

Hello, my name is Ann Marie Harootunian, I am Nurse Practitioner and I have been a nurse for 51 years, working in Pain Management for 25 years. I am also co-chair of the Massachusetts Pain Initiative and am currently working in a Pain Clinic and have been there for 20 years since its inception. I care for people from all walks of life, professional and non-professional, who experience pain on a daily basis. These people contribute to society usually following a multimodal approach to effective pain management which often includes opioid medication.

First I would like to thank you all for your time and expertise devoted to the Drug Formulary Commission and for considering our input before making final decisions.

You are charged with the very challenging issue of which medications can or should be used when dealing with opioid medication. Opioids are dangerous for those with the disease of addiction, I know that, BUT they are life improving for those in our population who live with painful conditions on a daily basis.

I know there is a heightened PH risk with opioid medications that are not abuse deterrent and subsequently all of the movement toward public safety is correctly underway. I also know there are many different pathways to decrease this PH crisis not limited to but including public and professional education, addiction treatment, and decreasing the availability of opioids in circulation.

It does make sense to substitute abuse deterrent opioid for those that are not as long as the medications to be substituted are the same formulation as those ordered.

There are a few issues I would like to point out when considering accessibility to opioid medications.

1. Not all people respond effectively to the same medication in the same way. There needs to be individualized plans of care for each patient. If a healthcare provider who knows the patient, prescribes a specific pain

medication, they know which formulation is best for this patient. If a new formulation is given to a patient, the pharmacogenetics may interfere with the way it is absorbed and may or may not be effective for managing their pain. The substitute abuse deterrent medication will need to be the same formulation as the opioid the patient is already receiving as I said previously.

2. The substitute medication needs to be communicated to the healthcare provider. Is this substitution going to allow the pharmacist to prescribe? Will this be akin to going from a brand name to a generic medication?
3. Marybeth Singer, CNS, who works with cancer patients at Tufts medical center describes an accessibility issue with one of her patients with advanced cancer pain. The scrutiny with filling and obtaining her prescription monthly is interfering with her patient's ability to get her opioid medications refilled as needed. Cancer pain has become a chronic illness in some instances and she is sometimes not able to get all of the medications she needs because of the prior authorization form (PAF) that need to be filled out. The accessibility issue is not only with cancer patient but insurance companies are sometimes a worst barrier to accessibility for all pain patients. The forms needed to get the medications can be cumbersome and take longer to process than the patient has a supply of medications available. There can be an interruption in effective pain management due to inconsistency in approval of PAFs. If we could get consistency in PAFs it would make access easier and we can give our patients the care they deserve.
4. A few other concerns are: Healthcare providers may object to having their prescriptions changed once they have been ordered and submitted.

Patients may become confused if they receive something other than what their provider described to them.

It is also important to remember that low dose opioids are very effective for some patients in order to allow them to live as productive members of society. I have seen a difference in my patients with taking a low dose of opioids between not being able to function to being able to partake in their ADLs as well as to be able work. With these patients, AD opioids will be a blessing.

Marybeth Singer also mentioned that part of accessibility includes patient education and the need for better access to consumer education including translated materials.

To reiterate my comments, barriers to accessibility include but are not limited to: HC providers' objections, patient education, insurance companies intrusion into prescribing practices, pharmacists' communication with providers and ensuring the formulations substituted are the same formulations the patient is already receiving.

In closing, we look forward to further development of abuse deterrent medications and the impact of these medications on our society. I do understand that the Formulary will be used as guidelines and we do hope that healthcare providers will continue to be allowed provide the best pain medication regimen possible for our patients.

Thank you.