



NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT



NATIONAL DRUG INTELLIGENCE CENTER
DRUG ENFORCEMENT ADMINISTRATION
U.S. DEPARTMENT OF JUSTICE



2009

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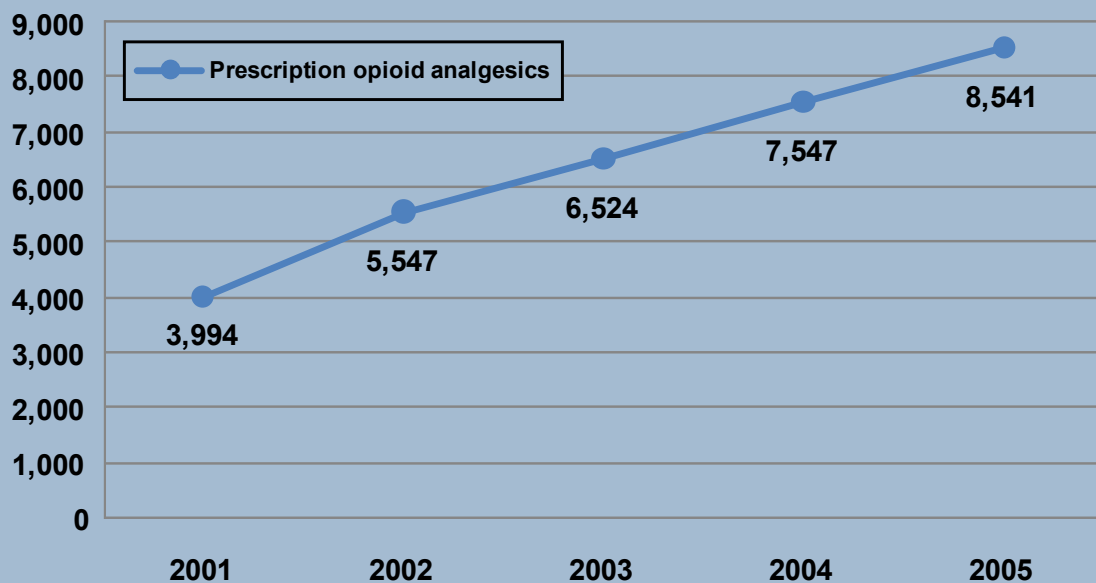
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EXECUTIVE SUMMARY

Approximately 6.9 million individuals aged 12 or older were current (past month) nonmedical users of prescription-type psychotherapeutic drugs (opioid pain relievers,¹ tranquilizers, sedatives, or stimulants) during 2007, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2007 National Survey on Drug Use and Health (NSDUH). Current nonmedical use of these drugs, collectively referred to as “controlled prescription drugs (CPDs)” (see text box on page 2) for the purposes of this report, remained relatively stable from 2003 (6.5 million) to 2007 (6.9 million); however, the number of deaths and treatment admissions involving CPDs, particularly prescription opioids, increased significantly. According to the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics, unintentional overdose deaths involving prescription opioids increased 114 percent from 2001 (3,994) to 2005 (8,541), the most recent nationwide data available. (See Figure 1.) Further, the number of treatment admissions for prescription opioids as the primary drug of abuse increased 74 percent from 46,115 in 2002 to 80,131 in 2006, the most recent data available, according to the SAMHSA Treatment Episode Data Set (TEDS).

Figure 1. Prescription Opioid Analgesic Deaths Nationwide, 2001–2005



Source: Centers for Disease Control and Prevention.

1. Different data sources use different terminology for prescription drug categories. This report uses the terminology referenced in each source so as to accurately portray the data. For example, some sources use the term “pain relievers” when these drugs typically fall under the category of “opioids.”

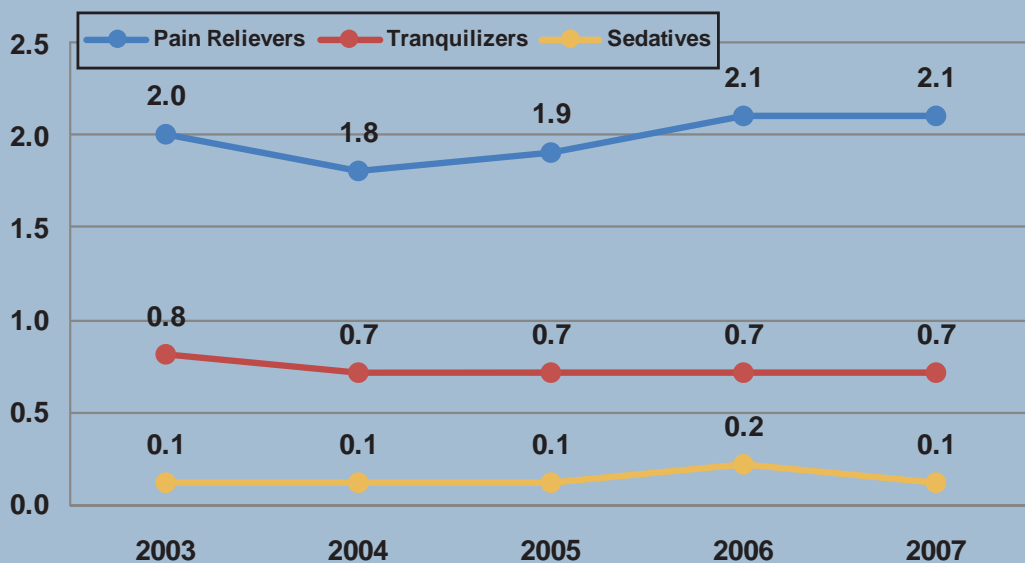


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Pain relievers are the most widely diverted and abused prescription psychotherapeutics, according to NSDUH. (See Figure 2.) The Drug Enforcement Administration (DEA) believes that most of these pain relievers are controlled prescription opioids.² Abusers use opioid pain relievers largely for their euphoric effect. Tranquilizers and sedatives are abused, although to a lesser extent; abusers often use the drugs in combination with opioid pain relievers because they potentiate the effects of the opioid. Opioid pain relievers, tranquilizers, and sedatives are abused primarily by young adults aged 18 to 25; adolescents (12 to 17 years of age) also compose a significant user group for these drugs. Prescription stimulants are abused to a much lesser extent, primarily by young adults who reportedly use the drugs in an attempt to enhance their academic, professional, or athletic performance. Diverted CPDs are generally distributed by individuals, among friends and family, and through rogue Internet pharmacies; they typically are not distributed in the same manner as illicit drugs such as heroin, cocaine, marijuana, and methamphetamine—through drug trafficking organizations (DTOs) and criminal groups. However, some illicit drug distributors, particularly street gangs and outlaw motorcycle gangs (OMGs), have added diverted CPDs to their drug supplies. CPDs are also acquired by abusers through such diversion techniques as doctor-shopping, prescription fraud, and theft.

The societal impact of CPD diversion and abuse is considerable. Violent and property crime associated with CPD diversion and abuse has increased in all regions of the United States over the past 5 years, according to the National Drug Intelligence Center (NDIC) National Drug Threat Survey (NDTS). However, the association between crime and CPD diversion is reported much less frequently than the association between

Figure 2. Past Month Nonmedical Use of Psychotherapeutics by Individuals 12 or Older, by Percentage, Nationwide, 2003–2007



Source: National Survey on Drug Use and Health.

2. Drug Enforcement Administration (DEA) Deputy Assistant Administrator Joseph T. Rannazzisi, Statement to the Committee on House Government Reform, Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2006, and Mr. Rannazzisi, Statement to members of the Judiciary Committee, May 16, 2007. Information was presented at the Good Medicine Bad Behavior exhibit at DEA Headquarters and can be found at http://www.goodmedicinebadbehavior.org/explore/pain_management.html.

crime and illicit drugs. Increases in crime rates often result in higher budgetary expenditures for additional law enforcement resources. Moreover, the estimated cost of CPD diversion and abuse to public and private medical insurers is \$72.5 billion a year,³ much of which is passed to consumers through higher health insurance premiums. Additionally, the abuse of prescription opioids is burdening the budgets of substance abuse treatment providers, particularly as prescription opioid abuse might be fueling heroin abuse rates in some areas of the United States. Treatment providers anecdotally report that some prescription opioid abusers are switching to heroin as they build tolerance to prescription opioids and seek a more euphoric high. Further anecdotal reporting by treatment providers indicates that some prescription opioid abusers are switching to heroin in a few areas where heroin is less costly or more available than prescription opioids. Such reporting could be an indicator that an increasing number of prescription opioid abusers might switch to heroin. However, DEA has not evidenced a trend in any investigative or intelligence systems showing the substitution of heroin for CPDs.

Prescription Drug Monitoring Programs (PDMPs) have been established legislatively in many states to curb CPD diversion and abuse. PDMPs have decreased CPD diversion and abuse by reducing the amount of doctor-shopping by drug-seeking individuals, according to the most recent U.S. Government Accountability Office (GAO) report regarding PDMPs. However, law enforcement and public health officials indicate an increased need for information sharing between physicians, pharmacists, and law enforcement officers, particularly between such individuals in neighboring states. To this end, the Bureau of Justice Assistance (BJA) has provided technical assistance and funding for a project through which public and private technology solutions providers, the Integrated Justice Information Systems (IJIS) Institute,⁴ and PDMP representatives are working to establish a nationwide information-sharing platform that will facilitate the interstate exchange of PDMP data.

3. This is an estimate provided by the Coalition Against Insurance Fraud (CAIF), a nongovernment source.

4. The Integrated Justice Information Systems (IJIS) Institute is a nonprofit organization responsible for bringing private industry and government together to assist in the development of new standards and practices across the justice, public safety, and homeland security communities.



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SCOPE AND METHODOLOGY

INFORMATION SOURCES

The principal sources of information used in this assessment include the following. (Note: Agencies that responded to the NDTs⁵ have not been included in the source list at the end of this assessment.)

- 3,049 state and local law enforcement agency responses (of 3,469 solicited) to the 2008 NDTs.
- 3,050 state and local law enforcement agency responses (of 3,470 solicited) to the 2007 NDTs.
- 3,267 state and local law enforcement agency responses (of 3,474 solicited) to the 2006 NDTs.
- 3,436 state and local law enforcement agency responses (of 3,477 solicited) to the 2005 NDTs.
- 3,429 state and local law enforcement agency responses (of 3,484 solicited) to the 2004 NDTs.
- Information from 21 DEA Field Offices specifically tasked to report the CPD threat.
- NDIC Field Program Specialist (FPS)⁶ interviews with local law enforcement officers.
- Reporting from federal, state, and local law enforcement agencies.
- NDIC FPS interviews with treatment providers in each Organized Crime Drug Enforcement Task Force (OCDETF) Region.

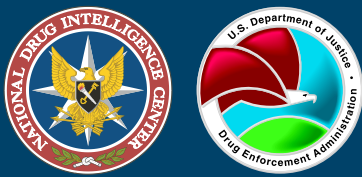
COLLECTION IMPEDIMENTS

The greatest impediment to the collection of accurate abuse-related data is the lack of standardized terminology used in surveys and drug-related death reporting. Moreover, NDTs respondents provide anecdotal information based on individual perceptions of the situation. Additional impediments include lack of data regarding the following:

- Abusers' and distributors' primary sources of supply.
- The amount of CPDs recovered following loss in transit or theft incidents.
- The number of Internet pharmacies selling CPDs.

5. The National Drug Intelligence Center (NDIC) administers its annual National Drug Threat Survey (NDTS) to a probability-based sample of thousands of state and local law enforcement agencies designed to represent all national, regional, and state agencies. Since 2003, the survey response rate has been close to 90 percent or higher. Agencies are asked to identify the drug that poses the greatest threat, the drug that most contributes to violent and property crime, the level of gang involvement in drug distribution, and the number of gangs and gang members in their jurisdictions. Agencies are also asked if gang-related drug distribution has increased or decreased in their jurisdictions.

6. The NDIC Field Program Specialist (FPS) program was created to increase the flow of strategic and current domestic drug intelligence from local and state law enforcement agencies to NDIC and other counterdrug agencies. The FPS program is staffed by retired law enforcement officers, each of whom has approximately 25 years' experience. FPSs often work closely with law enforcement agencies within their assigned regions, enabling them to rapidly query state and local officials. In addition, these reports were used to validate information collected through the NDTs.



- The number of abusers who use the Internet to divert CPDs.
- Differentiation between legitimate users and abusers in poison control center, hospital emergency department, treatment provider, and mortality reporting.

COLLECTION METHODS

The collection of diversion- and abuse-related data for this assessment was fostered by the large number of NDTs responses in 2008 (3,049). Additionally, private industry, treatment experts, academicians, and researchers provided valuable data and information for this assessment.

RANGE OF DATA

The data contained in this report reflect the most recent data available at the time of publication and typically cover a 5-year period. For example, when 2008 data are available, the period examined commences in 2004. When 2005 data are the most recent available, the period examined commences in 2001.

DATA TERMINOLOGY

Different data sources use different terminology for various prescription drugs. This report uses the terminology referenced in each source in order to accurately portray the data. For example, some sources use the term “pain relievers” (which includes both opioids and nonopioids), others may specifically use the term “opioid pain relievers,” and still others may refer to such drugs as “opiates” or “narcotic pain relievers.”

DATABASE VARIANCES

CPD data often vary according to the source of the data. Some studies and surveys mention specific CPDs, while others use a more general approach to collection and refer only to Schedule II, III, or IV prescription drugs. For example, the National Center on Addiction and Substance Abuse (CASA) at Columbia University uses a general approach in its Internet studies and targets CPDs, “primarily those appearing in Schedules II and III.” NSDUH is slightly more specific when conducting surveys and uses “pain relievers, stimulants, depressants, and tranquilizers” as categories under an umbrella term of “psychotherapeutics.” The National Seizure System (NSS) captures all prescription drug seizures and lists specific drugs when possible while maintaining one “prescription drugs – other” category to record seizures that involve possibly unknown prescription drugs. DEA Automation of Reports and Consolidated Orders System (ARCOS) data include Schedule II and III narcotic controlled drugs, while the Drug, Theft, and Loss database includes Schedule II through V CPDs. In this assessment, all attempts have been made to be as inclusive as possible in reporting data sets while maintaining some consistency in the drug types being compared. Thus, some portions of the assessment refer generically to Schedule II, III, or IV drugs, while others discuss specific drugs that are the most frequently reported diverted and abused CPDs.

TABLE OF CONTENTS

Executive Summary.....	iii
Scope and Methodology	vii
Information Sources.....	vii
Collection Impediments.....	vii
Collection Methods	viii
Range of Data	viii
Data Terminology.....	viii
Database Variances	viii
Background.....	1
Overview	1
Foreword.....	3
Legitimate Distribution of CPDs.....	3
Diversion of CPDs	6
Combating Diversion	16
Illicit Finance	19
Abuse	20
Intelligence Gaps	26
Predictive Estimates.....	27
Regional Deviations From National Trends.....	29
Florida/Caribbean Region	30
Great Lakes Region	30
Mid-Atlantic Region	30
New England Region.....	30
New York/New Jersey Region	30
Pacific Region	30



NATIONAL DRUG INTELLIGENCE CENTER DRUG ENFORCEMENT ADMINISTRATION

Southeast Region30

Southwest Region31

West Central Region31

Appendix A. NDTs Comparative Data33

 Greatest Drug Threat33

 Availability34

 Drugs Associated With Violent Crime35

 Drugs Associated With Property Crime36

Appendix B. Controlled Prescription Drug Prices Collected in 2008.....37

Sources59

BACKGROUND

The *National Prescription Drug Threat Assessment 2009 (NPDTA 09)* is a collaborative effort between NDIC and DEA to assess the threat posed by the distribution, diversion, and abuse of CPDs in the United States. This assessment draws upon the *National Drug Threat Assessment 2009*; NDTs data collected by NDIC; regional drug intelligence products prepared by NDIC; open-source information; public- and private-sector research; reporting from federal, state, and local law enforcement agencies; and state-level treatment data. DEA's 21 Domestic Field Divisions assessed the CPD situation in their areas and provided reports that contributed significantly to this assessment. The *NPDTA 09* examines and evaluates the principal issues and recent developments pertaining to the diversion and abuse of CPDs; it also updates data and analysis published in the NDIC November 2004 *Pharmaceuticals Threat Assessment*, Product No. 2004-L0487-001.

The *NPDTA 09* focuses primarily on domestic diversion of CPDs and does not discuss the abuse of over-the-counter pharmaceuticals such as dextromethorphan; non-CPDs such as carisoprodol (Soma®); illicitly produced amphetamine, methamphetamine, and fentanyl; or controlled prescription and illicitly produced anabolic steroids.

OVERVIEW

The distribution and use of CPDs are regulated by the Federal Controlled Substances Act (CSA),⁷ which classifies controlled substances under one of five schedules according to their potential for abuse, their use in accepted medical treatment in the United States, and their potential for physical or psychological dependence. All businesses that manufacture or distribute CPDs, all health professionals entitled to dispense or prescribe them, and all pharmacies entitled to fill prescriptions must comply with the CSA, Code of Federal Regulations (CFR), and state regulations; this includes registering with DEA and

complying with a series of requirements related to drug security and records accountability.

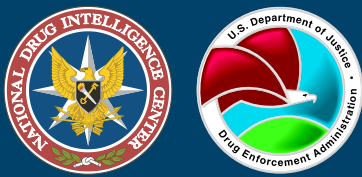
Despite the strict requirements of the CSA and regulations under the CFR, CPDs are diverted from legitimate sources for illicit distribution and/or abuse. CPD diversion typically involves individuals who doctor-shop and forge prescriptions, unscrupulous physicians who sell prescriptions to drug dealers or abusers, unscrupulous pharmacists who falsify records and subsequently sell the drugs, employees who steal from inventory, executives who falsify orders to cover illicit sales, individuals who commit burglaries or robberies of pharmacies, and individuals who purchase CPDs from rogue Internet pharmacies.⁸ CPD diversion also involves the sharing or purchasing of drugs between family and friends or individual theft from family and friends. In some instances CPD diversion involves purchases from strangers or street dealers.

The most commonly diverted CPDs are opioid pain relievers, according to DEA and NSDUH data. Opioid pain relievers are popular among drug abusers because of the euphoria they induce. Opioid pain relievers include codeine, fentanyl (Duragesic®, Actiq®⁹), hydromorphone (Dilaudid®), meperidine (Demerol®, which is prescribed less often because of its side effects), morphine (MS Contin®), oxycodone (OxyContin®), pentazocine (Talwin®), dextropropoxyphene (Darvon®), methadone (Dolophine®), and hydrocodone/

7. 21 U.S.C. Section 801, et seq.

8. Rogue Internet pharmacies are schemes established by a "facilitator" (operator) who employs physicians and pharmacists with DEA registration numbers to approve and fill prescriptions for CPDs. The doctors approve prescriptions for drugs without the required in-person physical examination of the patient. The facilitators often recruit pharmacists who own or are employed at small, independent, legitimate brick-and-mortar pharmacies, according to DEA.

9. The brand names provided in parentheses in this paragraph are examples of the most commonly used brand name drugs. Throughout the remainder of this assessment, generic drug names are used for clarity and brevity unless specific brand names are cited in surveys or other studies.



CPD Schedules

CPDs are regulated under the federal Controlled Substances Act (CSA), 21 U.S.C. Section 801, et seq. They are classified under various schedules set forth in the CSA; all are considered to be Schedule II, III, IV, or V drugs.

Schedule II prescription drugs have a high potential for abuse and a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions. Abuse of Schedule II drugs may lead to severe psychological or physical dependence.

Schedule III prescription drugs have a potential for abuse less than the drugs in Schedule II and a currently accepted medical use in treatment in the United States. Abuse of Schedule III drugs may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV prescription drugs have a low potential for abuse relative to the drugs in Schedule III and a currently accepted medical use in treatment in the United States. Abuse of Schedule IV prescription drugs may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.

Schedule V prescription drugs have a low potential for abuse relative to the drugs or other substances in Schedule IV and a currently accepted medical use in treatment in the United States. Abuse of Schedule V drugs may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.

For more detailed descriptions of each schedule, see <http://www.usdoj.gov/dea/pubs/csa/812.htm>.

combinations (Vicodin®, Lortab®, and Lorcet®).¹⁰ Prescription tranquilizers and sedatives are also commonly abused because they can potentiate the euphoric effect of opioids. The most frequently diverted and abused tranquilizers and sedatives include benzodiazepines such as alprazolam (Xanax®), diazepam (Valium®), and lorazepam (Ativan®); barbiturates such as pentobarbital (Nembutal®), phenobarbital (Luminal®), secobarbital (Seconal®); and zolpidem (Ambien®). Prescription stimulants are also diverted and abused, although to a lesser extent. Commonly diverted and abused prescription stimulants include amphetamines (Adderall®, Dexedrine®) and methylphenidate (Concerta®, Ritalin®).

CPDs can be as dangerous as illicit drugs when misused or abused. When taken by someone other

10. Hydrocodone combination CPDs are manufactured with acetaminophen, aspirin, or ibuprofen and sold as analgesics or manufactured with pseudoephedrine, guaifenesin, or phenylephrine and sold as cough preparations. The most common brand-name analgesic hydrocodone/combo product is Vicodin®.

than the patient for whom the medication was prescribed, in a manner or dosage other than what was prescribed, or in combination with other drugs and/or alcohol, CPDs can produce serious adverse health effects such as suppression of respiration. Moreover, unintentional misuse or intentional abuse of CPDs, particularly opioids, often produces feelings of euphoria, which can lead to increased levels of intentional abuse and subsequent tolerance,¹¹ physical dependence,¹² or addiction.¹³

11. Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect or a reduced effect is observed with a constant dose over time.

12. Physical dependence occurs when a body adapts to the presence of a drug and any abrupt cessation, rapid dose reduction, or decreasing blood level of the drug would result in withdrawal symptoms (restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps, or involuntary leg movements).

13. Addiction is a primary, chronic neurobiological disease characterized by behaviors that include impaired control over drug use, craving, compulsive use, and/or continued use despite harm.

FOREWORD

This assessment begins with a discussion of the legitimate distribution and diversion of CPDs, including the impact that increasing the legitimate distribution of prescription opioid pain relievers, methylphenidate, and amphetamine has had on illicit markets. It also discusses the methods used by diverters and distributors to launder proceeds and the methods used by law enforcement agencies to combat CPD diversion. Additionally, the report addresses CPD abuse levels in the United States, regional CPD diversion and abuse trends, and significant CPD-related intelligence gaps; it also estimates future illicit CPD activity.

LEGITIMATE DISTRIBUTION OF CPDs

Increases in legitimate distribution of prescription opioid pain relievers (the most commonly diverted and abused CPDs), amphetamine, and methylphenidate have expanded the amount of these drugs available for diversion and abuse.

Legitimate distribution¹⁴ per capita of most prescription opioid pain relievers, amphetamine, and methylphenidate increased nationwide from 2003 through 2007, according to the latest data from ARCOS.¹⁵ (See Figure 3 on page 4.) Additionally, the number of prescriptions written for controlled

14. Legitimate distribution refers to the sale of CPDs from the manufacturer to pharmacies, hospitals, practitioners, and teaching institutions.

15. The Automation of Reports and Consolidated Orders System (ARCOS) is an automated, comprehensive drug reporting system that monitors the flow of DEA-controlled substances from their point of manufacture through commercial distribution channels to point-of-sale or distribution at the dispensing/retail level (hospitals, retail pharmacies, practitioners, midlevel practitioners, and teaching institutions). Included in the list of controlled substance transactions tracked by ARCOS are the following: All Schedule I and II materials (manufacturers and distributors), Schedule III narcotic and gamma-hydroxybutyric acid (GHB) materials (manufacturers and distributors), and selected Schedule III and IV psychotropic drugs (manufacturers only).

prescription opioids increased during the same time, according to publicly available prescription dispensing data. (See Table 1 on page 5.)

While the increase in legitimate distribution of opioid pain relievers by licensed practitioners and pharmacies has aided patients in chronic pain management, law enforcement and public health officials report that it has also increased the amount of such drugs susceptible to diversion and abuse. The increase in use of opioid pain relievers—particularly methadone—has been linked by public health officials with a parallel increase in drug overdose deaths and emergency department (ED) visits involving these drugs. Areas with the highest rates of opioid distribution are those with the highest drug overdose mortality rates.

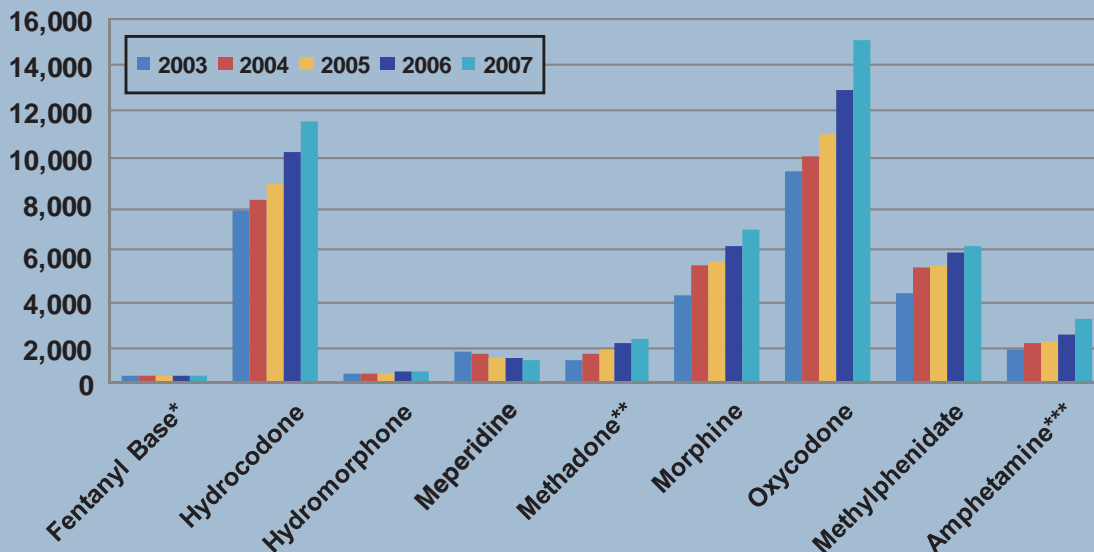
Factors That Contribute to CPD Diversion and Abuse

The recent increase in the extent of prescription drug abuse in this country is quite likely the result of a confluence of factors, such as significant increases in the number of prescriptions; significant increases in drug availability; aggressive marketing by the pharmaceutical industry; the proliferation of illegal Internet pharmacies that dispense these medications without proper prescriptions and surveillance; and a greater social acceptability for medicating a growing number of conditions. The fact that doctors are prescribing these drugs legitimately and with increasing frequency to treat a variety of ailments leads to the misguided and dangerous conclusion that their nonmedical use should be equally safe. This misperception of safety may contribute, for example, to the casual attitude of many college students toward abusing stimulants to improve cognitive function and academic performance.

Source: Statement by National Institute on Drug Abuse Director Nora D. Volkow, M.D., before the Subcommittee on Criminal Justice, Drug Policy, and Human Resources, U.S. House of Representatives, July 26, 2006.



Figure 3. Cumulative Distribution of Opioids, Methylphenidate, and Amphetamine, in Grams, per 100,000 Population, 2003–2007



Source: Drug Enforcement Administration Automation of Reports and Consolidated Orders System.

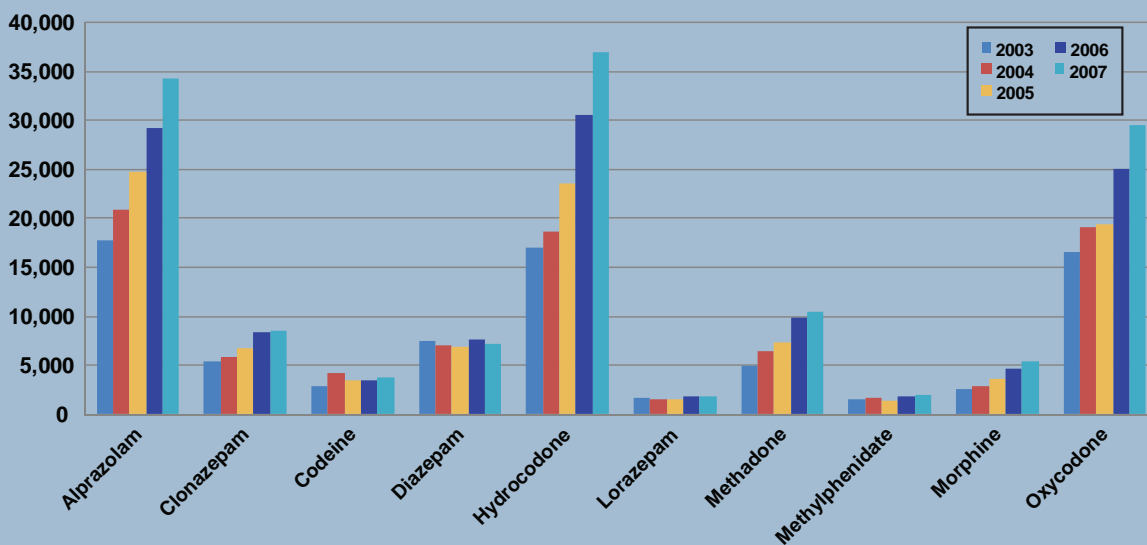
*Fentanyl base is used to produce other fentanyl products.

**Excludes methadone distributed to narcotic treatment programs.

***Includes dl-amphetamine base and d-amphetamine base.

Note: ARCOS provides complete data for all Schedule II and Schedule III narcotic materials (manufacturers and distributors).

Figure 4. Estimated Number of Total Analyzed Controlled Prescription Drug Items, 2003–2007



Source: National Forensic Laboratory Information System.

Note: Since 2001, NFLIS has produced estimates for the number of drug items and drug cases analyzed by state and local laboratories from a nationally representative sample of laboratories.

Table 1. Prescriptions Written for Generic or Brand Name Opioid Pain Relievers, Methylphenidate, and Amphetamine,* in Thousands, 2003–2007

	2003	2004	2005	2006	2007
Acetaminophen/codeine	18,503	16,616	15,679	14,773	14,092
Adderall XR®	6,443	7,635	8,653	8,870	9,190
Amphetamine Salt Combination	2,730	3,073	3,513	3,954	4,761
Concerta®	6,960	7,627	8,201	7,859	7,821
Duragesic®	3,659	4,114	1,690	**	**
Endocet®	4,858	5,361	3,259	4,601	3,537
Fentanyl transdermal	**	4,524	**	2,606	3,818
Hydrocodone/acetaminophen	87,096	117,200	93,680	101,639	109,652
Hydrocodone/ibuprofen	134	2,394	2,185	2,282	2,389
Hydromorphone HCL	1,503	**	**	**	**
Methadone HCL	1,161	1,161	1,335	**	3,176
Methadose	**	1,616	2,084	1,555	**
Methylphenidate	2,098	1,930	1,939	1,879	1,785
Morphine	1,949	2,242	2,495	2,803	2,357
Oxycodone	1,083	4,375	1,772	4,715	8,472
Oxycodone/acetaminophen	10,185	23,443	13,360	18,373	19,014
OxyContin®	6,598	6,068	3,967	1,414	2,005
Promethazine/codeine	5,366	4,390	4,912	4,264	4,390
Ritalin LA®	**	**	1,391	**	**
Roxicet®	2,299	1,810	1,496	1,784	**
Suboxone®	**	**	**	**	1,888
Tussionex®	3,204	2,724	3,306	2,973	2,861

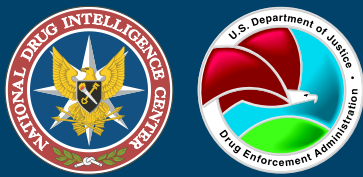
Source: *Drug Topics* via Verispan.

*Drugs that were listed among the Top 200 generic and brand name drugs prescribed in these years.

**Not in the top 200 generic and brand name drugs in these years.

Legitimate distribution of amphetamine increased from 2003 through 2007, according to ARCOS; the number of prescriptions written for brand and generic amphetamine drugs (Adderall® and amphetamine salt combinations)

also increased during that time (see Table 1). In contrast, legitimate distribution of methylphenidate increased while the number of prescriptions written for the generic drug decreased slightly overall.



DIVERSION OF CPDs

CPDs are diverted for nonmedical use. Law enforcement reporting and statistical data indicate that CPD diversion nationwide increased overall from 2004 through 2007. According to the National Forensic Laboratory Information System (NFLIS),¹⁶ the estimated number of diverted CPDs analyzed by state and local laboratories nationwide increased for most of the commonly diverted and abused prescription opioid pain relievers and benzodiazepines from 2003 through 2007, the latest year for which such data are available. (See Figure 4 on page 4.) The highest percentage increases for the 5-year period were for the prescription opioid pain relievers hydrocodone (118%), morphine (111%), and methadone (109%). Dosage unit CPD¹⁷ seizures reported to the NSS fluctuated from 2003 through 2008; the highest number of dosage units was seized in 2003. The number of pills seized fluctuated as well, peaking in 2006. The number of milliliters of CPDs seized annually increased significantly, while the number of kilograms fluctuated over the 6-year period. (See Table 2 on page 7.)

Abusers of opioid pain relievers divert the drugs through various methods, including prescription fraud, theft, and exploitation of the Internet; however, most diversion occurs when individuals with a prescription pass their drugs to family and friends. NSDUH data show that among individuals aged 12 or older who used prescription opioid pain relievers nonmedically in the past year, 56.5 percent reported that they acquired these drugs from a friend or relative for free. Additionally, 81 percent of those who acquired the pain relievers from a friend or relative indicated that the drugs originally were acquired from one doctor. NSDUH data also show that 18.1 percent

acquired the drugs directly from one doctor, 8.9 percent bought the drugs from a friend or family member, and 5.2 percent stole them from a friend or family member. Moreover, 4.1 percent purchased the opioid pain relievers from a dealer or stranger, and only 0.5 percent reported that they purchased prescription opioid pain relievers on the Internet.

Rogue Internet pharmacies¹⁸ are a significant source for diverted CPDs, particularly Schedule III and Schedule IV drugs. Unscrupulous physicians and pharmacists working through rogue Internet pharmacies engage in “script mill” practices whereby patients obtain CPDs without a face-to-face medical evaluation. Rogue pharmacy operators often recruit doctors who believe that Schedule III and IV prescription drugs are less scrutinized than Schedule II prescription drugs and, therefore, are more willing to prescribe them to a patient. Some physicians who prescribe Schedule III and IV prescription drugs without meeting with a patient may be less willing to do so with Schedule II prescription drugs because the criminal penalties for violations involving Schedule II drugs can be four times higher than those involving Schedule III and IV drugs.¹⁹ Additionally, the requirement for a hard copy of a Schedule II prescription makes

16. The National Forensic Laboratory Information System (NFLIS) is a program sponsored by DEA, Office of Diversion Control. NFLIS systematically collects results from drug analyses conducted by state and local forensic laboratories. Because of changes in reporting, NFLIS data should not be used for trending analysis.

17. Includes seizures of CPDs from air cargo, air passengers, buses, express mail/parcel, mail, maritime cargo, individuals on foot, trains, and all vehicles including tractor-trailers and cargo vehicles.

18. The Ryan Haight Online Pharmacy Consumer Protection Act of 2008, enacted in October 2008, legally established the definition of “online pharmacy.” The Act prohibits the delivery, distribution, or dispensing of CPDs over the Internet without a prescription written by a doctor who has conducted at least one in-person examination of the patient. This Act is expected to have a significant impact on CPD diversion and abuse by decreasing the number of rogue Internet pharmacies operating on the Internet.

19. Federal trafficking penalties for illegal Internet distribution of Schedule II drugs are not more than 20 years imprisonment for the first offense and a fine of \$1 million for an individual and \$5 million for other than an individual. Federal trafficking penalties effective as of October 2008 for Schedule III drugs are not more than 10 years imprisonment (up from 5 years) and fines of not more than \$500,000 (up from \$250,000) for an individual and \$2.5 million (up from \$1 million) for other than an individual. Penalties effective as of October 2008 for Schedule IV drugs are not more than 5 years imprisonment (up from 3 years) and fines of not more than \$250,000 for an individual and \$1 million for other than an individual.

Table 2. Controlled Prescription Drug Seizures Reported to the National Seizure System, by Measurement Provided, 2003–2008

	2003	2004	2005	2006	2007	2008
Dosage units	1,190,125	667,040	478,685	774,238	425,021	504,170
Kilograms	97	1,434	2,668	325	3,953	902
Milliliters	7,179	30,659	120,490	131,269	249,081	901,487
Pills	3,000	0	8,696	764,830	196,388	15,852

Source: National Seizure System.

Note: Data are presented in the format reported with regard to unit of measure.

Schedule II through IV CPDs reported to NSS during this period include barbiturates, clonazepam, codeine, Darvocet®, Darvon®, depressants, Dilaudid® (hydromorphone), hydrocodone (Vicodin®), lorazepam (Ativan®), meperidine (Demerol®), methadone, morphine, oxycodone, Ritalin® (methylphenidate), stimulants, Tylenol III®, Valium® (diazepam), Xanax® (alprazolam), and Percocet®. The category “Other Prescription Drugs” was also reported; however, that category has been omitted from this table because it probably included noncontrolled prescription drugs.

Rogue Pharmacies Dispense Inordinate Amount of Schedule III and IV Products

CPDs usually account for 11 percent of the prescription drugs dispensed at legitimate brick-and-mortar pharmacies in the United States; however, CPDs often account for as much as 95 percent of the prescription drugs dispensed at rogue Internet pharmacies investigated by DEA.

In November 2008 the owner/operator of several Internet pharmacies was convicted of illegal distribution of prescription medication (primarily Schedule IV diet pills), conspiracy, and money laundering. The individual's son, who also owned an illegal Internet pharmacy, was convicted of illegal distribution of prescription medication. The defendants' convictions were based on their distribution of millions of dollars' worth of CPDs without valid prescriptions to customers located throughout the United States. Upon conviction the father was ordered to forfeit \$10 million in illegal proceeds that he had obtained through the scheme. The son agreed to forfeit \$1.8 million in illegal proceeds based on his conviction. The father faces a maximum of 25 years' imprisonment; his son faces a maximum of 5 years' imprisonment.

In September 2008 a New York man pleaded guilty to conspiracy to distribute controlled substances. From 2004 to 2007 he had dispensed approximately 440,000 Schedule IV prescription drugs to individuals worldwide who had placed orders over the Internet with his companies. The man faces a term of imprisonment of up to 5 years, a fine of \$250,000, or both.

In January 2007 an Illinois doctor was sentenced to imprisonment as a result of a nationwide Internet investigation that was initiated in Dubuque, Iowa. The doctor pleaded guilty on July 14, 2006, to conspiring to dispense Schedule III and IV CPDs without a legitimate medical purpose and outside the usual course of medical practice as well as laundering proceeds of his illegal distributions. He admitted to prescribing more than 62 million Schedule III and IV dosage units illegally over the Internet.

In fiscal year (FY) 2007, DEA issued Immediate Suspension Orders to 10 registered pharmacies operating in Florida. These pharmacies diverted millions of dosage units of Schedule III hydrocodone across the United States via the Internet. Nine of the pharmacies chose to surrender their registration or shut down business rather than face a hearing. The tenth pharmacy did not prevail at its hearing and lost its DEA registration.

In 2006 Operation Click4Drugs targeted a DTO that used more than 300 web sites to distribute large quantities of Schedule III and IV prescription drugs and passed \$25 million through six bank accounts monthly. One pharmacy filled more than 2,000 prescriptions per day.

Source: Drug Enforcement Administration.



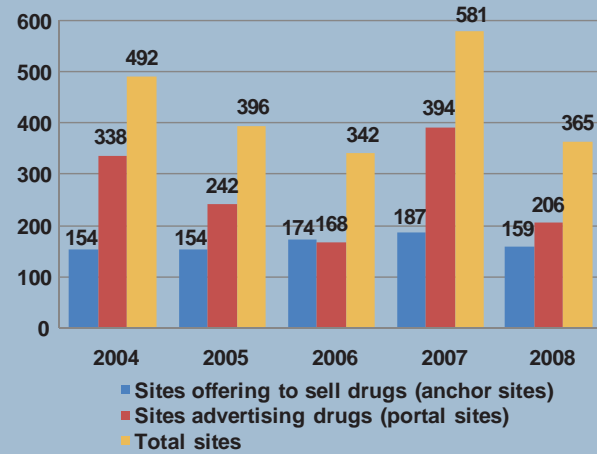
Internet diversion more difficult to accomplish. Distributors and abusers typically acquire larger quantities of Schedule III and IV prescription drugs per diversion incident than Schedule II prescription drugs. Further, legitimate patients purchasing Schedule III and IV CPDs on the Internet typically obtain larger quantities of the drugs per order, according to DEA.

The number of Internet sites offering to sell CPDs appears to have decreased in 2008; however, the Internet may remain a significant source of supply for Schedule III and IV drugs. Federal law enforcement reporting indicates that the number of Internet sites offering to sell CPDs decreased in 2008. Federal officials cite cooperation between federal and state law enforcement agencies, Internet service providers (ISPs), package delivery services, and financial services companies typically used by rogue Internet pharmacy operators as a primary reason for the reduction in rogue pharmacies that operate on the Internet. Studies conducted by CASA confirm the law enforcement reporting. According to CASA, the number of identified rogue Internet pharmacies that advertised (portal sites) or offered to sell (anchor sites) selected Schedule II, III, or IV prescription drugs decreased 37 percent, from 581 in 2007 to 365 in 2008. (See Figure 5.) The number of Internet sites that offered CPDs²⁰ for sale decreased from 187 in 2007 to 159 in 2008. Most of the Internet pharmacies identified in the CASA study appeared to be rogue Internet pharmacies.²¹ In fact, only two of the 159 anchor sites identified in 2008 were certified by the National Association of Boards of Pharmacy (NABP) as legitimate pharmacy sites. Approximately 85 percent of the sites

20. The National Center on Addiction and Substance Abuse (CASA) at Columbia University used a list of drugs that included controlled prescription drugs as defined by DEA in Schedules II through V but concentrated on prescription drugs in Schedules II and III.

21. The goal of the CASA study was to uncover as many web sites as possible that were involved in the sale of CPDs by using Internet searches and e-mail advertisements. CASA researchers did not complete any transactions by purchasing the drugs because doing so would have been illegal. The methodology used in this study can be found at <http://www.casacolumbia.org/articlefiles/531-2008%20You've%20Got%20Drugs%20V.pdf>

Figure 5. Internet Sites Advertising or Offering to Sell Controlled Prescription Drugs, 2004–2008



Source: National Center on Addiction and Substance Abuse at Columbia University.

that offered to sell CPDs did not require a physician's prescription, a percentage statistically unchanged from the 2007 study (84 percent).

A relatively small number of unscrupulous physicians lose their DEA registrations for improper prescribing practices. DEA estimates that in any given year, fewer than 1 in 10,000 physicians (0.01%)²² lose their DEA registration based on a DEA investigation for improper prescribing. Unscrupulous physicians who do prescribe CPDs outside the course of professional practice, however, can divert a large quantity of drugs. Typically, CPD abusers are aware of the physicians in their areas who are willing to supply unlawful services for a cash fee. When doctors are arrested, lose their registrations, or lose their licenses, the resulting decrease in availability of CPDs on the street usually leads to increases in treatment admissions and/or the street prices of diverted CPDs, according to DEA reporting.

22. Approximately 750,000 medical doctors and doctors of osteopathic medicine were registered with DEA in 2006.

DEA's Drug Theft and Loss Database (DTL)

DEA's DTL database reflects information provided by registrants under regulatory requirement to report thefts and losses of controlled substances (21 CFR §1301.74 and 1301.76). Registrants are not required to report ultimate recovery of these drugs. According to DEA, anyone attempting to draw conclusions from these data should proceed with caution because no direct correlation exists between a reported theft or loss of a controlled substance and placement of the drug into illicit channels.

Millions of dosage units of CPDs were stolen or lost in transit from 2003 through 2007. Significant quantities of CPDs were diverted from legitimate commerce through armed robberies, customer theft, employee pilferage, transit losses, and night break-ins at pharmacies between 2003 and 2007, according to the latest data available from DEA (see [Table 3 on page 10](#)). The amount of CPDs stolen or lost in transit seemingly increased from approximately 19.4 million milliliters/quantities in 2003 to nearly 28.3 million milliliters/quantities in 2007; however, of the 28.3 million milliliters/quantities reported stolen in 2007, 16 million were quickly recovered by law enforcement officials. (See [text box, above right](#).)

The amount of CPDs stolen in armed robberies doubled from over 0.5 million milliliters/quantities in 2003 to nearly 1.1 million in 2007; the amount stolen by customers during that time decreased from nearly 79,000 to slightly more than 66,000 milliliters/quantities. The amount of CPDs stolen by employees of healthcare facilities and pharmacies decreased from 8.9 million milliliters/quantities in 2003 to 4.5 million in 2007. The amount lost in transit increased from more than 1.4 million milliliters/quantities in 2003 to more than 18.5 million in 2007; however, when the 16 million recovered units are subtracted from the total, the amount lost in transit is slightly more than 2.5 million (still an increase). The amount of CPDs stolen in night break-ins of

Tractor-Trailer Hauling 16 Million Dosage Units of Hydrocodone/Combination Products Stolen

A tractor-trailer hauling more than 16 million dosage units of hydrocodone/combination products was stolen at a truck stop in June 2007. The tractor-trailer had been traveling from the Watson Pharmaceuticals manufacturing plant in Corona, California, to its distributor in Gurnee, Illinois, when it was stolen in Troy, Illinois. A monetary reward was offered, and an individual called with information on the tractor-trailer "almost immediately," according to police reporting. The vehicle and the hydrocodone were recovered.

Source: Drug Enforcement Administration, St. Louis Field Office.

pharmacies decreased substantially, from more than 8.5 million milliliters/quantities in 2003 to more than 4 million milliliters/quantities in 2007; however, the quantity of CPDs stolen in such break-ins peaked substantially in 2005 at 15.7 million milliliters/quantities. While these data indicate that significant quantities of scheduled drugs are lost or stolen annually, DEA reports that the amount of such drugs actually distributed on the illicit market is unknown because a portion of the lost and stolen drugs are quite likely recovered but not reported to DEA.

The percentage of state and local law enforcement agencies reporting high levels of prescription depressant and narcotic diversion/illicit use increased overall in the United States from 2006²³ through 2008, while the percentage of agencies reporting high levels of prescription stimulant diversion/illicit use decreased or was stable in most regions. The most significant increases in the percentages of law enforcement agencies reporting high levels of diversion/illicit use of pharmaceuticals were for depressants, according to the NDTs. (See [Table 4 on page 11](#).) The greatest increases occurred in the Pacific (167%), New York/New Jersey (89%), and

23. Survey data prior to 2006 are not comparable because of changes in the format of the question.



Table 3. Schedule II–V Controlled Prescription Drugs Reported Stolen or Lost in Transit Nationwide in Milliliters* and Quantities, 2003–2007**

	2003	2004	2005	2006	2007
Armed Robberies					
Milliliters	18,292	11,907	51,006	52,557	100,703
Quantities	562,642	394,172	497,014	576,005	998,623
Customer Theft					
Milliliters	12,388	21,801	10,819	16,514	12,718
Quantities	66,601	106,891	26,252	42,858	53,512
Employee Pilferage					
Milliliters	5,126,879	5,223,779	3,148,651	795,427	1,240,482
Quantities	3,756,590	4,627,624	3,413,824	3,137,128	3,274,706
Lost in Transit					
Milliliters	419,983	841,405	601,985	484,887	377,602
Quantities	1,002,207	1,239,354	1,556,462	2,241,642	18,193,469
Night Break-Ins					
Milliliters	810,252	819,383	8,888,027	433,664	406,308
Quantities	7,646,336	4,356,118	6,833,214	6,403,356	3,602,619
Total					
Milliliters	6,387,794	6,918,275	12,700,488	1,783,049	2,137,813
Quantities	13,034,376	10,724,159	12,326,766	12,400,989	26,122,929

Source: Drug Enforcement Administration.

*Milliliters include ampules, syringes, injectibles, bottles, vials, lotions/ointments, liquids, and nasal spray.

**Quantities include tablets, capsules, patches, lollipops, powders, diskettes, and suppositories.

Note: Over 16 million of the 18 million dosage units lost in transit in one incident in 2007 were recovered.

Mid-Atlantic (83%) OCDETF Regions.²⁴ Moreover, in 2008 more than one-half of law enforcement agencies in seven of nine OCDETF Regions reported high levels of diversion/illicit use of narcotics.

24. For the purposes of this report, regional discussions will be delineated along boundaries established under the Organized Crime Drug Enforcement Task Force (OCDETF) program. The OCDETF program was established in 1982 to mount a comprehensive attack against organized drug traffickers. The OCDETF program is the centerpiece of the United States Attorney General's drug strategy to reduce the availability of drugs by disrupting and dismantling major DTOs and money laundering organizations and related criminal enterprises. The program operates nationwide and combines the resources and unique expertise of numerous federal agencies in a coordinated attack against major drug trafficking and money laundering organizations. See Figure 6 on page 12 for regional demarcations.

The greatest increases over the 3-year period occurred in the Pacific (107%), Florida/Caribbean (72%), and West Central Regions (72%). The percentage of law enforcement agencies reporting high levels of diversion/illicit use of stimulants trended upward in only four of the nine regions and downward in three regions; in two regions there were no changes overall.

CPD diversion is prevalent throughout the United States; however, CPD diversion is highest in eastern states. Law enforcement officials in the eastern portion of the United States report the highest levels of diverted CPD availability, according to NDTs data. (See Figure 6 on page 12.) The largest percentage—61 percent—of law enforcement agencies reporting high availability of

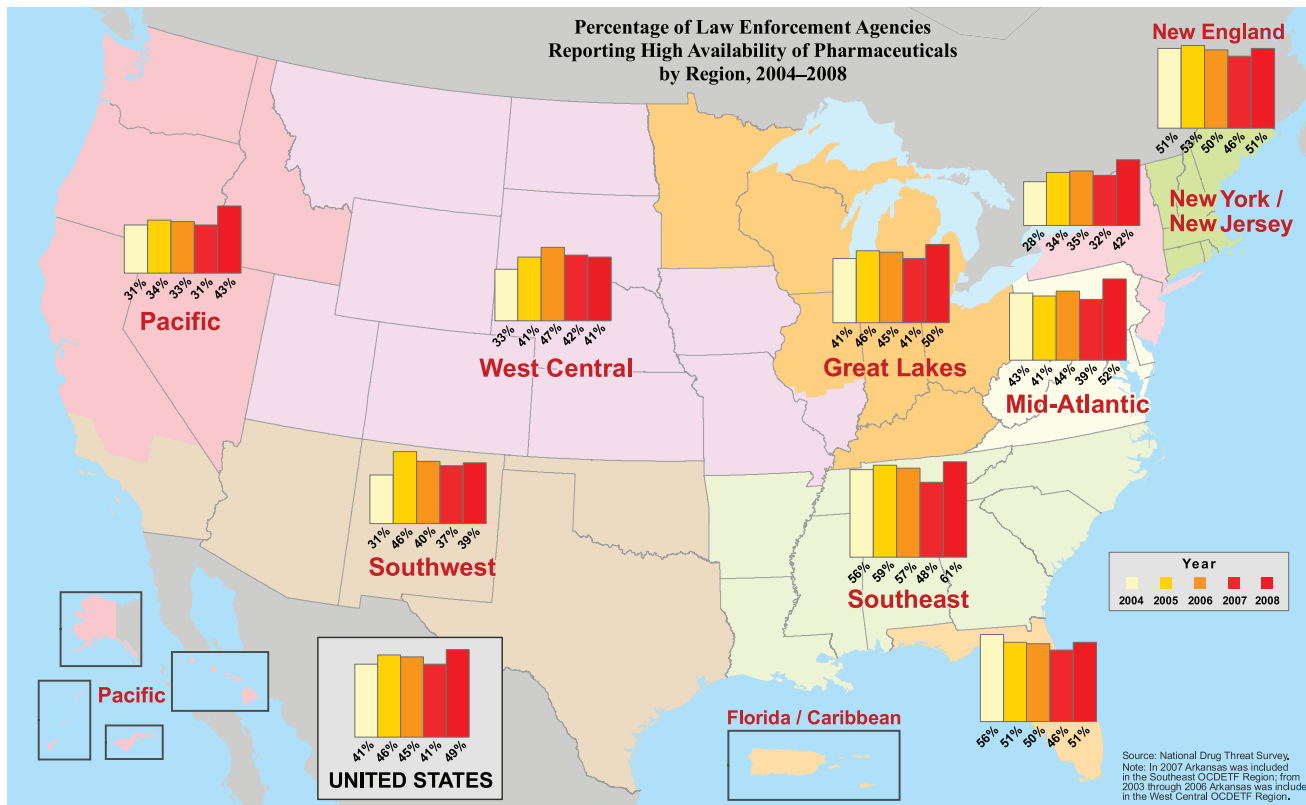
Table 4. Percentage of Law Enforcement Agencies Reporting High Levels of Diversion/Illicit Use of Pharmaceuticals, 2006*–2008

	2006	2007	2008	Percent of Change
Narcotics				
Florida/Caribbean	36	45	62	72%
Great Lakes	38	40	58	53%
Mid-Atlantic	38	44	55	45%
New England	48	48	65	35%
New York/New Jersey	29	27	46	59%
Pacific	28	36	58	107%
Southeast	48	49	63	31%
Southwest	35	38	42	20%
West Central	32	38	55	72%
Depressants				
Florida/Caribbean	33	25	51	55%
Great Lakes	23	26	39	70%
Mid-Atlantic	23	27	42	83%
New England	25	22	42	68%
New York/New Jersey	18	11	34	89%
Pacific	9	14	24	167%
Southeast	37	40	61	65%
Southwest	27	30	42	56%
West Central	20	23	32	60%
Stimulants				
Florida/Caribbean	8	17	14	75%
Great Lakes	17	20	21	24%
Mid-Atlantic	17	23	18	6%
New England	17	19	23	35%
New York/New Jersey	13	11	12	-8%
Pacific	13	11	12	-8%
Southeast	17	24	17	0%
Southwest	18	17	9	-50%
West Central	16	19	16	0%

Source: National Drug Threat Surveys.

*NDTS survey question was changed beginning in 2006; previous data are not comparable.

Figure 6. Percentage of Law Enforcement Agencies Reporting High Availability of Pharmaceuticals, by OCDETF Region, 2004–2008



Source: National Drug Threat Surveys.

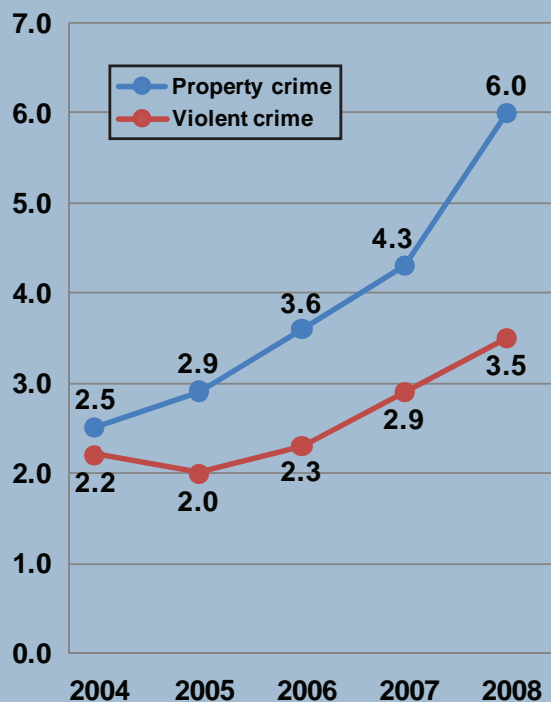
pharmaceuticals in 2008 was in the Southeast OCDETF Region. Law enforcement agencies also reported high availability in the Mid-Atlantic, New England, Florida/Caribbean, and Great Lakes Regions. The percentage of law enforcement agencies in the United States reporting high availability of pharmaceuticals has trended upward in most OCDETF Regions over the past 5 years, with the exception of the Florida/Caribbean Region,²⁵ where 5 percent fewer agencies reported high availability over that period, and in the New England Region, where availability remained relatively stable.

25. Federal law enforcement reporting indicates that numerous investigations from 2006 through 2008 targeting diversion using the Internet have significantly decreased the number of rogue Internet pharmacies operating in Florida. The success of these initiatives is believed to have had a considerable impact on the availability of CPDs in the state.

CPD diversion is associated with increases in crime. Law enforcement agencies are increasingly associating CPD diversion and abuse with violent and property crimes nationwide, particularly in regions where CPD availability is high. The percentage of law enforcement agencies reporting an association between the diversion and abuse of CPDs and property or violent crime trended upward from 2004 through 2008, according to the NDTs. (See Figure 7 on page 13.) The highest percentages of law enforcement agencies reporting an association between property crime and CPD diversion and abuse were in the New England, Great Lakes, and Mid-Atlantic OCDETF Regions (15.1%, 10.0%, and 8.8%, respectively). The highest percentages of law enforcement agencies reporting an association between violent crime and CPD diversion and abuse were in the New England, Great Lakes, and Florida/Caribbean Regions (9.8%, 6.2%, and

5.5%, respectively). (Law enforcement agencies in these regions also reported high availability of diverted pharmaceuticals;²⁶ see Figure 6 on page 12.) The percentage of overall change annually was slight; however, over the 5-year period, the trend upward was 3.5 percent for property crime and 1.3 percent for violent crime.²⁷ State and local law

Figure 7. Percentage of Law Enforcement Agencies Reporting an Association Between Diverted Pharmaceuticals and Crime, 2004–2008



Source: National Drug Threat Surveys.

Note: Such trends are not reflected in DEA investigative and intelligence systems.

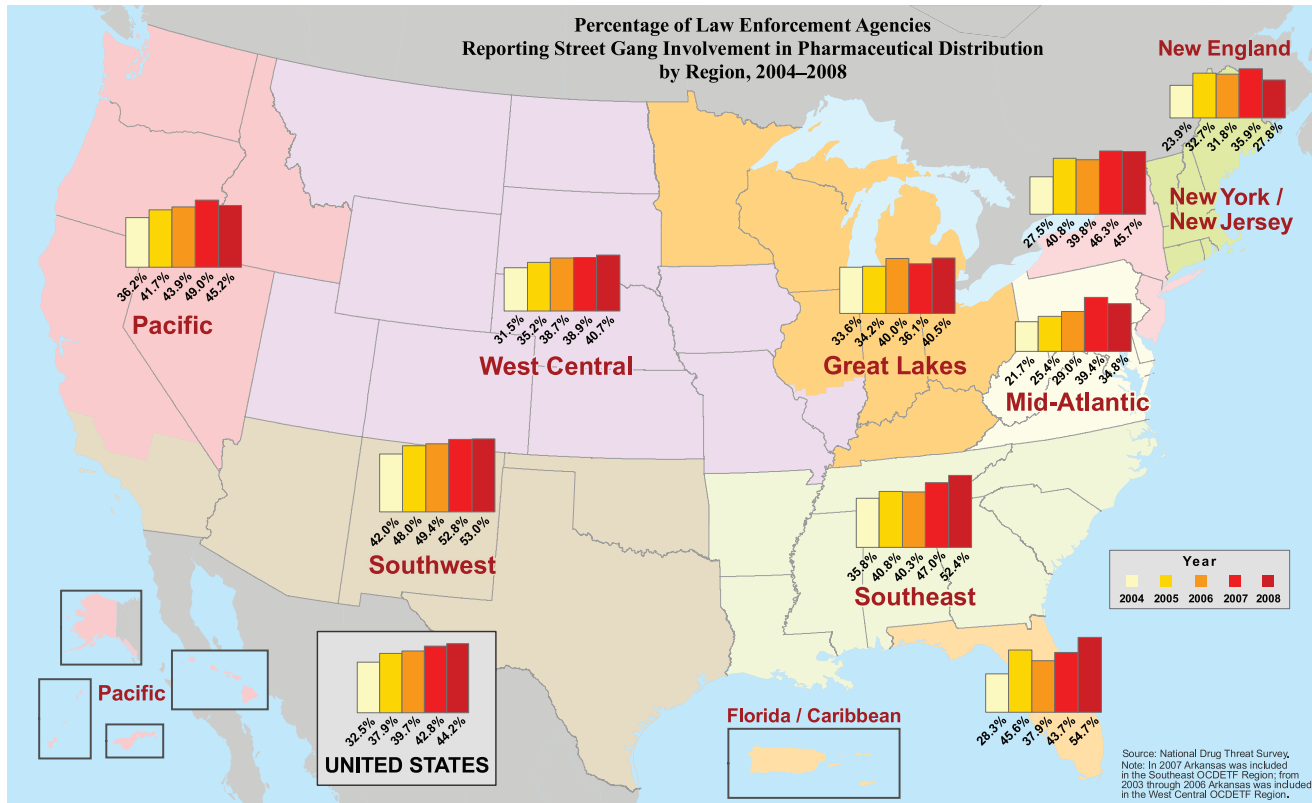
26. The NDTs uses the term “diverted pharmaceuticals” with the understanding that law enforcement agencies responding to the survey would report diverted pharmaceutical activity related only to distribution of scheduled prescription drugs prosecutable under the Federal Controlled Substances Act.

27. NDTs data regarding the association between violent and property crime and illicit drugs are shown in Figures 23 and 24 on pages 35 and 36, respectively.

enforcement agencies in several areas of the United States report that some murders, retail thefts, daytime break-ins, thefts at seasonal camps, car break-ins, pharmacy burglaries, and mail and identity theft that have occurred in their jurisdictions have been linked to diversion and abuse of CPDs. Moreover, some treatment providers anecdotally report that prescription opioid abusers engage in criminal activity to obtain money when they can no longer afford to purchase the quantity of drugs that they require to achieve their intended euphoria or to prevent opioid withdrawal symptoms.

DTO involvement in CPD diversion and distribution is minimal; however, street gangs are increasingly distributing the drugs. The diversion and distribution of CPDs by DTOs and criminal groups have not been reported to any meaningful extent by law enforcement officials throughout the nation. Some law enforcement agencies and treatment providers as well as federal and private surveillance surveys have reported, however, that some CPD abusers purchase drugs from strangers and “dealers.” Additionally, periodic law enforcement reporting indicates that some street dealers who sell marijuana, heroin, and cocaine have started to sell CPDs. While DTOs and criminal groups do not appear to be heavily involved in CPD distribution, law enforcement reporting does indicate that street gang and OMG involvement in CPD distribution has increased in many areas of the country. The percentage of law enforcement agencies nationwide reporting street gang involvement in illicit pharmaceutical distribution trended upward from approximately 32 percent in 2004 to 44 percent in 2008, according to the NDTs. Regionally, the percentage of law enforcement agencies reporting street gang involvement in CPD distribution during those years ranged from an average of 30 percent in the Mid-Atlantic and New England Regions to an average of 49 percent in the Southwest Region. (See Figure 8 on page 14.) A few law enforcement agencies in California reported in 2008 that African American street gangs had become involved in OxyContin® distribution and that Caucasian young adults were purchasing OxyContin® from these street gang

Figure 8. Percentage of Law Enforcement Agencies Reporting Street Gang Involvement in Pharmaceutical Distribution, by OCDETF Region, 2004–2008



Source: National Drug Threat Surveys.

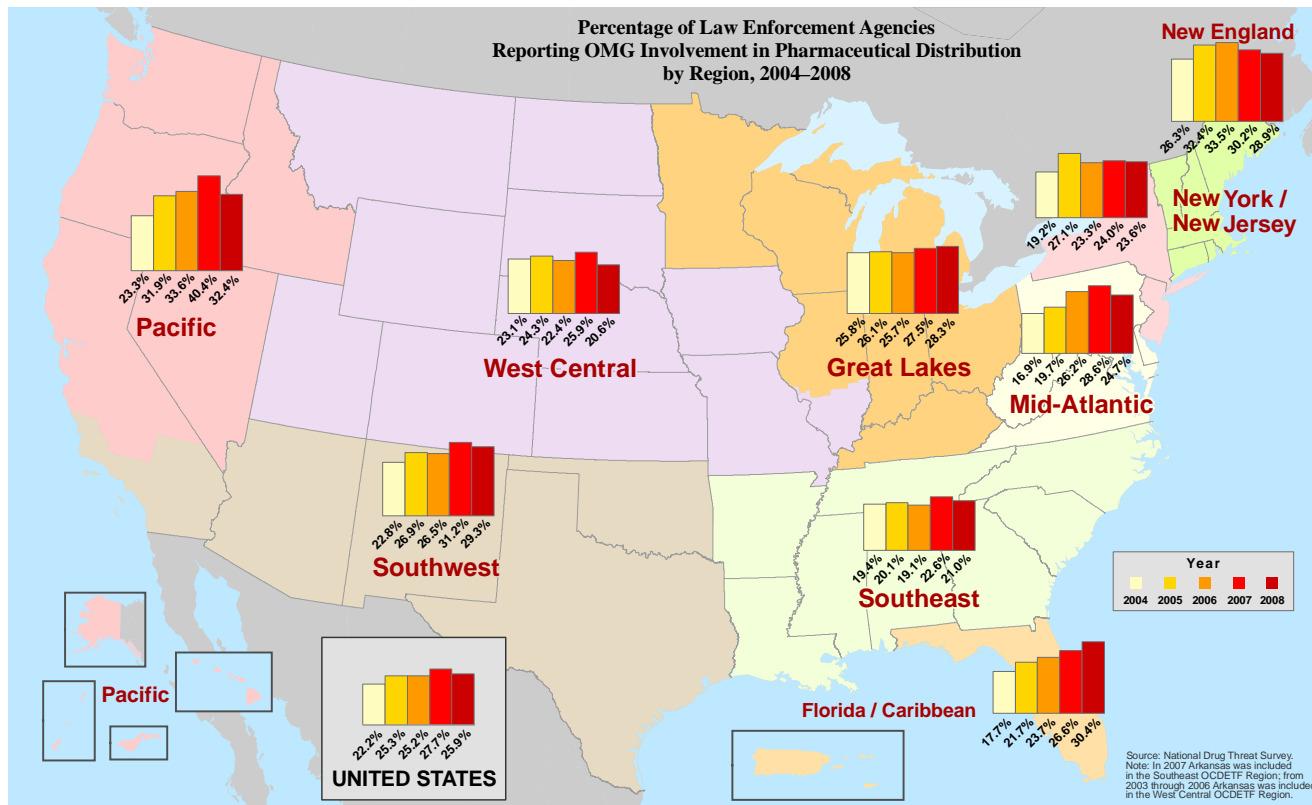
members. Moreover, one law enforcement agency in New Hampshire reported in 2008 that Bloods gang members routinely obtain OxyContin® in Massachusetts and distribute the drug in its jurisdiction, while another law enforcement agency in Texas reported in 2008 that female associates of street gangs and OMGs earn income primarily by selling diverted CPDs that they obtain through prescription fraud. Finally, a law enforcement agency in Washington State reported in 2008 that some African American street gang members were involved in the distribution of CPDs.

According to NDTs estimates, the percentage of law enforcement agencies nationwide reporting OMG involvement in illicit pharmaceutical distribution trended upward from approximately 22 percent

in 2004 to 26 percent in 2008; however, regionally, that percentage fluctuated. (See Figure 9 on page 15.) The percentage of law enforcement agencies reporting OMG involvement in CPD distribution between 2004 and 2008 ranged from an average of 20 percent in the Southeast Region to an average of 32 percent in the Pacific Region. A law enforcement agency in Virginia reported in 2008 that the War Lords Motorcycle Gang had established a local chapter, and its members reportedly were involved in trafficking Schedule II and III prescription drugs.

Teenagers find diverted CPDs readily available; they can often obtain them at no cost. According to CASA’s 2008 National Survey of American Attitudes on Substance Abuse XIII, for the first time in the survey’s history, more teenagers reported

Figure 9. Percentage of Law Enforcement Agencies Reporting OMG Involvement in Pharmaceutical Distribution, by OCDEF Region, 2004–2008



Source: National Drug Threat Survey.

that prescription drugs²⁸ were easy to purchase without a prescription (19%) than reported that beer was easy to purchase (15%). Teenagers also reported that they could easily obtain CPDs from family and friends. Of the 1,002 teens participating in the 2008 CASA survey who knew a prescription drug abuser, one-third reported that the abusers could get prescription drugs from home, the medicine cabinet, or parents, while another one-third reported that abusers could acquire prescription drugs from friends or classmates.

Friends or relatives are the primary sources for CPDs among most abusers. More than half of the nonmedical users of prescription-type opioid

pain relievers, tranquilizers, stimulants, and sedatives obtained the drugs they used most recently “from a friend or relative for free,” according to 2006 and 2007 NSDUH data. NSDUH data further reveal that among individuals aged 12 or older who used opioid pain relievers nonmedically in the past 12 months, 55.7 percent reported in 2006 that they had obtained the opioid pain relievers from a friend or relative for free, and 56.5 percent reported the same in 2007. Another 9.3 and 8.9 percent bought the drugs from a friend or family member in 2006 and 2007, respectively. Moreover, data from a 2006 study released in the June 2008 edition of the *American Journal of Public Health* indicated that 22.9 percent of 700 participants in the study

28. The specific drugs mentioned in the survey question were OxyContin®, Percocet®, Vicodin®, and Ritalin®.



NATIONAL DRUG INTELLIGENCE CENTER DRUG ENFORCEMENT ADMINISTRATION

“loaned” their medications²⁹ to someone else, and 26.9 percent “borrowed” someone else’s prescription medication. Nearly 22 percent of study participants reported sharing prescription pain medications.

COMBATING DIVERSION

PDMPs limit traditional diversion methods by enabling practitioners and pharmacists to monitor patients’ prescription drug use and intervene when diversion and/or abuse are suspected. As of January 1, 2009, 32³⁰ states had implemented operational PDMPs³¹ in an effort to stem the diversion of CPDs; another 6 states and one U.S. territory had enacted legislation requiring PDMPs. (See Figure 10 on page 17.) In 2007 nearly 9,600 prescribers, dispensers, and law enforcement officials received formal training on the use of PDMPs, according to BJA. Also in 2007, administrators of operational PDMPs responded to nearly one million report requests made by prescribers, dispensers, or individuals authorized to conduct investigations; these respondents subsequently generated more than 56,000 reports providing prescribers or dispensers with information on patients who

29. Specific medication categories listed in the survey were allergy, pain, mood, antibiotic, acne, birth control, and “other.”

30. The Washington State Department of Health suspended the state’s Prescription Monitoring Program in December 2008 because of state budget shortfalls.

31. Prescription drug monitoring programs (PDMPs) are systems in which CPD data are collected in a database, centralized by each state, and administered by an authorized state agency to facilitate the early detection of trends in diversion and abuse. Data collected include the physician visited, the number of times the physician is visited, the drugs for which each individual receives a prescription, the quantity of drugs prescribed, and the pharmacy or pharmacies that fill the prescriptions. Each state controls the language of its PDMP with regard to how the prescription information gathered as part of the program will be shared, not only within the state but also with other states. For instance, one PDMP may share information among law enforcement, treatment providers, physicians, and pharmacists within the state but not with any agency in other states. Another may opt to share its prescription data only with physicians and pharmacists nationwide, while a third may choose to share all its data with all other state agencies.

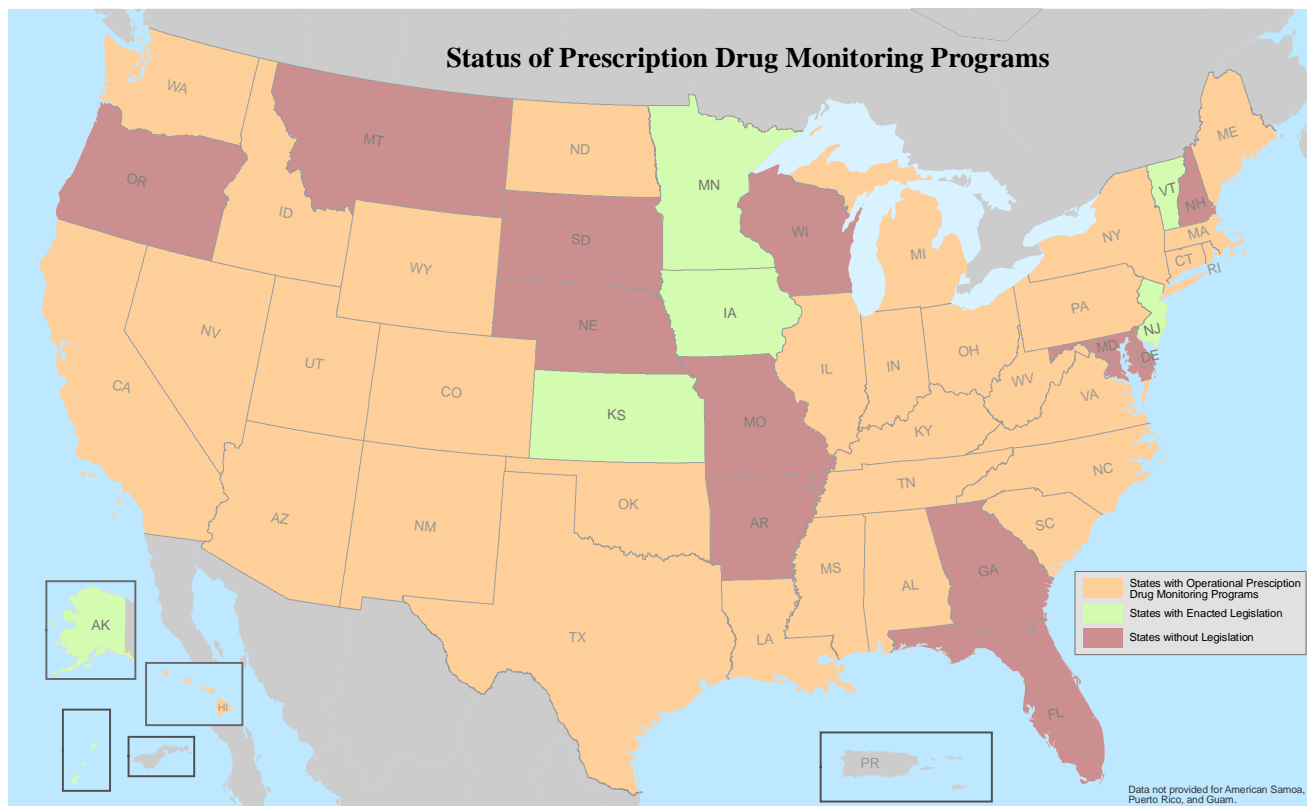
may have been abusing prescription drugs and/or doctor-shopping during that year. Additionally, a 2002 GAO report³² determined that state PDMPs improved the timeliness of law enforcement and regulatory investigations by at least 80 percent and that the programs had deterred doctor-shopping in the three states involved in the study. Moreover, a 2006 Simeone Associates, Inc. evaluation of PDMPs nationwide indicated that the presence of a PDMP reduced the per capita supply of prescription pain relievers and stimulants, decreasing the probability of abuse for these drugs. According to the Simeone study, states that are proactive in their approach to regulation may be more effective in reducing the per capita supply of prescription pain relievers and stimulants than states that take a reactive approach.

PDMPs often affect diversion levels in neighboring states. When states implement PDMPs, diversion activity often increases in neighboring states without PDMPs or with PDMPs that do not share data gathered, according to law enforcement reporting and GAO officials. For example, law enforcement agencies in Florida reported in 2008 that CPD distributors and abusers from Alabama, Georgia, Massachusetts, and North Carolina often travel to Florida to obtain CPDs from pain clinic doctors, in part because Florida does not have an operational PDMP. Additionally, law enforcement agencies in Kentucky, a state that has an operational PDMP, report that distributors transport CPDs, particularly OxyContin®, from Michigan and, to a lesser extent, Dayton and Cincinnati, Ohio; Miami and Tampa, Florida; and Philadelphia, Pennsylvania, to Kentucky for local distribution.³³ Law enforcement agencies in New England report that

32. The cited report is the latest U.S. Government Accountability Office (GAO) study pertaining to PDMPs. It was released in 2004.

33. State PDMPs, such as the ones mentioned in this paragraph, vary in the way that they share data. Most that do share data require formal requests for the information. Individuals may obtain drugs in multiple states before they are suspected of doctor-shopping, and any formal requests are submitted through the PDMP(s). Compounding the situation, the time period for processing the data requests varies.

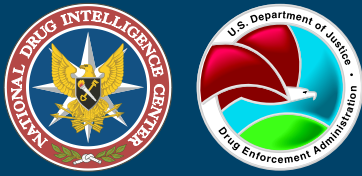
Figure 10. Status of Prescription Drug Monitoring Programs as of January 1, 2009



Source: Bureau of Justice Assistance.

trafficking organizations hire individuals as “runners” and provide them with airline tickets and cash to travel to Florida to obtain CPDs, primarily oxycodone products; the organizations then sell the drugs in New England. Law enforcement agencies in the District of Columbia area report that individuals in Virginia and West Virginia travel to neighboring states to obtain and fill prescriptions in order to avoid having the transactions recorded in the PDMP databases in Virginia and West Virginia. Interstate information-sharing requirements vary among PDMPs, creating potential diversion opportunities for abusers and distributors. To facilitate information sharing between states, BJA has provided technical assistance and funding for a project through which public and private technology solutions providers, the IJIS Institute, and

PDMP representatives are working to establish a nationwide information-sharing platform that will facilitate the interstate exchange of PDMP data. Currently (early 2009) the technical aspect of the project is in final development, and initial testing between states is being planned. Additionally, through the Harold Rogers Prescription Drug Monitoring Program (HRPDMP), BJA competitively awards state PDMP planning, implementation, and enhancement grants and makes available to the states, via Brandeis University and the Alliance of States with Prescription Drug Monitoring Programs, technical assistance on fulfilling project goals and objectives. Implementing new PDMPs and facilitating the interstate exchange of PDMP data are priorities for HRPDMP funding.



Investigative cooperation between DEA, ISPs, package delivery services, and financial services companies has made it increasingly difficult for rogue Internet pharmacy operators to conduct business. Rogue Internet pharmacy operators rely on traditional commercial businesses such as ISPs, package delivery services, and financial services businesses to ensure that their Internet transactions are completed in a timely and discreet manner and that their orders are expeditiously shipped. In an effort to prevent the use of their services in illicit enterprises, many of these businesses report suspected diversion activity to DEA and cooperate in subsequent investigations. Moreover, many financial institutions, including major credit card companies and third-party payment providers, prevent rogue Internet pharmacies from accepting their payment systems for purchases involving the illegal sale of CPDs; some financial institutions have explored the use of third-party web-crawling services³⁴ to identify sites involving potentially illegal CPD activities. When they identify such a site, the financial institutions remove access to their payment systems from the site. In FY2007, with the cooperation of commercial businesses, DEA initiated 132 Internet investigations, a 17 percent increase from FY2006, when 113 Internet investigations were initiated. As a result of these investigations, DEA seized approximately \$39 million in cash, bank accounts, property, and computers in FY2007, a 319 percent increase over FY2006. In the first quarter of FY2008, DEA initiated 27 Internet investigations and seized \$9.2 million.

DEA is combating CPD diversion, particularly Internet diversion, by holding distributors accountable for monitoring the supply of CPDs that they sell to businesses and requesting fines against those that do not diligently do so. In 2005 DEA established a "Distributor Initiative" to reemphasize to CPD distributors their responsibility under the CSA to notify DEA of any requests by customers to purchase suspiciously large quantities

34. A web crawler is a program or automated script that methodically browses the Internet for up-to-date data. Web crawlers are mainly used to create a copy of each visited page for later processing by a search engine that will index the downloaded pages to provide fast searches. Crawlers can be used to gather specific types of information from web pages.

Shipments of CPDs to West Virginia From Unregistered Internet Pharmacies Reduced Following Registration Requirement

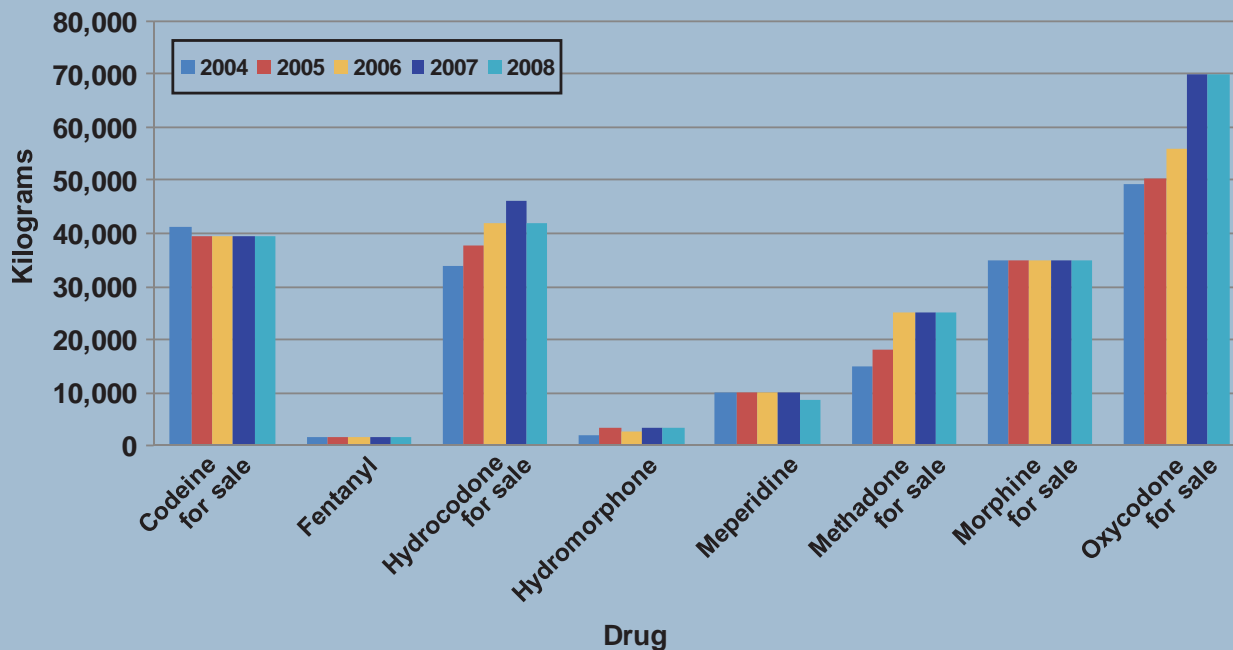
In 2006 West Virginia State Police and the West Virginia Board of Pharmacy, with the assistance of package delivery services, began a program to stop the illicit delivery of CPDs into West Virginia from out-of-state rogue Internet pharmacies. Only pharmacies registered with the West Virginia Pharmacy Board are permitted to ship CPDs to customers within the state. The pharmacy board provides a list of registered pharmacies to package delivery service providers that segregate prescription drug deliveries from unregistered companies. West Virginia State Police officers seize these segregated deliveries as contraband and notify the pharmacies that they are not registered with the Pharmacy Board as required. According to law enforcement reporting, as of 2008 most rogue Internet pharmacies no longer ship prescription drugs to West Virginia.

Source: Drug Enforcement Administration.

Production Quotas

Aggregate production quotas represent those quantities of controlled substances in Schedules I and II that manufacturers may produce in the United States each year to provide for the estimated medical, scientific, research, and industrial needs of the United States; lawful export requirements; and the establishment and maintenance of reserve stocks. Bulk manufacturers base requests for a production quota on the estimated quantity needed to supply DEA registrants. The quantity requested is based on past sales of the finished product, the quantity exported, the number of businesses requesting the product, and the inventory remaining from the previous year. Bulk manufacturers are permitted to keep an average of 50 percent of their production quota in stock, and dosage manufacturers are permitted to keep 50 percent of their current year's allocation in stock annually.

Figure 11. Aggregate Production Quotas for Selected Schedule II Controlled Prescription Drugs, in Kilograms, 2004–2008



Source: Drug Enforcement Administration.

of CPDs. When distributors³⁵ detect and report suspicious orders,³⁶ DEA opens an investigation into the business suspected of diverting CPDs. Distributors that fail to report suspicious orders and sell unusually large quantities of CPDs to businesses can face administrative action by DEA. Since beginning the initiative in 2005, DEA has suspended the registrations of several wholesale distributors, four of which are owned by two Fortune 500 companies. Moreover, since the inception of the initiative, aggregate production quotas for several commonly abused prescription drugs have remained stable and have not increased as dramati-

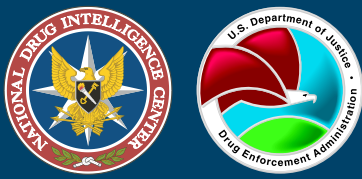
cally as in the past (see Figure 11), particularly from 2007 through 2008, indicating that distributors are adhering to the CSA by monitoring supplies of CPDs distributed to businesses.

ILLICIT FINANCE

Insurance fraud is used to finance the purchase of CPDs. According to law enforcement reporting, some individuals and criminal groups divert CPDs through doctor-shopping and use insurance fraud to fund their schemes. In fact, Aetna, Inc. reports that nearly half of its 1,065 member fraud cases in 2006 (the latest year for which data are available) involved prescription benefits, and most were related to doctor-shopping, according to the Coalition Against Insurance Fraud (CAIF). CAIF further reports that diversion of CPDs collectively costs insurance companies up to \$72.5 billion

35. Distributors are frequently able to detect potential diversion activity in the supply chain because they can determine normal quantities of supply required by businesses of particular sizes, including their usual customers, and can readily identify potentially fraudulent orders.

36. 21 CFR §1301.74(b) defines suspicious orders as those deviating from the norm in size, frequency, or pattern.



annually, nearly two-thirds of which is paid by public insurers. Individual insurance plans lose an estimated \$9 million to \$850 million annually, depending on each plan's size; much of that cost is passed on to consumers through higher annual premiums. CAIF also reports that a typical doctor-shopper can cost insurers between \$10,000 and \$15,000 per year in total costs related to diversion as well as emergency room treatment, hospital stays, physician's office visits, tests, and rehabilitation. To illustrate the magnitude of this problem, from 2004 through July 2008, NDIC Document and Media Exploitation (DOMEX)³⁷ teams supported 101 federal diversion cases; approximately 20 percent involved public or private insurance fraud. Individuals and criminal groups that commit insurance fraud multiple times are at risk of being identified by insurance companies; thus, they eventually turn to cash payment for the prescription drugs to avoid scrutiny.

Proceeds derived from the sale of diverted CPDs are laundered by distributors using methods similar to those employed by traditional drug traffickers. Rogue Internet pharmacy operators and unscrupulous physicians and pharmacists who divert and distribute CPDs primarily launder the illicit proceeds they derive through traditional depository institutions—banks, savings associations, and credit unions—typically through structured transactions, particularly deposits, according to law enforcement reporting. They also use other techniques that involve money orders and casinos. Law enforcement reporting reveals that unscrupulous physicians and pharmacists also launder illicit proceeds by investing in real estate, luxury vehicles, and high-tech electronic equipment; such purchasing activities generally do not raise suspicion, because individuals in these professions commonly purchase high-value items. Additionally, some physicians funnel large amounts of illicit proceeds through their own medical practices or other legitimate businesses, while some pharmacists use illicit proceeds to expand their pharmacy holdings.

37. The NDIC Document and Media Exploitation (DOMEX) Branch extracts vital information from document- or computer-related evidence seized in connection with law enforcement and intelligence operations. The evidence is used to further the investigation.

Government Employees Arrested in Health Insurance/OxyContin® Scam

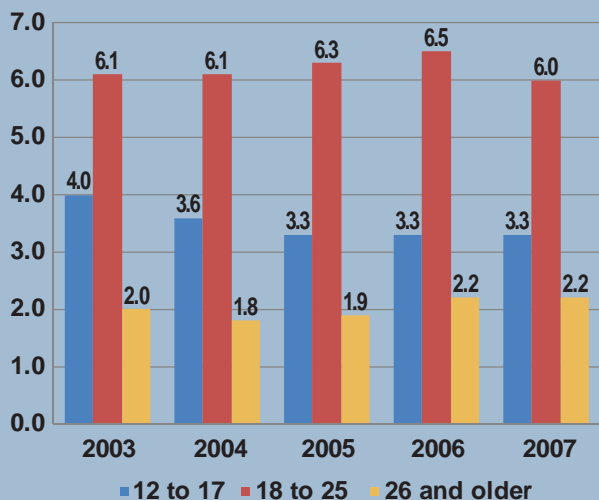
On August 6, 2008, the Miami-Dade (Florida) Police Department and the Miami-Dade County State Attorney's Office announced arrest warrants for 62 individuals, 52 of whom were public employees, charging them with crimes related to alleged health insurance fraud to obtain large quantities of OxyContin®. According to the Florida State Attorney's Office, beginning in January 2003, six recruiters enlisted local government employees and others to participate in an illegal operation in which those recruited would provide their health insurance identification information to a recruiter. The government employees and others who were recruited allegedly obtained prescriptions for OxyContin® (for which they had no medical need) from a complicit physician. They then presented the fraudulent prescriptions at local pharmacies in Miami-Dade County to obtain the OxyContin® tablets and sold the pills for cash to another individual involved in the scam. The government employees and others recruited also submitted insurance claims to their employer-issued health insurance company, fraudulently claiming reimbursement for the cost of the prescriptions. Officials estimate that approximately 130 medically unnecessary prescriptions for OxyContin® were presented to the pharmacies, accounting for more than 12,000 tablets with an estimated street value of almost \$400,000.

Source: Florida State Attorney's Office.

ABUSE

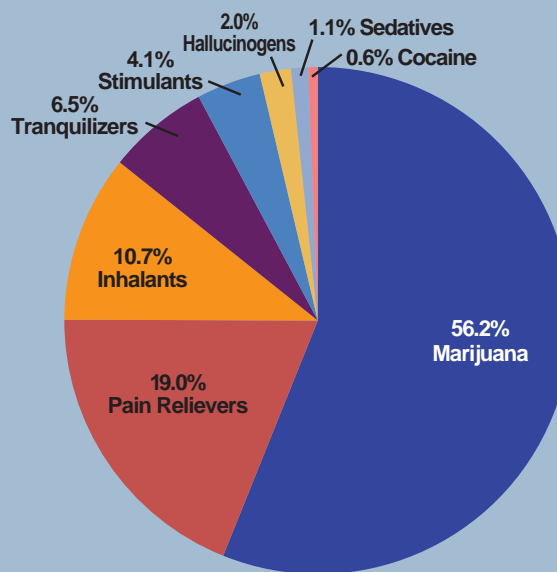
CPD abuse is most prevalent among young adults. Past month nonmedical use of CPDs is evident among individuals from teens to the elderly but is most prevalent among 18 to 25 year olds, according to NSDUH. (See Figure 12 on page 21.) NSDUH data indicate that abuse rates among young adults were relatively stable from 2003 through 2007; however, law enforcement and treatment providers reported in July 2008 that some college age individuals were increasingly abusing

Figure 12. Percentage of Past Month Nonmedical Use of Psychotherapeutics,* by Age, 2003–2007



Source: National Survey on Drug Use and Health.
 *NSDUH collectively categorizes pain relievers, stimulants, tranquilizers, and sedatives as “psychotherapeutics.”

Figure 13. Specific Drug Used When Initiating Illicit Drug Use Among Past Year Initiates of Illicit Drugs, Aged 12 or Older, 2007



Source: National Survey on Drug Use and Health.

stimulants (amphetamines and methylphenidate). They reportedly use the drugs to help them remain awake to study for extended periods. Moreover, some medical and law students as well as young professionals reportedly use stimulants nonmedically as performance enhancers to enable them to study longer or work for longer periods, which they believe gives them an edge over their peers. Some treatment providers report that students are initially attracted to stimulants because of their ability to enhance performance or to moderate the effects of other drugs used to enhance performance; however, many abusers become dependent on the drugs and require treatment.

Nearly one third of past year substance abuse initiates reported that their first drug was a psychotherapeutic. In 2007 an estimated 2.7 million individuals aged 12 or older reported having used an illicit drug for the first time within the past 12 months, according to NSDUH. Nearly

one-third initiated with psychotherapeutics (30.6 percent—including 19 percent with pain relievers, 6.5 percent with tranquilizers, 4.1 percent with stimulants, and 1.1 percent with sedatives; see Figure 13), while a majority reported that their first drug was marijuana (56.2%). Many of these substance abuse initiates used more than one substance; first-time use of marijuana and first-time nonmedical use of psychotherapeutics are often co-occurring phenomena. The specific drug categories with the largest number of recent initiates among persons aged 12 or older were pain relievers (2,147,000) and marijuana or hashish (2,090,000), according to NSDUH. (See Figure 14 on page 22.) Additionally, more initiates (1,232,000) tried prescription tranquilizers nonmedically for the first time in 2007 than tried any illicit drug other than marijuana or hashish (2,090,000).

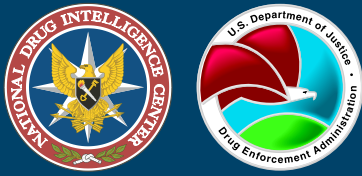
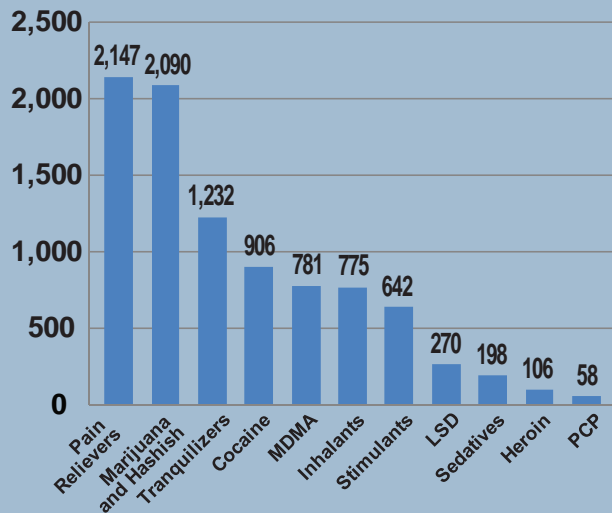
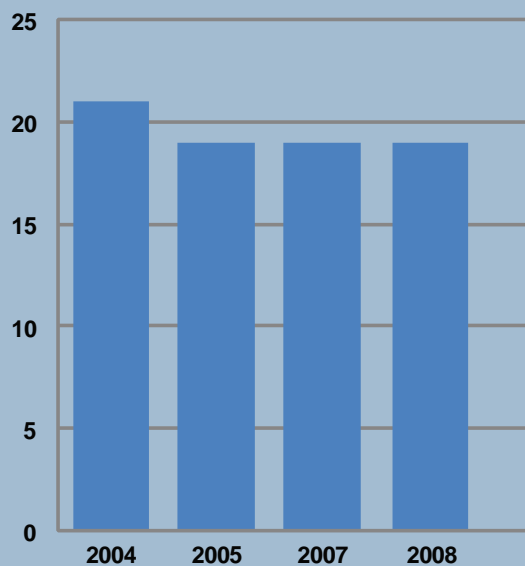


Figure 14. Past Year Initiates for Specific Illicit Drugs Among Persons Aged 12 or Older, in Thousands, 2007



Source: National Survey on Drug Use and Health.

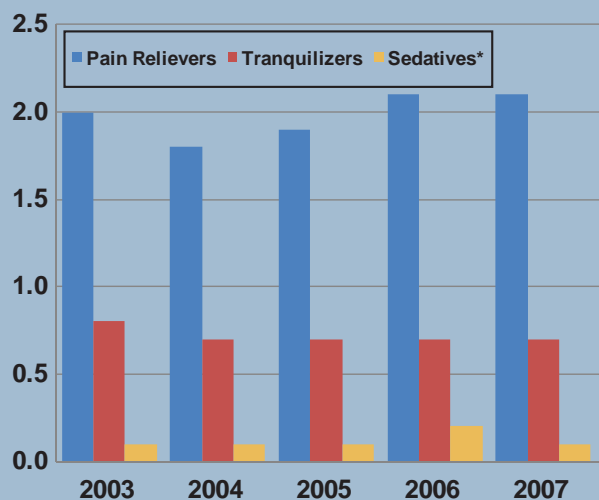
Figure 16. Percentage of Teenagers Who Used a Prescription Pain Reliever or Stimulant Not Prescribed for Them, 2004–2008*



Source: Partnership Attitude Tracking Study.

*The Partnership Attitude Tracking Study teen report for 2006 was held for review and comparison with the 2007 data and as of March 4, 2009, had not been released. These are the most recent comparable data.

Figure 15. Past Month Nonmedical Use of Psychotherapeutics by Individuals 12 and Older, in Percentages, 2003–2007

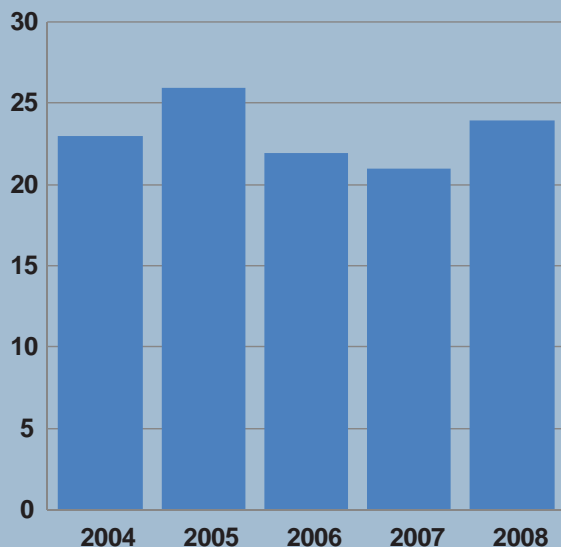


Source: National Survey on Drug Use and Health.

*Differences between the 2003 and 2004 sedative estimates and the 2007 sedative estimates are statistically significant at the 0.01 level.

Past month abuse rates for prescription pain relievers, tranquilizers, and sedatives among individuals 12 and older were stable overall from 2003 through 2007. According to NSDUH data, pain relievers were the psychotherapeutic drug used most frequently for nonmedical purposes in 2007—an estimated 5.2 million individuals aged 12 or older, or 2.1 percent of the population, reported past month nonmedical use of prescription pain relievers in 2007—the same percentage that reported nonmedical use in 2006, according to NSDUH. (See Figure 15.) Moreover, the rate of past month nonmedical use of pain relievers, tranquilizers, and sedatives among individuals 12 or older in 2007 did not differ significantly from the 2003 rate.

Figure 17. Percentage of Teenagers With Friends or Classmates Who Abuse Prescription Drugs, 2004–2008



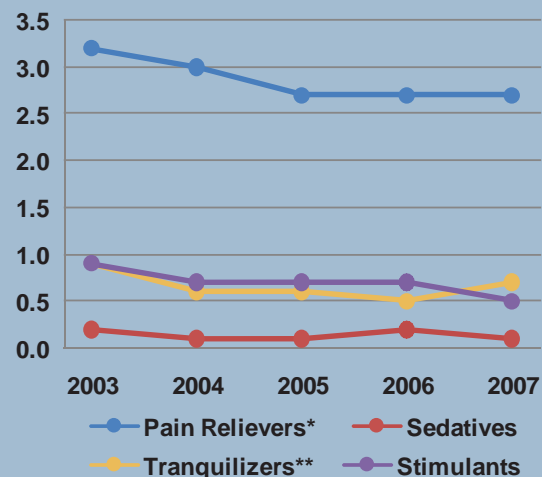
Source: National Center on Addiction and Substance Abuse at Columbia University.

Most national-level prevalence data indicate that CPD abuse rates among teenagers have remained stable, while NSDUH data indicate a significant decrease in pain reliever and stimulant abuse rates. Monitoring the Future (MTF), Partnership Attitude Tracking Study (PATS), and CASA data indicate that abuse rates among teenagers for most CPDs remained stable from 2003 through 2008. Additionally, the percentage of eighth and twelfth graders reporting nonmedical use of the opioid pain reliever Vicodin®³⁸ (hydrocodone) was stable, and changes in the rates of nonmedical use of OxyContin®³⁹ (oxycodone) were not statistically significant among teenagers, according to MTF. (See Table 5 on page 25.) Moreover, in the 2008, 2007 and 2005 PATS surveys, 19 percent of teenagers

38. Vicodin® is specifically mentioned in this survey.

39. OxyContin® is specifically mentioned in this survey.

Figure 18. Past Month Use of Psychotherapeutics Among 12- to 17-Year-Olds, in Percentages, 2003–2007



Source: National Survey on Drug Use and Health.

*The difference between the 2003 and 2007 estimates for pain relievers is statistically significant at the 0.01 level.

**The difference between the 2006 and 2007 estimates for tranquilizers is statistically significant at the 0.05 level.

reported using a prescription drug⁴⁰ not prescribed for them, slightly lower than the 21 percent who reported using such drugs in 2004. (See Figure 16 on page 22.) The percentage of teenagers reporting that they knew friends or classmates who abused prescription drugs remained relatively stable overall from 2004 through 2008 (see Figure 17), according to CASA. NSDUH data indicate that pain reliever and stimulant abuse rates among persons aged 12 to 17 decreased significantly overall from 2003 through 2007. (See Figure 18.)

CPD-related deaths involving opioid pain relievers increased from 2001 through 2005.

The number of unintentional deaths nationwide involving prescription opioid analgesics increased 114 percent, from approximately 3,994 in 2001 to 8,541 in 2005, according to the CDC. (See Figure 19 on page 24.) Unintentional poisoning

40. Prescription pain reliever or stimulant.



deaths in which methadone was mentioned increased 220 percent, from 1,158 in 2001 to 3,701 in 2005. Moreover, the number of unintentional prescription opioid analgesic deaths surpassed the number of cocaine and heroin deaths throughout the period. State medical examiner studies indicate that a high percentage of individuals who die from prescription drug overdoses have a history of substance abuse, many have no prescriptions for their drugs and misuse them in combination with illicit drugs, and some alter them by crushing and snorting them or dissolving and injecting them.

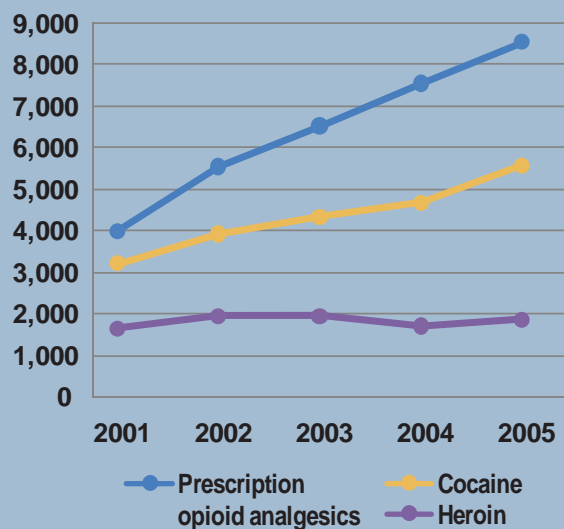
The number of treatment admissions and ED visits involving nonmedical use of CPDs varied depending on the drug type. The number of treatment admissions with prescription opioids (other opiates⁴¹) as the primary reported drug of abuse increased 71 percent from 52,840 in 2003 to 90,516 in 2007 (the most recent year for which such data are available), according to TEDS. At the same time, heroin treatment admissions steadily decreased from 273,996 to 246,871. Additionally, the number of treatment admissions for tranquilizers increased slightly during that time, from 8,164 in 2003 to 9,949 in 2007. Conversely, the number of treatment admissions for prescription barbiturates as the primary drug of abuse has been declining, and admissions are not frequently reported.

ED visits for nonmedical use of narcotic analgesics and benzodiazepines increased from 2004 through 2006 (the most recent year for which comparable data are available; see Table 6 on page 26). The number of ED visits for nonmedical use of narcotic analgesics⁴² increased 39 percent, from 144,644 in 2004 to 201,280 in 2006, according to

41. The category “other opiates” in SAMHSA data refers to codeine, Dilaudid®, morphine, Demerol®, opium, oxycodone, and any other drug with morphine-like effects. It does not include heroin or nonprescription methadone (methadone obtained and used without a legal prescription).

42. Narcotic analgesics include buprenorphine/combinations, codeine/combinations, fentanyl/combinations, hydrocodone/combinations, hydromorphone/combinations, meperidine/combinations, methadone, morphine/combinations, oxycodone/combinations, and propoxyphene/combinations.

Figure 19. Unintentional Prescription Opioid Analgesic, Cocaine, and Heroin Deaths Nationwide, 2001–2005



Source: Centers for Disease Control and Prevention.

the Drug Abuse Warning Network (DAWN) and 20 percent from 2005 through 2006. Specifically, ED visits involving hydrocodone/combinations, morphine/combinations, and oxycodone/combinations⁴³ increased 44, 46, and 56 percent, respectively. ED mentions involving nonmedical use of benzodiazepines increased 36 percent (143,546 to 195,625) from 2004 through 2006.

Some prescription opioid abusers (particularly teens and young adults) switch to heroin. Treatment providers in some areas of the United States anecdotally reported in 2008 that a few prescription opioid abusers switch to heroin as they build tolerance to prescription opioids and seek a more euphoric high. Traditionally it was more common for some heroin abusers to switch to opioid CPDs in the absence of their drug of choice. Further anecdotal reporting by treatment providers indicates that some prescription opioid abusers are switching to heroin in a few areas where heroin is less costly or more available than prescription opioids. Diverted CPDs are often more readily

43. Oxycodone/composition CPDs are manufactured with either aspirin or acetaminophen.

Table 5. Trends in Annual Prevalence of Nonmedical Use of Prescription Drugs in Grades 8, 10, and 12, by Percentage, 2004–2008

	2004	2005	2006	2007	2008
Amphetamines					
8th Grade	4.9	4.9	4.7	4.2	4.5
10th Grade	8.5	7.8	7.9	8.0	6.4
12th Grade	10.0	8.6	8.1	7.5	6.8
OxyContin®					
8th Grade	1.7	1.8	2.6	1.8	2.1
10th Grade	3.5	3.2	3.8	3.9	3.6
12th Grade	5.0	5.5	4.3	5.2	4.7
Ritalin®					
8th Grade	2.5	2.4	2.6	2.1	1.6
10th Grade	3.4	3.4	3.6	2.8	2.9
12th Grade	5.1	4.4	4.4	3.8	3.4
Sedatives					
8th Grade	NA	NA	NA	NA	NA
10th Grade	NA	NA	NA	NA	NA
12th Grade	6.5	7.2	6.6	6.2	5.8
Tranquilizers					
8th Grade	2.5	2.8	2.6	2.4	2.4
10th Grade	5.1	4.8	5.2	5.3	4.6
12th Grade	7.3	6.8	6.6	6.2	6.2
Vicodin®					
8th Grade	2.5	2.6	3.0	2.7	2.9
10th Grade	6.2	5.9	7.0	7.2	6.7
12th Grade	9.3	9.5	9.7	9.6	9.7
Other narcotics					
8th Grade	NA	NA	NA	NA	NA
10th Grade	NA	NA	NA	NA	NA
12th Grade	9.5	9.0	9.0	9.2	9.1

Source: Monitoring the Future.

NA—Not available.



Table 6. Emergency Department Visits for Nonmedical Use of Selected Controlled Prescription Drugs and Percent of Change, 2004–2006

				Percent of Change*	
	2004	2005	2006	2004, 2006	2005, 2006
Benzodiazepines	143,546	189,704	195,625	36	–
alprazolam	46,526	57,419	65,236	40	–
clonazepam	28,178	30,648	33,557	–	–
diazepam	15,619	18,433	19,936	–	–
lorazepam	17,674	23,210	23,720	–	–
Stimulants	9,801	10,965	13,892	42	–
amphetamine-dextroamphetamine	2,303	2,669	5,027	118	–
methylphenidate	2,446	2,519	2,192	–	–
Narcotic Analgesics	144,644	168,376	201,280	39	20
codeine/combinations	7,171	6,180	6,928	–	–
fentanyl/combinations	9,823	11,211	16,012	–	–
hydrocodone/combinations	39,844	47,192	57,550	44	–
hydromorphone/combinations	3,385	4,714	6,780	–	–
meperidine/combinations	782	383	1,440	–	–
methadone	36,806	42,684	45,130	–	–
morphine/combinations	13,966	15,762	20,416	46	–
oxycodone/combinations	41,701	52,943	64,888	56	–
propoxyphene/combinations	6,744	7,648	6,220	–	–

Source: Drug Abuse Warning Network 2006.

*These columns denote statistically significant ($p < 0.05$, where “p” is an estimate of the probability that the result has occurred by statistical accident) increases or decreases between estimates for the periods shown. A dash (–) in a table cell indicates a change that was not statistically significant.

available than heroin in all drug markets; however, prescription opioids are typically more expensive than heroin. For example, oxycodone abusers with a high tolerance may ingest 400 milligrams of the drug daily (five 80-milligram tablets), for an average cost of \$400. These abusers could maintain their addictions with 2 grams of heroin daily, at a cost of one-third to one-half that of prescription opioids, depending on the area of the country and the purity of the heroin. Such reporting may be an indicator that an increasing number of prescription opioid abusers might switch to heroin and treatment providers could experience an increase in

heroin admissions. DEA has not evidenced a trend in any investigative or intelligence systems showing the substitution of heroin for opioid CPDs.

INTELLIGENCE GAPS

The full extent of CPD diversion is unknown.

Data collection methodologies with regard to CPD diversion and abuse in drug markets throughout the country are often inconsistent, incomplete, or nonexistent. For example, complete analysis of prescription drug-related deaths is constrained because

of inconsistencies in state-level reporting by medical examiners or health departments. Moreover, theft and loss data collected by law enforcement agencies generally include the number of incidents in which CPDs are stolen as well as the quantities stolen; however, recovery of the stolen drugs is usually not reported, resulting in incomplete data with regard to the quantity of stolen drugs that could be diverted to the illicit market.

The extent to which prescription opioid abusers are switching to heroin is unknown. Anecdotal reporting by treatment providers indicates that some prescription opioid abusers around the country have begun seeking out heroin, particularly when it is less costly than prescription opioids. Empirical data are limited.

Survey estimates regarding the extent of CPD abuse may be conservative. CPD abuse is most likely underreported because many abusers may be reluctant to report inappropriate behavior such as the nonmedical use of CPDs. This reluctance on the part of nonmedical users of CPDs (particularly those who respond to surveys) may account for inconsistencies between law enforcement/treatment provider data and national survey data such as NSDUH, PATS, and MTF. For instance, survey data indicate that abuse of CPDs, particularly among teenagers, has been generally stable over the past 5 years; however, law enforcement and treatment provider reporting indicate increases in abuse.

Information regarding the number of Internet pharmacies that actually sell CPDs without a prescription and the number of individuals ordering CPDs online (intentionally or unwittingly) is limited. Individuals or organizations that conduct Internet pharmacy research do not actually purchase prescription drugs as part of their studies. Because they do not culminate a transaction, these researchers cannot accurately determine which web sites do in fact sell CPDs and which financial institutions will accept payment for the illicit purchase of such drugs. The number of individuals ordering CPDs online could be determined by mail and package delivery services; however,

privacy laws restrict the random interception and inspection of packages by delivery services without a search warrant. Nevertheless, the sheer volume of packages sent daily through mail and package delivery services would largely prevent interception and inspection of suspected diverted CPDs.

PREDICTIVE ESTIMATES

The number of unintentional opioid overdose deaths may level off or decrease. Scientific initiatives aimed at determining specific prescription opioid overdose abuse patterns in conjunction with law enforcement initiatives targeting the availability of diverted prescription opioids may affect the number of reported unintentional overdose deaths.

CPD abuse among teenagers will decrease. About 40 percent of teenagers believe that taking CPDs recreationally is safer than taking illicit drugs, and nearly one-third believe that there is nothing wrong with using a prescription drug not prescribed for them, according to PATS. Educational campaigns focusing on the dangers of CPD abuse are being instituted in most schools nationwide. Moreover, many communities have become proactive with educational campaigns aimed at parents. CPD abuse among teenagers has remained stable or decreased over the past 5 years, according to survey data. As more teenagers—and their parents—learn the dangers of taking CPDs nonmedically, particularly the high risk of death from abuse of prescription opioids, abuse rates among teenagers will go down.

Some heroin distributors will add diverted prescription opioids to their drug supplies. Law enforcement agencies in some areas of the country report that polydrug dealers have begun distributing CPDs. Street dealers have not regularly been the primary source of supply for CPD abusers; however, heroin distributors who add prescription opioids to their street supplies will ensure continuity in their customer base, particularly as prescription opioid abusers realize that heroin is less costly.

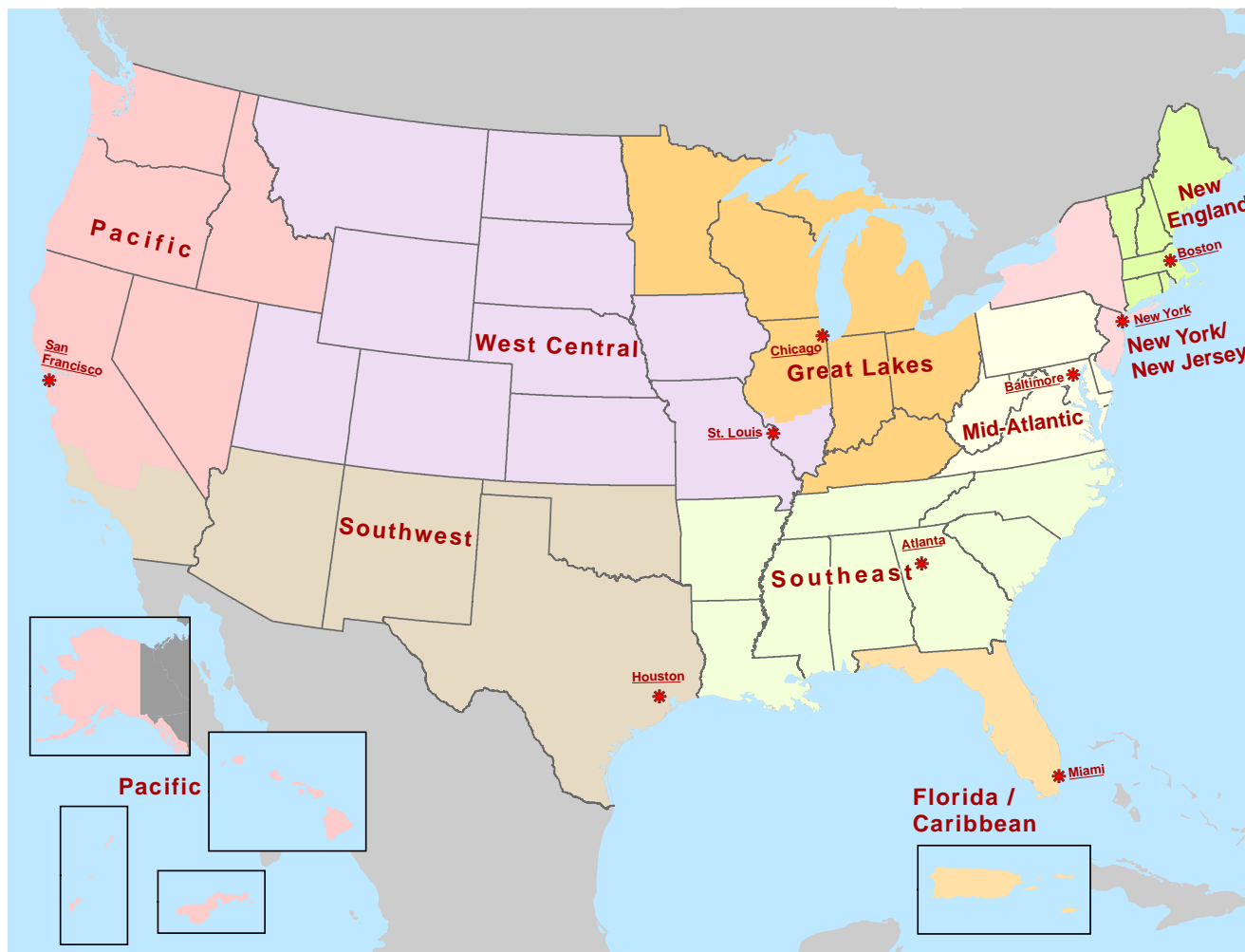


Large-scale diversion of CPDs will decrease as distributors become more diligent in monitoring the amount of CPDs that they sell to businesses. Distributors will seek to avoid license revocation and fines by becoming aware of their customers' purchasing habits, recognizing when those customers request quantities of CPDs that are unusually high, and reporting the activity to DEA. Decreases in large-scale diversion will ultimately have an effect on Internet availability of CPDs.

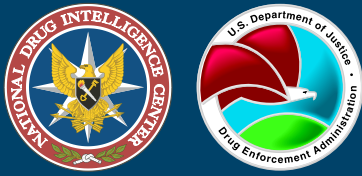
New federal legislation will reduce the number of U.S.-based rogue Internet pharmacies selling CPDs. The Ryan Haight Online Pharmacy Consumer Protection Act of 2008, enacted in October 2008, legally establishes online pharmacies and prohibits the delivery, distribution, or dispensing of CPDs over the Internet without a prescription written by a doctor who has conducted at least one in-person examination of the patient. Under the law, criminal penalties have been increased for illegal Internet prescribing of Schedule II, III, IV and V controlled substances. The law will deter some U.S.-based Internet pharmacy operators from engaging in "script mill" practices, which provide alleged "medical consultations" (for a fee), after which prescriptions are sent to local pharmacies or directly to customers who can have them filled at a local pharmacy.

REGIONAL DEVIATIONS FROM NATIONAL TRENDS

Figure 20. Organized Crime Drug Enforcement Task Force Regions.



The following regional summaries provide overviews of the diversion and abuse situation in the nine OCDETF regions, highlighting significant regional deviations from national-level trends. The summaries were prepared through detailed analysis of recent law enforcement reporting, information obtained through interviews with law enforcement and public health officials, and currently available statistical data.



FLORIDA/CARIBBEAN REGION

- The number of medical facilities from which large amounts of narcotic painkillers are dispensed has increased over the past 5 years. DEA-registered physicians working at these facilities dispense prescription narcotics directly to patients.
- The number of Internet pharmacies operating in Florida has decreased significantly since 2005, following criminal investigations, administrative actions against pharmacies, and the DEA Distributor Initiative.
- Individuals from Kentucky, Massachusetts, New Jersey, Ohio, and West Virginia travel to Florida, primarily Fort Lauderdale, to acquire CPDs for illicit distribution, primarily oxycodone products.

GREAT LAKES REGION

- No deviations from national trends were reported in 2008.

MID-ATLANTIC REGION

- Propoxyphene-related deaths have increased in Philadelphia over the past 5 years.
- Many CPD abusers in Philadelphia seek a lower-dose formulation of Percocet® over OxyContin®.
- Prescription drug rings often use global positioning systems (GPSs) to locate pharmacies at which they can fill fraudulent prescriptions. The drugs are traded or sold at the retail level, often for other illicit drugs, such as marijuana or cocaine.
- Street dealers of marijuana, cocaine, and heroin in Pennsylvania also sell CPDs.

- Diverted CPDs are sold from open-air drug markets located near narcotic treatment program (NTP) facilities in the District of Columbia.

NEW ENGLAND REGION

- Heroin in New England is often more than 90 percent pure, which makes transitioning from prescription opioid abuse to heroin easier for abusers.
- Individuals crossing the U.S.–Canada border smuggle CPDs into the United States.

NEW YORK/NEW JERSEY REGION

- Members of traditional organized crime, a Dominican organization, and Bloods and Crips street gangs are involved in CPD trafficking.

PACIFIC REGION

- Diversion and abuse are increasing on some Native American reservations in New Mexico, Washington State, and the northwestern portion of California.
- Bulk quantities of CPDs are transported to Oregon from southern California and Mexico.

SOUTHEAST REGION

- The number of treatment programs in Georgia, North Carolina, South Carolina, and Tennessee has risen, primarily as a result of the increase in the number of prescription opioid and benzodiazepine abusers.
- Pain clinics in Tennessee are not regulated and often employ doctors whose licenses have been suspended or revoked.

SOUTHWEST REGION

- Many residents of Arizona, New Mexico, Texas, and southern California travel to Mexico to obtain CPDs both with and without legitimate prescriptions.
- Doctors at pain clinics in Houston supply hydrocodone products to other cities in Texas and in Louisiana.
- Organized diversion rings operate in Houston; they involve “crew bosses” who round up homeless individuals and occupants of half-way houses in groups of 15 or more and take them to pain clinics, where doctors readily provide prescriptions. After the prescriptions have been faxed to pharmacies and filled, the homeless individuals pick up the drugs and provide them to the crew bosses.
- Mexican traffickers walk CPDs across the U.S.–Mexico border; they often distribute the drugs themselves or supply them to street dealers, who sell the drugs in the United States, particularly in border towns.
- Oklahoma currently has more narcotic treatment programs than at any prior time in the state’s history; a majority of patients are receiving treatment for prescription opioid abuse.
- Organized criminal groups divert CPDs and sell them in Mexico to some pharmacies. The pharmacies in turn resell them to U.S. citizens who purchase the drugs on rogue Internet pharmacy sites.
- Street gang members in southern California divert CPDs and sell the drugs to their own gang members.
- Criminals use stolen laptops and free Wi-Fi (wireless Internet connections) to access web sites from which they can obtain the names of physicians and their DEA registration numbers. They use this information to create fraudulent prescriptions.
- Diverted CPDs are sold at flea markets, outside NTP facilities, and near colleges in El Paso.
- A significant clustering of opioid abuse and overdose deaths are evident along the New Mexico portion of the U.S.–Mexico border.
- The same methods used by traffickers to smuggle illicit drugs such as cocaine, heroin, marijuana, and methamphetamine into the United States from Mexico—private vehicles, commercial trucks, tractor-trailers, and pedestrians—are used by distributors to transport CPDs from Mexico into New Mexico.

WEST CENTRAL REGION

- In Kansas City, Missouri, some 15- to 25-year-old CPD abusers have switched to methamphetamine.
- Native Americans on South Dakota reservations fill the same prescription twice, once at Indian Health Service pharmacies and once at off-reservation pharmacies.
- Colorado gang members divert CPDs by using individuals who doctor-shop for them.



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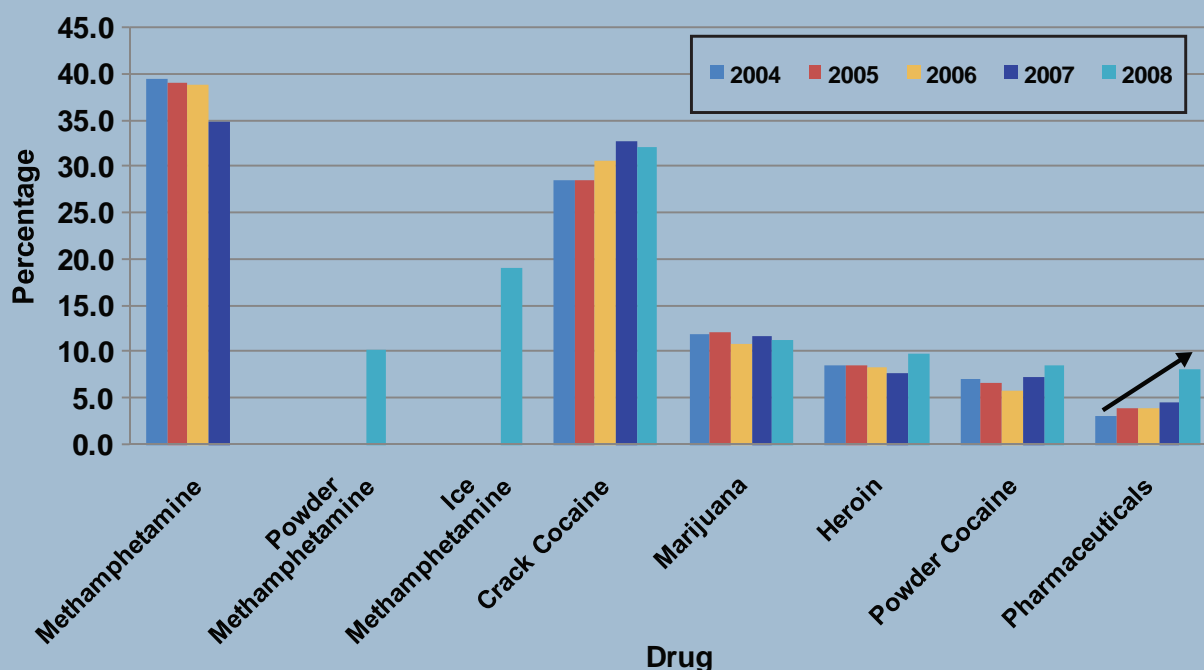
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APPENDIX A. NDTs COMPARATIVE DATA⁴⁴

GREATEST DRUG THREAT⁴⁵

NDTS data from 2004 through 2008 indicate that diverted CPDs pose much less of a drug threat nationwide than the threat posed by illicit drugs such as cocaine, crack cocaine, heroin, marijuana, or powder or ice methamphetamine. Methamphetamine was reported as the greatest drug threat nationwide by the highest percentages of law enforcement agencies during the 5-year period, followed by crack cocaine. However, the threat posed by pharmaceuticals trended upward from 3.1 in 2004 to 8.1 percent in 2008. While this is the fastest-growing trend reported by law enforcement agencies during that time, less than 10 percent of law enforcement agencies report pharmaceuticals as their greatest drug threat. (See Figure 21.)

Figure 21. Percentage of Law Enforcement Agencies Reporting Greatest Drug Threat, by Drug, Nationwide, 2004–2008



Source: National Drug Threat Surveys.

Note: Beginning in 2008, the NDTs established powder and ice methamphetamine as specific categories for greatest drug threat; therefore, general methamphetamine comparisons are not made.

44. Respondents to the NDTs are too numerous (more than 3,000) to include in the source list at the end of this assessment.

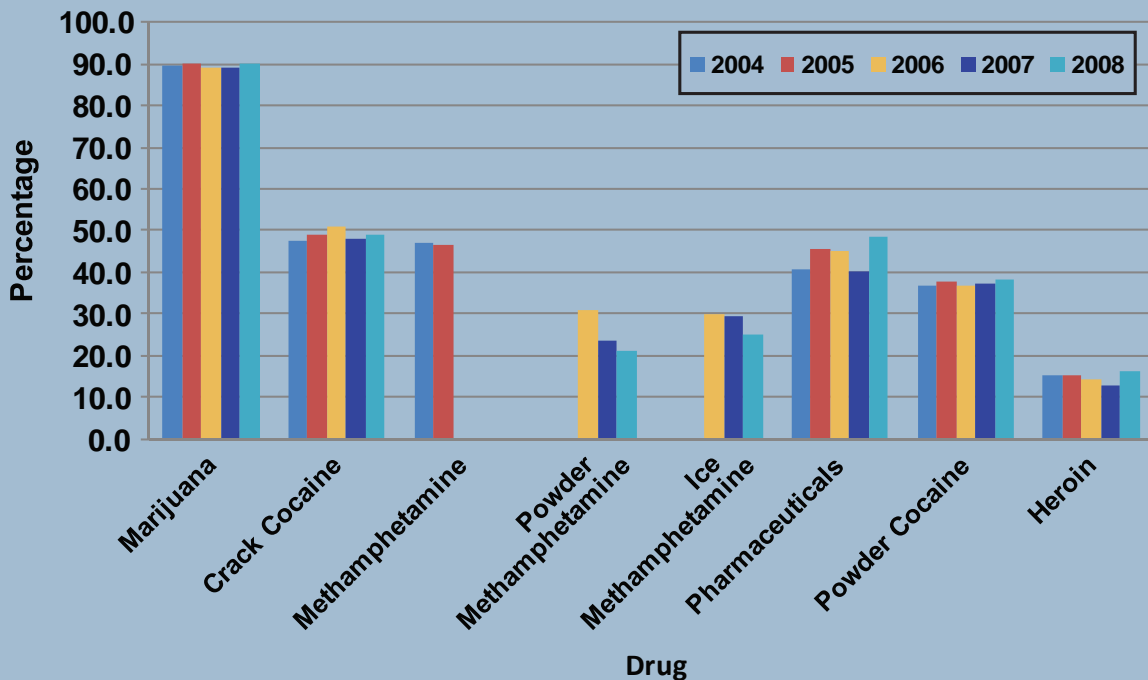
45. The relative threat posed by a specific drug requires a subjective analytic assessment based on many considerations, such as the cost of interdiction, seizure, and eradication; the number of individuals using or addicted to the drug; the level of availability in U.S. drug markets; the extent and organization of distribution groups; the level of violence associated with distribution and use of the drug; the level of property crime associated with use of the drug; and the level of involvement by international drug trafficking organizations (DTOs) and gangs.



AVAILABILITY

Marijuana was reported as the drug most highly available nationwide by the largest percentages of law enforcement agencies during the 5-year period, followed by crack cocaine. However, a greater percentage of law enforcement agencies nationwide reported high availability of pharmaceuticals than reported high availability of heroin or powder cocaine from 2004 through 2008. Law enforcement agency reporting indicated that high availability of pharmaceuticals nationwide trended upward over the period from 40.8 percent in 2004 to 48.7 percent in 2008. (See Figure 22.)

Figure 22. Percentage of Law Enforcement Agencies Reporting High Availability, by Drug, Nationwide, 2004–2008



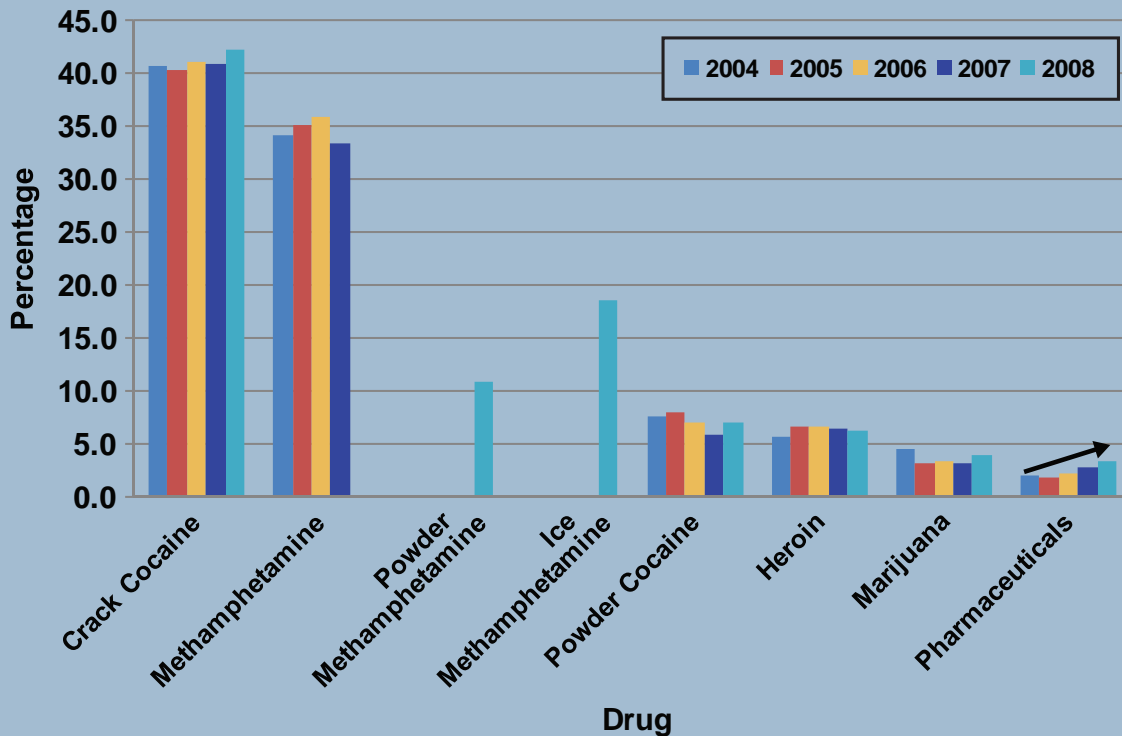
Source: National Drug Threat Surveys.

Note: Beginning in 2006, the NDTs established mentioned powder and ice methamphetamine as specific categories for high availability; therefore, general methamphetamine comparisons are not made.

DRUGS ASSOCIATED WITH VIOLENT CRIME

Crack cocaine and methamphetamine were reported by the greatest percentages of law enforcement agencies as being associated with violent crime nationwide from 2004 through 2008. The smallest percentages of law enforcement agencies nationwide reported an association between pharmaceuticals and violent crime. The largest upward trend was for crack cocaine, which went from 40.7 percent in 2004 to 42.3 percent in 2008, followed by pharmaceuticals, which went from 2.2 percent to 3.5 percent during that time. (See Figure 23.)

Figure 23. Percentage of Law Enforcement Agencies Reporting Association Between Drug Type and Violent Crime, Nationwide, 2004–2008



Source: National Drug Threat Surveys.

Note: Beginning in 2008, the NDTs established powder and ice methamphetamine as specific categories for association between drugs and violent crime; therefore, general methamphetamine comparisons are not made.

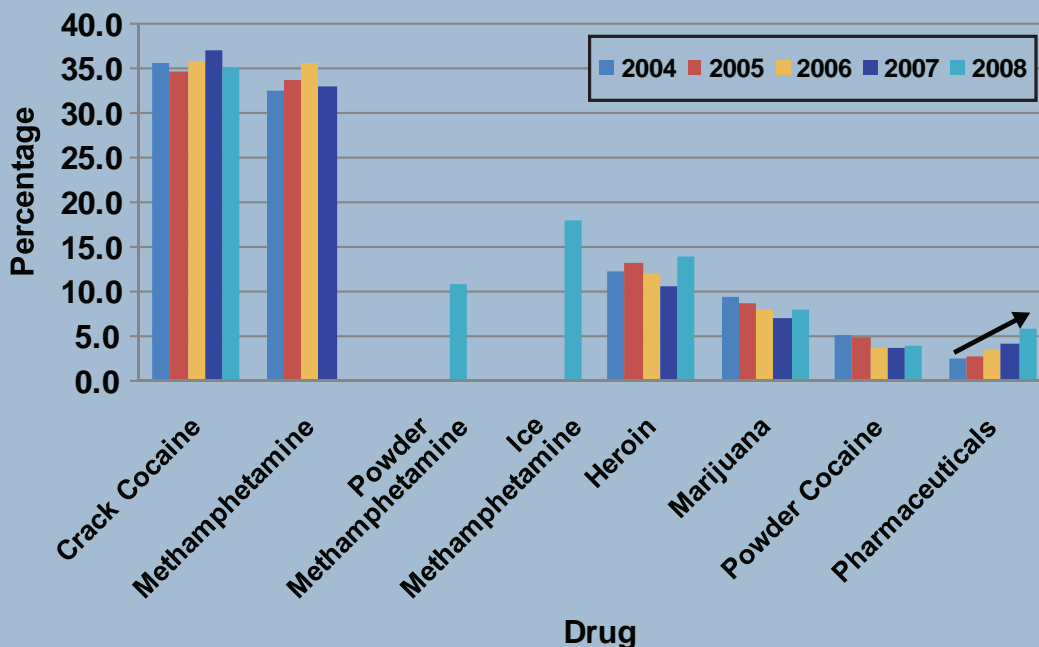
Note: Such trends are not reflected in DEA investigative and intelligence systems.



DRUGS ASSOCIATED WITH PROPERTY CRIME

Crack cocaine and methamphetamine were reported by the greatest percentages of law enforcement agencies as being associated with property crime nationwide during the 5-year period. However, the percentages of law enforcement agencies reporting an association between drugs and property crime trended downward overall for crack cocaine; the percentages for marijuana and powder cocaine also trended downward. The largest upward trend was for pharmaceuticals, which went from 2.5 percent in 2004 to 6.0 percent in 2008. (See Figure 24.)

Figure 24. Percentage of Law Enforcement Agencies Reporting Association Between Drug Type and Property Crime, Nationwide, 2004–2008



Source: National Drug Threat Surveys.

Note: Beginning in 2008, the NDTs established powder and ice methamphetamine as specific categories for association between drugs and property crime; therefore, general methamphetamine comparisons are not made.

Note: Such trends are not reflected in DEA investigative and intelligence systems.

APPENDIX B. CONTROLLED PRESCRIPTION DRUG PRICES COLLECTED IN 2008⁴⁶

NDIC's FPSs collected available diverted CPD prices from state and local law enforcement agencies while gathering information for this assessment.⁴⁷ Additionally, DEA Field Offices contributed pricing data. The average street prices for many diverted CPDs have been stable at \$1 per milligram for many years. However, it appears that some diverted CPD prices may have increased slightly, according to law enforcement reporting in July 2008. The specific pricing information collected in July 2008 indicates a slight increase in the average prices of methadone, oxycodone, and oxycodone/combination products and more significant increases in the average prices of alprazolam and hydrocodone/combination products.

The *average per-milligram* prices nationwide for the most commonly diverted CPDs are as follows:

- alprazolam (Xanax®) – \$3.50
- hydrocodone (Vicodin®, Lortab®) – \$1.90
- methadone – \$1.45
- oxycodone (OxyContin®, Percocet®, Roxicodone®) – \$1.15

Street prices for drugs are affected by numerous variables, including availability, demand, law enforcement investigations, area of the country, and the relationship between the purchaser and the seller. CPD availability is reportedly high in most areas of the country; this high availability should result in price stability. The increases reported in 2008 in the average prices of CPDs may be a result of the willingness of the abusers to pay whatever price the dealer is asking, coupled with the dealer's desire to increase profits. Additionally, dealers may believe that they face an increased risk in selling the drugs on the street because of increased law enforcement activity targeting distribution. It is possible that these dealers have increased street prices to reflect that risk.

All prices collected in July 2008 are presented (in the quantities/weights in which they were received) in the following table.

46. Sources are listed at the end of this assessment.

47. Many state and local law enforcement agencies do not collect prices for diverted CPDs. All pricing information available to NDIC FPSs is reported in the following table.



Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Actiq®	Nevada		50.00	70.00	1 lollipop
Actiq®	Pennsylvania	Philadelphia	25.00	25.00	1 lollipop
Actiq®	Pennsylvania		20.00	20.00	800- to 1,200-microgram lollipop
Actiq®	Pennsylvania		40.00	40.00	1,600-microgram lollipop
Alprazolam	Colorado		3.00	5.00	1 tablet
Alprazolam	Montana		3.00	5.00	1 tablet
Alprazolam	Nevada		2.00	5.00	4 milligrams
Alprazolam	New York	New York City	3.00	4.00	1 tablet
Alprazolam	New York	Troy	2.00	6.00	1 tablet
Alprazolam	North Carolina		3.00	3.00	1 tablet
Alprazolam	Ohio	Clermont	5.00	5.00	1 tablet
Alprazolam	Ohio	Warren	3.00	3.00	1 tablet
Alprazolam	Pennsylvania	Philadelphia	2.00	2.00	1 milligram
Alprazolam	Pennsylvania	Pittsburgh	3.00	3.00	1 dosage unit
Alprazolam	Pennsylvania	Scranton	2.00	4.00	1 dosage unit
Alprazolam	Texas	Houston	2.00	4.00	1 tablet
Alprazolam	Utah		3.00	5.00	1 tablet
Alprazolam	Wyoming		3.00	5.00	1 tablet
Ambien®	Pennsylvania	Philadelphia	2.00	2.00	1 dosage unit
Ambien®	North Carolina	Greensboro	5.00	10.00	1 dosage unit
Ambien®	South Carolina	Columbia	2.00	6.00	1 dosage unit
Amphetamines	North Carolina	Greensboro	10.00	15.00	1 dosage unit
Amphetamines	South Carolina	Charleston	3.00	7.00	1 dosage unit
Ativan®	California	Atascadero	6.00	8.00	10 milligrams
Ativan®	California	El Monte	1.00	1.00	10 milligrams
Ativan®	California	Modesto	2.00	2.00	10 milligrams
Ativan®	California	Oxnard	2.00	2.00	10 milligrams
Ativan®	California	Roseville	3.00	5.00	10 milligrams
Ativan®	California	Santa Maria	2.00	2.00	10 milligrams
Ativan®	California	Santa Paula	2.00	2.00	10 milligrams
Ativan®	California	West Covina	7.00	10.00	10 milligrams
Benzodiazepines	California	Oakland	1.00	2.00	1 tablet
Benzodiazepines	California	San Jose/San Francisco	1.00	2.00	1 tablet
Benzodiazepines	Hawaii		20.00	20.00	1 dosage unit

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Benzodiazepines	Illinois		1.00	3.00	1 tablet
Benzodiazepines	Indiana		1.00	3.00	1 tablet
Benzodiazepines	Minnesota		1.00	3.00	1 tablet
Benzodiazepines	North Carolina	Greensboro	2.00	10.00	1 dosage unit
Benzodiazepines	North Carolina	Raleigh	2.00	40.00	1 dosage unit
Benzodiazepines	North Dakota		1.00	3.00	1 tablet
Benzodiazepines	South Carolina	Charleston	2.00	8.00	1 dosage unit
Benzodiazepines	South Carolina	Columbia	2.00	8.00	1 dosage unit
Benzodiazepines	South Carolina	Florence	10.00	20.00	1 dosage unit
Benzodiazepines	Wisconsin		1.00	3.00	1 tablet
Buprenorphine	Vermont	Essex Junction	20.00	20.00	1 tablet
Codeine	California	Los Angeles	1.00	2.50	1 tablet
Codeine	California	Los Angeles	80.00	200.00	1 pint
Codeine	California	Oakland	1.00	2.50	1 tablet
Codeine	California	Oakland	80.00	200.00	1 pint
Codeine	Hawaii		50.00	60.00	4 ounces
Codeine	New York	New York City	3.00	4.00	1 tablet
Codeine	Pennsylvania	Philadelphia	15.00	15.00	1 ounce
Codeine syrup	Texas	Houston	200.00	400.00	1 pint
Codeine syrup	Texas	Houston	20.00	20.00	1 ounce
Codeine syrup	Texas	Plano	10.00	10.00	1 ounce
Codeine syrup	Texas		35.00	175.00	1 ounce
Codeine syrup	Texas		20.00	40.00	1 ounce
Darvon®	North Carolina	Greensboro	2.00	10.00	1 dosage unit
Darvon®	South Carolina	Greenville	10.00	20.00	1 dosage unit
Demerol®	North Carolina	Greensboro	3.00	5.00	1 dosage unit
Demerol®	South Carolina	Columbia	10.00	15.00	1 dosage unit
Diazepam	California	Los Angeles	1.00	1.00	5 milligrams
Diazepam	Colorado		3.00	5.00	1 tablet
Diazepam	Connecticut		2.00	2.00	10 milligrams
Diazepam	Maine		2.00	2.00	10 milligrams
Diazepam	Massachusetts		2.00	2.00	10 milligrams
Diazepam	Montana		3.00	5.00	1 tablet
Diazepam	Nevada		2.00	5.00	5 milligrams



(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Diazepam	New Hampshire		2.00	2.00	10 milligrams
Diazepam	New Mexico		0.50	1.00	1 tablet
Diazepam	Rhode Island		2.00	2.00	10 milligrams
Diazepam	Texas		3.00	3.00	10 milligrams
Diazepam	Utah		3.00	5.00	1 tablet
Diazepam	Vermont		2.00	2.00	10 milligrams
Diazepam	Wyoming		3.00	5.00	1 tablet
Dilaudid®	Arkansas		25.00	50.00	2 milligrams
Dilaudid®	California	El Monte	15.00	20.00	4 milligrams
Dilaudid®	California	Roseville	5.00	6.00	4 milligrams
Dilaudid®	California	Santa Maria	5.00	5.00	4 milligrams
Dilaudid®	California	Santa Paula	10.00	10.00	4 milligrams
Dilaudid®	California	West Covina	7.00	10.00	4 milligrams
Dilaudid®	Hawaii		20.00	60.00	4 milligrams
Dilaudid®	Kentucky	Bowling Green	40.00	45.00	1 tablet
Dilaudid®	Louisiana		50.00	50.00	4 milligrams
Dilaudid®	Mississippi		10.00	20.00	2 milligrams
Dilaudid®	Mississippi		20.00	50.00	4 milligrams
Dilaudid®	New Jersey		5.00	5.00	1 tablet
Dilaudid®	Texas	Houston	10.00	15.00	1 tablet
Dilaudid®	Texas		20.00	80.00	1 dosage unit
Dilaudid®	Texas		20.00	80.00	1 dosage unit
Dilaudid®	Connecticut		40.00	40.00	4 milligrams
Dilaudid®	Connecticut		25.00	30.00	4 milligrams
Dilaudid®	Maine		40.00	40.00	4 milligrams
Dilaudid®	Maine		25.00	30.00	4 milligrams
Dilaudid®	Massachusetts		40.00	40.00	4 milligrams
Dilaudid®	Massachusetts		25.00	30.00	4 milligrams
Dilaudid®	New Hampshire		40.00	40.00	4 milligrams
Dilaudid®	New Hampshire		25.00	30.00	4 milligrams
Dilaudid®	Rhode Island		25.00	40.00	4 milligrams
Dilaudid®	South Carolina	Columbia	10.00	40.00	1 dosage unit
Dilaudid®	Vermont		40.00	40.00	4 milligrams
Dilaudid®	Vermont		25.00	30.00	4 milligrams

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Dilaudid®/ hydromorphone	New York	New York City	20.00	25.00	1 tablet
Fentanyl	California	San Jose/San Francisco	5.00	10.00	1 dosage unit
Fentanyl	Colorado		20.00	70.00	1 patch
Fentanyl	Connecticut		50.00	60.00	1 patch
Fentanyl	Connecticut		35.00	35.00	1 patch
Fentanyl	Georgia		0.50	1.00	50 micrograms
Fentanyl	Maine		50.00	60.00	1 patch
Fentanyl	Maine		35.00	35.00	1 patch
Fentanyl	Massachusetts		50.00	60.00	1 patch
Fentanyl	Massachusetts		35.00	35.00	1 patch
Fentanyl	Montana		20.00	70.00	1 patch
Fentanyl	Nevada		20.00	25.00	1 patch
Fentanyl	New Hampshire		50.00	60.00	1 patch
Fentanyl	New Hampshire		35.00	35.00	1 patch
Fentanyl	New Jersey	Middletown	35.00	50.00	1 lollipop
Fentanyl	New York	New York City	20.00	25.00	1 patch
Fentanyl	New York	Norwich	35.00	35.00	80 milligrams
Fentanyl	New York	Norwich	50.00	50.00	100 milligrams
Fentanyl	New York		50.00	75.00	1 patch
Fentanyl	North Carolina	Greensboro	10.00	100.00	1 patch
Fentanyl	Pennsylvania	Scranton	25.00	25.00	1 patch
Fentanyl	Rhode Island		35.00	60.00	1 patch
Fentanyl	South Carolina	Charleston	25.00	25.00	1 lollipop
Fentanyl	South Carolina	Charleston	10.00	25.00	1 patch
Fentanyl	South Carolina	Columbia	15.00	25.00	1 lozenge
Fentanyl	Utah		20.00	70.00	1 patch
Fentanyl	Vermont		50.00	60.00	1 patch
Fentanyl	Vermont		35.00	35.00	1 patch
Fentanyl	Virginia	Big Stone	100.00	100.00	1 patch
Fentanyl	Wyoming		20.00	70.00	1 patch
Hydrocodone	Alaska	Nome	5.00	10.00	1 tablet
Hydrocodone	California	Los Angeles	1.00	5.00	10 milligrams
Hydrocodone	California	Oakland	1.00	5.00	10 milligrams



(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Hydrocodone	California	Oakland	2.00	5.00	5 milligrams
Hydrocodone	California	Sacramento	1.00	5.00	1 tablet
Hydrocodone	California	San Jose/San Francisco	1.00	5.00	1 tablet
Hydrocodone	California		5.00	5.00	1 dosage unit
Hydrocodone	Colorado		3.00	5.00	1 milligram
Hydrocodone	Connecticut		4.00	4.00	5 milligrams
Hydrocodone	District of Columbia		5.00	10.00	1 tablet
Hydrocodone	Florida	Davie	2.00	5.00	5 milligrams
Hydrocodone	Florida	Davie	3.00	4.00	7 milligrams
Hydrocodone	Florida	Fort Lauderdale	2.00	2.00	1 dosage unit
Hydrocodone	Florida	Fort Myers/Naples	0.10	20.00	1 dosage unit
Hydrocodone	Florida	Jacksonville	5.00	5.00	1 dosage unit
Hydrocodone	Florida	Miami	5.00	15.00	1 dosage unit
Hydrocodone	Florida	Orlando	2.00	5.00	1 dosage unit
Hydrocodone	Florida	Palm Beach Gardens	10.00	10.00	1 tablet
Hydrocodone	Florida	Pensacola	4.00	10.00	1 dosage unit
Hydrocodone	Florida	Port St. Lucie	4.00	6.00	1 dosage unit
Hydrocodone	Florida	Sarasota	10.00	10.00	1 tablet
Hydrocodone	Florida	Tallahassee	25.00	25.00	1 dosage unit
Hydrocodone	Florida	Tampa	0.75	5.00	1 dosage unit
Hydrocodone	Florida	West Palm Beach	20.00	20.00	1 dosage unit
Hydrocodone	Georgia		3.00	10.00	1 tablet
Hydrocodone	Hawaii		2.00	5.00	7.5-milligram tablet/500 tablets
Hydrocodone	Idaho		2.00	3.00	1 tablet
Hydrocodone	Illinois		2.00	5.00	1 tablet
Hydrocodone	Indiana		2.00	5.00	1 tablet
Hydrocodone	Iowa		5.00	10.00	1 tablet
Hydrocodone	Kentucky	Bowling Green	8.00	10.00	1 tablet
Hydrocodone	Kentucky		0.50	1.00	1 milligram
Hydrocodone	Maine		4.00	4.00	5 milligrams
Hydrocodone	Maryland		5.00	10.00	1 tablet
Hydrocodone	Massachusetts		4.00	4.00	5 milligrams
Hydrocodone	Michigan		0.50	1.00	1 milligram
Hydrocodone	Minnesota		2.00	5.00	1 tablet

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Hydrocodone	Missouri	Kansas City	5.00	15.00	1 tablet
Hydrocodone	Missouri	St. Louis	3.00	5.00	1 tablet generic
Hydrocodone	Missouri	St. Louis	5.00	7.00	1 tablet brand
Hydrocodone	Montana		3.00	5.00	1 milligram
Hydrocodone	Nebraska		10.00	up	1 tablet
Hydrocodone	Nevada		2.00	7.00	10 milligrams
Hydrocodone	New Hampshire		4.00	4.00	5 milligrams
Hydrocodone	New York	Cooperstown	5.00	5.00	7 milligrams
Hydrocodone	New York	Cooperstown	10.00	10.00	10 milligrams
Hydrocodone	New York	Troy	3.00	5.00	7 milligrams
Hydrocodone	New York	Troy	3.00	5.00	10 milligrams
Hydrocodone	New York	Upstate	3.00	3.00	5 milligrams
Hydrocodone	New York	Western	5.00	5.00	7 milligrams
Hydrocodone	North Carolina	Greensboro	3.00	25.00	1 dosage unit
Hydrocodone	North Carolina	Raleigh	10.00	25.00	1 dosage unit
Hydrocodone	North Carolina		3.00	7.00	1 tablet
Hydrocodone	North Carolina		5.00	5.00	1 tablet
Hydrocodone	North Dakota		2.00	5.00	1 tablet
Hydrocodone	Ohio	Warren	6.00	6.00	1 tablet
Hydrocodone	Ohio		0.50	1.00	1 milligram
Hydrocodone	Oregon	Portland	2.50	5.00	1 tablet
Hydrocodone	Pennsylvania	Scranton	5.00	7.00	1 dosage unit
Hydrocodone	Rhode Island		4.00	4.00	5 milligrams
Hydrocodone	South Carolina	Columbia	3.00	6.00	1 dosage unit
Hydrocodone	South Carolina	Florence	20.00	40.00	1 dosage unit
Hydrocodone	South Carolina	Greenville	10.00	20.00	1 dosage unit
Hydrocodone	Texas	Houston	2.00	5.00	1 tablet
Hydrocodone	Texas		2.00	10.00	1 dosage unit
Hydrocodone	Texas		1.00	4.00	1 dosage unit
Hydrocodone	Utah	Salt Lake/Davis County	1.00	1.00	1 milligram
Hydrocodone	Utah		3.00	5.00	1 milligram
Hydrocodone	Vermont		4.00	4.00	5 milligrams
Hydrocodone	Virginia	Roanoke	5.00	10.00	1 tablet
Hydrocodone	Virginia		5.00	10.00	1 tablet



(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Hydrocodone	West Virginia	Braxton County	1.00	1.00	1 milligram
Hydrocodone	West Virginia	Lewis County	1.50	2.00	1 milligram
Hydrocodone	West Virginia	Ripley	5.00	8.00	7.5 milligrams
Hydrocodone	West Virginia	Ripley	5.00	8.00	10 milligrams
Hydrocodone	West Virginia		5.00	10.00	1 tablet
Hydrocodone	Wisconsin		2.00	5.00	1 tablet
Hydrocodone	Wyoming		15.00	20.00	10 milligrams
Hydrocodone	Wyoming		15.00	20.00	20 milligrams
Hydrocodone	Wyoming		80.00	100.00	80 milligrams
Hydrocodone	Wyoming		3.00	5.00	1 milligram
Hydrocodone/ combination	New Mexico		3.00	5.00	1 tablet
Hydromorphone	California	Los Angeles	20.00	60.00	4 milligrams
Hydromorphone	Florida	Fort Lauderdale	25.00	25.00	1 dosage unit
Hydromorphone	Florida	Fort Myers/Naples	15.00	30.00	1 dosage unit
Hydromorphone	Florida	Jacksonville	40.00	50.00	1 dosage unit
Hydromorphone	Florida	Orlando	25.00	50.00	1 dosage unit
Hydromorphone	Florida	Port St. Lucie	20.00	30.00	1 dosage unit
Hydromorphone	Florida	Tampa	10.00	10.00	1 dosage unit
Hydromorphone	Nevada		2.00	5.00	4 milligrams
Klonopin®	Georgia		3.00	5.00	1 milligram
Klonopin®	New York	New York City	2.00	3.00	1 tablet
Lorcet®	Hawaii		3.00	9.00	1 tablet
Lorcet®	Pennsylvania	Pittsburgh	5.00	8.00	7 milligrams
Lorcet®	Pennsylvania	Pittsburgh	5.00	8.00	10 milligrams
Lorcet®	Pennsylvania	Scranton	4.00	6.00	7 milligrams
Lorcet®	Pennsylvania	Scranton	4.00	6.00	10 milligrams
Lorcet®	Virginia	Christiansburg	8.00	8.00	1 tablet
Lortab®	Arizona	Phoenix	5.00	6.00	10 milligrams
Lortab®	Hawaii		3.00	9.00	1 tablet
Lortab®	Pennsylvania	Pittsburgh	5.00	8.00	7 milligrams
Lortab®	Pennsylvania	Pittsburgh	5.00	8.00	10 milligrams
Lortab®	Pennsylvania	Scranton	4.00	5.00	7 milligrams
Lortab®	Pennsylvania	Scranton	4.00	5.00	10 milligrams

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Lortab®	Utah	Salt Lake/Davis County	1.00	1.00	1 milligram
Lortab®	Virginia	Big Stone	10.00	10.00	1 dosage unit
Lortab®	Virginia	Christiansburg	5.00	7.00	1 tablet
Methadone	Alabama		1.00	1.00	1 milligram
Methadone	Alaska		1.00	1.00	1 milligram
Methadone	Arkansas		10.00	10.00	1 milligram
Methadone	California	Atascadero	5.00	6.00	10 milligrams
Methadone	California	Los Angeles	10.00	10.00	1 tablet
Methadone	California	Modesto	40.00	40.00	80 milligrams
Methadone	California	Oakland	10.00	15.00	1 tablet
Methadone	California	Oxnard	1.00	1.00	1 milligram
Methadone	California	Roseville	5.00	5.00	10 milligrams
Methadone	California	San Jose/San Francisco	8.00	10.00	1 tablet
Methadone	California	Santa Paula	60.00	100.00	80 milligrams
Methadone	Colorado		0.50	0.50	10 milligrams
Methadone	Colorado		0.50	0.50	40 milligrams
Methadone	Connecticut		0.75	1.00	1 milligram
Methadone	Connecticut		15.00	20.00	10 milligrams
Methadone	District of Columbia		10.00	20.00	1 diskette
Methadone	Georgia		0.50	0.50	1 milligram
Methadone	Illinois		1.50	1.50	1 milligram
Methadone	Indiana		1.50	1.50	1 milligram
Methadone	Kentucky		10.00	20.00	1 dosage unit
Methadone	Louisiana		1.00	1.00	1 milligram
Methadone	Maine	Rockland	1.00	1.00	1 milligram
Methadone	Maine	Rockland	50.00	50.00	40 milligrams
Methadone	Maine		0.75	1.00	1 milligram
Methadone	Maine		15.00	20.00	10 milligrams
Methadone	Maine		25.00	40.00	10 milligrams
Methadone	Maryland		10.00	20.00	1 diskette
Methadone	Massachusetts		0.75	1.00	1 milligram
Methadone	Massachusetts		15.00	20.00	10 milligrams
Methadone	Michigan		10.00	20.00	1 dosage unit



(Table continued from previous page.)

**Table B1. Diverted Controlled Prescription Drug Prices Reported
by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008**

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Methadone	Minnesota		1.50	1.50	1 milligram
Methadone	Montana		0.50	0.50	10 milligrams
Methadone	Montana		0.50	0.50	40 milligrams
Methadone	Nevada		5.00	10.00	10 milligrams
Methadone	Nevada		10.00	15.00	40 milligrams
Methadone	New Hampshire		0.75	1.00	1 milligram
Methadone	New Hampshire		15.00	20.00	10 milligrams
Methadone	New Jersey	Middletown	40.00	40.00	40 milligrams
Methadone	New Mexico		3.00	5.00	10 milligrams
Methadone	North Carolina	Greensboro	2.00	5.00	1 dosage unit
Methadone	North Carolina	Raleigh	15.00	15.00	1 dosage unit
Methadone	North Carolina		10.00	10.00	1 tablet
Methadone	North Dakota		1.50	1.50	1 milligram
Methadone	Ohio	Clermont	15.00	35.00	1 tablet
Methadone	Ohio		10.00	20.00	1 dosage unit
Methadone	Oregon	Medford	0.50	0.75	1 milligram
Methadone	Pennsylvania	Philadelphia	5.00	10.00	1 dosage unit
Methadone	Pennsylvania	Philadelphia	5.00	5.00	5 milligrams
Methadone	Rhode Island		0.75	1.00	1 milligram
Methadone	Rhode Island		15.00	20.00	10 milligrams
Methadone	South Carolina	Columbia	10.00	25.00	1 dosage unit
Methadone	Texas	Plano	10.00	20.00	1 tablet
Methadone	Texas		20.00	40.00	1 dosage unit
Methadone	Texas		5.00	10.00	1 dosage unit
Methadone	Texas		1.00	1.00	1 milligram
Methadone	Texas		0.50	0.50	1 ounce
Methadone	Utah		0.50	0.50	10 milligrams
Methadone	Utah		0.50	0.50	40 milligrams
Methadone	Vermont		30.00	30.00	10 milligrams
Methadone	Vermont		0.75	1.00	1 milligram
Methadone	Vermont		15.00	20.00	10 milligrams
Methadone	Virginia	Big Stone	10.00	10.00	1 dosage unit
Methadone	Virginia	Roanoke	40.00	50.00	1 tablet
Methadone	Virginia		10.00	20.00	1 diskette
Methadone	Washington	Seattle	0.40	1.00	1 milligram

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Methadone	West Virginia		10.00	20.00	1 diskette
Methadone	Wisconsin		1.50	1.50	1 milligram
Methadone	Wyoming		0.50	0.50	10 milligrams
Methadone	Wyoming		0.50	0.50	40 milligrams
Methylphenidate	California	San Jose/San Francisco	5.00	10.00	1 tablet
Methylphenidate	Illinois		5.00	5.00	1 tablet
Methylphenidate	Indiana		5.00	5.00	1 tablet
Methylphenidate	Minnesota		5.00	5.00	1 tablet
Methylphenidate	North Dakota		5.00	5.00	1 tablet
Methylphenidate	Wisconsin		5.00	5.00	1 tablet
Morphine	California	Sacramento	30.00	30.00	10 tablet
Morphine	North Carolina		50.00	50.00	1 tablet
Morphine	Pennsylvania	Philadelphia	25.00	25.00	30 milligrams
Morphine	Pennsylvania	Philadelphia	8.00	10.00	15 milligrams
Morphine	Pennsylvania	Pittsburgh	60.00	60.00	100 milligrams
Morphine	South Carolina	Columbia	15.00	20.00	1 dosage unit
Morphine	Virginia	Big Stone	50.00	50.00	1 dosage unit
Morphine	Virginia	Christiansburg	30.00	30.00	1 tablet
MS Contin®	California	Los Angeles	20.00	20.00	60 milligrams
MS Contin®	Connecticut		40.00	40.00	40 milligrams
MS Contin®	Connecticut		15.00	15.00	60 milligrams
MS Contin®	Maine		40.00	40.00	40 milligrams
MS Contin®	Maine		15.00	15.00	60 milligrams
MS Contin®	Massachusetts		40.00	40.00	40 milligrams
MS Contin®	Massachusetts		15.00	15.00	60 milligrams
MS Contin®	New Hampshire		40.00	40.00	40 milligrams
MS Contin®	New Hampshire		15.00	15.00	60 milligrams
MS Contin®	Rhode Island		40.00	40.00	40 milligrams
MS Contin®	Rhode Island		15.00	15.00	60 milligrams
MS Contin®	Vermont		50.00	50.00	60 milligrams
MS Contin®	Vermont		40.00	40.00	40 milligrams
MS Contin®	Vermont		15.00	15.00	60 milligrams
Oxycodone	California	Los Angeles	12.00	40.00	80 milligrams
Oxycodone	California	Oakland	12.00	40.00	80 milligrams



(Table continued from previous page.)

**Table B1. Diverted Controlled Prescription Drug Prices Reported
by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008**

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Oxycodone	California	Oakland	45.00	45.00	80 milligrams
Oxycodone	California	Oakland	65.00	65.00	80 milligrams
Oxycodone	California	Oakland	7.00	10.00	10 milligrams
Oxycodone	California	Oakland	30.00	30.00	80 milligrams
Oxycodone	California		65.00	80.00	80 milligrams
Oxycodone	Colorado		0.50	1.00	1 milligram
Oxycodone	Connecticut		5.00	12.00	1 dosage unit
Oxycodone	Florida	Coral Springs	10.00	15.00	30 milligrams
Oxycodone	Florida	Davie	8.00	15.00	30 milligrams
Oxycodone	Florida	Davie	25.00	30.00	80 milligrams
Oxycodone	Florida	Orlando	25.00	25.00	30 milligrams
Oxycodone	Georgia		0.50	1.00	1 milligram
Oxycodone	Hawaii		6.00	8.00	1 tablet
Oxycodone	Illinois		0.50	1.00	1 milligram
Oxycodone	Indiana		0.50	1.00	1 milligram
Oxycodone	Maine		5.00	12.00	1 dosage unit
Oxycodone	Massachusetts		5.00	12.00	1 dosage unit
Oxycodone	Minnesota		0.50	1.00	1 milligram
Oxycodone	Montana		0.50	1.00	1 milligram
Oxycodone	Nevada		30.00	35.00	80 milligrams
Oxycodone	New Hampshire		5.00	12.00	1 dosage unit
Oxycodone	New York	Norwich	75.00	80.00	80 milligrams
Oxycodone	New York	Norwich	40.00	50.00	40 milligrams
Oxycodone	North Carolina	Charlotte	20.00	40.00	1 dosage unit
Oxycodone	North Carolina	Greensboro	8.00	50.00	1 dosage unit
Oxycodone	North Carolina	Raleigh	15.00	15.00	1 dosage unit
Oxycodone	North Dakota		0.50	1.00	1 milligram
Oxycodone	Ohio	Warren	6.00	8.00	1 tablet
Oxycodone	Pennsylvania	Philadelphia	5.00	10.00	1 milligram
Oxycodone	Rhode Island		5.00	12.00	1 dosage unit
Oxycodone	South Carolina	Charleston	10.00	15.00	1 dosage unit
Oxycodone	South Carolina	Columbia	10.00	80.00	1 dosage unit
Oxycodone	South Carolina	Florence	20.00	80.00	1 dosage unit
Oxycodone	South Carolina	Greenville	20.00	30.00	1 dosage unit
Oxycodone	Utah		0.50	1.00	1 milligram

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Oxycodone	Vermont		0.50	0.50	1 milligram
Oxycodone	Vermont		5.00	12.00	1 dosage unit
Oxycodone	Virginia	Roanoke	12.00	40.00	1 tablet
Oxycodone	Wisconsin		0.50	1.00	1 milligram
Oxycodone	Wyoming		15.00	20.00	10 milligrams
Oxycodone	Wyoming		15.00	20.00	20 milligrams
Oxycodone	Wyoming		80.00	100.00	80 milligrams
Oxycodone	Wyoming		0.50	1.00	1 milligram
Oxycodone/ combination	California	Los Angeles	1.00	5.00	5 milligrams
Oxycodone/ combination	Nevada		2.00	5.00	5 milligrams
OxyContin®	Alabama		1.00	1.00	1 milligram
OxyContin®	Alaska		1.00	2.00	1 milligram
OxyContin®	Arizona	Phoenix	20.00	25.00	40 milligrams
OxyContin®	Arizona	Phoenix	20.00	80.00	80 milligrams
OxyContin®	Arkansas		1.00	1.00	1 milligram
OxyContin®	California	Atascadero	10.00	10.00	20 milligrams
OxyContin®	California	Atascadero	20.00	20.00	40 milligrams
OxyContin®	California	Atascadero	35.00	50.00	80 milligrams
OxyContin®	California	Clovis	2.00	2.00	1 milligram
OxyContin®	California	Clovis	35.00	35.00	80 milligrams bulk
OxyContin®	California	Fresno	2.00	2.00	1 milligram
OxyContin®	California	Marysville	10.00	10.00	40 milligrams
OxyContin®	California	Marysville	20.00	20.00	80 milligrams
OxyContin®	California	Modesto	10.00	15.00	1 tablet
OxyContin®	California	Sacramento	50.00	50.00	80 milligrams
OxyContin®	California	Sacramento	30.00	35.00	80 milligrams bulk
OxyContin®	California	San Jose/San Francisco	50.00	50.00	1 tablet
OxyContin®	Connecticut		52.00	62.00	80 milligrams bulk
OxyContin®	Delaware	Wilmington	40.00	80.00	80 milligrams
OxyContin®	District of Columbia		0.50	1.25	1 milligram
OxyContin®	Florida	Fort Lauderdale	10.00	12.00	30 milligrams
OxyContin®	Florida	Fort Lauderdale	20.00	20.00	80 milligrams



(Table continued from previous page.)

**Table B1. Diverted Controlled Prescription Drug Prices Reported
by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008**

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
OxyContin®	Florida	Jacksonville	25.00	35.00	40 milligrams
OxyContin®	Florida	Jacksonville	50.00	60.00	80 milligrams
OxyContin®	Florida	Jacksonville	25.00	35.00	40 milligrams
OxyContin®	Florida	Jacksonville	60.00	60.00	80 milligrams
OxyContin®	Florida	Miami	10.00	15.00	40 milligrams
OxyContin®	Florida	Miami	20.00	20.00	80 milligrams
OxyContin®	Florida	Okeechobee	0.50	1.00	1 milligram
OxyContin®	Florida	Orlando	1.00	1.00	1 milligram
OxyContin®	Florida	Orlando	0.50	1.00	1 milligram
OxyContin®	Florida	Palm Beach Gardens	10.00	10.00	1 tablet
OxyContin®	Florida	Panama City	60.00	100.00	1 tablet
OxyContin®	Florida	Pensacola	20.00	40.00	40 milligrams
OxyContin®	Florida	Pensacola	60.00	80.00	80 milligrams
OxyContin®	Florida	Port St. Lucie	20.00	35.00	40 milligrams
OxyContin®	Florida	Sarasota	10.00	10.00	20 milligrams
OxyContin®	Florida	Sarasota	20.00	25.00	40 milligrams
OxyContin®	Florida	Sarasota	40.00	50.00	80 milligrams
OxyContin®	Florida	Tallahassee	100.00	100.00	1 tablet
OxyContin®	Florida	West Palm Beach	15.00	15.00	40 milligrams
OxyContin®	Florida	West Palm Beach	25.00	25.00	80 milligrams
OxyContin®	Georgia		1.00	1.00	1 milligram
OxyContin®	Hawaii		1.00	1.00	1 milligram
OxyContin®	Idaho		0.80	1.00	1 milligram
OxyContin®	Iowa		0.50	1.00	1 milligram
OxyContin®	Kentucky	Bowling Green	0.80	0.80	1 milligram
OxyContin®	Kentucky	Hazard	120.00	120.00	80 milligrams
OxyContin®	Kentucky		0.50	1.00	1 milligram
OxyContin®	Kentucky		1.00	1.00	1 milligram
OxyContin®	Louisiana		1.00	1.00	1 milligram
OxyContin®	Maine	Rockland	70.00	110.00	80 milligrams
OxyContin®	Maine		100.00	100.00	80 milligrams
OxyContin®	Maine		50.00	50.00	40 milligrams
OxyContin®	Maine		52.00	62.00	80 milligrams bulk
OxyContin®	Maryland		0.50	1.25	1 milligram
OxyContin®	Massachusetts	Boston/Worcester	0.35	1.00	1 milligram

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
OxyContin®	Massachusetts		52.00	62.00	80 milligrams bulk
OxyContin®	Michigan		0.50	1.00	1 milligram
OxyContin®	Mississippi		20.00	80.00	40 milligrams
OxyContin®	Missouri	St. Louis	0.50	1.00	1 milligram
OxyContin®	Nebraska		15.00	20.00	1 tablet
OxyContin®	New Hampshire		52.00	62.00	80 milligrams bulk
OxyContin®	New Jersey		20.00	25.00	1 tablet
OxyContin®	New Mexico		0.25	0.50	1 milligram
OxyContin®	New York	Cooperstown	0.50	0.50	1 milligram
OxyContin®	New York	Hawthorne	20.00	30.00	1 tablet
OxyContin®	New York	New York City	15.00	17.00	1 tablet
OxyContin®	New York	Syracuse	0.40	0.50	1 milligram
OxyContin®	New York	Upstate	40.00	50.00	1 tablet
OxyContin®	New York	Western	30.00	50.00	1 tablet
OxyContin®	North Carolina	Beaufort	1.00	1.00	1 milligram
OxyContin®	Ohio	Clermont	0.60	0.60	1 milligram
OxyContin®	Ohio	Lorain County	1.00	1.00	1 milligram
OxyContin®	Ohio	Warren	1.00	1.00	1 milligram
OxyContin®	Ohio		0.50	1.00	1 milligram
OxyContin®	Oregon	Portland	0.50	1.00	1 milligram
OxyContin®	Pennsylvania	Harrisburg	20.00	60.00	80 milligrams
OxyContin®	Pennsylvania	Philadelphia	1.00	1.00	1 milligram
OxyContin®	Pennsylvania	Philadelphia	40.00	75.00	80 milligrams
OxyContin®	Pennsylvania	Philadelphia	10.00	15.00	30 milligrams
OxyContin®	Pennsylvania	Philadelphia	30.00	35.00	40 milligrams
OxyContin®	Pennsylvania	Philadelphia	20.00	30.00	20 milligrams
OxyContin®	Pennsylvania	Pittsburgh	25.00	25.00	40 milligrams
OxyContin®	Pennsylvania	Pittsburgh	45.00	50.00	80 milligrams
OxyContin®	Pennsylvania	Scranton	0.50	1.00	1 milligram
OxyContin®	Rhode Island	Providence	0.50	0.75	1 milligram
OxyContin®	Rhode Island	Providence	100.00	120.00	80 milligrams
OxyContin®	Rhode Island		52.00	62.00	80 milligrams bulk
OxyContin®	South Dakota		15.00	20.00	1 tablet
OxyContin®	Texas		8.00	35.00	1 dosage unit
OxyContin®	Texas		25.00	50.00	1 dosage unit



(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
OxyContin®	Texas		1.00	1.00	1 milligram
OxyContin®	Utah	Salt Lake/Davis County	60.00	65.00	80 milligrams
OxyContin®	Vermont	Essex Junction	40.00	45.00 (10 or more)	80 milligrams
OxyContin®	Vermont	Essex Junction	1.00	10.00	1 milligram
OxyContin®	Vermont	Newport	1.00	1.00	1 milligram
OxyContin®	Vermont		100.00	120.00	80 milligrams
OxyContin®	Vermont		52.00	62.00	80 milligrams bulk
OxyContin®	Virginia	Big Stone	2.00	2.00	1 milligram
OxyContin®	Virginia	Christiansburg	1.00	1.00	1 milligram
OxyContin®	Virginia		0.50	1.25	1 milligram
OxyContin®	Washington	Bainbridge Island	1.00	1.00	1 milligram
OxyContin®	Washington	Olympia	52.50	90.00	80 milligrams
OxyContin®	Washington	Port Angeles	1.00	1.00	1 milligram
OxyContin®	Washington	Seattle	0.50	2.00	1 milligram
OxyContin®	Washington	Yakima	1.00	1.00	1 milligram
OxyContin®	West Virginia	Barboursville	1.00	1.00	1 milligram
OxyContin®	West Virginia	Braxton County	1.00	1.00	1 milligram
OxyContin®	West Virginia	Charleston	1.00	1.00	1 milligram
OxyContin®	West Virginia	Morgantown	1.00	1.00	1 milligram
OxyContin®	West Virginia	Ripley	1.00	1.00	1 milligram
OxyContin®	West Virginia		0.50	1.25	1 milligram
OxyContin® (liquid)	Pennsylvania	Philadelphia	100.00	100.00	5 milliliters
Percocet®	Caribbean		5.00	5.00	1 tablet
Percocet®	Connecticut		5.00	5.00	1 dosage unit
Percocet®	Hawaii		1.00	25.00	1 tablet
Percocet®	Kentucky		5.00	10.00	1 tablet
Percocet®	Maine	Rockland	1.00	1.00	1 milligram
Percocet®	Maine		5.00	5.00	1 dosage unit
Percocet®	Massachusetts		5.00	5.00	1 dosage unit
Percocet®	Missouri	St. Louis	10.00	10.00	1 tablet
Percocet®	New Hampshire		5.00	5.00	1 dosage unit
Percocet®	New York	Hawthorne	20.00	20.00	1 tablet

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Percocet®	New York	New York City	10.00	15.00	1 tablet
Percocet®	New York	Troy	10.00	10.00	5 milligrams
Percocet®	New York	Upstate	3.00	7.00	1 tablet
Percocet®	North Carolina	Beaufort	5.00	5.00	1 tablet
Percocet®	Ohio	Clermont	20.00	25.00	1 tablet
Percocet®	Ohio	Lorain County	8.00	10.00	1 tablet
Percocet®	Pennsylvania	Montgomery County	10.00	10.00	5 milligrams
Percocet®	Pennsylvania	Philadelphia	3.00	5.00	5 milligram
Percocet®	Pennsylvania	Pittsburgh	7.00	7.00	5 milligrams
Percocet®	Rhode Island		5.00	5.00	1 dosage unit
Percocet®	Vermont	Essex Junction	1.00	1.00	1 milligram
Percocet®	Vermont		5.00	5.00	1 dosage unit
Percocet®	Virginia	Big Stone	25.00	25.00	1 dosage unit
Percocet®	Virginia	Christiansburg	8.00	8.00	1 tablet
Percocet®/ Percodan®	Connecticut		6.50	8.00	1 dosage unit
Percocet®/ Percodan®	Maine		6.50	8.00	1 dosage unit
Percocet®/ Percodan®	Massachusetts		6.50	8.00	1 dosage unit
Percocet®/ Percodan®	New Hampshire		6.50	8.00	1 dosage unit
Percocet®/ Percodan®	New Jersey		3.00	6.00	1 tablet
Percocet®/ Percodan®	Rhode Island		6.50	8.00	1 dosage unit
Percocet®/ Percodan®	Vermont		6.50	8.00	1 dosage unit
Percodan®	Louisiana		5.00	15.00	1 dosage unit
Percodan®	Vermont		10.00	10.00	1 dosage unit
Promethazine/ codeine	Arkansas		15.00	15.00	1 ounce
Promethazine/ codeine	California	Atascadero	20.00	40.00	1 bottle
Promethazine/ codeine	California	Los Angeles	200.00	300.00	1 pint



(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Promethazine/codeine	California	Oxnard	5.00	5.00	1 bottle
Promethazine/codeine	California	Roseville	5.00	20.00	1 bottle
Promethazine/codeine	California	Santa Paula	30.00	30.00	1 bottle
Promethazine/codeine	Louisiana		250.00	300.00	1 pint
Promethazine/codeine	Pennsylvania	Philadelphia	20.00	30.00	1 ounce
Promethazine/codeine	Pennsylvania	Philadelphia	40.00	40.00	1 pint
Promethazine/codeine	Pennsylvania	Scranton	12.00	12.00	1 pint
Promethazine/codeine	Texas		12.00	12.00	1 bottle
Propoxyphene	New Mexico		1.00	2.00	1 tablet
Propoxyphene	Texas		0.50	0.50	1 dosage unit
Ritalin®	Maine	Rockland	5.00	10.00	1 tablet
Ritalin®	Nevada		3.00	4.00	1 tablet
Ritalin®	Virginia	Big Stone	10.00	10.00	1 dosage unit
Roxicodone®	Florida	Fort Lauderdale	10.00	10.00	80 milligrams
Roxicodone®	Florida	Fort Lauderdale	700.00	800.00	100 tablets
Roxicodone®	Florida	Okeechobee	0.50	1.00	1 milligram
Roxicodone®	Florida	Palm Beach Gardens	10.00	10.00	1 tablet
Roxicodone®	Florida	Pinellas County	10.00	15.00	1 tablet
Roxicodone®	Florida	Sarasota	12.00	15.00	1 tablet
Roxicodone®	Virginia	Christiansburg	5.00	5.00	1 tablet
Suboxone®	Connecticut		8.00	20.00	8 milligrams
Suboxone®	Maine	Rockland	8.00	10.00	8 milligrams
Suboxone®	Maine		8.00	20.00	8 milligrams
Suboxone®	Massachusetts		8.00	20.00	8 milligrams
Suboxone®	New Hampshire		8.00	20.00	8 milligrams
Suboxone®	Pennsylvania	Scranton	25.00	50.00	1 dosage unit
Suboxone®	Rhode Island		8.00	20.00	8 milligrams
Suboxone®	Vermont		8.00	20.00	8 milligrams
Suboxone®	Virginia	Big Stone	25.00	25.00	1 dosage unit

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Tussionex®	California	Atascadero	30.00	40.00	1 bottle
Tussionex®	California	Oxnard	5.00	5.00	1 bottle
Tussionex®	California	Roseville	10.00	10.00	1 bottle
Tylenol #3®	Pennsylvania	Pittsburgh	5.00	5.00	1 dosage unit
Tylenol #3®	Virginia	Christiansburg	3.00	3.00	1 tablet
Tylenol #4®	Pennsylvania	Pittsburgh	5.00	5.00	1 dosage unit
Valium®	Alabama		1.00	5.00	10 milligrams
Valium®	Arkansas		1.00	5.00	10 milligrams
Valium®	California	Atascadero	5.00	5.00	5 milligrams
Valium®	California	Sacramento	1.00	2.00	1 tablet
Valium®	Connecticut		3.00	5.00	10 milligrams
Valium®	Florida	Palm Beach Gardens	10.00	10.00	1 tablet
Valium®	Hawaii		5.00	7.00	5 milligrams
Valium®	Louisiana		2.00	2.00	5 milligrams
Valium®	Louisiana		2.00	15.00	10 milligrams
Valium®	Maine		3.00	5.00	10 milligrams
Valium®	Massachusetts		3.00	5.00	10 milligrams
Valium®	Mississippi		2.00	2.00	5 milligrams
Valium®	New Hampshire		3.00	5.00	10 milligrams
Valium®	New Jersey		1.00	3.00	1 tablet
Valium®	Pennsylvania	Bucks County	2.00	4.00	1 dosage unit
Valium®	Pennsylvania	Pittsburgh	4.00	4.00	1 dosage unit
Valium®	Pennsylvania	Scranton	1.00	2.00	1 dosage unit
Valium®	Rhode Island		3.00	5.00	10 milligrams
Valium®	Vermont		3.00	5.00	10 milligrams
Vicodin®	Alabama		3.00	6.00	5 milligrams
Vicodin®	Alabama		4.00	7.00	7.5 milligrams
Vicodin®	Alabama		4.00	9.00	10 milligrams
Vicodin®	Alaska		3.00	5.00	1 tablet
Vicodin®	Arizona	Phoenix	5.00	5.00	1 tablet
Vicodin®	Arkansas		8.00	8.00	5 milligrams
Vicodin®	Idaho		5.00	5.00	1 tablet
Vicodin®	Louisiana		5.00	5.00	5 milligrams
Vicodin®	Louisiana		5.00	5.00	7.5 milligrams
Vicodin®	Louisiana		6.00	10.00	10 milligrams



(Table continued from previous page.)

**Table B1. Diverted Controlled Prescription Drug Prices Reported
by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008**

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Vicodin®	Maine	Rockland	1.00	1.00	1 milligram
Vicodin®	Mississippi		4.00	5.00	5 milligrams
Vicodin®	New York	Hawthorne	10.00	10.00	1 tablet
Vicodin®	New York	New York City	8.00	8.00	26 tablets bulk
Vicodin®	New York	Norwich	2.00	2.00	5 milligrams
Vicodin®	New York	Norwich	3.00	3.00	7 milligrams
Vicodin®	New York	Norwich	5.00	5.00	10.5 milligrams
Vicodin®	New York	Western	2.00	5.00	1 tablet
Vicodin®	New York		10.00	10.00	1 tablet
Vicodin®	North Carolina	Beaufort	5.00	5.00	1 tablet
Vicodin®	Ohio	Clermont	10.00	10.00	1 tablet
Vicodin®	Ohio	Lorain County	5.00	10.00	1 tablet
Vicodin®	Pennsylvania	Scranton	5.00	7.00	1 dosage unit
Vicodin®	Vermont	Essex Junction	1.00	1.00	1 milligram
Vicodin®	Washington	Seattle	3.00	15.00	1 tablet
Vicodin ES®	California	Atascadero	5.00	5.00	10 milligrams
Vicodin ES®	California	El Monte	1.00	2.00	10 milligrams
Vicodin ES®	California	Marysville	3.00	4.00	10 milligrams
Vicodin ES®	California	Modesto	2.00	5.00	10 milligrams
Vicodin ES®	California	Oxnard	2.00	3.00	10 milligrams
Vicodin ES®	California	Roseville	2.00	10.00	10 milligrams
Vicodin ES®	California	Santa Maria	1.00	2.00	10 milligrams
Vicodin ES®	California	Santa Paula	5.00	5.00	10 milligrams
Vicodin ES®	California	West Covina	1.00	1.00	10 milligrams
Vicodin®/ Vicodin ES®	Connecticut		5.00	8.00	1 dosage unit
Vicodin®/ Vicodin ES®	Maine		5.00	8.00	1 dosage unit
Vicodin®/ Vicodin ES®	Massachusetts		5.00	8.00	1 dosage unit
Vicodin®/ Vicodin ES®	New Hampshire		5.00	8.00	1 dosage unit
Vicodin®/ Vicodin ES®	Rhode Island		5.00	8.00	1 dosage unit
Vicodin®/ Vicodin ES®	Vermont		5.00	8.00	1 dosage unit

NATIONAL PRESCRIPTION DRUG THREAT ASSESSMENT 2009

(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Xanax®	Alabama		2.00	4.00	2 milligrams
Xanax®	Arkansas		3.00	5.00	2 milligrams
Xanax®	California	Atascadero	3.00	5.00	4 milligrams
Xanax®	California	El Monte	1.00	1.50	4 milligrams
Xanax®	California	Los Angeles	1.00	1.00	4 milligrams
Xanax®	California	Modesto	3.00	3.00	4 milligrams
Xanax®	California	Oxnard	4.00	4.00	4 milligrams
Xanax®	California	Roseville	3.00	5.00	4 milligrams
Xanax®	California	Santa Maria	4.00	4.00	4 milligrams
Xanax®	California	Santa Paula	2.00	3.00	4 milligrams
Xanax®	California	West Covina	3.00	5.00	4 milligrams
Xanax®	Caribbean		3.00	3.00	1 tablet
Xanax®	Connecticut		5.00	5.00	1 milligram
Xanax®	Connecticut		7.00	7.00	2 milligrams
Xanax®	Connecticut		3.00	3.00	1 milligram
Xanax®	Delaware	Wilmington	1.00	3.00	1 dosage unit
Xanax®	Florida	Fort Lauderdale	1.00	2.00	1 dosage unit
Xanax®	Florida	Fort Myers/Naples	3.00	20.00	1 dosage unit
Xanax®	Florida	Jacksonville	4.00	5.00	2 milligrams
Xanax®	Florida	Jacksonville	4.00	5.00	1 dosage unit
Xanax®	Florida	Miami	2.00	10.00	1 dosage unit
Xanax®	Florida	Okeechobee	8.00	10.00	1 tablet
Xanax®	Florida	Orlando	1.00	2.00	1 dosage unit
Xanax®	Florida	Palm Beach Gardens	10.00	10.00	1 tablet
Xanax®	Florida	Pensacola	4.00	4.00	1 dosage unit
Xanax®	Florida	Port St. Lucie	4.00	4.00	1 dosage unit
Xanax®	Florida	Sarasota	5.00	10.00	1 tablet
Xanax®	Florida	Tallahassee	10.00	10.00	1 dosage unit
Xanax®	Florida	Tampa	2.00	2.00	1 dosage unit
Xanax®	Florida	West Palm Beach	3.00	5.00	1 dosage unit
Xanax®	Georgia		3.00	5.00	1 milligram
Xanax®	Hawaii		1.00	20.00	1 tablet
Xanax®	Kentucky		3.00	5.00	1 dosage unit
Xanax®	Louisiana		2.00	5.00	2 milligrams
Xanax®	Maine		5.00	5.00	1 milligram



(Table continued from previous page.)

Table B1. Diverted Controlled Prescription Drug Prices Reported by Federal, State, and Local Law Enforcement Agencies, by Drug, July 2008

Drug	State/Territory	City/County*	Low \$	High \$	Quantity/Weight
Xanax®	Maine		7.00	7.00	2 milligrams
Xanax®	Maine		3.00	3.00	1 milligram
Xanax®	Massachusetts		5.00	5.00	1 milligram
Xanax®	Massachusetts		7.00	7.00	2 milligrams
Xanax®	Massachusetts		3.00	3.00	1 milligram
Xanax®	Michigan		3.00	5.00	1 dosage unit
Xanax®	Mississippi		3.00	3.00	2 milligrams
Xanax®	Missouri	Kansas City	1.00	1.00	1 milligram
Xanax®	Missouri	St. Louis	2.00	2.00	1 tablet
Xanax®	New Hampshire		5.00	5.00	1 milligram
Xanax®	New Hampshire		7.00	7.00	2 milligrams
Xanax®	New Hampshire		3.00	3.00	1 milligram
Xanax®	New Jersey	Newark	3.00	5.00	1 tablet
Xanax®	New Jersey		7.00	7.00	1 tablet
Xanax®	New York	Hawthorne	4.00	4.00	1 tablet
Xanax®	New York	New York City	5.00	5.00	2 milligrams
Xanax®	New York	Western	2.00	2.00	1 tablet
Xanax®	North Carolina		3.00	5.00	1 dosage unit
Xanax®	Ohio		3.00	5.00	1 dosage unit
Xanax®	Pennsylvania	Philadelphia	2.00	5.00	1 dosage unit
Xanax®	Pennsylvania	Philadelphia	1.00	2.00	1 milligram
Xanax®	Pennsylvania	Pittsburgh	3.00	3.00	1 dosage unit
Xanax®	Pennsylvania	Scranton	2.00	4.00	1 dosage unit
Xanax®	Rhode Island		5.00	5.00	1 milligram
Xanax®	Rhode Island		7.00	7.00	2 milligrams
Xanax®	Rhode Island		3.00	3.00	1 milligram
Xanax®	Texas	Houston	2.00	5.00	1 tablet
Xanax®	Vermont		5.00	5.00	1 milligram
Xanax®	Vermont		7.00	7.00	2 milligrams
Xanax®	Vermont		3.00	3.00	1 milligram

Source: National Drug Intelligence Center; Drug Enforcement Administration.

*Blank cells in City/County column indicate no city/county specified.

More than 3,000 state and local law enforcement agencies throughout the United States provided valuable input to this report through their participation in the NDTs. These agencies are too numerous to list individually.

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STATE

ALASKA

Kenai Police Department
 Nome Police Department

ARKANSAS

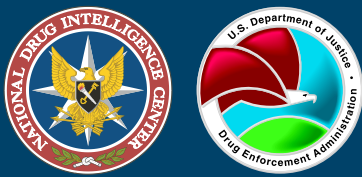
Fort Smith Police Department

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Coral Springs Police Department



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Sarasota County Sheriff's Office

KENTUCKY

Bowling Green Drug Task Force
Northern Kentucky Drug Strike Force
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State Police

MAINE

Department of Health and Human Services
Lincoln County Sheriff's Department

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Bureau of Narcotics Enforcement
City of Yonkers Police Department
Norwich Police Department
Otsego County Sheriff's Department
State Police
Syracuse Police Department
Westchester County Police Department

NORTH CAROLINA

Beaufort County Sheriff's Office
Board of Pharmacy
Ocean Isle Beach Police Department
State Bureau of Investigations
Whiteville Police Department

NEW JERSEY

Atlantic County Prosecutor's Office
Fairview Police Department

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Memphis Police Department

TEXAS

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Task Force
Thurston County Narcotics Task Force

WEST VIRGINIA

Braxton County Sheriff's Office

Fayette County Sheriff's Office
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 Metropolitan Drug Network Enforcement Team
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 State Police
 Wayne County Sheriff's Office

WYOMING

Division of Criminal Investigation

OTHER

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