American Pharmacists Association, says:

President and Chief Executive Officer of the

stances, which constitute about 10% of

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he Drug Enforcement Administra-

tion (DEA) has raised hackles up

and down the pharmacy distribu-

tion chain with its proposal to allow

electronic prescribing of controlled sub-

stances. Computer-generated prescrip-

tions from physicians to pharmacies for

drugs such as oxycodone (OxyContin,

Purdue), methylenidate (Ritalin, No-

tarits), diazepam (Valium, Roche), and

hydrocodone bitartrate/acetaminophen

(e.g., Abbott’s Vicodin or Forest’s Lorcet

and Lortab), are illegal—until the DEA

finalizes this rule. Even though the DEA

believes that e-prescribing of those and

other Schedule II–V controlled sub-

stances will help combat diversion of

sedatives and pain medications, the secu-

rity measures that the agency wants

physicians and pharmacies to adopt have

those groups up in arms.

John A. Gans, PharmD, Executive Vice

President and Chief Executive Officer of

the American Pharmacists Association, says:

“We are concerned with several provi-
sions in the proposed rule that would

create undue burdens on prescribers and

pharmacists that, if left unaddressed, may

have the unintended consequence of lim-

iting prescriber and pharmacist uptake of

e-prescribing of controlled substances.”

Paradoxically, pharmacies and phar-

macists have been waiting for the “green

light” from the DEA, viewing it as a kind

of catalyst for physicians to move much

more aggressively to electronic prescrib-

ing, which is seen as saving time and

money for pharmacies. In the current

environment, physicians have been hesi-
									

all prescriptions. That two-tiered system

was viewed as a pain, even though many

physicians have e-prescribing capabilities

through the electronic health record

(EHR) systems. They simply have not

been using that e-prescribing capability.

The DEA, of course, is concerned about

diversion of Schedule II–V controlled

substances such as OxyContin and those

mentioned previously, to name a few. Di-

version of those drugs, whether through

theft at pharmacies, alteration of legiti-
mately written prescriptions, or the ac-
tions of rogue Internet pharmacies has

become more of a problem over the past

decade, leading to what the DEA calls an

“alarming” increase in substance abuse.

Recently, Cardinal Health agreed to pay

$34,000,000 in civil penalties for the diver-
sion of millions of dosage units of hydro-
codone from its 27 DEA-registered distri-

bution chain with its proposal to allow

electronic prescribing of controlled sub-

stances such as OxyContin and those

beliefs that e-prescribing of those and

other Schedule II–V controlled sub-

stances will help combat diversion of

illegal Internet pharmacy Web sites.

The DEA believes that a secure elec-
tronic system for prescribing Schedule

II–V controlled substances would actu-

ally reduce diversion. But that’s where

the rub is: ensuring a pharmacy system

is secure. Almost all pharmacies have

computerized prescription records, which

are integrated into overall phar-

macy management systems that process

insurance claims and billings. Many

pharmacies have the ability to accept

electronic prescriptions, but few orders

of this type are currently sent. Many of

the “electronic prescriptions” generated

are actually transmitted to the pharmacy

as faxes, or they are simply printed out

given to the patient. Renewals, rather

than original prescriptions, are more

likely to be handled electronically. None-

theless, the capability to accept elec-
tronic prescriptions is widespread in the

pharmacy sector.

Having said that, though, many prob-
lems exist with the current system, not

only at the pharmacy levels. The service

providers to whom the electronic pre-

scription system is outsourced do not

know whether a physician signing up to

transmit electronic prescriptions is le-

gally permitted to do so. Some services,

which enroll practices over the Internet,
don’t ask for the presumed physician’s

DEA registration and state license.

But the DEA has proposed a number of

security measures that haven’t gone over

well with anyone. C. Edwin Webb, Direc-
tor of Government and Professional

Affairs for the American College of Clin-

ical Pharmacy (ACCP), says the proposal
does not fully recognize the authority of

pharmacists to practice drug therapy

management under collaborative prac-
tice agreements with physicians in 45 of

the 50 states. Pharmacists in those states

are legally allowed to prescribe drugs,

but they might not be able to do so under

the DEA proposal.

Pharmacy groups are also worried about an additional workload. For exam-
ple, to help get around a physician’s DEA

registration, a pharmacist would have to

check the DEA database before giving a

customer a controlled substance to make

sure that the prescribing physician is in

the database. Mark Merritt, president of

the Pharmaceutical Care Management

Association, says that would be costly

and ineffective. Moreover, the DEA data-

base is updated not in real time but on a

weekly basis. The lack of real-time infor-
mation may result in the rejection of

scripts from prescribers who have not

yet been integrated into the database.

Maybe a bigger problem for pharmacy

benefit managers and formularies is that

the DEA doesn’t want to allow the phar-
macist to switch an electronic prescrip-
tion for a brand-name drug to a generic

agent; it wants the DEA to clarify that

pharmacists are allowed to change pre-
scriptions according to state law and

should not be considered to be “altering

the prescription during transmission.”

Given the necessity of pushing e-pre-
scribing into higher gear, the DEA is

likely to accommodate pharmacy groups

to some extent when it publishes the final

rule on controlled substances.