SB 162

<TARGET><BILL>SB 162</BILL><SUBJECT>SB 162</SUBJECT><COMM>SHSS28</COMM></TARGET>

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

SENATE DISTRICT T

Session
Alaska State Capitol, Rm. 508
Juneau, AK 99801
(907) 465-3707
Fax (907) 465-4821
Sen.Donny.Olson@akleg.gov

Interim
716 W. 4th Ave. Ste 530
Anchorage, AK 99501
Toll Free 800-597-3707
(907) 269-0254
Fax (907)269-2031

Date: February 11, 2014

To: Senator Bert Stedman
Chair, Senate Health and Social Services

From: Senator Donald Olson

I respectfully request a hearing for SB 162 – An Act authorizing a licensed optometrist to prescribe a pharmaceutical agent containing hydrocodone.

My staff contact for this legislation is David Scott, who can be reached at 465-3877.

Thank you for your consideration of this request.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/7/14

FURTHER: Rules

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/24/14

Health and Social Services Committee considered SENATE BILL NO. 162

SB 162-HYDROCODONE PRESCRIPTION BY OPTOMETRISTS

"An Act authorizing a licensed optometrist to prescribe a pharmaceutical agent containing hydrocodone."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
CED			✓	1

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Micciche			✓	
	Meyer	✓			
	Ellis			✓	
CHAIR:	Stedman			✓	

Fiscal Note

State of Alaska
2014 Legislative Session

Bill Version: SB 162
Fiscal Note Number:
() Publish Date:

Identifier: SB162-DCCED-CBPL-02-14-2014
Title: HYDROCODONE PRESCRIPTION BY OPTOMETRISTS
Sponsor: OLSON
Requester: Senate Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Corporations, Business and Professional Licensing
Allocation: Corporations, Business and Professional Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2015 Appropriation Requested	Included in Governor's FY2015 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2014) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2015) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Don Habeger, Director Phone: (907)465-2536
Division: Corporations, Business and Professional Licensing Date: 02/14/2014 02:00 PM
Approved By: Jeanne Mungle, Director Date: 02/14/14
Agency: Administrative Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2014 LEGISLATIVE SESSION

BILL NO. SB162

Analysis

SB162 will retain licensed optometrists' ability to prescribe hydrocodone to patients. Licensed optometrists may currently prescribe Schedule III medications as part of their treatment of patients. The federal Drug Enforcement Agency (DEA) has proposed to change hydrocodone to a Schedule II drug to combat the nationwide epidemic of hydrocodone-based drug abuse. The bill specifies that optometrists shall be able to prescribe the drug regardless of how it is classified by the DEA.

The Division of Corporations, Business, and Professional Licensing does not anticipate a fiscal impact from this legislation.

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON
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Senate Bill 162
HYDROCODONE PRESCRIPTION BY OPTOMETRISTS

This is a technical change to the statute. This bill does not increase or change the current scope of practice of optometry.

Optometrists endorsed to prescribe medications currently have authority to prescribe Schedule III controlled substances such as hydrocodone+acetaminophen, a combination drug (also known as Vicodin).

The federal FDA is proposing to reclassify hydrocodone combination drugs such as Vicodin to a Schedule II. If this occurs, then optometrists will lose their current ability to prescribe this medication. So this bill simply makes an exception to the statute specifically for hydrocodone in case the FDA changes the classification, allowing optometrists to continue prescribing in the same manner as current law allows.

David Scott

From: Sherry Lentfer <sherry_lentfer@yahoo.com>
Sent: Wednesday, February 19, 2014 1:42 PM
To: Sen. Donny Olson
Subject: SB162

Dear Senator Olsen,

I am writing this letter in reference to, SB 162 been scheduled for a hearing in the Senate Health and Social Services committee next Friday February 21st at 1:30pm. In the years that I have prescribed oral medications for Optometric eye care, the times which I use hydrocodone has been limited. However at these times of extreme eye pain, the short use of hydrocodone becomes very significant and important. In our conservative profession, discontinuing the use of a drug that has not been abused does not make sense, and is not better of the health care of a patient.

Thank you for your time!

Sheryl Lentfer, OD

David Scott

From: Steven Dobson <stevendobsonod@gmail.com>
Sent: Wednesday, February 19, 2014 11:40 PM
To: Sen. Donny Olson
Cc: Jerry Mackie; David Karpik; Lisa Johnson; victoria_blower@hotmail.com; Andrea Eberle; Jim Falconer; JEFFREY GONNASON
Subject: Senate Bill 162

Dear Senator Olson,

First of all I want to thank you for your support and sponsorship of SB 162.

As you are well aware, optometrist's in Alaska are currently authorized to prescribe a very limited quantity (up to a maximum of only four days) of hydrocodone containing compounds and also only for the management of acute, severe, ocular pain, due to injuries and or infections of the eye and surrounding ocular tissue. Currently, hydrocodone is a schedule "three" controlled substance. Recently, the federal government has recommended hydrocodone be re-classified from a schedule "three" to a schedule "two" controlled substance in an effort to reduce abuse. Clearly, the potential for abuse is with "chronic" long term/recurrent pain management conditions. Currently,optometrist's in Alaska are authorized to prescribe schedules three, four, and five.

SB 162 would allow optometrists throughout Alaska to continue prescribing hydrocodone containing compounds for a limited period(maximum four days) and for limited use(pain management for ocular/surrounding tissues) without expanding their current scope of practice.

Even though the need for prescribing hydrocodone containing compounds is infrequent in most optometric practices, I am reminded from time to time how such medication is a godsend to those patients who suffer from a significant injury or infection resulting in extreme ocular pain. I recall one of my female patients who presented with a large,deep corneal fingernail abrasion received from her 16 month old daughter. I had to anesthetize the eye so she could stop crying, open her eyes to allow me to examine.She then went on to explain what had happened. Her first comments were... " I have delivered three of my own babies, and that pain was nothing compared to the pain I am currently feeling from this injury to my eye". Needless to say, aside from antibiotics, patching and follow up for the next several days, she benefited tremendously from a three-four day course of a hydrocodone containing medication to help manage the pain and allow her to sleep while healing.

Again, on behalf of all Alaskans throughout our state who may be in need of urgent optometric eyecare services--thank you for your support of SB162.

Sincerely,

Steven Dobson, O.D.
President-elect, Alaska Optometric Association

David Scott

From: victoria blower <victoria_blower@hotmail.com>
Sent: Thursday, February 20, 2014 9:47 PM
To: Sen. Donny Olson
Subject: SB 162

Dear Senator Olsen,

As a member of the Alaska optometric community of health care providers I want thank you for sponsoring SB 162.

As you know, this act authorizes licensed optometrists to continue utilizing a medication in our current arsenal of medications to treat our patients when temporary analgesia is needed for acute ocular pain. This medication, hydrocodone, when used for ocular care is used for short course treatment of 2-4 days when aspirin or other NSAIDs are not adequate for pain management. In my own practice it is rare that I need to utilize something other than a Schedule III medication (which currently includes hydrocodone) for controlling ocular pain. However, with the proposed FDA rescheduling of the medication to Schedule II it will no longer be available for my patients when needed. It would be a shame to lose this very effective medication for pain control in the case of abrasions, post-surgical foreign body removal and other ocular injuries.

SB 162 will help the optometric community of health care providers continue to responsibly treat our patients as we have for years.

Sincerely,
Victoria Blower, OD

Victoria Blower, O.D.
Accurate Vision Clinic
Care as Personal as it is Effective
207 E. Northern Lights Blvd
Suite 101
Anchorage, AK 99503
907-272-9800
victoria_blower@hotmail.com

Drugs

Statement on Proposed Hydrocodone Reclassification from Janet Woodcock, M.D., Director, Center for Drug Evaluation and Research

[10-24-2013] Over the past several years, the U.S. Food and Drug Administration (FDA) has been carefully evaluating and weighing the appropriate use of opioid analgesic drug products. For the millions of American patients experiencing an acute medical need or living with chronic pain, opioids, when prescribed appropriately, can allow patients to manage their pain as well as significantly improve their quality of life.

However, in recent years, the FDA has become increasingly concerned about the abuse and misuse of opioid products, which have sadly reached epidemic proportions in certain parts of the United States. While the value of and access to these drugs has been a consistent source of public debate, the FDA has been challenged with determining how to balance the need to ensure continued access to those patients who rely on continuous pain relief while addressing the ongoing concerns about abuse and misuse.

In 2009, the U.S. Drug Enforcement Administration (DEA) asked the U.S. Department of Health and Human Services (HHS) for a recommendation regarding whether to change the schedule for hydrocodone combination products, such as Vicodin. The proposed change was from Schedule III to Schedule II, which would increase the controls on these products. Due to the unique history of this issue and the tremendous amount of public interest, we are announcing the agency's intent to recommend to HHS that hydrocodone combination products should be reclassified to a different and more restrictive schedule. This determination comes after a thorough and careful analysis of extensive scientific literature, review of hundreds of public comments on the issue, and several public meetings, during which we received input from a wide range of stakeholders, including patients, health care providers, outside experts, and other government entities.

By early December, FDA plans to submit our formal recommendation package to HHS to reclassify hydrocodone combination products into Schedule II. We anticipate that the National Institute on Drug Abuse (NIDA) will concur with our recommendation. This will begin a process that will lead to a final decision by the DEA on the appropriate scheduling of these products.

Going forward, the agency will continue working with professional organizations, consumer and patient groups, and industry to ensure that prescriber and patient education tools are readily available so that these products are properly prescribed and appropriately used by the patients who need them most.

Related Information

- Opioid Medications[1]

Page Last Updated: 10/24/2013
Note: If you need help accessing information in different file formats, see Instructions for Downloading Viewers and Players.

U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
Ph. 1-888-INFO-FDA (1-888-463-6332)
Email FDA

Links on this page:

1. /Drugs/DrugSafety/InformationbyDrugClass/ucm337066.htm

FOR IMMEDIATE RELEASE

Contact: Alexis Geier Horan, ageier@asam.org, 202-276-7873

American Society of Addiction Medicine Applauds FDA Recommendation to Reschedule Hydrocodone

CHEVY CHASE, MD, OCTOBER 31, 2013 – The American Society of Addiction Medicine (ASAM) applauds the FDA's recommendation to reschedule hydrocodone combination products into a more tightly controlled class of narcotics. ASAM has advocated for the rescheduling of hydrocodone combination products since September 2011, when it sent a letter to the FDA Commissioner in response to an Associated Press news story that called the level of hydrocodone abuse a "national crisis." ASAM has since sent additional letters to the FDA, has testified before the FDA Drug Safety and Risk Management Advisory Committee and has supported U.S. House and Senate legislative language, all calling for the rescheduling of hydrocodone.

"Hydrocodone combination products are potent, effective pain pharmacotherapies but they are also highly addictive," says Dr. Stuart Gitlow, ASAM President. "We are hopeful that tighter restrictions on the prescribing of these drugs sends a message to prescribers and patients alike that hydrocodone is a powerful drug that could have unintended, deadly consequences if misused."

ASAM recognizes the important role that opioid analgesics play in the management of chronic, severe pain. However, most opioid analgesic prescribers have had little to no formal pain management or addiction treatment training. "The vast majority of doctors prescribing hydrocodone are dealing with patients who have significant pain and for whom these drugs provide serious relief," maintains Dr. Brad Hall, an ASAM member practicing in West Virginia. "The problems begin when doctors and patients don't know how or when to taper these medications. A little education about pain management and addiction risk evaluation could go a long way toward stemming the opioid epidemic and overdose rates I see at home." Dr. Hall also testified on behalf of the Society, before the January 2013 meeting of the FDA Drug Safety and Risk Management Advisory Committee.

The American Society of Addiction Medicine is a national medical specialty society of over 3,100 physicians. Its mission is to increase access to and improve the quality of addiction treatment, to educate physicians, and other health care providers and the public, to support research and prevention, to promote the appropriate role of the physician in the care of patients with addictive disorders, and to establish Addiction Medicine as a specialty recognized by professional organizations, governments, physicians, purchasers and consumers of health care services and the general public. ASAM was founded in 1954, and has had a seat in the American Medical Association House of Delegates since 1988.

http://www.asam.org/docs/default-source/pressreleases/asam-applauds-fda-recommendation-to-reschedule-hydrocodone-2013-10-31.pdf

State of Alaska Epidemiology Bulletin

Department of Health and Social Services
William J. Streur, Commissioner

Division of Public Health
Ward B. Hurlburt, MD, MPH, CMO

Editors:
Joe McLaughlin, MD, MPH
Louisa Castrodale, DVM, MPH

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Bulletin No. 26 December 5, 2012

Toxicity and Hospitalizations due to Opioid Pain Relievers — Alaska, 2001–2010

Background

Opioid pain reliever (OPR) overdoses constitute a growing public health threat nationally.[1] In 2008, the rate of prescription drug overdose deaths in Alaska was more than twice that of the United States overall (14.2 versus 6.5 per 100,000 persons, respectively), and most of these overdoses were due to opioids (79% in Alaska and 74% in the United States).[1,2] This *Bulletin* presents Alaska's OPR-related poison control center reports and hospitalizations during 2001–2010.

Methods

The National Poison Data System (NPDS) -- a national database of human exposures reported to participating U.S. poison control centers since 1985 -- was queried to characterize OPR-related toxicity reports in Alaska during 2001–2010.[3] The Alaska Trauma Registry (ATR) was queried to characterize the epidemiology of hospitalizations due to OPRs using ICD-9-CM Codes 965.00–09. Crude and age-adjusted rates (per 100,000 persons) were calculated using Alaska Population Estimates and 2010 U.S. Census data.

Results

During 2001–2010, there were 1,422 cases of OPR-related toxicity reports in NPDS, and half of these were identified as intentional exposures (Table 1). Overall, 41% of the reported cases were managed in a health care facility.

Table 1. OPR-related Toxicity Reports in NPDS — Alaska, 2001–2010

	Total*	Intentional Exposure†	Unintentional Exposure	Managed in HCF±
Hydrocodone	465	259 (56%)	171 (37%)	175 (38%)
Oxycodone	388	186 (48%)	171 (44%)	150 (39%)
Codeine	203	97 (48%)	95 (47%)	77 (38%)
Tramadol	179	111 (62%)	58 (32%)	97 (54%)
Methadone	86	47 (55%)	29 (34%)	50 (58%)
Morphine	77	7 (9%)	46 (60%)	24 (31%)
Meperidine	24	6 (25%)	12 (50%)	8 (33%)
Total	1,422	713 (50%)	582 (41%)	581 (41%)

** Totals include intentional and unintentional exposures, as well as "other" exposures and adverse reactions (data not shown); totals do not include cases where intent was undetermined.*

† Defined as intentional improper or incorrect use of a substance to achieve a euphoric or psychotropic effect or to cause self-harm.

± HCF = health care facility

During 2001–2010, 283 hospitalizations due to OPRs were captured in the ATR. Of the 283 hospitalized persons, 183 (65%) were female; the median age was 34 years (range: <1–82 years). Of the 283 hospitalizations, 231 (82%) were due to a suicide attempt, and 39 (14%) were due to unintentional poisonings; most of the unintentional poisonings were among children aged 0–4 years (54%; 21/39), followed by persons aged 15–19 years (28%; 11/39). Forty percent (112/283) of the hospitalizations involved a stay in an intensive care unit (duration range: <1–15 days); the overall hospital charges totaled $8.6 million (median: $5,965 per hospitalization).

The average annual age-adjusted rate of hospitalizations due to OPRs was 4.0 per 100,000 persons (range: 1.7–5.6 per 100,000 persons; Figure). Age-adjusted rates by sex were 5.4 per 100,000 females and 2.7 per 100,000 males. Crude rates by race were highest among Alaska Native/American Indian (AI/AN) people, followed by Whites, and all other races (7.2, 3.8, and 3.0 per 100,000 persons, respectively). Crude rates by region show that OPR overdoses are a problem statewide (Table 2).

Figure. OPR Overdose Hospitalization Rates by Year — Alaska, 2001–2010

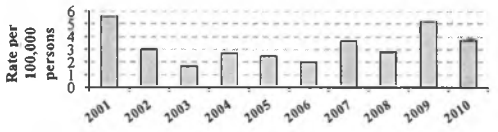

Table 2. OPR Overdose Hospitalization Rates by Region — Alaska, 2001–2010 (N=283)

Region	Number (%)*	Crude Rate†	Region	Number (%)*	Crude Rate†
Anchorage/ Mat-Su	152 (54)	4.3	Northern	16 (6)	6.7†
Gulf Coast	28 (10)	3.7	Southeast	27 (10)	3.8
Interior	40 (14)	3.8	Southwest	16 (6)	4.1†
Unknown	4 (1)	–			

** Percentages do not add up to 100% due to rounding.*

† Rates calculated from ≤20 observations should be interpreted with caution.

Discussion

In Alaska from 2001–2010, hospitalization rates due to OPRs were highest among females and AI/AN people. Regional data indicate that OPR overdoses are a problem statewide. The majority of OPR overdose hospitalizations were due to intentional self-harm. The fact that most of the unintentional poisonings involved children aged <5 years underscores the importance of routinely educating adults about safely storing and disposing of OPRs to assure that they are inaccessible to children. Hydrocodone and oxycodone were the most frequently reported OPRs associated with toxicity.

Emergency response for OPR overdose involves prompt administration of first aid and the appropriate use of naloxone, an opioid antagonist.[4,5] Nationally, many states have opioid overdose prevention programs that distribute naloxone at the community level.[4] Despite our high rate of OPR overdose hospitalizations and deaths, Alaska does not yet have any local drug overdose prevention programs that provide naloxone.[4]

Health care providers should follow guidelines for prescribing prescription pain relievers correctly, including the following:

- prescribe only the quantity needed based on the expected length of pain;
- use pain agreements for chronic pain management;
- screen and monitor patients for substance abuse and mental health issues;
- use prescription drug monitoring programs to identify patients who are misusing prescription pain relievers;
- educate patients on how to safely use, store, and dispose of prescription pain relievers;[6] and
- provide treatment options for OPR-addicted patients.[7]

References

1. CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999–2008. *MMWR*;60(43);1487-92. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w
2. Alaska Bureau of Vital Statistics (http://dhss.alaska.gov/dph/VitalStats/)
3. American Assn of Poison Control Centers (http://www.aapcc.org/)
4. Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010. MMWR 2012;61(6);101-5. Available at: http://www.cdc.gov/mmwr/pdf/wk/mm6106.pdf
5. HRC. Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects. Available at: http://harmreduction.org/wp-content/uploads/2012/11/od-manual-final-links.pdf
6. CDC Vital Signs: Prescription Painkiller Overdoses. Available at: http://www.cdc.gov/vitalsigns/MethadoneOverdoses/
7. Alaska Behavioral Health Resource Guide. Available at: http://health.hss.state.ak.us/abada/pdf/200804resourceguide.pdf

(Contributed by Deborah Hull-Jilly, MPH, Injury Surveillance Programs, Section of Epidemiology.)

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

February 19, 2014

The Honorable Bert Stedman
Chairman, Alaska Senate Health and Social Services Committee
State Capitol
120 4th Street Juneau, AK 99801-1182

Dear Chairman Stedman:

On behalf of the American Academy of Ophthalmology and its worldwide membership of 31,531 medical eye physicians and surgeons, I am writing to ask you to oppose SB 162.

SB 162 would authorize optometrists to prescribe pharmaceutical agents containing hydrocodone, regardless of the schedule of the controlled substance.

In explaining our opposition, it is essential for the committee to know the context of this legislation. In 2009, the U.S. Drug Enforcement Administration (DEA) asked the U.S. Department of Health and Human Services (HHS) for a recommendation regarding whether to change the schedule for hydrocodone combination products, from Schedule III to Schedule II. A Schedule II classification increases the controls on these products. In October 2013, after extensive analysis, public comments, and public meetings, the Food and Drug Administration (FDA) determined that it would recommend to HHS that hydrocodone products be reclassified to Schedule II. In 2013, the American Optometric Association provided public testimony to the FDA Drug Safety and Risk Management Advisory Committee arguing that hydrocodone remain a Schedule III drug. That view held by the American Optometric Association (as well as other providers) did not prevail. After carefully evaluating and weighing the evidence, the FDA concluded that it was in the public interest to restrict access to frequently abused narcotics. SB 162 plainly runs counter to the FDA's intent to restrict hydrocodone combination products.

This legislation is also premature. No final decision on rescheduling has been made. The FDA announced that it would submit a formal recommendation package in December 2013 to HHS to reclassify hydrocodone combination products into Schedule II. Only after the National Institute on Drug Abuse (NIDA) makes its own recommendation will a process begin that will lead to a final decision by the DEA on the appropriate scheduling of these products. We have yet to see notification in the Federal Register of this process.

There are ample reasons to restrict hydrocodone combination products. As you know, narcotic overdose is a serious problem in Alaska. A recent data set published by the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that opiates including prescription drugs were the second leading cause of substance abuse primary treatment admissions in Alaska in 2010. Restricting provider access will reduce community availability of these medicines in the recreational market.

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

Consider this problem also in relation to the actual need to prescribe these drugs for eye care. Hydrocodone containing medicines are RARELY prescribed by ophthalmologists except after surgery or in the setting of severe trauma. Optometrists have access to other medicines to effectively treat acute pain, including Tylenol with Codeine amongst others. The vast majority of eye pain is treated with topical measures - ointments, drops, bandage contact lenses, patches... Oral acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs) are also used. In a typical surgical ophthalmology practice, it is uncommon to use oral narcotics.

In addition to the addiction risks, hydrocodone is often combined with acetaminophen which can amplify risks to patients. On January 14, 2014, the FDA specifically issued a warning against prescribing analgesics containing more than 325 mg of acetaminophen due to the risk of liver injury. Some pharmaceuticals containing hydrocodone contain more than this 325 mg of acetaminophen. In the near future, the FDA intends to institute proceedings to withdraw approval of prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit that remain on the market. Moreover, according to the FDA, cases of severe liver injury with acetaminophen have occurred in patients who:

- took more than the prescribed dose of an acetaminophen-containing product in a 24-hour period;
- took more than one acetaminophen-containing product at the same time; or
- drank alcohol while taking acetaminophen products.

For all these reasons, the Alaska Society of Eye Physicians and Surgeons and the Academy ask you to oppose SB 162.

Sincerely,

Dan Briceland, MD
Secretary for State Affairs
American Academy of Ophthalmology
Surgeons

Scott A. Linstrom, MD
President
Alaska Society of Eye Physicians &

CC:
VICE-CHAIR, Peter Micciche
Senator Kevin Meyer
Senator Pete Kelly
Senator Johnny Ellis

[redacted]

Affiliate

American Optometric Association

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Telephone: 907.770.3777 · Fax: 907.272.7532
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February 18, 2014

Senator Donny Olson,

On behalf of the patients of Alaska, the practicing optometrists, and the Alaska Optometric Association, I wish to extend sincere gratitude for sponsoring SB 162.

This act, authorizing licensed optometrists to continue prescribing short courses of hydrocodone-containing pharmaceutical agents, is intended to allow for continued use of these drugs for temporary analgesia of eye-related pain. Optometrists in Alaska and throughout most of the United States have been safely and effectively prescribing hydrocodone containing drugs for a number of years as part of their responsibility to controlling pain secondary to eye abrasions, lacerations, other injuries and inflammations as well as following foreign body removals. While these drugs have and will continue to be used judiciously and conservatively by optometrists, when they are needed by a patient they are indispensable. As you are aware, there are other pain-relieving drugs that may be prescribed, however the ratio of side-effect to relief of pain is very favorable for the hydrocodone combination drugs making them an effective choice.

While optometrists today can prescribe hydrocodone-containing drugs, there is a likely change at the federal level coming that is prompting the need for the passage of SB 162. Most hydrocodone-containing compounds that are Schedule III are proposed to be rescheduled by the Food and Drug Administration to Schedule II. This federal change would supersede the intent of current Alaska optometry statute without SB162's necessary addition to the language of our statute to include "a licensee may prescribe and use a pharmaceutical agent containing hydrocodone." In summary, SB 162 is not intended to expand or alter the scope of practice of optometry but rather to maintain it.

Sincerely,
David Karpik, OD
President, Alaska Optometric Association