# Prescribing Limits and Pain Management

ACS CAN applauds Governor Shumlin and the Vermont legislature for taking the critical issue of opioid addiction head on, as this problem is at crisis level in Vermont. We share in the Governor's concerns that these drugs must not be overprescribed and must be kept out of the wrong hands. However, it is critically important that the state move forward with a balanced approach that promotes safe prescribing and dispensing of pain management medication that does not interfere with access to pain-relieving medicines for Vermont patients who need them to ease their daily suffering.

Over 1.6 million new cancer cases are expected to be diagnosed this year, and more than 595,000 cancer deaths are anticipated. Many of these patients will experience cancer-related pain – either from the disease or its treatment. Policies aimed at preventing drug diversion, regulating professional practice, and improving patient care must be balanced so they do not restrict medical decision-making and the availability of controlled substances for legitimate medical purposes.

Currently, Vermonters read daily of the dangers of prescription painkillers and their widespread misuse, while rarely do we hear the other side of the story – the individuals who are suffering from chronic pain and in need of these same medications to maintain their basic quality of life. These stories are often equally heartrending and distressful. Therefore, we urge you to consider the 35,000 Vermont residents who currently live with cancer, and potentially chronic pain, when considering putting new prescribing policies into law.

Unfortunately, studies continue to show that large numbers of cancer patients suffer from moderate or severe pain when treatments are available to control it. Numerous studies have documented a variety of barriers that contribute to the problem.

The words associated with pain management – "narcotics", "addiction", "painkillers" – are strong, scary, and carry stigmas. Patients, families, and even practitioners often have misperceptions and are confused about addiction, dependence and tolerance, which contribute to patient and family fears about using pain medications as well as physicians' reluctance to prescribe them.

In the case of cancer, people often think pain is an inevitable part of living with or dying from the disease. They do not understand that pain can and should be treated effectively alongside disease-directed treatment and should continue as needed for the rest of a patient's life. For a variety of reasons, patients may be reluctant to raise pain as a problem when they see their doctor or nurse or they may not feel comfortable about asking for it to be assessed and treated.

We ask you to look closely at the following issues in **S.243** and **S.201:**

**S.243**

- As introduced, S.243 would require health care providers to check the VPMS database every time when writing a prescription for an opioid Schedule II, III, or IV

controlled substance. Current law calls for this check to occur when writing the initial prescription and then at least annually.

- We would agree that annually is probably a bit too infrequently, but we also believe that checking for every prescription described is not practical. Even in a most efficient situation, utilizing the system properly requires approximately 3-5 minutes. This proposal would create tremendous backlogs in provider offices and that would have impacts on not only office staff but on patients, like many cancer patients, who legitimately need these pain medications to get through their day and/or night with some degree of a decent quality of life.
- We agree that there is an opioid problem, and we applaud law enforcement and policymakers who attempt to curb the illegal abuse and diversion of these drugs. But we also ask for a balance to these policies to avoid turning cancer patients into criminals just because they need pain medication.
- We would suggest and support an ammendment stating that the VPMS be checked for the initial prescription and then after not less frequently than 6 months.
- Finally, we believe that patients in palliative care should be afforded the same protections as all other patients and for that reason request that the bill's exemption for patients receiving palliative care be removed

**S.201**

- The same above-mentioned concerns apply for S.201, as well as, we believe;
- Screening a patient for substance use disorder every 30 days is not practical and would subject even low-risk, stable individuals to an office visit monthly adding potentially substantive additional costs for patients, insurers and the state. Not to mention the additional scheduling issues that would be thrust upon doctor offices already overburdened with few if any appointment slots. For these reasons we believe that screening for a substance use disorder should occur every 6 months.

We understand that there are at least two more proposals coming forward with the same aim and therefore, we urge the Senate Health and Welfare Committee to recognize the needs of cancer patients and others whose chronic conditions necessitate pain management as the committee considers an opioid prescribing proposal.

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