Testimony submitted via email.

March 10, 2017

Regarding: House Bill 2128

To: Oregon State Legislature Representatives

I would like to testify in favor of House Bill 2128. As a local pharmacist, I have found the classification of pseudoephedrine as a Schedule III drug very problematic for helping customers deal with nasal congestion. As I am sure Mr. Buckstein from the Cascade Policy Institute will testify, there is scant evidence that making pseudoephedrine prescription only (in comparison to the sales behind the counter done almost everywhere else in the country) has done much to lower methamphetamine use or production in the state of Oregon, especially when you compare use and production in our neighboring states that do not have that requirement. I refer you to Cascade Policy Institute's work for a more comprehensive picture of that argument.

I want to focus on what this requirement has done to Oregonians and visitors to our wonderfully green and allergen rich state and how in inconveniences all of us to a significant degree. First is the obvious, requiring a prescription from a health care provider is a barrier to obtaining a medication that is usually very safe (safer than many other over-the-counter medications). Do you have a good enough relationship with your doctor where you can just call them up and get a prescription? Do you have to take time off work and visit your doctor for a prescription (and pay a fee for the visit)? Also, since it is over the counter in most places in the United States, it is not usually covered by many insurances. So, you have to go to the inconvenience of getting a prescription and pay the full price for it!

Since the law has been in place over a decade, I don't get too many people asking for it who are Oregonians anymore, but I still get plenty of visitors from out of state. I would estimate I have to tell someone that we need a prescription for pseudoephedrine in Oregon at least once a month.

On top of that, making it a scheduled item adds more problems. First, prescriptions for non-scheduled items do not have refill limits and are valid for a year. Once you schedule the item, you only have 5 refills maximum and the prescription expires 6 months from the date written. Bottom line, the patient must pester his doctor for a prescription at least twice as frequently if he needs to use it throughout the year.

The second issue with pseudoephedrine being scheduled as a controlled substance is the provider must have an active DEA number. If a provider has an expired DEA number (has popped up occasionally when a provider has trouble renewing), that could invalidate the prescription. More often is the situation when you deal with prescriptions from medical residents. First, many new ones are from out of state and may not be aware of the prescription only requirement. Second is when they do give you a prescription, tracking down and validating a DEA number is a little more complicated since they use the institution's DEA number with a personal number behind it and it is not easily verified, especially if the medical resident's office is closed when we receive the prescription. This is not usually a big issue, but it can significantly delay the dispensing of the medication while we try to clarify these issues.

I know you may be asking, “Aren’t there other options?” There are, but they are usually inferior. Oral phenylephrine (Sudafed PE and the oral decongestant in every combination medication over-the-counter) is extensively metabolized in your gut and many studies show it no better than placebo. On the other hand, intranasal decongestants such as phenylephrine (Neo-Synephrine) or oxymetolazone (Afrin or Dristan), can be very effective for nasal congestion. Unfortunately, you can’t use them more than 3 days in a row without risking rebound congestion or “rhinitis medicamentosa.” Also, some patients have an aversion to shoving and squirting something up their nose.

Everything else you can think of either doesn’t help, or doesn’t help immediately. Antihistamines such as diphenhydramine (Benadryl), loratadine (Claritin), or cetirizine (Zyrtec) may help a little with runny noses, itchy and watery eyes, and sneezing; but they don’t deal with nasal congestion. Nasal steroids such as fluticasone (Flonase) and triamcinolone (Nasacort) usually do everything the antihistamines do, but better; and they can help with some congestion. Unfortunately, they don’t usually offer immediate relief and take up to a week for full congestion relief *if* the congestion is due to some allergy or allergic component to your condition.

The last Oregon legislature proudly passed legislation to make birth control more readily available by allowing pharmacists with additional training to follow a protocol and dispense birth control without a prescription from a doctor, nurse practitioner, or physician’s assistant. When you compare that bill to HB 2128, HB 2128 should be a much easier sell. All the reasons for making birth control more readily available to the public are more relevant for pseudoephedrine (birth control takes over a week to fully kick in, pseudoephedrine starts working within an hour; both have risks, but they are safe for most of the population if taken as directed); hence the reason why it is behind-the-counter in most of the country. This bill will help more Oregonians and visitors to the state since the former only helps ladies who want birth control who aren’t excluded from a protocol due to one of many criteria; HB 2128 helps all women *and* men who know they have congestion and have valid identification. Also, this bill would be much easier to implement since 48 other states are doing it for over a decade and we know it will work.

Please, take this opportunity to help save Oregonians time and money. Please take this opportunity to help lessen the work load on our doctors, nurse practitioners, and physical assistants. Please pass HB 2128 and repeal the ineffective scheduling law.

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