



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
OFFICE OF CONTROLLED SUBSTANCES
PRESCRIPTION MONITORING PROGRAM

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

**LAW ENFORCEMENT REQUEST FOR PRESCRIPTION REPORT
INSTRUCTION SHEET**

Who May Receive a Prescription Monitoring Program (PMP) Report

The Office of Controlled Substances may provide PMP reports to local, state, or federal law-enforcement or prosecutorial officials who are:

- Engaged in administering, investigating, or enforcing the laws governing controlled substances; and
- Involved in a *bona fide* specific drug-related investigation in which a report of suspected criminal activity involving controlled substances by an identified suspect has been made.

The PMP report will provide only information that is:

- Relevant and material to the investigation,
- Limited in scope to the extent reasonably practicable in light of the purpose the information is sought, and
- Non-identifying (redacted) as to patients unless it is substantiated that non-identifying information cannot be used.

Submitting Report Request

- Complete the entire form. All fields are required unless marked "optional."
- Both the requestor and the requestor's supervisor must sign the form.
- The form may be submitted either by regular or electronic mail following these procedures:

IF submitted by...	THEN...
Mail	Send the completed, signed form to the address above marked to the attention of "PMP."
Email	<ol style="list-style-type: none"> 1. Electronically scan the signed form. 2. Save the scanned file to your computer. 3. Rename the scanned file. Use this format for the new name: <ul style="list-style-type: none"> • Officer's last name followed by a dot • Patient or prescriber's last name followed by a dot • Case number <p>Example: jones.smith.A12345</p> 4. Email the form to delawarepmp@state.de.us. 5. <i>Send your request only by secure, encrypted email.</i> <p>Requests that do not conform to these steps will not be accepted for processing.</p>

Requested reports can be either emailed via secure email or sent by certified mail to your attention. **Requests will generally be processed within 10-14 business days.**



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LAW ENFORCEMENT REQUEST FOR PRESCRIPTION REPORT

Delaware law governing the law enforcement requests for information from the Delaware Prescription Monitoring Program can be found at [16 Del. C. § 4798\(i\)\(2\)d](#)

REQUESTING OFFICIAL – All fields in this section are required.

1. Name: _____
2. Title: _____ IBM/Sequence Number: _____
3. Law Enforcement Agency Name: _____
4. Office Phone: _____ Email: _____
5. Supervisor's Name: _____ Supervisor's Office Phone: _____
6. **Case Number:** _____
7. **By initialing each of the following, I attest that the statements are true and correct to the best of my knowledge.**

_____ As the requesting official, I attest that I am either a local, state, or federal law-enforcement or prosecutorial official engaged in the administration, investigation, or enforcement of the laws governing controlled substances.

_____ I attest that I am requesting the following information as part of a *bona fide* specific drug-related investigation, to which I have been assigned, in which **a report of suspected criminal activity involving controlled substances by an identified suspect** has been made.

_____ I attest that the information sought is relevant and material to such investigation and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought.

INFORMATION ABOUT INVESTIGATION – All fields in this section are required.

8. Identify the criminal activity under investigation **by title and citation to the appropriate statute:**

9. List and give a detailed description of each crime currently under investigation:

10. Only *non-identifying* (redacted) patient information will be provided from the PMP. Do you need *identifying* patient data?
Yes No If yes, explain, in detail, why identifying patient information is necessary:

REPORT DETAILS – All fields in this section are required.

11. Date Range for Report: From (month/day/year): _____ To (month/day/year): _____

12. Please check the PMP profile being requested: Patient Prescriber

PATIENT INFORMATION – Complete this section only “Patient” profiles.

13. Full Name: _____
Last/Family First Middle

14. Address (optional): _____
City State Zip

15. Date of Birth (month/day/year): _____

16. Does the patient use any other names, addresses, or birthdates (optional)? Yes No If yes, list below:

PRESCRIBER INFORMATION – Complete this section for “Prescriber” profile requests. Both fields are required.

17. Prescriber Full Name: _____

Prescriber may have multiple DEA numbers, list all that apply to your investigation:

DEA Number (1): _____ DEA Number (2): _____

DEA Number (3): _____ DEA Number (4): _____

REPORT DELIVERY

18. Select a report delivery option below:

- Secure (encrypted) Email – **Delaware agencies on the State network can use a State email account for secure email. Non-Delaware agencies must contact the PMP Administrator (302) 744-4518 or delawarepmp@state.de.us.**
- Mail – The report will be sent by certified mail, marked confidential. **The requestor must assure that the information is handled in a secure manner and remains confidential.** Enter mailing address:

Address: _____
City State Zip

By checking the items below and signing this form, I certify that I agree and understand:

- HIPAA and all confidentiality and non-disclosure provisions of Delaware Law cover the information contained in the PMP database. All PMP reports are protected health information and **not** subject to public disclosure under the Freedom of Information Act or any other provision of law.
- Inappropriate access or disclosure of this information is a felony under Delaware Law (16 Del. C. § 4798) and may result in criminal prosecution.
- Records on this report must be verified before any actions are taken.** A PMP report is an accumulation of data gathered from Delaware-licensed pharmacies and prescribers. The Office of Controlled Substances does not warrant any report to be accurate or complete and expressly disclaims liability for errors and omissions in the contents of this report. For more information about any prescription in a PMP report or to verify a prescription, contact the dispensing practitioner or pharmacy.

Signature of Requesting Official: _____ **Date:** _____

Signature of Requesting Official’s Supervisor: _____ **Date:** _____