TO: Patty Salazar, Executive Director, Colorado Department of Regulatory Agencies
Members of the Colorado General Assembly

FROM: Colorado Consortium for Prescription Drug Abuse Prevention

DATE: July 1, 2025

RE: 2024-2025 Prescription Drug Monitoring Program Task Force Report

The Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) submits the enclosed report on behalf of the Prescription Drug Monitoring Program (PDMP) Task Force pursuant to 12-280-409(2), C.R.S. This report details the Consortium's work in response to the DORA Executive Director's requests to the PDMP Task Force.

Respectfully,

Colorado Consortium for Prescription Drug Abuse Prevention

COLORADO ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

2024-2025 TASK FORCE REPORT

July 1, 2025

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COLORADO ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

2024-2025 TASK FORCE REPORT

Introduction:

Pursuant to Section 12-280-409(1), Colorado Revised Statutes (C.R.S.), the Executive Director of the Department of Regulatory Agencies (DORA) is required to create a Prescription Drug Monitoring Program (PDMP) Task Force or consult with and request assistance from the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) to:

1. Examine issues, opportunities, and weaknesses of the program, including how personal information is secured in the program and whether inclusion of personal identifying information in the program and access to that information is necessary;

2. Make recommendations to the Executive Director on ways to make the program a more effective tool for prescribers and pharmacists in order to reduce prescription drug abuse in Colorado; and

3. Evaluate and make recommendations to the Executive Director, after engaging in a stakeholder process, regarding balancing the program as a health-care tool with the enforcement of Colorado Revised Statutes, Title 12, Article 280.

Should the Executive Director convene a Task Force, it shall submit an annual report to the Executive Director and the General Assembly detailing its findings and recommendations, per §12-280-409(2), C.R.S.

This report provides the recommendations of the Task Force to the Executive Director in response to the items assigned to the Task Force by the DORA Executive Director as detailed below.

This report is a product of the Colorado Consortium for Prescription Drug Abuse Prevention and Prescription Drug Monitoring Program (PDMP) Task Force pursuant to 12-280-409(2), C.R.S. This report and the recommendations herein do not represent the views of Colorado's Governor's Office, Office of State Planning and Budgeting, the Colorado Department of Regulatory Agencies, or other state agencies.

Requests for 2024-2025 PDMP Task Force Report

Following the issuance of the 2023-2024 PDMP Task Force Annual Report, DORA's Executive Director requested that the Task Force evaluate the following:

Evaluate the Benefits and Risks of Allowing PDMP Access to Opioid Rapid Response Program Trusted Contacts

Patients on long-term opioid therapy or medication for opioid use disorder who experience interrupted or discontinued treatment are at an elevated risk of experiencing withdrawal symptoms, seeking illicit substances, and overdose. The CDC's Opioid Rapid Response Program (ORRP)[1] receives notification from law enforcement agencies about potential disruptions to healthcare access and facilitates coordinated responses by state agencies to minimize care disruptions for at-risk patients and has provided 15 notifications to Colorado's ORRP trusted contacts as of October 1, 2024. The CDC reports that PDMP data can be a valuable tool for the state trusted contacts of these rapid response teams, but only 7 states are able to share PDMP identified data while 28 states can provide aggregate PDMP data to inform responses.[2] I request that the Task Force evaluate the potential benefits and risks of statutory changes that would allow PDMP data access to ORRP's trusted contacts in Colorado.

The Executive Director's request can be found in **Appendix A.**

[1] CDC Opioid Rapid Response Program. https://www.cdc.gov/overdose-prevention/orrp/index.html

[2] Stephanie K. Rubel., CDR Patrick Neubert. Preventing Overdoses in Today's Opioid Prescribing and Illegal Drug Market Context. CDC Opioid Rapid Response Program (ORRP). Presentation at the National Association of State Controlled Substances Authorities 2024 Annual Meeting. https://nascsa.org/wp-content/uploads/2024/10/Stephanie-Rubel-Patrick-Neubert.pdf.

Task Force Review and Responses to DORA Executive Director's Request for Assistance

The Executive Director's requests were submitted to the PDMP Work Group at the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium), which was designated as the PDMP Task Force by the Executive Director. Established in 2013, the Consortium is a coordinated, statewide, inter-university/inter-agency network. It now supports 11 different work groups with more than 1,000 participants, including providers, professionals, laypersons and other stakeholders. The participants and work groups study, recommend and implement ways to reduce prescription drug abuse in Colorado. The PDMP work group focuses on issues relating to the use and improvement of the state's PDMP.

The PDMP Work Group at the Consortium is composed of representatives with medical, legal, or health information technology expertise, interested patients and family members, members of the Colorado General Assembly, as well as representatives from various state and federal agencies. A full list of the PDMP Work Group members and their corresponding organizations can be found in **Appendix B**.

Patient Risks When Facing Care Interruptions

Patients receiving long-term opioid therapy who face sudden discontinuation are at heightened risk of pursuing illicit opioids,[3] experiencing acute withdrawal symptoms, uncontrolled pain, and psychological distress for patients with physical dependence,[4] emergency department visits or hospitalization with a substance use disorder diagnosis,[5] non-fatal overdose, fatal overdose, and suicide.[6,7] Patients on long-term opioid therapy also often encounter challenges in finding a primary care provider willing to continue opioid therapy.[8,9,10] The most significant example of these challenges can be seen in the abrupt closure of 29 Lags Medical Center pain management clinics in California in 2021, affecting approximately 20,000 patients receiving pain management treatment. Patients who were on long-term opioid therapy received a 30-day supply of medications and were given instructions to contact their primary care provider or find a new provider. Many patients found that their primary care providers were unwilling to

[3] Binswanger, Ingrid A., et al. The Association between Opioid Discontinuation and Heroin Use: A Nested Case-Control Study. Drug Alcohol Depend. Dec. 1, 2020. https://doi.org/10.1016/j.drugalcdep.2020.108248

[4] U.S. Food & Drug Administration. FDA Drug Safety Communication. FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering. www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes

[5] Mark, Tami L. and Parish, William. Opioid Medication Discontinuation and Risk of Adverse Opioid-Related Health Care Events. Journal of Substance Abuse Treatment, Volume 103, 58 – 63. www.jsatjournal.com/article/S0740-5472(19)30037-6/fulltext

[6] Oliva, Elizabeth M., et al. Associations Between Stopping Prescriptions for Opioids, Length of Opioid Treatment, and Overdose or Suicide Deaths in US Veterans: Observational Evaluation. BMJ 2020; 368. doi.org/10.1136/bmj.m283

[7] James, Jocelyn R., et al. Mortality After Discontinuation of Primary Care-Based Chronic Opioid Therapy for Pain: A Retrospective Cohort Study. J Gen Intern Med. 2019 Dec;34(12):2749-2755. doi.org/10.1007/s11606-019-05301-2

[8] Lagisetty, Pooja A., et al. Access to Primary Care Clinics for Patients With Chronic Pain Receiving Opioids. JAMA Netw Open. 2019;2(7):e196928. jamanetwork.com/journals/jamanetworkopen/fullarticle/2737896

[9] Lagisetty, Pooja A., et al. Assessing Reasons for Decreased Primary Care Access for Individuals on Prescribed Opioids: an Audit Study. PAIN 162(5):p 1379-1386, May 2021. doi.org/10.1097/j.pain.0000000000002145

[10] Bicket, Mark C. et al. Access to Care for Patients with Chronic Pain Receiving Prescription Opioids, Cannabis, or Other Treatments. Health Aff Sch. 2024 Jun 12;2(6). doi.org/10.1093/haschl/qxae086

prescribe opioids, and those without a primary care provider found that very few primary care providers would prescribe opioids to new patients. Referrals to pain management specialists took as long as six months for some patients. Many of the affected patients went from emergency department to emergency department trying to obtain medications to avert opioid withdrawal.[11]

Opioid Rapid Response Program (ORRP)

Considering these risks to patients affected by law enforcement actions against their prescribing practitioner, public health agencies have implemented response protocols to mitigate risk and support patients affected by care interruptions caused by law enforcement actions. The Opioid Rapid Response Program (ORRP) became a formal program managed by U.S. Centers for Disease Control and Prevention (CDC) Division of Overdose Prevention's Public Health and Public Safety Team in 2020. The ORRP is led by the U.S. Centers for Disease Control and Prevention (CDC), in coordination with the Office of the Inspector General within the U.S. Department of Health and Human Services (HHS OIG) with oversight by the Office of the US Assistant Secretary for Health (OASH).[12] The ORRP receives notification from federal law enforcement agencies regarding imminent actions by federal law enforcement that may interrupt patients' access to prescribed controlled substances or treatment for opioid use disorder. Such actions include a search warrant served on a facility where opioid prescribing occurs or medications for opioid use disorder are provided, a practitioner arrest, a DEA registration suspension, or DEA registration surrender by a practitioner. The CDC ORRP is not directly involved in these public health responses but instead helps develop protocols and response plans with state and local health authorities and offers remote technical assistance to state and local health officials throughout their response.[13]

The ORRP has established partnerships and implemented protocols with the HHS OIG and the U.S. Drug Enforcement Administration (DEA) to formalize timely notification and coordination of law enforcement activities that may potentially disrupt patients' access to controlled substance medications. In 2021, the DEA formally implemented an ORRP notification protocol with its Pharmaceuticals Investigations field agents to ensure the DEA notifies ORRP in advance of an action being taken against a practitioner or pharmacy. The ORRP also maintains active partnerships with the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resource and Services Administration (HRSA), the Centers for Medicare and Medicaid Services (CMS), and OASH to ensure federal resources are leveraged by state and local public health agencies responding to disruptions in patient access to controlled substances.[14]

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[11] Coffin, Phillip and Barreveld, Antje. Inherited Patients on Opioids for Chronic Pain – Considerations for Primary Care. New England Journal of Medicine. 2022 Feb 12;386(7):611–613. doi.org/10.1056/NEJMp2115244

[12] Centers for Disease Control and Prevention (CDC). Overdose Prevention. About CDC's Opioid Rapid Response Program. https://www.cdc.gov/overdose-prevention/orrp/index.html

[13] Rubel, Stephanie K. MPH; Neubert, Patrick MSPH, MSSA; Navarretta, Nancy MA, LPC, NCC; Logan, Susan MS, MPH. Facilitating Overdose Risk Mitigation Among Patients Following a Clinician Office Closure: A Connecticut Case Study of the Opioid Rapid Response Program. Journal of Public Health Management and Practice. 2022 Nov-Dec 01;28(Suppl 6):S381-S387 doi.org/10.1097/PHH.0000000000001555

[14] Ibid.

Through ORRP, the CDC established "trusted contacts" within each state's public health and behavioral health agencies. These individuals were selected for their ability to maintain confidentiality and identify, coordinate, and mobilize appropriate overdose prevention and substance use disorder (SUD) treatment resources throughout their state. Diversion investigators and agents from the DEA or HHS OIG contact ORRP coordinators about impending law enforcement actions that might disrupt patients' access to controlled substances. The ORRP coordinators work with agents to discuss possible patient risks and determine what information can be shared with the state's trusted contacts before and immediately after the law enforcement action. The goal is to disclose only enough information to inform state-led response strategies while not compromising the investigation or law enforcement operations.

The ORRP also coordinates with the Association of State and Territorial Health Officials (ASTHO) to develop protocols, response plans, and materials for state and local response teams and for clinicians inheriting patients receiving long-term opioid therapy whose access to medications is disrupted because of these actions against a practitioner, clinic, or pharmacy. ASTHO published a guide for state health departments and their partners which provides extensive detail regarding responses to interruptions, resources for developing a response plan, structuring response teams, and potential actions for response teams. It also discusses known challenges, risk mitigation strategies, and how to monitor the response process and outcomes.[15] ASTHO and CDC ORRP also host virtual Opioid Preparedness exercises with state response teams. The state trusted contacts coordinate and implement responses when actions are taken against an individual or organization. State- and local-level responses to these actions may include:

- Arranging on-site support for patients while an action is taking place if requested by law enforcement.
- Identifying available providers to whom patients can be referred.
- Developing notices with contact information for patient referrals.
- Preparing health alert notices for local hospitals, emergency departments, first responders, and harm reduction organizations.
- Increasing naloxone distribution in the area.
- Accessing care coordinators to help patients navigate options, including offering treatment for substance use disorders.
- Contacting local law enforcement to assess current illicit supply risks such as counterfeit pills and incorporating this information into patient or public education.
- Issuing a press release or providing risk reduction information to include in a law enforcement press release.
- Monitoring outcomes through Medicare and Medicaid claims data.[16]

[15] Association of State and Territorial Health Officials. Responding to Disruptions in Access to Opioid Prescriptions: A Guide for State Health Departments and Their Partners. Nov. 30, 2022. www.astho.org/topic/report/responding-to-disruptions-in-access-to-opioid-prescriptions

[16] CDC National Center for Injury Prevention and Control. Opioid Rapid Response Program: Background and Description. February 2021. https://www.cdc.gov/overdose-prevention/media/pdfs/ORRP-Background-Description-508.pdf

PDMP Data Informing ORRP Responses in Other States

PDMP data can also be leveraged in some states by ORRP state trusted contacts to inform responses. The ORRP team reports that 28 states can obtain aggregate data from their PDMP in connection with ORRP responses to assess metrics including the number of patients receiving opioids, benzodiazepines, concurrent opioids and benzodiazepines, concurrent stimulants and sedatives, buprenorphine, or methadone by a practitioner, clinic, or pharmacy facing a law enforcement action. Aggregate PDMP data or other data sources can also be leveraged to identify other prescribers or pharmacies in the area to determine what other providers or pharmacies may be capable of accepting new patients who lose access as the result of a law enforcement action. Identified PDMP information can also be used in a few states to directly contact affected patients, prioritize patients by identifying patients who are due first for a new prescription based on their most recent fill date, and perform ongoing assessments regarding care continuity, length of disruptions for patients receiving medications by comparing the length of time between a prescription from a provider facing a law enforcement action and a prescription from a new practitioner, and potentially unsafe tapering rates for affected patients. [17]

The CDC ORRP team advised the Task Force that seven states (Idaho, Illinois, Indiana, Kentucky, Nebraska, Pennsylvania, and Rhode Island) can mail letters containing support resources to patients who recently received controlled substance prescriptions from a practitioner or pharmacy affected by a law enforcement action. However, the Task Force reached out to each of these states for additional information, and Indiana and Rhode Island advised that identified PDMP data is not being leveraged in ORRP-related responses and no provision in their state laws allows for this activity. Idaho advised that their PDMP staff have agreed to mail letters to patients to help connect them with resources that could help patients find a new practitioner upon request by their state ORRP trusted contacts, but the Idaho PDMP has not yet been asked to contact patients in connection with an ORRP-related action. Nebraska advised that the Nebraska Department of Health and Human Services only leverages PDMP data for internal purposes in connection with ORRP responses and does not leverage PDMP data for direct patient outreach.

The Task Force attempted to confirm Illinois' use of identified PDMP data in ORRP responses but did not receive a response. Illinois law allows for PDMP data to be released to a governing body that licenses practitioners and is involved in an investigation, an adjudication, or a prosecution of a violation under any state or federal law that involves a controlled substance. [18] The Pennsylvania Patient Advocacy Program, which handles patient outreach in response to ORRP-related actions, is housed within the Pennsylvania Department of Health, which is also the administering entity for the Pennsylvania PDMP. Pennsylvania law authorizes an authorized employee of a county or municipal health department or the state Department of Health to access Pennsylvania PDMP data for public health interventions relating to specific prescribing

[17] Rubel, Stephanie (CDC ORRP) and Neubert, Patrick (HHS OIG). Preventing Overdose. Presentation at 2024 National Association of State Controlled Substances Authorities Annual Meeting. nascsa.org/wp-content/uploads/2024/10/Stephanie-Rubel-Patrick-Neubert.pdf

[18] 720 ILCS 570/318(d)(1). www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1941&ChapterID=53

practices, controlled substances and the prevention of fraud and abuse.[19] Pennsylvania confirmed that they leverage this statutory provision to share PDMP data with ORRP state trusted contacts for direct patient outreach.

Kentucky law specifically authorizes direct outreach to patients in connection with actions against a practitioner, per Kentucky Revised Statutes 218A.240(10):

> If the office or clinic of a practitioner abruptly closes or is subject to emergency closure or other enforcement action resulting in a suspension or termination of the practitioner's controlled substance prescribing privileges, the Cabinet for Health and Family Services or applicable professional licensing board may use data from the electronic system established under KRS 218A.202 to issue notification as soon as practicable to the practitioner's patients to help prevent the disruption of medical treatment and promote continuity of care.[20]

Connecticut formalized its own intervention protocols before the CDC formally established the ORRP and responds to local or state-level law enforcement and regulatory actions against practitioners in addition to federal law enforcement actions. Connecticut's Prescription Monitoring and Reporting System (CPRMS) is housed under the Connecticut Department of Consumer Protection, and the Director of Drug Control at the Connecticut Department of Consumer Protection (DCP) oversees the CPRMS and is an ORRP state trusted contact. Connecticut State statute allows health officials to obtain de-identified CPRMS data for epidemiological or educational purposes, but neither state nor local health departments can access identifiable patient data that would enable them to conduct direct outreach to high-risk patients or track patient outcomes.[21,22] However, a case study report of an ORRP-facilitated response to a Connecticut clinician office closure details the state's response to one DEA investigation which resulted in search warrants executed on a psychiatrist's three clinic locations and resulted in the voluntary surrender for cause of the psychiatrist's DEA registration. This case study is the only published report concerning an ORRP response. The state's response was guided by the following goals: (1) do not abandon any patient/client/person, (2) provide treatment on demand, (3) inform individuals, families, and communities of resources, and (4) mitigate overdose risk and prevent illegal drug purchases. The response team engaged a psychiatric nurse practitioner and recovery coach to provide on-site support and printed materials on local resources, assisted with referrals to clinicians and treatment and recovery support, harm reduction materials, and bridge prescriptions for a limited supply of medication in urgent situations. The response team also notified the state's behavioral health and Medicaid agencies, emergency departments, community health care providers, local mental health authorities, and Connecticut's PDMP (CPRMS). CPRMS identified

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[19] PA 2014 Act 191 Section 9(b)(13)(j)(A). www.legis.state.pa.us/cfdocs/legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=191&chpt=0&sctn=9&subsctn=0

[20] Kentucky Revised Statutes KRS Chapter 218A.240. apps.legislature.ky.gov/law/statutes/statute.aspx?id=49984

[21] CT Gen Statute §§21a-254; 21a-254a; 21a-265; 21a-274. eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_21aSubtitle_21a-254_HTML

[22] Rubel, Stephanie K. MPH; Neubert, Patrick MSPH, MSSA; Navarretta, Nancy MA, LPC, NCC; Logan, Susan MS, MPH. Facilitating Overdose Risk Mitigation Among Patients Following a Clinician Office Closure: A Connecticut Case Study of the Opioid Rapid Response Program. Journal of Public Health Management and Practice. 2022 Nov-Dec 01;28(Suppl 6):S381-S387 doi.org/10.1097/PHH.0000000000001555

pharmacies at which patients had been filling their prescriptions and sent a communication to those pharmacies through CPRMS notifying them of the disruption. Though Connecticut law does not allow for ORRP response teams to leverage CPRMS data to identify patients for direct outreach, Connecticut's contracted behavioral and medical Administrative Service Organizations serving Medicaid members identified impacted patients leveraging the state Medicaid payer system and immediately began calling all patients of the clinician to inform them of the office closure and attempt to provide care continuity assistance. These staff members made at least three attempts to reach members for more than three weeks, and mailings or emails were sent to all affected Medicaid beneficiaries for whom contact information was available. These teams also contacted practitioners in the affected areas to see whether they were accepting new patients and facilitated care transfers where possible. The response team conducted an after-action debriefing session, which noted that the state's response could be improved if state law allowed the response team to leverage PDMP data to identify affected patients for broader patient outreach.[23]

Connecticut internally evaluated patient outcomes following four practice closures that affected 1,000 patients by leveraging CPRMS data and state death records to determine whether patients received similar controlled substance prescriptions from another provider following the action against their previous prescribing provider and to determine whether any patients who did not transition to a new provider had died following the interruption. This evaluation found that 833 patients (83%) transitioned to a new provider, with average transition times in each of the four cases ranging between 37 and 77 days. Of the 167 patients who did not transition to a new provider, 11 had died of the following causes according to their death certificates, with counts of cause of death noted in parentheses:

- Stroke/Heart Failure & Heart Disease (2)
- Alcohol Abuse and/or Cirrhosis of Liver (2)
- Accidental Overdose (2)
- Respiratory Failure (1)
- Chronic Lower Respiratory Disease (1)
- COVID (1)
- Homicide (1)
- Cancer (1)
- Intentional Self-Harm by Hanging (1).[24]

This evaluation of patient transition outcomes provides additional supporting evidence that patients are at high risk following an abrupt disruption in care. ORRP also advised that several states are evaluating ways to improve their response plans and the CDC ORRP's website states that efforts to evaluate different rapid response strategies are being explored,[25] but the CDC ORRP team advised the Task Force that no such evaluations had been performed as of the time

[23] Ibid.

[24] Marriott, Rodrick. CT Clinic & Practice Closures: Tracking Patient Transition Outcomes 2024. Presentation at 2024 National Association of State Controlled Substances Authorities Annual Meeting. nascsa.org/wp-content/uploads/2024/10/CT-clinic-closure_ct_template_final.pdf

[25] CDC National Center for Injury Prevention and Control. About CDC's Opioid Rapid Response Program: Future direction. www.cdc.gov/overdose-prevention/orrp/index.html

of this report. As the ORRP was only formalized at the CDC in 2020, state responses are evolving and becoming more formalized, with debriefing sessions and lessons learned from previous responses informing future response protocols. New information regarding best practices and patient outcomes will likely become available as states respond to ORRP notifications and state laws may be updated in the coming years to support patients facing care disruptions considering the heightened risk for adverse patient outcomes because of these actions. The Task Force will continue to monitor emerging ORRP best practices and changes in state laws on this subject.

ORRP Responses in Colorado

The CDC ORRP has provided 15 notifications to Colorado's state trusted contacts from the time the program was formalized in 2020 through October 1, 2024.[26] Upon notification of an imminent action from a federal law enforcement agency, the ORRP provides notification to trusted contacts within the state government of an impending law enforcement action. Colorado's ORRP state trusted contacts are the Director of the Overdose Prevention Unit at the Colorado Department of Health and Environment (CDPHE) and the State Opioid Treatment Authority (SOTA) and Controlled Substance Administrator at the Colorado Behavioral Health Administration (BHA) within the Department of Human Services.

Representatives from the Colorado PDMP attended virtual Opioid Preparedness Exercises hosted by ASTHO and CDC ORRP in July 2024 along with Colorado's ORRP state trusted contacts and a variety of other stakeholders in Colorado who may be involved in an ORRP response. These exercises were hosted to develop a state response protocol using a mock scenario, gave opportunities for discussion and collaboration among participants, and provided resources for developing communications and other resources for patients and other key stakeholders. Representatives from the Colorado PDMP also met with the CDC and HHS OIG representatives of ORRP regarding ORRP actions and how some states leverage identified PDMP data to support ORRP responses by directly contacting affected patients.

The Task Force also met with Colorado's ORRP state trusted contacts to learn more about the state's current response protocols and to discuss whether being able to obtain PDMP data to identify affected patients could benefit the state's ORRP responses. Colorado's state trusted contacts advised that they tend to receive ORRP notifications approximately once every two months, and the situations regarding notices are highly variable. ORRP sometimes provides the state ORRP trusted contacts with general information regarding the county or general area of a practitioner's practice, patient population, and approximate numbers of patients receiving opioids, sedatives and stimulants as reported by the DEA or DOJ to CDC ORRP, with more detailed information being provided the day before or day of a law enforcement action to law enforcement action. In one case, an initial ORRP notification was sent weeks in advance of an action against a practitioner that only identified the practitioner's county and the number of patients affected, with detailed notifications identifying the practitioner provided the night before the action. ORRP responses can be more effective when state trusted contacts receive advance notice regarding the location and patient population to allow local or county public

[26] Rubel, Stephanie (CDC ORRP) and Neubert, Patrick (HHS OIG). Preventing Overdose. Presentation at 2024 National Association of State Controlled Substances Authorities Annual Meeting. nascsa.org/wp-content/uploads/2024/10/Stephanie-Rubel-Patrick-Neubert.pdf

health agencies to prepare for a response, but such advanced notices are relatively rare. Usually, the state trusted contacts receive notice from ORRP the night before or day of a law enforcement action.

Public health responses can vary widely based on the practitioner's location and nearby health system and public health capacity, the types and quantities of controlled substances prescribed by the practitioner, the number of patients treated by the practitioner, whether the practitioner is a solo practitioner or involved in a larger organization that could inherit affected patients, and patients' health insurance. Some practitioners or their staff are cooperative with the state response teams while others are not. Some affected patients have been receiving long-term high dosage opioid therapy, or have been receiving concurrent opioid and benzodiazepine prescriptions, or concurrent stimulant and sedative prescriptions. Patients with these complex prescription histories are more likely to experience challenges in finding new practitioners willing to continue prescribing to these patients. Some may have an undiagnosed substance use disorder (SUD), but ensuring these patients are evaluated for SUD can be challenging. Patients requiring treatment for SUD also face a lack of SUD providers in many communities, regardless of the complexity of the case. Some SUD patients in Colorado currently must travel long distances for appropriate SUD treatment.

In the ASTHO ORRP virtual Opioid Preparedness Exercises, participants noted that finding new providers willing to take on inherited patients with complex controlled substance prescription history can be a significant challenge, though this is highly dependent on the capacity and size of the surrounding community. Colorado Senate Bill 23-144 (SB23-144) sought to alleviate prescribers' concerns with prescribing high dosages of opioids to patients on long-term opioid therapy for chronic pain. SB23-144 states that a healthcare provider is not subject to disciplinary action by their prescribing board for appropriately prescribing controlled substance when treating patients for chronic pain or prescribing or for prescribing a dosage that may be higher than dosage recommendations or thresholds specified in state or federal opioid guidelines or policies and prohibits and prohibits pharmacies, carriers, pharmacy benefit managers, and healthcare practices from enacting policies that require the pharmacist or prescriber to refuse to prescribe or dispense an opioid solely because the prescription exceeds a predetermined dosage recommendation or threshold.[27] However, this legislation does not protect practitioners from federal law enforcement or regulatory actions, and the DEA is the primary law enforcement entity taking action against practitioners for alleged inappropriate prescribing practices.

The ASTHO exercise participants also noted that the lack of advanced notice regarding an impending law enforcement action is a primary challenge in ensuring an effective public health response. Colorado's state trusted contacts usually coordinate with local or county health departments who directly handle the response within their community, though this duty can fall on the state trusted contacts or their staff if a community's local or county public health resources are limited. Typically, local or county health departments dispatch coordinators to the site of the law enforcement action and distribute patient support materials. State or local public health officials also notify area hospitals, emergency departments, health systems, the

[27] Colorado Senate Bill 23-144. leg.colorado.gov/bills/sb23-144

state Medicaid office (Department of Health Care Policy and Financing), and others who may see an influx of patients facing care disruption.

Potential Risks and Benefits of Identified PDMP Data in Colorado ORRP Responses

The ORRP response teams are usually unable to directly contact affected patients because patients currently must consent to be contacted by the state or local health department, which is modeled after patient releases leveraged during the COVID-19 pandemic allowing exposed patients to be contacted by CDPHE. Making these releases available to patients and ensuring patients submit the completed releases is a significant challenge in ORRP responses, especially when the practitioner's staff do not assist ORRP responses by contacting affected patients. PDMP records include a patient's name, date of birth, recent addresses, and sometimes phone numbers. Colorado legislation authorizing state trusted contacts to receive identified PDMP records for a practitioner subject to law enforcement response and allowing for response teams to contact patients who recently received controlled substance prescriptions from the practitioner could improve response effectiveness. Identified PDMP data could also be leveraged to triage patient outreach by prioritizing patients who are due for a new prescription sooner than others or to prioritize patients with complex medication histories who may experience greater challenges in finding a new provider or who may benefit from an evaluation for an undiagnosed substance use disorder. Direct outreach to affected patients by ORRP state trusted contacts could include mailed letters notifying patients that their practitioner was the subject of a recent law enforcement action without disclosing any sensitive or protected health information. These mailed letters could also provide resources to help patients find new practitioners along with contact information of care coordinators who can assist affected patients in navigating their options and finding a new practitioner or receiving evaluation and treatment for a substance use disorder. Proactively contacting affected patients via phone calls by leveraging patient phone numbers in the PDMP could also improve patient outcomes by providing more timely patient notification. If phone calls are leveraged for patient outreach, public health officials would likely need to establish protocols to verify the patient's identity and obtain written releases to authorize care coordinators' access to the patient's PDMP records or other pertinent health records.

Direct patient outreach to assist patients in navigating their healthcare options in response to these law enforcement actions can be a complex and resource intensive endeavor. It should be noted that robust public health responses with direct patient outreach could require additional resources and staffing at CPDHE, BHA, or local or county public health departments to maximize response efforts. This could be especially challenging due to the recent termination of $250 million in CDC grants allocated to states under the American Rescue Plan Act, which will primarily affect CDPHE, BHA, and local public health agencies. These federal funding cuts may also impact Colorado's current budget shortfall.[28] As public health resources may be limited and the number of affected patients and complexity of care transition needs can vary widely in these responses, CDPHE or BHA staff may need to prioritize their efforts toward those with

[28] Birkeland, Bente. Colorado losing $250 million in federal funding for health services. Colorado Public Radio News. March 26, 2025. www.cpr.org/2025/03/26/federal-funding-terminated-for-colorado-health-services

the highest expected need for assistance based on their prescription history. Authorizing PDMP access to the state trusted contacts in this context but not mandating any specific actions would allow those coordinating public health responses to determine how to most effectively expend limited resources by prioritizing which patients may require more intensive assistance.

The Task Force believes there would be minimal risk of inappropriate disclosure of PDMP data considering the state trusted contacts are state employees entrusted with sensitive law enforcement and health information related to these public health responses to law enforcement to help prevent the disruption of medical treatment and promote continuity of care. State trusted contacts at CDPHE and BHA may need to share PDMP information with their staff for direct patient outreach, so the trusted contacts would benefit by having the authority to share this information with qualified CDPHE or BHA staff responsible for patient outreach in connection with law enforcement actions against practitioners or clinics. It would also be beneficial if the trusted contacts had the authority to share certain patient information from the PDMP with local or county health department officials if the affected patient consents to this information being shared with state or local care coordinators for these purposes. Interagency agreements between DORA, BHA and CDPHE could further delineate authorized use of PDMP data in public health responses and identify the authorized trusted state contact at each agency. If the General Assembly wishes to authorize the PDMP to share information with state trusted contacts responsible for public health responses to law enforcement actions against practitioners or clinics, such authority will need to be added to Colorado's PDMP statute in Section 12-280-404(3), C.R.S. Kentucky law cited above provides an example guiding the following suggested language:

> If the office or clinic of a practitioner abruptly closes or is subject to emergency closure or other enforcement action resulting in a suspension or termination of the practitioner's controlled substance prescribing privileges, the [electronic prescription drug monitoring] program may share data from the program with trusted contacts at the Colorado Department of Public Health and Environment and the Colorado Behavioral Health Administration who engage in public health responses to law enforcement actions against practitioners or clinics to issue notification as soon as practicable to the practitioner's patients to help prevent the disruption of medical treatment and promote continuity of care.

Though the Task Force believes that the General Assembly should ideally authorize trusted contacts at CDPHE and BHA to access PDMP information in this context because they are directly involved in coordinating the public health response, the General Assembly may alternatively consider authorizing the PDMP to send notifications to affected patients upon notification from the state trusted contacts at CDPHE or BHA of a law enforcement action. Under this structure, PDMP data would not be shared with the state trusted contacts, but PDMP staff could send resources and contact information through mailed letters to patients who could then contact public health staff for assistance with care coordination. State trusted contacts could also coordinate with PDMP staff to establish certain criteria for direct patient contact via mailed letters if public health resources are limited. In this scenario the public health respondents and care coordinators would not have information regarding a patient's prescription history, though patients could obtain their own records from the Colorado PDMP and share this information with care coordinators if desired. However, the additional hurdle of requiring patients to

request their own PDMP records and share this information with care coordinators could increase care transition times for affected patients. Currently, the Colorado PDMP is only authorized to send proactive or "unsolicited reports" under Section 12-280-404(8), C.R.S. after developing "criteria for indicators of misuse, abuse, and diversion of controlled substances and, based on those criteria, provide unsolicited reports of dispensed controlled substances to prescribing practitioners and dispensing pharmacies for purposes of education and intervention to prevent and reduce occurrences of controlled substance misuse, abuse, and diversion." If the General Assembly were to authorize the PDMP to send notifications to patients who face care disruptions due to law enforcement actions against their prescribing practitioner, such authority would need to be added to Colorado's PDMP statute. Kentucky law cited above provides an example guiding the following suggested language:

> If the office or clinic of a practitioner abruptly closes or is subject to emergency closure or other enforcement action resulting in a suspension or termination of the practitioner's controlled substance prescribing privileges, the [electronic prescription drug monitoring] program may use data from the program to proactively issue notification as soon as practicable to the practitioner's patients to help prevent the disruption of medical treatment and promote continuity of care.

Additionally, CDPHE is authorized under Section 12-280-404(3)(k), C.R.S. for purposes of population-level analysis with the caveat that they remove any identifying information unless exempted from the requirement. This existing statutory authority could potentially be leveraged by CDPHE to assess patient outcomes following a care interruption due to legal action taken against a practitioner associated with an ORRP response, with any public reports providing aggregate data that does not identify a specific practitioner or patient. However, the General Assembly should be cognizant of the additional resources required to perform such evaluations and the potential resource constraints at CDPHE due to federal and state funding challenges.

As the CDC ORRP team only receives notification from the DEA or HHS OIG regarding federal law enforcement action, the Colorado ORRP state trusted contacts are currently only advised of federal law enforcement actions. As the ORRP continues to evolve, Colorado's state licensing boards and/or the Colorado Office of the Attorney General may consider establishing similar protocols to notify Colorado's existing ORRP trusted contacts of impending state law enforcement activities or state licensing board actions that may interrupt patients' access to care and controlled substance medications.

Conclusion: Task Force Recommendation

Patients experiencing a disruption in access to controlled substance medication following legal action against their prescribing practitioner are at elevated risk of adverse outcomes including acute withdrawal, psychological distress, emergency department visits or hospitalization, and non-fatal or fatal overdose due to obtaining illicit substances. The ORRP was created to mitigate these risks and support patients affected by care interruptions caused by law enforcement actions, but current Colorado law makes it difficult for ORRP state trusted contacts and response teams to directly contact affected patients which can limit ORRP response

effectiveness. Allowing ORRP's Colorado trusted contacts to receive identified PDMP data relating to a practitioner who is subject to a law enforcement action has the potential to improve ORRP responses by directly providing resources and support services to affected patients with minimal risk of unauthorized disclosure of protected information by the ORRP trusted contacts at CDPHE and BHA.

The Task Force recommends that the Colorado General Assembly enact legislation to allow PDMP data to be leveraged for direct patient outreach to patients who are subject to care interruption due to a law enforcement or regulatory action that results in the suspension or termination of the practitioner's controlled substance prescribing privileges to help prevent the disruption of medical treatment and promote continuity of care. This could ideally be enabled through authorizing the state trusted contacts at BHA and/or CDPHE to access PDMP records for the subject of an ORRP-related law enforcement action. An alternative but less-preferred avenue would entail authorizing the PDMP to send proactive or unsolicited notices to affected patients. As Colorado's ORRP responses continue to evolve, Colorado's licensing boards and/or the Colorado Office of the Attorney General may consider leveraging the existing Colorado ORRP trusted contacts to support public health responses following state-level law enforcement or licensing board actions. The General Assembly should also recognize that these responses can be resource intensive, and additional staffing at CDPHE, BHA and/or county or local health departments may be necessary to maximize response effectiveness and to formally assess the role that direct patient outreach may have on minimizing adverse patient outcomes and promoting effective care transition, though the recent termination of federal grants and Colorado's state budget issues could limit these agencies' ability to provide robust and direct patient outreach.

Appendix A: Requests for the 2024-2025 Task Force Report

COLORADO
Department of Regulatory Agencies
Executive Director's Office

March 21, 2025

Robert J. Valuck, PhD, RPh, FNAP | Professor
University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences On behalf of the Colorado Consortium for Prescription Drug Abuse Prevention 12850 E. Montview Blvd, Mail Stop C238
Aurora, CO 80045 Dear

Dr. Valuck:

On behalf of the Department of Regulatory Agencies (DORA or the Department), thank you and the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) for your continued support and advice concerning the Prescription Drug Monitoring Program (PDMP), including the Consortium's 2023-2024 Task Force Report. The Consortium's support and expertise this past year was invaluable.

Section 12-280-409, Colorado Revised Statutes (C.R.S.) requires the Executive Director of the Department to consult with and request assistance from the Consortium as the PDMP Task Force. To that end, I am requesting assistance from the Consortium to examine issues and opportunities regarding the PDMP and to make recommendations on ways to make the PDMP a more effective tool to reduce prescription drug abuse in Colorado. In doing so, please prepare and submit an annual report to the Executive Director and the Colorado General Assembly detailing the Consortium's findings and recommendations by July 1, 2025.

Task #1: Evaluate the Benefits and Risks of Allowing PDMP Access to Opioid Rapid Response Program Trusted Contacts

Patients on long-term opioid therapy or medication for opioid use disorder who experience interrupted or discontinued treatment are at an elevated risk of experiencing withdrawal symptoms, seeking illicit substances, and overdose. The CDC's Opioid Rapid Response Program (ORRP)[29] receives notification from law enforcement agencies about potential disruptions to healthcare access and facilitates coordinated responses by state agencies to minimize care disruptions for at-risk patients and has provided 15 notifications to Colorado's ORRP trusted contacts as of October 1, 2025. The CDC reports that PDMP data can be a valuable tool for the state trusted contacts of these rapid response teams, but only 7 states are able to share PDMP identified data while 28 states can provide aggregate PDMP data to inform responses.[30] I request that the Task Force evaluate the potential benefits and risks of statutory changes that would allow PDMP data access to ORRP's trusted contacts in Colorado.

[29] CDC Opioid Rapid Response Program. https://www.cdc.gov/overdose-prevention/orrp/index.html

[30] Stephanie K. Rubel., CDR Patrick Neubert. Preventing Overdoses in Today's Opioid Prescribing and Illegal Drug Market Context. CDC Opioid Rapid Response Program (ORRP). Presentation at the National Association of State Controlled Substances Authorities 2024 Annual Meeting. https://nascsa.org/wp-content/uploads/2024/10/Stephanie-Rubel-Patrick-Neubert.pdf.

Sincerely,

Patty Salazar
Executive
Director
Colorado Department of Regulatory Agencies

CC: Jill Hunsaker Ryan, MPH | Executive Director, Colorado Department of Public Health and Environment (CDPHE)
Dr. Ned Calonge, MD, MPH | Chief Medical Officer, CDPHE

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Appendix C: PDMP Statutory History and Milestones

The progression of the Colorado PDMP includes the following milestones:

- In 2005, House Bill 05-1130 (HB 05-1130) authorized the creation of the Colorado PDMP. Pharmacies began submitting prescription data to the Colorado PDMP in 2007, and the Colorado PDMP web portal went live to users in 2008.

- In 2011, Senate Bill 11-192 (SB 11-192) reauthorized the Colorado PDMP through 2021.

- In 2013, Colorado began sharing PDMP data with other states through PMP InterConnect.

- In 2014, an administrative change increased controlled substance dispensing reporting from bi-weekly to daily, thereby providing up to date PDMP patient data for prescribers and pharmacists.

- In 2014, House Bill 14-1283 (HB 14-1283) made several updates to the PDMP, including:
    - The Colorado Department of Public Health and Environment (CDPHE) was authorized to collect PDMP data for population-level analysis, expanding Colorado's ability to study the effectiveness of the PDMP through statistical analysis, including CDPHE's Prescription Drug Data Profiles for each of Colorado's 64 counties. This access also allows CDPHE to work with healthcare organizations to evaluate the effectiveness of PDMP integration and other organizational initiatives related to controlled substance prescribing and PDMP utilization, including CDPHE's PDMP integration pilot project evaluation and the University of Colorado's PDMP integration.

    - Prescribers and pharmacists were authorized to designate up to three delegates to access the PDMP on their behalf with proper authorization.

    - The Colorado PDMP was authorized to issue unsolicited reports (Push Notices) to prescribers and pharmacies that inform them of their patients being prescribed controlled substances by multiple prescribers, at multiple pharmacies, over set periods of time. These Push Notices reduce potential patient misuse, abuse, and diversion of controlled substances, while increasing patient safety.

- In 2014, the Colorado Dental Board, Colorado Medical Board, State Board of Nursing, State Board of Pharmacy and the Nurse-Physician Advisory Task Force for Colorado Healthcare collaborated to develop The Policy for Prescribing and Dispensing Opioids to provide meaningful guidance to prescribers and dispensers of opioids in Colorado. This Policy was subsequently adopted by the State Board of Optometry and the Colorado Podiatry Board and endorsed by the Colorado State Board of Veterinary Medicine. This policy was the first of its kind to be adopted across numerous healthcare boards and groups within the Division of Professions and Occupations ("DPO").

- In 2015, DORA was awarded a grant through the US Department of Justice Bureau of Justice Assistance (BJA). DORA contracted with the University of Colorado as a grant subrecipient and researcher. Pursuant to the grant, funding was used to strengthen PDMP efforts to develop and test innovative strategies and to implement evidence-based approaches that demonstrate the impact of expanded use of PDMP data to support decision making.

- In 2017, Senate Bill 17-146 (SB 17-146) broadened access to the PDMP, allowing prescribers and pharmacists to check the PDMP for reasons apart from controlled substance prescription considerations, including drug-drug interactions, dangerous side- effects and possible abuse or diversion issues. Specifically, the Bill authorized:

    - Prescribers to query the PDMP to the extent the query relates to a current patient of the prescriber;

    - Pharmacists to query the PDMP when considering dispensing any prescription drug to a specific patient; and

    - Veterinarians to query the PDMP when they suspect a client (person responsible for the animal) is diverting the patient's (animal) controlled substance(s) or when they suspect a client is purposely abusing the animal to obtain a controlled substance.

- In 2018, the Colorado prescribing boards and State Board of Pharmacy published the Guidelines for the Safe Prescribing and Dispensing of Opioids ("Opioid Guidelines") after soliciting statewide stakeholder feedback, consulting with experts in the fields of pain management, addiction and mental health, and reviewing current literature, policy and guidelines related to the safe prescribing and dispensing of opioids for pain. These guidelines updated the 2014 Policy for Prescribing and Dispensing Opioids to both harmonize the guidelines with current policies and to provide Colorado prescribers and dispensers with current, evidence-based guidance with best practices including regularly checking the PDMP, risk assessment, assessing pain and function, considering opioid alternatives, patient education and treatment agreements, collaboration with members of a patient's healthcare team, establishing a strategy for reducing or discontinuing opioids, identifying aberrant drug-related behavior and referral for treatment of opioid use disorder.

- In 2018, the PDMP initiated Prescriber Scorecards. These individual scorecards are sent to eligible prescribers and provide information such as prescription volume data, PDMP usage, morphine milligram equivalent (MME) dosing information, and assessments comparing an individual's prescribing history to others within the same specialty to assist prescribers in making more informed prescribing decisions.

- In 2018, Senate Bill 18-022 (SB 18-022) limited a prescriber from prescribing more than a seven-day supply of an opioid to a patient who has not had an opioid prescription in the last twelve months by that prescriber, with certain exceptions. The law also restricted a second

fill to a seven-day limit with a requirement that prescribers query the PDMP prior to prescribing a second seven-day fill.

- In 2019, Senate Bill 19-228 (SB 19-228) expanded PDMP access to Colorado medical examiners and elected coroners for patients whose death occurred under unusual, suspicious, or unnatural circumstances and are the subject of an autopsy, and mandated opioid prescribers to complete up to four credit hours of training per licensing cycle in order to demonstrate competency regarding: best practices for opioid prescribing, recognition of substance use disorders, referral of patients with substance use disorders for treatment, and the use of the PDMP.

- In 2019, CDPHE was awarded the CDC Overdose Data to Action (OD2A) grant. CDPHE and DORA entered into an inter-agency agreement with funding from the OD2A grant. This inter-agency agreement is funding a Program Analyst position at DORA for the PDMP as well as funding to make improvements to the Colorado PDMP. The three-year OD2A grant was extended for a fourth year in 2021, ensuring continued funding through August 2023.

- In 2019, DORA was awarded a second grant from BJA. DORA contracted with the University of Colorado as a grant subrecipient and researcher and is using the funding to systematically investigate the impact of mandated PDMP use, automated PDMP screening, and adding high risk clinical features to PDMP screening, measuring the effects of each modification in all care settings and hospitals used in the research.

- In 2019, the Office of eHealth Innovation (OeHI) formed a new strategic policy subgroup that reports to the Consortium PDMP Task Force (PDMP Task Force) to advance statewide PDMP integration planning and implementation and to ensure alignment between various state agencies. This subgroup, comprised of representatives of the Department of Health Care Policy and Financing (HCPF), CDPHE, Office of Information Technology (OIT), DORA and OeHI, was focused on formulating recommendations involving funding, policy, governance, data sharing, research, and the future state of the PDMP technical architecture to advance PDMP integrations statewide.

- In 2020, the Division and CDPHE reimbursed PDMP integration costs for healthcare organizations through the award of mini grants via a Request for Applications (RFA) procurement process leveraging Overdose Data to Action grant funding from the Centers for Disease Control and Prevention (CDC).

- In 2020, OeHI and HCPF received funding from The Centers for Medicare and Medicaid Services (CMS) to implement the requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act)83 to expand integrated PDMP access for Medicaid providers.

- In 2021, Senate Bill 21-098 (SB 21-098) reauthorized the Colorado PDMP until September 1, 2028. The bill authorized the Board of Pharmacy to adopt rules to require reporting of

certain non-controlled drugs with the potential for abuse to the Colorado PDMP and to adopt rules for a retention schedule for PDMP data. The Colorado State Board of Pharmacy considered this authority and after thorough review, discussion and receipt of stakeholder feedback, decided it was not necessary or beneficial for the PDMP to collect this information.

- In 2021, House Bill 21-1276 (HB 21-1276) required the Division to enable the RxCheck data sharing hub for integrating the PDMP into the electronic medical records of practitioners and health systems within the state by December 1, 2021. This bill also allowed medical examiners and coroners to query the PDMP for individuals who are the subject of a death investigation. Also, within the PDMP statute, this bill required practitioners to query the PDMP before prescribing any opioid or benzodiazepine, subject to certain exceptions. However, this bill resulted in conflicts regarding the statutory requirement of when to query the PDMP in 12-30-109(1)(b), C.R.S. versus 12- 280-404(4), C.R.S. leaving PDMP query requirements unclear.

- In 2021, DORA began work on building out the requirements for the next PDMP RFP as the current vendor's contract was nearing expiration. In tandem with this effort, the Division led a market research effort to collect feedback from various private and government stakeholders, through individual and large stakeholder meetings regarding the PDMP RFP requirements. In 2022, the Division selected Bamboo Health (previously named Appriss, Inc.) to continue as the PDMP vendor.

- In December 2021, the Division enabled RxCheck for in-state PDMP integrations with electronic health records.

- In 2022, Senate Bill 22-027 (SB 22-027) clarified that the statutory PDMP query requirement enacted in HB 21-1276 applies to any opioid or benzodiazepine prescription, subject to certain established exceptions. The bill also clarified that all DEA-licensed practitioners and all pharmacists licensed in Colorado are required to register and maintain a user account with the Colorado PDMP and requires the PDMP Task Force to evaluate and make recommendations to the DORA Executive Director, after engaging in a stakeholder process, regarding balancing the program as a health- care tool with the requirements of Title 12, Article 280, C.R.S.

- In 2022, House Bill 22-1115 (HB 22-1115) also clarified the statutory PDMP query requirement enacted in HB 21-1276 applies to any opioid or benzodiazepine prescription, subject to certain established exceptions. It also removed restrictions on the number of delegate users that a practitioner or pharmacist may authorize to query the PDMP on the supervising practitioner or pharmacist's behalf. The bill also required the Division to implement a process whereby practitioners and pharmacists may apply for and receive reimbursement from the Division for all or a portion of the costs of integrating the PDMP with electronic medical records.

- In 2023, House Bill 23-1072 (HB 23-1071) authorized the creation of a prescriptive authority certificate to certain psychologists which authorizes the psychologist to prescribe psychotropic medications. Psychologists with a prescriptive authority certificate will be authorized to obtain a DEA license to prescribe psychotropic controlled substance medications. These prescribing psychologists will be subject to the PDMP requirements applicable to DEA-licensed practitioners.

- In 2023, Senate Bill 23-144 (SB 23-144) clarified that practitioners are not subject to disciplinary action for prescribing a dosage of an opioid above a morphine milligram equivalent (MME) recommendation or threshold specified in state or federal opioid prescribing guidelines or policies. It also prevented practitioners from being required to taper a patient's medication dosage solely to meet predetermined dosage recommendations and prohibited pharmacies, health insurance carriers, pharmacy benefit managers, health-care practices and clinics from having a policy that requires the practitioner to refuse to prescribe, administer, fill, or dispense a prescription for an opioid solely because the prescription exceeds a predetermined MME dosage recommendation or threshold.

- In 2023, CDPHE was awarded the five-year CDC Overdose Data to Action in States (OD2A-S) grant. CDPHE and DORA entered into an inter-agency agreement with funding from the OD2A-S grant. This inter-agency agreement funds a Program Analyst position at DORA for the PDMP, prescriber scorecards, maintenance costs for the RxCheck hub, and other tools to enhance the PDMP.

- In 2024, Senate Bill 24-047 (SB 24-047) authorized practitioners with prescriptive authority who lack controlled substance prescriptive authority to access the PDMP, exempted veterinarians from the PDMP use mandate, authorized the Department of Health Care Policy and Finance to access the PDMP for the purposes of care coordination, utilization review, and federally required reporting, and allowed medical directors or their delegates to access the PDMP for any patient at a facility under the medical director's supervision.

- In 2024, House Bill 24-1045 (HB24-1045) amended the practice of pharmacy to include prescriptive authority for any FDA-approved product indicated for opioid use disorder in accordance with federal law, if authorized through a collaborative practice agreement. In 2025, the Colorado State Board of Pharmacy, in collaboration with the Colorado Medical Board and the Colorado State Board of Nursing adopted a statewide protocol authorizing qualified, Colorado-licensed pharmacists to provide pertinent assessment of patients with opioid use disorder (OUD) and prescribe and dispense medications indicated for OUD for the purposes of medication assisted treatment of OUD, in collaboration with other healthcare practitioners pursuant to HB24-1045.