6000 McColl Drive, Savage, MN 55378
Scott County Sheriff's Office // 301 Fuller Street S, Shakopee, MN 55379
SMSC Pharmacy // 15045 Mystic Lake Drive, Prior Lake, MN 55372

Sherburne County

Becker County Sheriff 's Department // 925 Lake Ave, Detroit Lakes, MN 56501
Big Lake Police Department // 160 Lake St N, Big Lake, MN 55309
Sherburne County Sheriff 's Department // 4180 105th Ave SE, Clear Lake, MN 55319
Sherburne County Sheriff // 13880 Business Center Drive, Elk River, MN 55330

Sibley County

Sibley County Sheriff's Department // 419 Harrison Street, Gaylord, MN 55334

St. Louis County

Babbitt Police Department // 71 South Drive, Babbitt, MN 55706
Chisholm Police Department // 301 W. Lake St., Chisholm, MN 55719
Duluth City Police Department // 5830 Grand Ave, Duluth, MN 55807
Ely City Hall // 209 East Chapman Street, Ely, MN 55731
Essentia Health Lakeside Pharmacy // 4621 East Superior Street, Suite A, Duluth, MN 55804
Essentia Health Duluth 1st Street Pharmacy // 420 East First Street, Suite A, Duluth, MN 55805
Essentia Health West Duluth Pharmacy // 4212 Grand Ave, Suite A, Duluth, MN 55807
Essentia Health Duluth 3rd Street Pharmacy // 400 East Third Street, Suite A, Duluth, MN 55805
Essentia Health Lakewalk Pharmacy // 1502 London Road, Suite 101, Duluth, MN 55812
Essentia Health Hermantown Pharmacy // 4855 W Arrowhead Rd, Suite A, Hermantown, MN 55811
Essentia Health Hibbing Pharmacy // 730 E. 34th St., Suite A, Hibbing, MN 55746
Essentia Health Virginia Pharmacy // 101 9th St No. Suite A, Virginia, MN 55792
Eveleth Police Department // 415 Pierce Street, Eveleth, MN 55734
Floodwood City Hall // 111 8th Ave West, Floodwood, MN 55736
Gilbert Police Department // 16 Broadway St South, Gilbert, MN 55741
Hermantown Police Department // 5111 Maple Grove Rd, Hermantown, MN 55811
Hibbing Sheriff's Department // 1810 12th Ave East, Hibbing, MN 55746
Proctor Police Department // 100 Pionk Dr Suite 1, Proctor, MN 55810
Sheriff's Department // 300 South 5th Ave, Virginia, MN 55792
St. Louis County Sheriff 's Department // 2020 N Arlington Ave, Duluth, MN 55811
Virginia // 327 1st St S, Virginia City Hall, Virginia, MN, 55792
Walgreens Pharmacy // 1131 E. Superior St, Duluth, MN

Stearns County

Albany Police Department // 400 Railroad Avenue, Albany, MN 56307
Avon Police Department // 140 Stratford Street E, Avon, MN 56310
Belgrade Police Department // 120 Washburn Avenue, Belgrade, MN 56312
Cold Spring Police Department // 27 Red River Avenue S, Cold Spring, MN 56320
Kimball Police Department // 1 N Main Street, Kimball, MN 55353
Melrose City Hall // 225 E First St N, Melrose, MN 56352
Paynesville Police Department // 221 Washburne Avenue, Paynesville, MN 56362
Sartell City Police Department // 310 2 St S, Sartell, MN 56377
Sauk Centre Police Department // 320 Oak Street S, Sauk Centre, MN 56378
St. Joseph Police Department // 25 College Avenue N, St Joseph, MN 56374
Stearns Law Enforcement Center // 807 Courthouse Square Rm S100, St Cloud, Minnesota 56303
Waite Park City Police Department // 19 13th Ave N, Waite Park, MN 56387
Walgreens Pharmacy // 2505 W Division St, St. Cloud, MN

Steele County

Astrup Drug Inc. Pharmacy // 1601 State Ave N, Owatonna, MN 55060
Blooming Prairie Police Department // 138 Hwy 218 S, Blooming Prairie, MN 55917
Paynesville City Police Department // 221 Washburne Ave, Paynesville, MN 56362
Steele Law Enforcement Ctr., 204 E Pearl Street // Owatonna, MN 55060

Stevens County

Stevens County Sheriff 's Department // 400 Colorado Ave, Morris, MN 56267

Swift County

None listed

Todd County

Eagle Valley Clinic // 815 Hwy 71 S, Eagle Bend, MN 56446
Long Prairie City Hall // 615 Lake Street South, Long Prairie, MN 56347
Staples Police Department // 301 2nd Ave NE, Staples, MN 56479

Traverse County

Traverse County Sheriff 's Department // 203 7th Street N, Wheaton, MN 56296

Wabasha County

Lake City Police // 209 S High St, Lake City, MN 55041
Wabasha County Sheriff 's Department // 848 17th St E Suite 1, Wabasha, MN 55981

Wadena County

Wadena County Sheriff's Department // 415 S Jefferson St, Wadena, MN 56482

Waseca County

Waseca County Sheriff's Department // 122 3rd Ave NW, Waseca, MN 56093

Washington County

Cottage Grove Service Center // 13000 Ravine Pkwy. S, Cottage Grove, MN
HealthPartners Woodbury Clinic // 8450 Seasons Pkwy, Woodbury, MN 55125
Lake Shore Police Department // 8583 Interlachen Rd, Lake Shore, MN 56468
Lakeview Community Pharmacy // 1500 Curve Crest Blvd, Stillwater, MN 55082
Walgreens Pharmacy // 7135 E Point Douglas Road S, Cottage Grove, MN
Walgreens Pharmacy // 1965 Donegal Dr., Woodbury, MN 55125
Washington County Service Center // 19955 Forest Rd N, Forest Lake, MN
Washington County Law Enforcement Center // 15015 62nd St N, Stillwater, MN

Watonwan County

Watonwan County Sheriff's Department // 715 3rd Street S, Saint James, MN 56081

Wilkin County

Wilkin County Sheriff's Department // 515 Dacotah Ave, Breckenridge, MN 56520

Winona County

Winona Law Enforcement Center // 201 W 3rd St, Winona, MN 55987

Wright County

Annandale Police Department // 30 Cedar St E, Annandale, MN 55302
Buffalo Police // 215 1st Ave NE, Buffalo, MN 55313
Howard Lake Police Department // 625 8th Ave PO Box 736, Howard Lake, MN 55349
Walgreens Pharmacy // 135 E Broadway St, Monticello, MN
Wright County Sheriff 's Department // 3800 Braddock Ave NE, Buffalo, MN 55313
Wright County Sheriff 's Department // 11800 Town Center De NE, St Michael, MN 55376

Yellow Medicine

Yellow Medicine County Sheriff 's Department // 930 4th St, Ste 1, Granite Falls, MN 56241

Tribal Communities

Grand Portage Health Service // 62 Upper Rd, Grand Portage MN 55605

Leech Lake Tribal Police Department // 6242 U.S. Hwy#2, Cass Lake, MN 56633

Lower Sioux Community // None listed

Mille Lacs Band Government Center // 43408 Oodena Dr, Onamia, MN 56359

Prairie Island Tribal Public Safety // 1960 Island Blvd, Welch, MN 55089

STATE OF MINNESOTA
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