HB 2642 Testimony

Context
The Oregon Prescription Drug Monitoring Program (PDMP) has evolved into a powerful tool checked by the vast majority of prescribers in Oregon on a daily basis. Barriers to checking it have been reduced by both support staff having been delegated rights and being integrated into most electronic health record (EHR) systems.

Current Rules and Best Practices
It is already in Oregon law that for *each and every time* a prescriber writes for a schedule II controlled substance, they must check the PDMP or clearly indicate why it was not possible.[i] This also exempts patients receiving these medications in hospice, palliative, active oncologic, and sickle cell disease care, in addition to those in long term care. One suspects CMS did not want to create an undue burden on clinicians who serve those truly vulnerable populations.

The 2022 CDC guidelines are also clear on when a provider should check the PDMP when prescribing opioids (in this case, the vast majority are schedule II): [ii]

> When **initiating opioid therapy** for acute, subacute, or chronic pain.
>
> Every 3 months or more frequently when **continuing opioid therapy**.
>
> Ideally, PDMP data should be reviewed before every opioid prescription for acute, subacute, or chronic pain.

Issues with HB2642

The safety of all Oregonians drives us to craft health-related legislation that both protects our citizens and ensures the proposed measures are unique, supported by evidence, and do not create an undue burden on the health care delivery system. Our concern is that HB 2642 does none of that.

HB 2642 requires a PDMP check *every* single time a provider refills a medication that is reportable to the PDMP, which is way beyond just schedule II medications. It is already best practice that any time a clinician initiates a class 3-4 controlled substance, they should check the PDMP and also do so at least yearly. The Oregon medical and nursing boards often will discipline providers who fail to do this. In addition, it is already a law that class 2 medications require a PDMP inquiry at every prescription occurrence.

We place requirements of providers to ensure they practice safe medicine. Yet we also do not want to dissuade providers to prescribing lifesaving medications such as buprenorphine (schedule III). If HB 2642 were enacted, the burden of checking the PDMP *every single time* a clinician prescribes buprenorphine for a patient who is at a high risk of return to their opioid use disorder could discourage providers from offering these medications. In addition, buprenorphine has a much stronger safety profile than other opioids and has a significantly lower abuse potential than schedule II medications.

On a similar note, HB 2642 includes medications in class V, which includes Lyrica (a non-opioid used for many conditions, including diabetic neuropathy), cough syrups which contain codeine, and the anti-diarrheal drug Lomotil (also a non-opioid).

One could imagine a provider on call who is out with their family at dinner, who wants to call in an effective cough syrup for a patient who has called after hours. How would they check the PDMP in that case? (besides the fact that a single dose of codeine cough syrup contains less than 1 equivalent mg dose of morphine.) The same goes for a patient with debilitating diarrhea who has run out over the weekend. How are we keeping patients safe in these scenarios?

Finally, gabapentin is also a medication that is reportable to the PDMP. This is not even a scheduled DEA medication. Yes, there is occasional abuse of this medication by people, often with profound polysubstance use disorder histories. However, this medication serves as a lifeline for those who suffer from debilitating diabetic neuropathy, shingles nerve pain, radicular low back pain, cravings for alcohol use, and anxiety. Adding a PDMP requirement for every prescription of gabapentin will overburden providers and possibly dissuade them from prescribing this versatile medication. It will also potentially delay the refilling of such a crucial pharmaceutical.

Conclusion

It is very unclear who HB 2642 seeks to protect. It is clearly not patients suffering from opioid use disorder, complications from diabetes or shingles, or those trying to reduce their alcohol use. As mentioned previously, for medications with high abuse potential, laws are already in place requiring providers to use the PDMP.

If this bill were to be enacted, the only part which *could serve as a protection* to Oregonians, would be to require a PDMP check *initially* when starting a patient on a schedule 3 or 4 medication, and at *least* annually after that. This would also help the medical and nursing boards in creating standards and expectations for providers. It would likely also help create clear, strong rules for clinicians to follow that do **not** create an undue burden on their practice.

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[i] https://www.oregon.gov/oha/HSD/OHP/Policies/141-3855-100121.pdf
[ii] https://www.cdc.gov/opioids/healthcare-professionals/pdmps.html