American Society of Anesthesiologists

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April 26, 2016

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives
2125 Rayburn House Office Building
Washington, DC 20510

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
House of Representatives
2125 Rayburn House Office Building
Washington, DC 20510

Dear Chairman Upton and Ranking Member Pallone:

The American Society of Anesthesiologists (ASA), on behalf of more than 53,000 members, applauds the dedication and leadership that you and the Committee have demonstrated by working in a bipartisan fashion to identify solutions to the prescription opioid epidemic. As the medical specialty representing the largest number of practicing pain medicine physicians, we are eager to work with Congress on legislation to reduce opioid overdose fatalities and improve public health. ASA believes that expanding access to naloxone, allowing patients to partially fill prescriptions for opioids, and promoting access to and insurance coverage for multimodal pain therapies are three important components of a comprehensive strategy to achieve these goals.

In particular, ASA supports H.R. 4586, Lali's Law and H.R. 3680, the Co-Prescribing to Reduce Overdoses Act of 2015, which would expand access to naloxone and encourage co-prescribing naloxone with opioid therapy. ASA supports making naloxone more accessible to laypersons who might witness an opioid overdose, including first responders and family members and caregivers of high-risk individuals, in order to reduce the incidence of opioid overdose fatalities.[1] ASA also encourages physicians to consider co-prescribing naloxone with an opioid for patients at high risk of overdose, which includes individuals who have an underlying respiratory condition such as sleep apnea, have a history of a non-opioid substance use disorder or a mental health disorder, or are currently prescribed a benzodiazepine or other sedative/hypnotic. Prior to receiving access to naloxone, it is integral that laypersons who might witness an opioid overdose be trained on how to recognize an opioid overdose, and on effective resuscitation and post-resuscitation care, which includes administering naloxone and calling emergency services.

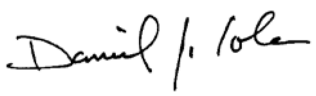
[1] ASA Committee on Pain Medicine Statement on Naloxone, available at http://www.asahq.org/about-asa/newsroom/news-releases/2016/03/american-society-of-anesthesiologists-announces-a-committee-to-address-opioid-abuse

ASA also supports H.R. 4599, the Reducing Unused Medications Act of 2016, which would allow a physician or patient to request a schedule II opioid to be partially filled by a pharmacist. Permitting partially filled opioid prescriptions is one approach to decrease the amount of unused medications in the home while still allowing patients to fill the remaining prescription if necessary. When a medication is partially filled, this information should be integrated into the prescription drug monitoring program to maintain consistency and reliability and the pharmacy should inform the prescribing physician.

Finally, any comprehensive solution to the prescription opioid epidemic needs to include policies that support access to and insurance coverage of non-opioid treatments. Research has demonstrated that multimodal interventions, meaning more than one therapy, should be part of the treatment strategy for patients with chronic pain. This may include interventional pain therapies, which are a key non-opioid therapy for the treatment of chronic pain and have been shown to reduce and eliminate pain, improve function, decrease reliance on opioids, and eliminate the need for surgery for patients. However, non-opioid therapies are often not covered by insurance, which inhibits physicians' ability to treat patients using these approaches. The federal government should encourage insurance coverage of therapies that would prevent opioid dose escalation or promote reduction, and reimbursement policies should reflect the complexity of treating patients with chronic pain and the importance of utilizing a broad range of medical services to minimize the use of opioid therapy. Insurance coverage should include non-opioid therapies (all modalities available), and payers should reduce patient co-insurance and co-pays to encourage the use of these therapies.

Thank you for your leadership on this pressing public health issue, and we hope that ASA can be a resource to the Committee as it moves forward with legislative solutions.

Sincerely,



Daniel Cole, M.D.
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