

December 28, 2017

Scott Gottlieb, M.D.  
Commissioner  
U.S. Food and Drug Administration  
10903 New Hampshire Avenue  
Silver Spring, MD 20993

**Re: FDA-2017-N-5608**

Dear Commissioner Gottlieb:

The Patient Quality of Life Coalition (PQLC) welcomes the opportunity to offer comments regarding questions relevant to the Food and Drug Administration's (FDA's) new Opioid Policy Steering Committee. The PQLC was established to advance the interests of patients and families facing serious illness. The coalition includes over 40 organizations dedicated to improving quality of care and quality of life for all patients from pediatrics to geriatrics, as well as supporting public policies that improve and expand access to palliative care and appropriate pain management. PQLC members represent patients, health professionals, and health care systems.

Pain management is an integral part of palliative care for many patients with serious illness.<sup>1</sup> These patients commonly experience pain due to the underlying illness(es) and sometimes the treatment itself, yet pain and other symptoms tend to be under-recognized and under-treated as part of regular care.<sup>2</sup> Poorly managed pain in this population can contribute to intense suffering, decreased productivity, poorer quality of life, increased health care utilization, and even increased mortality.<sup>3</sup> Palliative care helps prevent and relieve pain by systematically screening and assessing for pain and other symptoms, tailoring pharmacological interventions to patients' individual circumstances (including medical history and stated goals of care), and carefully monitoring and adjusting treatment regimens as needed over the course of the illness.<sup>4</sup> By doing so, palliative care helps maximize patient function and quality of life.

One landmark study conducted in 2011 showed that a majority of consumers identified making patients comfortable and alleviating stress and physical pain as the most important aspect of

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<sup>1</sup> "Serious illness" is defined as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life, or excessively strains their caregivers. See Kelley AS, Bollen-Lunds E. Identifying the population with serious illness: The "denominator" challenge. *J Palliat Med*. 2017 Nov 10. doi: 10.1089/jpm.2017.0548.

<sup>2</sup> Wilkie DJ, and Ezenwa MO. Pain and symptom management in palliative care and at end of life. *Nurs Outlook*. 2012; 60(6):357-364. doi: 10.1016/j.outlook.2012.08.002. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3505611/pdf/nihms408159.pdf>

<sup>3</sup> "Management of pain in older adults." *Geriatric Palliative Care*. Eds. Chai E, Meier DE, Morris J, and Goldhirsch S. New York: Oxford University Press, 2014. 159-169. Print.

<sup>4</sup> Morrison LJ, and Morrison RS. Palliative care and pain management. *Med Clin N Am*. 2006; 90(5):983-1004. doi: 10.1016/j.mcna.2006.05.016. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/16962853>

palliative care.<sup>5</sup> For example, dyspnea occurs in over 50 percent of patients with underlying serious illness (e.g., COPD, heart failure, or chronic lung disease) and is correlated with lower quality of life and with physical, emotional, and cognitive changes including anorexia, fatigue, poor concentration, depression, and memory loss.<sup>6</sup> Opioids are widely accepted as the first line treatment of dyspnea after other disease-targeting or modifying therapies are optimized.<sup>7,8</sup>

PQLC is mindful of the serious and growing public health crisis caused by the *inappropriate* use of opioid analgesics, and support evidence-based efforts to reduce harms and adverse events associated with such misuse. At the same time, we want to make sure that public policies intended to reduce inappropriate use of opioids do not simultaneously create access barriers to pain management for patients for whom opioids are medically indicated and who are benefiting from such treatment.

We offer the following comments regarding the specific topics/questions posed in the public docket:

### **I. Assessing Benefit and Risk in the Opioids Setting**

FDA asks for comments on its approach to assessing benefits and risks when making regulatory decisions regarding opioids. It asks for comments specifically in relation to the approach that incorporates extensive review of the risks related to misuse and abuse detailed in the July 6, 2017 article in the *Journal of the American Medical Association (JAMA)*.<sup>9</sup> The agency also states it is reviewing the recommendations in the report it commissioned from the National Academy of Sciences, Engineering, and Medicine: *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use, Consensus Study Report*,<sup>10</sup> and asks for comments regarding this report and its recommendations.

FDA specifically asks the following questions:

1. *How should FDA tailor, or otherwise amend, its assessment of benefit and risk in the context of opioid drugs to ensure that the Agency is giving adequate consideration to the*

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<sup>5</sup> Public Opinion Strategies. "2011 Public Opinion Research on Palliative Care." Available at <http://patientqualityoflife.org/wp-content/uploads/2014/03/1.2-Palliative-Care-Consumer-Research-Findings-Summary.pdf>

<sup>6</sup> Kamal AH, Maguire JM, Wheeler JL, et al. Dyspnea review for palliative care professional: assessment, burdens, and etiology. *J Palliat Med*. 2011 Oct;14(10):1167-1172

<sup>7</sup> Mahler DA, Selecky PA, Harrod CG, et al. American College of Chest Physicians consensus statement on the management of dyspnea patients with advanced lung or heart disease. *Chest*. 2010;137(3):674-691

<sup>8</sup> Mahler DA. Opioids for refractory dyspnea. *Expert Rev Respir Med*. 2013 Apr;7(2):123-34; quiz 135.

<sup>9</sup> Gottlieb S and Woodcock J. Marshaling FDA benefit-risk expertise to address the current opioid abuse epidemic. *JAMA*. 2017;318(5):421-422. Doi:10.1001/jama.2017.9205. Available at <http://jamanetwork.com/journals/jama/fullarticle/2643333>.

<sup>10</sup> National Academies of Sciences, Engineering, and Medicine. *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use, Consensus Study Report*. Eds. Bonnie RJ, Ford MA, and Phillips JK. 2017. Available at <https://www.nap.edu/catalog/24781/pain-management-and-the-opioid-epidemic-balancing-societal-and-individual>.

*risks associated with the labeled indication of these drugs and the risks associated with the potential abuse and misuse of these products?*

**PQLC comments:** We note that this question is written to focus on the risks, but many patients receiving palliative care are found on the “benefits” side of this benefit-risk scenario. PQLC urges FDA to focus on the benefits – in addition to the risks – of opioids when making regulatory decisions. As the 2017 *JAMA* article notes in its first paragraph, “opioids...have significant benefits when used as prescribed, yet cause enormous harm when misused and abused.”<sup>11</sup> We strongly urge FDA and other policymakers to consider the impacts of any new rules, regulations, guidelines, or requirements on patients in need of pain management – particularly those receiving it as part of palliative care. Additionally, while FDA is focused on the risks of misuse and abuse of opioids, the agency must also acknowledge the risks of policies that might intentionally or unintentionally decrease legitimate patient access to opioids.

Lastly, it is important to note that palliative care should not be considered the same as end-of-life care. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment to help patients get well faster. Some patients receiving, or in need of, palliative care are at the end of their lives, but many are not. The benefit-risk calculation for a patient who is expected to live many years is different from the calculation for a patient who is only expected to live months.

- 2. Are there specific public health considerations other than misuse and abuse that FDA should incorporate into its current framework for benefit and risk assessment as a way to reduce the opioid addiction epidemic? That framework includes, but is not limited to, how FDA makes regulatory decisions to approve new opioids, evaluates their use in the postmarket setting, or limits or influences their prescribing through product labeling or other risk management measures.*

**PQLC comments:** FDA must consider the impacts on patients who are seriously ill and/or receiving palliative care in any measures it takes to prevent misuse and abuse of opioids. Again, we urge FDA to not ignore potential benefits or impacts on patients as it is considering the risks of misuse and abuse of opioids. To better understand these benefits and risks and impacts on patients, PQLC supports FDA and other entities conducting research to evaluate opioid use in a postmarket setting. We encourage FDA to focus postmarket evaluations on questions including:

- What particular populations are at risk for misusing or abusing opioids, particularly in the context of patients who are being treated for pain and receiving palliative care? What are evidence-based risk factors?
- To what extent are risk factors evident in patients who are legitimately being treated with opioids, as opposed to individuals who are misusing an opioid prescription or obtaining the drug through some other means?

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<sup>11</sup> See note 9 for full citation.

We note that a prescription for a high dose of opioids should not be considered an automatic risk factor for misuse and abuse without significant high-quality evidence showing that it is an independent risk factor regardless of individual patient characteristics. Patients receiving palliative care, or those at the end of the life, often do require high doses of these drugs to adequately manage severe pain – and considering high doses an independent risk factor can impact patient access, discouraging patients from asking for help treating their pain or providers from prescribing necessary and effective medication. Other questions to consider in a postmarket evaluation include:

- What are evidence-based risk mitigation strategies, particularly for patients in need of palliative care who have been identified as being at high risk of misuse or abuse?
- How are current guidelines, such as CDC Guideline, impacting patient access to opioids, particularly patients in need of or receiving palliative care?
- How are prescribing limits established by states, payers, and healthcare institutions impacting patient access to opioids, particularly patients in need of or receiving palliative care?

We note that the CDC Guideline specifically excludes patients receiving palliative care, yet many front-line clinicians report that institutions and payers are establishing dose limits for all patients, irrespective of their underlying diagnosis or context or goals.

Such postmarket evaluations must go beyond simply examining whether use of opioids or number of prescriptions has decreased, because those simple data points do not differentiate between appropriate and inappropriate, beneficial and harmful, or legal and illegal use.

## II. Steps to Promote Proper Prescribing and Dispensing

FDA references the 2016 Centers for Disease Control and Prevention (CDC) *Guideline for Prescribing Opioids for Chronic Pain*<sup>12</sup> and a 2017 *JAMA* study,<sup>13</sup> stating that it believes “there are situations in which patients are prescribed an opioid analgesic when a non-opioid pain treatment would be adequate or, when an opioid product is necessary, treatment with a shorter course of therapy would be more appropriate, and without specific requirements, variance in prescribing habits are likely to persist.” FDA does acknowledge that “there are clinical situations that may require a supply of opioid analgesics that exceeds current CDC guidelines and FDA wants to make sure that patients have what they need in those cases.” The agency asks for comments on how it can promote proper prescribing and dispensing.

FDA specifically asks the following questions:

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<sup>12</sup> Dowell D, Haegerich TM, and Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. Item 6 in “Determining when to initiate or continue opioids for chronic pain.” *Morbidity and Mortality Weekly Report Recommendations and Reports* 2016;65(No. RR-1):1-49. doi: <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

<sup>13</sup> Bicket M C, Long JJ, Pronovost PJ, et al. Prescription opioid analgesics commonly unused after surgery, a systematic review. *JAMA Surgery*. August 2, 2017, online doi:10.1001/jamasurg.2017.0831. Available at <http://jamanetwork.com/journals/jamasurgery/fullarticle/2644905>.

1. *Should FDA consider adding a recommended duration of treatment for specific types of patient needs (e.g., for specific types of surgical procedures) to opioid analgesic product labeling? Or, should FDA work with prescriber groups that could, in turn, develop expert guidelines on proper prescribing by indication?*

**PQLC Comments:** By prominently referencing the CDC guideline in its preamble, FDA implies that the “proper prescribing” it wants to promote is prescribing that follows this guideline. PQLC would be very concerned if FDA used the CDC guideline as the basis for package labeling requirements or other similar policies, despite the acknowledgement that “there are clinical situations that may require a supply of opioid analgesics that exceeds current CDC guidelines.”

PQLC expressed our concerns with the CDC guideline in a letter dated January 13, 2016,<sup>14</sup> including the limited opportunity for public input into the guideline development and the resulting recommendations that are not wholly supported by the evidence, or appropriately balanced to accommodate the legitimate needs of all patients who experience severe physical pain due to illness or injury. We also note that the final CDC guideline states it applies to “primary care clinicians who are prescribing opioids for chronic pain *outside of active cancer treatment, palliative care, and end-of-life care.*” (emphasis added)

It is unclear how the scope of the guideline would be applied in such recommended durations on product labels. FDA must carefully consider these questions and all the implications of this proposal:

- Since the guideline does not apply to clinicians delivering palliative care, would FDA include any recommendations for palliative care patients?
- What are the requirements for patients who do not fall into one of the population recommendations on the label?
- Would clinicians be evaluated based on, or penalized for not following, recommendations on opioid package labels that do not pertain to the conditions for which they are treating certain patients?
- If a patient is being treated for a condition that is included in a product label, but also receiving palliative care (for the same or a separate condition/procedure), which recommendation applies?

In the case of serious illness, it is critical that the FDA allow for individualization of treatment that comes down to the patient and their provider. A palliative care provider must have the authority to prescribe opioids based on the patient’s needs as identified through a comprehensive assessment. We are concerned that requiring recommended treatment durations on product labels would narrow the scope of how a specific drug can be used, which can inhibit access depending on a patient’s diagnosis and/or symptoms. PQLC’s mission is to

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<sup>14</sup> Patient Quality of Life Coalition. Letter to Drs. Thomas Frieden and Debra Houry, Centers for Disease Control and Prevention. Re: Draft Guideline for Prescribing Opioids for Chronic Pain, 2016 [CDC-2015-0112-0001]. January 13, 2016.

increase patient access to palliative care, and we believe this proposal would inhibit effective pain management – a critical component of high-quality palliative care.

If FDA does move forward with adding recommended durations to product labeling, we strongly urge FDA to base such requirements on robust scientific evidence. The CDC guideline noted that more research was needed in several areas regarding opioids. PQLC urges FDA to first focus on gathering needed evidence, working with the National Institutes of Health, CDC, and other appropriate agencies. Furthermore, if FDA were to move forward with such requirements, we strongly urge the agency to use a process that is open, transparent, and involves the opportunity for public comment.

PQLC believes the more appropriate option is to “work with prescriber groups that could, in turn, develop expert guidelines on proper prescribing by indication.” PQLC strongly encourages FDA to conduct outreach to stakeholders in this area and harmonize their efforts with other efforts. PQLC and its individual members welcome the opportunity to be engaged in such efforts.

2. *If opioid product labeling contained recommended duration of treatment for certain common types of patient needs, how should this information be used by FDA, other state and Federal health agencies, providers, and other intermediaries, such as health plans and pharmacy benefit managers, as the basis for making sure that opioid drug dispensing more appropriately and consistently aligns with the type of patient need for which a prescription is being written?*

**PQLC comments:** FDA must seriously consider the impact of requiring recommended treatment duration information on opioid package labeling. It is likely that this information would have serious influence on all the stakeholders referenced in the question. PQLC is concerned that requiring recommended durations on package labeling would impede the individualization of treatment, and affect treatment decisions that are best left between a patient and his or her clinician. We urge FDA to proceed with caution and if it chooses to move forward, to do so in an open, transparent, and evidence-based process. We also urge FDA to conduct extensive consumer testing before such requirements are launched, if applicable, as well as monitor the impact of such requirements post-launch for impacts on palliative care delivered to patients.

It should be noted that a number of states have instituted these treatment durations as statutes or regulations over the past 18 months. In many, if not most cases, the specific language of the policies provides flexibility for prescribers, by indicating that, for instance, a prescriber is limited to prescribing a seven-day supply of opioids when treating acute pain, unless the prescriber believes the patient needs a longer duration of treatment, in which case that prescriber can document the reason for the longer duration and write the prescription

accordingly.<sup>15</sup> It is crucial for FDA to enact policies that would preserve this flexibility, which is necessary for clinicians to individualize treatment for their patients.

### III. Requirements for Prescriber Education

In light of recent discussions and new rules being implemented or discussed in certain states, FDA asks for comments on mandating education or training for healthcare professionals who prescribe opioids. FDA specifically refers to a new law in New York state that requires health care professionals who prescribe controlled substances as of July 1, 2017 to register their completion of at least three hours of course work or training in pain management, palliative care, and addiction.<sup>16</sup>

FDA specifically asks the following questions:

1. *Are there circumstances under which FDA should require some form of mandatory education for health care professionals to ensure that prescribing professionals are informed about appropriate prescribing and pain management recommendations, understand how to identify the risk of abuse in individual patients, know how to get patients with a substance use disorder into treatment, and know how to prescribe treatment for—and properly manage—patients with substance use disorders, among other educational goals? Are there other steps FDA could take to educate health care professionals to ensure that prescribing professionals are informed about appropriate prescribing and pain management recommendations?*

**PQLC comments:** Provider education is an important way to address the opioid overdose epidemic. Educational opportunities or requirements for opioid prescribers are also an opportunity to educate more providers in palliative care. Many front line clinicians receive almost no training in pain/symptom management in their medical education. Therefore, in many instances, continuing education in these areas would not be a supplement, it would be an introduction to the subject. PQLC strongly supports expanding provider education on palliative care – along with building public awareness and increasing research – which is exemplified in our support of the Palliative Care & Hospice Education and Training Act.<sup>17</sup>

Provider education on pain management should include:

- Conducting a comprehensive pain assessment
- Matching the drug class to the pain
- Assessing risk for opioid substance use disorder
- Monitoring for opioid efficacy, side effects, and substance use disorder

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<sup>15</sup> See National Conference of State Legislatures. “Prescribing policies: States confront the opioid epidemic.” September 8, 2017. Available at <http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx>

<sup>16</sup> New York State Department of Health, Mandatory Prescriber Education. Available at [https://www.health.ny.gov/professionals/narcotic/mandatory\\_prescriber\\_education/](https://www.health.ny.gov/professionals/narcotic/mandatory_prescriber_education/).

<sup>17</sup> See <http://patientqualityoflife.org/wp-content/uploads/2017/04/PQLC-PCHETA-Bill-Summary-115th-Congress-03.28.2017.pdf>

- Converting from short-acting to long-acting opioids
- Prescribing practice and opioid conversions
- Managing pain in patients at risk for substance use disorder
- Nonpharmacological approaches to pain management
- Managing polypharmacy in seriously ill patients
- Differences in pain management for acute, chronic, and terminal pain

Many members of the PQLC have created or contributed to existing educational materials and trainings regarding pain management. These materials include:

- American Academy of Hospice and Palliative Medicine’s “Opioid Prescribing: Safe Practice, Changing Lives” REMS-compliant webinar<sup>18</sup> and *Essential Practices in Hospice and Palliative Medicine* Vol. 3: Pain Assessment and Management<sup>19</sup>
- Center to Advance Palliative Care’s Pain Management Curriculum<sup>20</sup>
- CSU Institute for Palliative Care Advanced Practice Nurse Certificate in Palliative Care course and other self-paced modules<sup>21</sup>
- End-of-Life Nursing Education Consortium’s Relias Library of ELNEC Courses<sup>22</sup>
- Hospice & Palliative Care Nurses Association’s Advancing Expert Care Shop<sup>23</sup>
- National Coalition of Hospice and Palliative Care’s National Consensus Project Clinical Practice Guidelines for Quality Palliative Care<sup>24</sup>

We encourage FDA to consider the materials, trainings, and requirements already created before creating its own materials or requirements, if applicable.

If FDA does not implement requirements for mandatory education, it should consider working with other agencies to use already existing tools to incentivize providers to complete training in palliative care and pain management, including value-based purchasing models and star ratings programs.

2. *How might FDA operationalize such a requirement if it were to pursue this policy goal? For example, should mandatory education apply to all prescribing health care professionals, or only a subset of prescribing health care professionals? If only a subset, how would FDA construct a framework that focuses mandatory education on only that subset—for example, by requiring mandatory education only for those writing prescriptions for longer durations as opposed to those for very short-term use?*

**PQLC comments:** If FDA creates provider education requirements, it is crucial that such requirements do not negatively impact patient access to palliative care. FDA and other

<sup>18</sup> See <http://aahpm.org/self-study/remc>

<sup>19</sup> See <http://aahpm.org/self-study/essentials>

<sup>20</sup> See <https://www.capc.org/providers/courses/pain-management-17/>

<sup>21</sup> See <https://csupalliativecare.org/wp-content/uploads/Institute-upgraded-catalog-V7-02.14.2017.pdf>

<sup>22</sup> See <https://www.relias.com/elnec>

<sup>23</sup> See [https://www.hpna.org/HPNA\\_Shop.aspx](https://www.hpna.org/HPNA_Shop.aspx)

<sup>24</sup> See <https://www.nationalcoalitionhpc.org/ncp-guidelines-2013/>

stakeholders must closely monitor any requirements to determine how they are impacting treatment access. We are concerned that many surveillance efforts regarding the opioid overdose epidemic seem to focus solely on the efforts' impact on overall prescribing or opioid utilization – not making any distinctions between reductions in access to opioids for patients who truly need them versus patients or users who are not appropriate recipients. FDA and other stakeholders must develop and use more sophisticated evaluative instruments to truly see the impact of education requirements and any other policies that could impact patient access.

#### **IV. Additional Matters for Consideration**

FDA invites interested parties to submit additional policy considerations or recommendations for actions that FDA could or should undertake to help the Agency better address the opioid addiction crisis.

**PQLC comments:** PQLC believes there are other policy changes the Opioid Policy Steering Committee should seriously consider to reduce misuse and abuse of opioids without denying access to patients receiving palliative care who need pain treatment. PQLC encourages the committee to consider the following topics:

- Expanding drug take-back programs and locations that allow patients to safely dispose of unused or expired medications. FDA could explore changes to package labeling that provide patients with information about how to safely dispose of medications, and the particular importance of doing so with certain types of medications, including opioids.
- Requiring childproof packaging.
- Requiring drug manufacturers to make opioids available in blister packs for prescriptions of short duration.

#### **Conclusion**

Thank you for the opportunity to submit comments to the FDA Opioid Policy Steering Committee. The Patient Quality of Life Coalition stands ready to work with you and other stakeholders to address the opioid crisis while also ensuring that patients with serious illness maintain access to the treatments they need. If you have any questions, please feel free to contact Keysha Brooks-Coley at [Keysha.Brooks-Coley@cancer.org](mailto:Keysha.Brooks-Coley@cancer.org) or 202-661-5720.

Sincerely,

Academy of Integrative Pain Management

American Academy of Hospice and Palliative Medicine

American Cancer Society Cancer Action Network

American Society for Clinical Oncology

Association of Oncology Social Work

Association of Pediatric Hematology/Oncology Nurses  
Cancer Support Community  
Catholic Health Association of the United States  
Center to Advance Palliative Care  
Coalition for Compassionate Care of California  
Hospice and Palliative Nurses Association  
Lung Cancer Alliance  
National Coalition for Hospice and Palliative Care  
National Comprehensive Cancer Network  
National Patient Advocate Foundation  
National Palliative Care Research Center  
Oncology Nursing Society  
Pediatric Palliative Care Coalition  
Physician Assistants in Hospice and Palliative Medicine  
ResolutionCare Network  
St. Baldrick's Foundation  
Supportive Care Coalition