Efforts to Control Prescription Drug Abuse: Why Clinicians Should Be Concerned and Take Action as Essential Advocates for Rational Policy

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Introduction

Faced with mounting evidence of a public health crisis so serious that the US Centers for Disease Control and Prevention (CDC) has termed it an “epidemic” of prescription painkiller abuse, resulting in an epidemic of prescription drug overdoses; federal and state government agencies have taken up the mantle in full force to implement a variety of far-reaching policy initiatives intended to address these related public health crises. Characteristic of most governmental efforts to rein in drug abuse over the past century or longer, many of these policy changes have focused almost exclusively on reducing the supply of medications available for abuse. Over the past decade, this has involved a particular emphasis on prescription opioid analgesics. From a policy standpoint, efforts to address the “supply side” of the drug abuse supply-and-demand equation are much easier to conceive and carry out than those focusing on primary prevention and access to appropriate substance abuse treatment on the “demand side.” Some have questioned the effectiveness of this heavy supply-side focus, but it nonetheless remains the staple of policy makers, regardless of whether the drugs in question are licit or illicit.

For health care professionals and the patients with pain for whom they care, supply-side solutions pose a major concern. The CDC suggests that increased pain treatment involving more frequent prescribing of opioid analgesics is responsible for the abuse and overdose epidemics. Clinicians certainly need to be cognizant of the potential for their opioid prescriptions to be misused, abused, and diverted, and they support taking reasonable steps to prevent such outcomes, not to mention the overdoses that can result. Concerned clinicians want to participate in a system that takes appropriate steps to prevent drug abuse and diversion, but they also need a system that allows them to provide optimal pain care for individuals with pain. Implementing a system that achieves both aims is challenging, especially in the current environment that focuses heavily on misuse, abuse, addiction, and overdose rather than on pain and suffering. Thus, the flip side of the connection between prescribing and misuse/abuse/diversion, as noted by the CDC, also should concern clinicians and their patients: the possibility that a restricted supply (in an effort to control prescription drug abuse) may reduce the availability of medications needed by patients who use them therapeutically to control their pain and maintain their quality of life. If supply limitations are severe enough, it is possible that many of the gains in controlling pain and relieving suffering over the past 2 decades could be reversed, which is a devastating consequence by any measure.

Management of cancer-related pain has, for many years, understandably been a driving force behind policies focused on improving clinical access to prescription opioid analgesics, spurred largely by studies documenting a high prevalence of untreated pain, particularly among patients with metastatic disease. Over time, the resulting prescribing practices for these medications were extended to treat other types of chronic and disabling noncancer pain, causing opioid analgesic prescribing to increase dramatically overall. Now, however, the quality care gains made in pain treatment that have helped preserve the functional status and quality of life for many individuals with pain, whether or not the pain is related to cancer, may be in jeopardy. That is a steep and unacceptable price to pay in the name of taking a strong national stand against prescription drug abuse.

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Noteworthy among federal efforts to address prescription drug abuse are 3 recent policy initiatives that may significantly impair legitimate access to prescription opioid analgesics for individuals with pain. Each of these policies will be outlined briefly, with particular attention to their implications for access to care, followed by a discussion of alternative policy solutions that offer a more balanced approach to current challenges. An important role for health care professionals in advocating for policies that do not unduly restrict access to prescription opioid analgesics will be proposed, and available resources for assisting clinicians as advocates will be presented.

Three Federal Policy Developments Threatening Patient Access to Opioid Analgesics

1) Changes to Label Indications for Extended-Release/Long-Acting Opioid Analgesics

In July 2012, a group calling itself Physicians for Responsible Opioid Prescribing (PROP) submitted a citizen petition to the US Food and Drug Administration (FDA), asking for changes to the label indication for long-acting or extended-release opioid analgesics (LA/ER OAs). At the time of PROP’s petition, labels for prescription opioid analgesics stated that they were indicated for the treatment of “moderate to severe pain,” with additional language adding “...when a continuous, around-the-clock analgesic is needed for an extended period of time” in reference to LA/ER OAs. PROP requested 3 changes to this label indication: 1) strike the term “moderate” from the indication for noncancer pain; 2) add a maximum daily dose, equivalent to 100 mg of morphine for noncancer pain; and 3) add a maximum duration of 90 days for continuous (daily) use for noncancer pain. Notably, all 3 requests are specifically oriented toward “noncancer pain.” This petition generated 1927 written submissions to the FDA docket and resulted in a February 2013 public hearing. In written comments and testimony at the public hearing, several organizations, including the American Cancer Society and the American Academy of Pain Management (the Academy), argued that having different label indications for “cancer pain” and “noncancer pain” would be inappropriate. These organizations also cautioned that the requested changes would significantly impair the ability of health care professionals to relieve pain effectively among many of their patients.

The FDA responded to the PROP petition by denying the requests related to the dose and duration of therapy, as well as the limitation to noncancer pain, but approved the request to strike the term “moderate” from the label. The FDA ruled that the label for LA/ER OAs now must read “[Tradename] is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.” The FDA expanded the label by adding a “Limitations of Use” section that reiterates the risks of addiction, abuse, and misuse of prescription opioid analgesics, and urges the prescriber to use LA/ER OAs only “in patients for whom alternative treatment options (eg, nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.”

The language decided upon by the FDA seems to have left considerable room for the clinician’s judgment when it comes to prescribing opioid analgesics. In its response letter, the FDA carefully elucidated the intention to not unduly tie the hands of prescribers by requiring them to progress through a “step therapy” protocol before being able to prescribe LA/ER OAs. However, by adding the phrase “...for which alternative treatment options are inadequate,” the FDA may have opened the door to the institution of step therapy protocols by third-party payers. Such a development would be unfortunate, and could result in individuals with pain suffering needlessly until they have worked through the payer’s protocol. Health care professionals need to be vigilant for such an occurrence and stand ready to take action through advocacy if it does happen.

2) Rescheduling of Hydrocodone-Containing Combination Products

Rescheduling of hydrocodone-containing combination products (HCCPs), which is an issue the FDA has been considering since receiving a citizen petition in 1999, has been a much-discussed policy decision that appears to be nearing its conclusion. In addition to the 1999 citizen petition, the US Drug Enforcement Administration (DEA) formally petitioned the FDA to move HCCPs from Schedule III to Schedule II in 2004. Four years later, the FDA recommended that HCCPs should remain in Schedule III. The DEA responded to this decision by requesting that the FDA reconsider, culminating in a 19-to-10 vote by an FDA advisory committee on January 25, 2013, recommending that HCCPs be moved to Schedule II. The FDA has followed the advisory committee’s advice and recommended rescoring to the DEA, which is now completing the rulemaking process for this change.

Rescheduling of HCCPs, the most commonly prescribed medication in the United States, has the potential to create a fair amount of chaos and substantially limit its availability for a number of reasons. To begin with, storage and record-keeping changes will be significant. As a Schedule II medication, wholesale distributors and retail pharmacies will need to store HCCPs more securely. For wholesalers, this likely means an expansion of secure holding areas in their warehouses, while retail pharmacies may be forced to
expand the size of their vaults. Given the extraordinarily high volume of HCCPs prescribed, the increased storage area required may be substantial, costing millions of dollars and threatening supplies if that expansion does not occur in a timely manner and to a sufficient extent. Furthermore, retail pharmacies will be forced to check their inventories of HCCPs more regularly and, given the volume of medication affected, will require hours of additional time from pharmacy employees each week.

The impact on wholesale distributors and retail pharmacies is potentially costly and very inconvenient, and may impose access limitations by virtue of insufficient capacity. However, the 2 greater challenges are related to the ability of health care professionals and the health care system to accommodate what is a potentially massive increase in the number of written prescriptions required by patients with pain. First, there are a number of states in which nonphysician prescribers (eg, nurse practitioners, physician assistants, optometrists, etc) have prescription privileges for Schedule III controlled substances, but not for Schedule II controlled substances. These health care professionals are responsible for a large number of prescriptions, but unless statutes and/or regulations in their states are changed, they would no longer be permitted to prescribe HCCPs after rescheduling. During 2014 state legislative sessions, optometrists in particular have sought to prepare themselves for this eventuality. They have advocated for bills that would permit them to continue prescribing HCCPs after they are shifted to Schedule II, but without expanding privileges to other Schedule II medications. This strategy, or else expanding the scope of practice to include full Schedule II prescribing privileges for nonphysicians, undoubtedly will be featured in a number of state legislatures over the next few sessions, assuming rescheduling proceeds as expected.

By far the biggest threat to access posed by HCCP rescheduling involves the fact that, when classified in Schedule II, HCCP prescriptions no longer will be eligible for automatic refills at the pharmacy. Each time a Schedule II medication is dispensed, federal law requires a new written prescription. Furthermore, after rescheduling, HCCP prescriptions cannot be phoned in by the prescriber, except for an emergency supply that must be followed by a written prescription. Given that there were approximately 26 million automatic refills of HCCP prescriptions in 2011,9 rescheduling will translate to as many as 26 million additional written prescriptions needing to be generated each year. Although it is likely that prescribers will opt not to write new prescriptions in some unknown percentage of these cases, the increased volume of paperwork that will be needed is staggering, as will be the increased traffic through medical clinics’ front offices. Furthermore, some prescribers may believe that, if they are going to write a prescription for a Schedule II prescription opioid analgesic, they should schedule an office visit to properly assess the patient and bill for that visit. The potential financial cost of up to 26 million additional office visits easily exceeds one-half a billion dollars per year. Of course, this assumes that up to 26 million appointments can be found in a health care system that is already stretched to its limits, even though some practitioners will not be involved because they cannot prescribe Schedule II medications, as highlighted above.

Although HCCPs are most commonly prescribed for those experiencing acute pain unrelated to cancer who are being cared for by a primary care physician, individuals with cancer-related pain may still be adversely affected by rescheduling. Patients with cancer use HCCPs when they are experiencing acute pain due to a cancer-related medical procedure or acute injury such as a pathologic bone fracture, for breakthrough pain in conjunction with an LA/ER OA, or even for around-the-clock treatment of chronic pain related to cancer and its treatment, not to mention those who use HCCPs to treat pain that is unrelated to their cancer.

Advocacy options for concerned health care professionals are limited at this stage of the regulatory process. Through comment letters from the Academy and others, several groups have proposed a compromise to the DEA in which HCCPs would remain in Schedule III but the amount that could be called in would be limited and the amount dispensed with an original prescription plus refills is limited to a 90-day supply. Although this compromise would go a long way toward ameliorating the concerns raised above, it is unknown how the DEA will respond. It may be that advocates will need to demonstrate a significant negative impact on individuals with pain resulting from rescheduling, and then seek regulatory or legislative changes that will rectify these unintended consequences, something that will be a tall order to accomplish.

3) Pressure on Wholesale and Retail Pharmacies to Control Inappropriate Prescribing

In the past few years, the DEA has stepped up its efforts to eliminate illegitimate “pill mill” enterprises as well as other sources of diverted opioid analgesics. These efforts have focused on wholesale distributors who have shipped massive quantities of controlled substances to retail pharmacies despite clear signs that such volumes were inappropriate, retail pharmacies that received these shipments and dispensed medications to patients despite the absence of information indicating that the prescriptions were legitimate, and prescribers who issued prescriptions that may not have been for a legitimate medical purpose. In 2012, the DEA suspended the distribution of controlled substances from Cardinal Health’s Lakeland, Florida, facility for 2 years12,13 and suspended the controlled substances registrations of 2 CVS stores in the Orlando, Florida area.14 In 2013, the nation’s largest pharmacy chain, Walgreens, was fined $80
In the wake of these events, individuals with pain have reported significant problems obtaining necessary pain medications (including patients with cancer) and a survey of members by the National Community Pharmacists Association revealed that most respondents were experiencing significant delays or other issues in receiving their controlled substance orders, affecting on average 55 patients per pharmacy. Commentators have blamed the DEA’s efforts to control the supplies of controlled substances for these access problems.

Health care professionals concerned about the DEA’s efforts to control medication supplies, and the effects those efforts have on their ability to care for patients with pain, have few options to remedy the situation. Those options start with forging strong working relationships between prescribers and pharmacists as a means of ensuring that pharmacists will feel confident when presented with a prescription written by those prescribers. Addressing the systemic issues that appear to be resulting from the DEA’s activities is much more challenging. Perhaps the most promising strategies involve making federal policymakers and executive branch levels, aware of the growing negative unintended consequences alongside achieving any positive outcomes. Consideration of the following 5 alternative, more targeted strategies may deliver better results in curbing misuse and abuse and cause less harm to those with pain.

1) Abuse-Deterrent Opioid Formulations
Formulations of opioid analgesics that discourage individuals from altering their extended-release properties to get high have received considerable attention in the past few years. The FDA has issued preliminary guidance to manufacturers regarding the steps necessary to obtain its designation as an abuse-deterrent product, but the final rules have not yet been issued. One opioid analgesic currently on the market has been designated an abuse-deterrent formulation, and preliminary research suggests a resulting shift away from that product as a drug of abuse, although it is also apparent that there has been a concomitant shift toward instead abusing other prescription opioids and heroin. Although this concerning “substitution effect” will require its own policy solutions, the widespread adoption of abuse-deterrent technology holds great promise as a more selective and effective prevention strategy to help curb abuse by those who would otherwise alter their native forms in ways that permit the extraction of the active ingredients for snorting, smoking, or injection.

2) Increased Medication Storage Security at Home
Home medicine cabinets are a major source for obtaining opioid analgesics that are ultimately misused or abused, presenting another significant abuse prevention opportunity through education and information about safe medication storage and disposal. Results reported from the 2013 National Survey on Drug Use and Health indicate that 69% of those respondents who reported using opioid analgesics nonmedically obtained the medications from a home medicine cabinet, with greater than one-half (54%) saying the medication was given to them by a friend or relative at no cost. An additional 15% said they had bought or taken it from a friend or relative. These data reinforce the importance of investing in strategies that educate consumers, prescribers, and pharmacists about the importance of safe medication storage and disposal, including at the time opioid analgesics are prescribed and dispensed, to specifically target known sources of opioid analgesic misuse without impeding the supply available for individuals with pain.

3) Drug Take-Back Opportunities
Since September 2010, the DEA has sponsored semiannual take-back events across the country in conjunction with local law enforcement agencies. At these events, individuals can deposit any expired, ineffective, unneeded, or excess medication (including opioid analgesics) for safe disposal

Finding Effective Supply-Side Solutions: How Can We Throw Out the Bath Water But Keep the Baby?
Thus far, our discussion has highlighted the dangers of applying broad and blunt supply-side policy approaches to prescription drug abuse that may produce negative unintended consequences alongside achieving any positive outcomes. Consideration of the following 5 alternative, more targeted strategies may deliver better results in curbing misuse and abuse and cause less harm to those with pain.
and with no questions asked. Strategies to expand and promote more frequent and convenient take-back opportunities continuously, to include local pharmacies in addition to local law enforcement offices, would help to encourage consumers to safely discard opioid analgesics they may otherwise stockpile in their medicine cabinets, which in turn would prevent those medications from remaining ripe for the picking by those intending to misuse or abuse them. The DEA is currently finalizing its rules for take-back programs, and making these events more widely available presents another important opportunity for preventing harm.

4) Improved Clinician Education
Educating clinicians about proper prescribing practices provides another targeted supply-side intervention. Teaching clinicians to prescribe only the number of doses they expect patients to need in acute pain settings and the importance of avoiding excess prescribing is one key goal of these educational efforts. Although clinicians often are motivated to provide adequate coverage for their patients’ acute pain needs, particularly as a result of surgery or traumatic injury, a number of factors can drive overprescribing and create pools of medication that could be accessible for subsequent misuse and abuse. Prescribing more judiciously might cause some inconvenience for clinicians and patients in rare instances in which the amount prescribed might be inadequate, but presents an important clinical practice opportunity to help prevent the possibility of proliferating prescription drug abuse.

5) Improved Effectiveness of Prescription Drug Monitoring Programs
Prescription drug monitoring programs (PDMPs) are electronic databases containing information on controlled substance prescriptions. They are operated by various agencies within state governments, most often boards of pharmacy, departments of health, or law enforcement agencies. Although they have since transitioned into primarily health care delivery tools, PDMPs were originally intended to allow for detection and intervention, targeting individuals who fraudulently obtained controlled substance prescriptions from multiple prescribers. One study of 2008 prescription data estimated that only 0.7% of all individuals met criteria for this behavior pattern, but that those individuals bought 1.9% of all opioid prescriptions and 4% of the weight of medication dispensed, which clearly is an outsized proportion of the medication for such a small group of individuals. Having clinicians obtain a PDMP report before writing an initial opioid prescription for a patient should, theoretically, completely eliminate this behavior by selectively reducing supplies bound for abuse and/or diversion.

More than helping to prevent and detect drug diversion activities, PDMPs also provide positive support for clinicians who need to prescribe opioid analgesics to treat their patients’ pain. In many cases, clinicians may be anxious about doing so because they know only the history related to them by their patients, as well as anything that is contained in their charts. Chart information may be incomplete because it may not include records from other clinical settings, and patients may not present complete and accurate information, for innocent or nefarious reasons, thereby leaving clinicians uncertain and anxious about how to proceed. Confirming the patient’s full controlled substance prescription history by obtaining a PDMP report often will allay those concerns and enable the clinician to prescribe confidently, thereby ensuring access for the appropriate clinical use of the medication.

One of the most important challenges in using PDMPs to their full potential is the generally low adoption of PDMP use by providers. Except in states in which PDMP use is required, anecdotal reports from PDMP administrators suggest that, typically, fewer than one-half of all prescribers and dispensers are even registered to access the PDMP, and even fewer (typically 30% to 35%) request reports on their patients even once a year. Given that no PDMP can be effective for any purpose if it is not used, one goal must be implementing practices that support education and other steps (eg, mandatory registration to access the PDMP) to increase awareness and use of the PDMP. Efforts to create policies that require practitioners to access PDMP data before prescribing have been undertaken in many states. Even given these developments, further evidence generally is needed to demonstrate program effectiveness at both reducing the fraudulent acquisition of prescriptions and improving patient treatment.

Addressing the Demand Side of the Equation
The policies highlighted above that selectively reduce supplies of opioids bound for misuse and abuse are essential, yet policies targeting the demand for prescription drugs may be just as important. Efforts to prevent individuals from developing the disease of addiction are, of course, vital and have been evident in our schools for many years. Research into ways to make primary drug abuse prevention more effective is needed, and the prominence of these prevention efforts as a national priority should be supported by policymakers, including through their budgetary authority.

For individuals who already have a substance use disorder, 2 forms of medication-assisted treatment (MAT) also are available. Methadone maintenance programs that seek to prevent relapse have existed for decades, and continue to play an important role in addressing prescription drug abuse. The most recent MAT innovation for opioid addiction involves using buprenorphine products in office-based settings. Buprenorphine treatment for substance use disorders
has become widely available, but is limited by the numbers of providers who are able to take on new patients. Policy approaches to increasing the availability of office-based MAT are currently under consideration, including increasing the maximum number of patients allowed for each provider and allowing nonphysician prescribers, such as nurse practitioners and physician assistants, to provide this treatment. Counseling is an important component of effective MAT, and therefore policy strategies must take steps to ensure adequate availability of that service as well.

Ready-Made Assistance and Resources for Clinicians to Activate as Advocates

Advocating for changes in pain management policy can be complicated and time-consuming. Clinicians are already subject to extreme time pressures, leaving many feeling helpless when considering involvement in policy advocacy. Fortunately, the issue is high on the radar screen of voluntary organizations such as the American Cancer Society and its advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN; acs-can.org), as well as the Academy through its State Pain Policy Advocacy Network (SPPAN; sppan.aapainmanage.org). Formed by the Academy in 2012, the goal of SPPAN is to serve as a central resource and rallying point for individuals and organizations advocating for balanced pain management policy. As a project focused entirely on state-level policy influencing pain treatment, SPPAN has the resources to provide the issue tracking, policy analysis, and dedicated strategic direction required to organize responses to policy proposals and engage both small grassroots organizations and large national organizations.

Both ACS CAN and SPPAN have invested significantly in national advocacy infrastructure, including policy development, legislative and grassroots campaign strategies, and coalition development. Both organizations have placed patient access to appropriate pain medication as a high policy and legislative priority. If pain management policy is to be shaped to allow clinicians to provide optimal pain care, clinicians must become more involved in educating policymakers about the impact that overly restrictive government policies are having on their ability to provide what is medically necessary for their patients. The voices of patients with pain who can describe the deleterious impact of onerous supply-side approaches to prescription drug abuse on their ability to access necessary pain treatment are especially powerful. Working with clinicians and patients, ACS CAN and the Academy/SPPAN can provide the essential advocacy needed to effectuate policy change.

Vital to these advocacy efforts, the University of Wisconsin’s Pain and Policy Studies Group (painpolicy.wisc.edu) has produced a series of progress report cards and accompanying evaluation guides that serve as essential strategic tools that both ACS CAN and SPPAN have used to build and implement advocacy action plans addressing various states’ pain policies. Applying a criteria-based policy evaluation methodology based on the concept of Balance,30 the Pain and Policy Studies Group’s reports assign state grades constructed from a review of all states’ legislation, regulation, and official agency policies governing medical and pharmacy practice related to the treatment of pain, with a particular focus on the requirements associated with the legitimate use of opioid analgesics for pain relief. Under a grant collaboratively funded by the American Cancer Society, ACS CAN, and the LIVESTRONG Foundation, the most recent policy evaluation reports were published in July 2014,31,32 covering all laws and regulatory policies in effect by December 31, 2013.

The most recent report findings31 show that, in the last year, 24 states changed or adopted policies containing language meeting one or more evaluation criteria; in 5 of those states the policy change resulted in a grade improvement. Currently, 15 states have achieved an A, having the most balanced pain policies in the country. Approximately 96% of states now have a grade above the average of C, compared with 88% in 2006. Importantly, no state’s grade decreased since 2012 or even since 2006. Recent grade increases typically resulted from: 1) adopting policies to encourage appropriate pain management, palliative care, or end-of-life care; and 2) state legislatures or regulatory agencies repealing restrictive or ambiguous policy language.

The policy improvement observed over the last decade seems to be continuing, with government and regulatory agencies generally avoiding requirements that could interfere with legitimate medical practice and patient care. However, in the last year, a number of state legislatures introduced bills that, when implemented in practice, could create barriers to appropriate pain treatment. Although these bills ultimately were not passed, due in large part to the effective state-level advocacy of such organizations as ASC CAN and SPPAN, ongoing vigilance is required to minimize policy backsliding and increase policymaker awareness about possible unintended consequences. Finally, policy does not necessarily equal practice. In fact, the potential for policy to influence clinical practice depends directly on the extent to which it is communicated and implemented. Clinicians should be knowledgeable about and comply with the federal and state policies that govern their pain management practice, including when relevant the prescribing, dispensing, and administering of opioid analgesics.

Conclusions

The dual public policy challenges of controlled substance abuse and chronic pain can be vexing at times for

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policymakers, health care practitioners, and individuals experiencing pain and other medical conditions. Clinicians and their patients grapple with the challenge of attaining optimal relief from these conditions while at the same time minimizing the risk of nonmedical use and diversion. Conversely, policymakers struggle with designing laws and other policies that are permissive enough to allow clinicians the latitude required for successful treatment, yet constraining enough to prevent the exacerbation of the prescription drug abuse problem. By focusing solely on supplies of medications, the policy initiatives outlined above are unlikely to meet these dual objectives, favoring instead efforts to reduce prescription drug abuse.

Policies related to the issues described in this article that are based on inaccurate or incomplete information are doomed to fail, by either being unable to effectively address the issue, imposing barriers on patient care decisions, or both. Unfortunately, there is little evidence available to guide policymakers in selecting policies that have been demonstrated to reduce prescription drug abuse without unduly restricting access to the medications. As a result, all stakeholders are involved in a delicate balancing exercise, albeit with differing areas of emphasis. It is essential that any new policy enacted to address these problems has a required monitoring and evaluation component that determines the new policy's efficacy with respect to its intended consequences, as well as the nature and extent of its unintended consequences. Having this information will justify revisions of policies when necessary, bringing us closer to achieving optimal outcomes for everyone. In addition to the federal policies discussed in this article, state laws and regulations erect substantial barriers to access and must be addressed also by coordinated advocacy efforts.

Clinicians and patients with pain who find themselves confronting access limitations should feel empowered to reach out to ACS CAN, the Academy, SPPAN, and others operating in this area of policy advocacy because it is ultimately going to be the personal involvement of passionate, experienced, and dedicated individuals that has the best potential to persuade policymakers to consider their needs. Only when this consideration is given the attention currently accorded to prescription drug abuse will we, as a society, successfully navigate the narrow and treacherous path to reaching our goal of appropriately addressing 2 public health crises: that of prescription drug abuse and untreated or undertreated chronic pain. That is a tall order, but one that can be accomplished if we apply and sustain our best collaborative efforts. Patients with pain and their families who are suffering deserve nothing less.

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