April 27, 2017

I am writing in opposition to parts of the governor's proposal in response to the "opioid epidemic", HB159 and SB79. I have no quarrel with several facets of this legislation. The educational requirements are reasonable. It will be useful to have a registry of who has had what dispensed which is updated daily. Patients have always had the right to ask for a partial fill of a prescription, resulting in the pharmacist canceling the rest and notifying the physician of the change, so that part of the bill changes nothing. I already discuss what kind of medicine I am prescribing with every patient, so again that won't require any changes to standard practice.

However, the part of the bill that specifies that no more than 7 days of opioid medication can be prescribed without seeing the patient again is unreasonable. I currently see many chronic pain patients every 3 months. (I also take care of their other medical needs at the same time – diabetes, skin cancer checks, medications for high blood pressure, smoking cessation, trigger finger injection, and physicals for work, to name a few.) This bill wants me to see these people weekly, requiring 48 more visits a year. The patients and their insurance companies don't have the money and neither they nor I have the time. On many insurance plans only one prescription of any particular medicine per month is allowed; patients will have to pay for ¾ of their medicine or I will be pressured to prescribe 5's one week, half of 10's the next week, and a slightly different medication for week 3 and 4. Or, even worse, the patient will ask me to prescribe 4 pills a day when they usually only average 2 so that they can get more weeks out of the prescription before they have to come back. These side deals will work for many patients, but some will be confused or tempted to overuse, and lying is never good policy. Even worse, some of the safeguards we try to abide by will be negated. I do random drug tests to try to detect those who are not taking the prescribed medication (perhaps selling it) or who are taking medicines not prescribed to them. Two or more different medications a month makes that useless. I do random pill counts to see that the patients are taking the number prescribed per day. What confusion if the pill bottle label isn't accurate! These safeguards do not deter dedicated drug seekers, I'm sure, but they do help deter pill sharing, letting your grandson steal part of your prescription, or slipping into taking more than prescribed.

It will be pointed out that the bill has built in loopholes for chronic patients. I can document that a given patient lives too far away to come once a week or that they need opioids for more than 7 days because other things don't work, but big brother will be keeping track, presumably with access to the chart. As a practical matter, practices like mine will be tempted to not prescribe opioids at all. Will our documentation be good enough? Will we get in trouble anyway if too many of our patients get 90 days instead of 7 days? You can be sure that the pill mills will be glad to see patients more often and will have preclicks set up in their electronic records to get all that documentation perfect every time, whether or not they really evaluate the patient or spend any time relating their pain complaint to the rest of their health. Are you sure that trading the generalist for the "pain specialist" will help patient and community safety?

I can even see that the number of pills prescribed after surgery may <u>increase</u>. If the orthopedist sends

the patient home to Valdez with his best guess of pain medicine needed and a little more is needed before I take the stitches out at day ten, now I can write for the 3 days until I see them. Under the new law, the patient would need to come into my office acutely (hard to schedule, hard to move around on the ice post-op, expensive) to get extra medication. So the good orthopedist will give more pain pills to be sure that the patient has enough. This scenario already happened when hydrocodone went to Schedule II a few years ago – the ER patient now often gets 20 all at once instead of 10 with a refill as we used to be able to do, because if they end up needing more than 10 the MD and the patient will have to deal with the refill request that requires a paper prescription. In my opinion, the doctors of patients who live far away may well increase the number of pills past what are commonly needed in response to these new rules.

I know that this bill is an attempt to protect the general public from a potentially dangerous category of drugs, but I think that this limited prescription part (and the maximum dose part that I'm sure is coming on its heels) is not the best way to protect the public. The vast majority of people who receive opioids, acutely or even chronically, do not progress to becoming drug addicts or die of overdoses. Those people that do move on to heroin or increase their doses of pain pills beyond what is helpful usually have other problems. These range from mental disorders to financial stress to intolerance of other medications to diseases we don't know how to fix. Did you know that a common copay for biologicals for certain kinds of arthritis is more than a thousand dollars a month? Do you know that non-steroidal anti-inflammatories like ibuprofen can't be used by people with bad kidneys? Do you know that a lot of people can't use gabapentin because it makes them too sleepy? Do you know that pain cocktail, one of the most effective ways to wean people from prolonged narcotic use for a medical condition, is not paid for by insurance any more? Do you know that Medicare pays for only 4 or 5 outpatient physical therapy visits a year? Do you know that Medicaid recently decided not to pay for urine drug screens, an essential part of Suboxone programs as well as chronic pain medication usage monitoring? Do you know that drug treatment facilities are always full in this state so that those who want to quit and need more than Suboxone can't get in for weeks or months(especially if they don't have a lot of money)?. Fixing those problems will do much more for the problems of narcotic addiction than this bill will.

I will leave you with an analogy. We all know that sometimes people get hurt with rifles. It happens every year, sometimes by mistake and sometimes on purpose. Would you be passing a bill to restrict the ownership of rifles, as recommended by those who don't do a lot of sheep or moose hunting but are sure that shotguns and 22's are plenty for any kind of hunting? Even if someone put a clause in there saying that hunters could be OK'd to check out a rifle with more range or firepower for 3 days for their sheep or moose hunt, would you consider the bill reasonable to protect the public safety? No. Even if there were provisions to bring it back late if you lived a long ways away or could explain your need well enough to a committee of people who have read a lot about hunting. You might say that people needed to take a safety course before using rifles or you might try to restrict sales of rifles to people known to have used rifles to shoot at other people, or you might even lock up the people who shot at other people on purpose. But you wouldn't be succumbing to scare tactics that say that letting anyone shoot a rifle bigger than a 22 puts them at so much risk of shooting themselves or someone else that rifles need to be severely restricted.

Please amend this bill to remove the requirement for short fills and leave medical decisions in the hands of the professionals. Put prevention efforts into those things that will help the “opioid epidemic” instead of creating expense and suffering.

Sincerely,

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