



American Cancer Society  
Cancer Action Network  
555 11<sup>th</sup> Street, NW  
Suite 300  
Washington, DC 20004  
202.661.5700  
[www.fightcancer.org](http://www.fightcancer.org)

May 28, 2019

Lowell J. Schiller JD  
Principal Associate Commissioner for Policy  
U.S. Food & Drug Administration  
10903 New Hampshire Avenue  
Silver Spring, MD 20993

**Re: FDA-2019-N-1646 – Joint Meeting of the Drug Safety and Risk Management Advisory Committee and the Anesthetic and Analgesic Drug Products Advisory Committee; Notice of meeting; Establishment of a Public Docket; Request for Comments**  
84 Fed. Reg. 82 (April 29, 2019)

Dear Mr. Schiller:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to respond to the request for comments concerning the clinical utility and safety concerns associated with the higher range of opioid dosing in the outpatient setting. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden.

Pain is one of the most feared symptoms for cancer patients and survivors - nearly 60 percent of patients in active treatment and 30 percent of patients who have completed treatment experience pain.<sup>1</sup> Pain can be caused by the cancer itself, for instance when tumors interfere with normal body function. Pain can also be caused by cancer treatments. Research has concluded that about one-quarter of women who have had breast cancer surgery have significant and persistent breast pain six months after the procedure.<sup>2</sup>

Despite the fact that millions of cancer patients and survivors experience chronic pain, it remains a highly stigmatized issue. But given proper attention most pain can be treated and relieved. Integrative pain care that includes non-drug therapies along with medications can be effective in keeping patient pain under control. While not the only tool, opioid medications are recognized as a mainstay of treatment for moderate to severe cancer pain and can be a beneficial treatment for managing serious, persistent pain for patients in active cancer treatment as well as cancer survivors. If not treated, chronic pain can have long-term negative effects, including prolonged recovery and a weakened immune

---

<sup>1</sup> Institute of Medicine. (2011). *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*. National Academy of Sciences.

<sup>2</sup> Miaskowski C, Cooper B, Paul SM, et al. (2012). Identification of Patient Subgroups and Risk Factors for Persistent Breast Pain Following Breast Cancer Surgery. *J Pain*; 13(12) pp 1172-1187.

system. It can also affect a patient's quality of life; their ability to eat, sleep, work and carry on every aspect of their daily life.

Many cancer patients, as well as other patients with serious illness, receive pain treatment as part of palliative care services.<sup>3</sup> Palliative care – which is essential throughout the course of cancer treatment – helps prevent and relieve pain by systematically screening and assessing for pain and other symptoms, tailoring pharmacological and other 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>

As a nation, we must take steps to identify balanced solutions that address the opioid epidemic, while also not causing harm to patient access to opioid medications for cancer patients, cancer survivors, and others with serious illness.

Following are our answers to the specific discussion questions/statements posed in the public notice:

**(1) The current clinical use and situations that may warrant pain management with opioid analgesics at higher products strengths and daily doses, factors influencing prescribing practices, and specific patient populations for whom there may be utility in prescribing these medications at higher doses**

ACS CAN urges the Committees to recognize that there are patients who must continue to have access to higher doses of opioid medications; despite any restrictions on opioid prescribing, coverage or dispensing that might exist. In 2018, ACS CAN engaged in a collaborative, consensus-building process with the Patient Quality of Life Coalition to create recommendations regarding exempting certain patients from limits on opioids. The recommendations concern the scope of such exemptions, identification of exempt patients, and how to operationalize the exemptions within various healthcare systems. The consensus document concluded that "in general, exemptions to opioid restrictions should:

- Include cancer patients in active treatment and cancer survivors who continue to receive treatment for pain because of the effects of cancer treatment or the cancer;
- Include patients receiving hospice care;
- Include other non-cancer patients experiencing pain or other symptoms related to a serious illness who are receiving, or would be eligible for, palliative care services."<sup>5</sup>

The entire consensus document is attached to this letter as Appendix A.

---

<sup>3</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>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>

<sup>5</sup> Patient Quality of Life Coalition. Letter to Centers for Medicare and Medicaid Services. June 6, 2018. [http://patientqualityoflife.org/wp-content/uploads/2018/06/PQLC-Memo-Exemption-Language-for-Opioid-Restrictions-05312018\\_FINAL-sent-to-HHS-1.pdf](http://patientqualityoflife.org/wp-content/uploads/2018/06/PQLC-Memo-Exemption-Language-for-Opioid-Restrictions-05312018_FINAL-sent-to-HHS-1.pdf)

Exempting such patients from opioid limits conforms with recent communications<sup>6</sup> from the Centers for Disease Control and Prevention (CDC) regarding the application of its 2016 Guideline for Prescribing Opioids for Chronic Pain.<sup>7</sup> Specifically, CDC stated in a public letter that “because of the unique therapeutic goals, and balance of risks and benefits with opioid therapy in such care, clinical practice guidelines specific to cancer treatment, palliative care and end of life care should be used to guide treatment and reimbursement decisions regarding use of opioids as part of pain control in these circumstances.”<sup>8</sup>

We urge FDA to review these consensus documents and CDC communications when considering populations for whom there may be utility in prescribing opioids at higher doses. ACS CAN has consistently urged policymakers and implementers to ensure that cancer patients, cancer survivors with ongoing cancer-related pain, and other seriously ill patients continue to have access to the pain treatments – including opioids at higher dosages – that are clinically appropriate for them.

***(3) Possible FDA interventions and their expected impact on patients and public health more broadly, including, for example, potential effects on prescribing and pain management practices, patient experience and behaviors, and adverse outcomes such as addiction and overdose***

ACS CAN appreciates the Committees’ seeking public input on possible FDA interventions regarding opioids. ACS CAN supports FDA taking an active role in ensuring that patients and providers have many treatment options when treating pain, that the treatments prescribed are safe and effective, and that opioids are properly handled in a manner that is safe and protects patients and their families.

ACS CAN recommends the Committees consider the following policies, and would welcome the opportunity to work with FDA on these options:

- ***Focus on bringing new pain treatments to market:*** We welcome FDA’s efforts to encourage the development and approval of new pain treatments that are less addictive, and/or that are opioid alternatives – including pharmacological and non-pharmacological treatments. We strongly support initiatives that will give providers and patients more and better options to treat pain. In addition to bringing new pain treatments to the market, it is also critical that these treatments are incorporated into insurance coverage, so patients can access them. We strongly encourage FDA to continue working with other agencies – particularly the Centers for Medicare

---

<sup>6</sup> Dowell D, Haegerich T, Chou R. No Shortcuts to Safer Opioid Prescribing. Perspective. New England Journal of Medicine. April 24, 2019. DOI: 10.1056/NEJMp1904190

<sup>7</sup> U.S. Centers for Disease Control and Prevention. Guideline for Prescribing Opioids for Chronic Pain. 2016. [http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm](http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm)

<sup>8</sup> Dowell D. U.S. Centers for Disease Control and Prevention. February 28, 2019 correspondence. <https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2019-CDC-Opioid-Guideline-Clarification-Letter-to-ASCO-ASH-NCCN.pdf>

and Medicare Services (CMS) – to ensure that new pain treatments are available and affordable to patients.

- **Continue to address the safe disposal of unused opioids:** Many communities have drug take-back or safe disposal programs, but these programs are not consistent across the country. A provision in last year’s SUPPORT for Patients and Communities Act gave FDA the authority to require opioid manufacturers to include a safe disposal method as part of drug packaging.<sup>9</sup> We encourage FDA to continue to explore the technology and regulations that would make such a policy possible. We also welcome other proposals to address safe disposal, including changes to package labeling that provide patients with information about the importance of and methods to safely dispose of medication.
- **Require opioid packaging that allows for a defined treatment duration:** Some patients, especially who are being treated for acute pain, only need a few days’ worth of medication. Having opioids available in duration-specific packaging, like a ‘blister pack,’ will make it easier for prescribers to use these shorter treatment durations, and potentially lead to fewer unused pills available for possible diversion or necessitating safe disposal.
- **Continue to use the Risk Evaluation Management System (REMS) to require prescriber training and address the risks of opioids:** ACS CAN supports FDA’s already-existing process to address the risks of medications. When considering new policies, particularly regarding prescriber training requirements, we encourage FDA to consider what might already be covered in REMS, or what could be modified within that existing structure. ACS CAN supports prescribers receiving education on safe opioid prescribing and on quality pain treatment and palliative care – but if training requirements become duplicative and too burdensome, patient access to such providers could become limited.
- **Engage in careful post-market research:** There are still many unanswered questions about opioids and pain treatment in general. ACS CAN supports FDA conducting post-market research on the pain treatments the agency has approved, with the aim of improving pain treatment for patients. Post-market analysis must include the impacts on patients who do or could benefit from proper treatment with opioids – as opposed to just focusing on the potential for misuse or abuse. We encourage such research to focus on questions such as:
  - What particular populations are at risk for misusing or abusing opioids, particularly in the context of patients who are being treated for pain?
  - 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?
  - What are evidence-based risk mitigation strategies?
  - How are current guidelines, like the Centers for Disease Control and Prevention (CDC) Guideline, impacting patient access to opioids? Such an analysis 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, or legal and illegal use.
  - How are prescribing limits impacting patient access to opioids? Such an analysis must go beyond simply examining whether use of opioids or number of prescriptions has

---

<sup>9</sup> [21 U.S.C. 355–1\(e\)\(4\)](#)

decreased, because those simple data points do not differentiate between appropriate and inappropriate, or legal and illegal use.

While we are supportive of FDA pursuing any of the policies discussed above, there are other policies that concern ACS CAN. We urge FDA not to pursue these policies:

- **Removing all high-dosage opioids from the market:** As previously stated, ACS CAN supports patients and providers having access to all the pain treatment options clinically appropriate for the patient's condition. Therefore, removing high-dosage opioids from the market would eliminate an important option for treatment and be detrimental to many patients with cancer and other serious illness. For more discussion of how this action would harm patient populations, we refer the committees to the Patient Quality of Life Coalition's comments regarding FDA-2017-P-5396, submitted on February 28, 2018.<sup>10</sup>
- **Prohibiting all new drug approvals for opioid medications:** A blanket prohibition on new approvals of opioids would prevent cancer patients and others with serious illness from using the most cutting-edge treatments to treat their disease and improve their quality of life. ACS CAN supports FDA using its already-existing REMS process to address the risk of any new drug approvals, but we would strongly oppose a prohibition on all new approvals.
- **Changing the factors FDA considers when reviewing new opioid drug approvals:** The drug approval paradigm has traditionally required that a drug sponsor demonstrate that the potential benefits of a drug outweigh the potential harms "...under the conditions prescribed, recommended, or suggested in the proposed labeling." (21 U.S.C. § 355(d)) While FDA has sometimes considered unintentional harms of drugs, e.g. accidental childhood exposure to testosterone gels, the recognition of these harms of misuse have largely been addressed with mitigation strategies, rather than playing into the product approval itself. Formally considering the harms of deliberate misuse against the benefits of appropriate use when making a drug approval decision sets a dangerous precedent, denying patients treatments that have otherwise been shown safe and effective for their needs simply because of inappropriate uses beyond their control. This is especially important in light of increasing evidence that a significant portion of recent increases in drug overdoses are driven by the use of other illicit opioid products like fentanyl rather than prescription opioids<sup>11</sup>.

## CONCLUSION

On behalf of the American Cancer Society Cancer Action Network thank you for the opportunity to contribute to the docket regarding this meeting. If you have any questions, please feel free to contact

---

<sup>10</sup> Patient Quality of Life Coalition. Letter to U.S. Food & Drug Administration. February 28, 2018. <http://patientqualityoflife.org/wp-content/uploads/2019/05/PQLC-FDA-Citizens-Petition-Comments-02282018-FINAL2.pdf>

<sup>11</sup> National Center for Health Statistics, "Drug Overdose Deaths Involving Fentanyl, 2011-2016," Vital Statistics Reports, Vol 68 (3), March 21, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_03-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_03-508.pdf)

me or have your staff contact Jennifer Singleterry of our policy team at [Jennifer.Singleterry@cancer.org](mailto:Jennifer.Singleterry@cancer.org) or 202-585-3233.

Sincerely,

A handwritten signature in black ink that reads "Lisa A. Lacasse". The signature is fluid and cursive, with a long horizontal stroke at the end.

Lisa A. Lacasse, MBA  
President

Attached: Appendix – Patient Quality of Life Coalition Consensus Document

# Appendix: PQLC Consensus Document

February 28, 2018

Dr. Scott Gottlieb  
Commissioner, U.S. Food & Drug Administration  
10903 New Hampshire Avenue  
Silver Spring, MD 20993



Re: FDA-2017-P-5396

Dear Commissioner Gottlieb:

The Patient Quality of Life Coalition (PQLC) welcomes the opportunity to offer comments regarding the citizen petition seeking immediate removal of ultra-high dosage unit (UHDU) oral and transmucosal analgesics from the market (FDA-2017-P-5396), submitted September 1, 2017. 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 their 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 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 and other 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>

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 aspects of palliative care.<sup>5</sup> For example, dyspnea occurs in over 50 percent of patients with underlying serious illness (e.g., cancer, heart failure, or COPD or other chronic lung disease) and is correlated with lower quality of life and with

---

<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>

<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>

# Appendix: PQLC Consensus Document

*Patient Quality of Life Coalition  
Comments on: FDA-2017-P-5396  
February 28, 2018  
Page 2*

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-targeted 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 opioids, and supports evidence-based efforts to reduce harm 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 believe the proposal made in this citizen petition requesting FDA immediately remove all so-called “ultra-high dosage unit” oral and transmucosal analgesics from the market will severely and unacceptably limit access to pain management treatment for patients receiving palliative care. **We therefore strongly object to this proposal and ask FDA to reject this request.**

The petitioners refer to “ultra-high dosage unit” opioid as a distinct category of medications. In the setting of the multidisciplinary palliative care team, patients’ opioid regimens are tailored in such a way as to achieve the best possible safe and effective analgesia. As such, there is no evidence-based ceiling dose of opioids and the dose strength and formulations of prescription opioids provided to these patients is based on the patients’ individual needs and tolerances. Therefore, there is no such thing as an “ultra-high” dose but rather only the dose that is most safe and effective for a particular patient at a particular moment in time.

The petitioners cite the 2016 Centers for Disease Control and Prevention Guideline for prescribing opioids for chronic pain<sup>9</sup> (CDC Guideline) to justify several aspects of their request; including defining UHDUs as formulations that “when taken as directed exceed 90 MME/day,” asserting that keeping dosages under a certain amount will reduce overdose risks and be safer for patients, and claiming that dosages larger than 50 MME/day “increase overdose risk without necessarily adding benefits for pain control or function.” PQLC has previously communicated our concerns regarding the CDC Guideline in letters to the CDC<sup>10</sup> and to Senator Patty Murray.<sup>11</sup>

We continue to have concerns that the CDC Guideline is being used to justify actions that are far beyond its intended scope. The petition is an extreme example of this. The CDC Guideline was intended to guide (but not absolutely restrict) primary care physicians (not all physicians) treating patients with chronic pain (not all patients). Granting the request in this citizen petition would go far beyond the Guideline by completely removing important treatment options from all physicians and all patients – including

---

<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> Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *JAMA.* 2016;315(15):1624-1645.

<sup>10</sup> Patient Quality of Life Coalition. Letter to Drs. Frieden and Houry re: Draft Guideline for Prescribing Opioids for Chronic Pain, 2016 [CDC-2015-0112-0001]. September 13, 2016.

<sup>11</sup> Patient Quality of Life Coalition. Letter to Senator Patty Murray. November 13, 2015.



physicians who are carefully trained in palliative care and care coordination, caring for patients with serious illness(es).

While the CDC Guideline contains exceptions for cancer, palliative care and hospice patients, the proposal in this petition would by its very nature not make such exceptions possible. If FDA were to grant the petitioner's request, physicians would simply no longer have the option of prescribing certain opioids for their patients – even patients who had previously been taking such drugs. It is crucial that palliative care practitioners have every evidence-based tool available to treat their seriously ill patients, and we have grave concerns with any proposal that takes away important treatment options without strong justification for doing so. We also note that the petition does not address how FDA should mitigate the huge disruptions this action would cause in treatment of patients who are already stable on medications that would be abruptly removed from the market.

Most importantly, we are extremely concerned about how removal of these drugs from the market would affect palliative care patients. Petitioners only briefly address access issues, saying “removing UHDO orally-administered opioids from the market will result in patients having to swallow more tablets or capsules. But this is unlikely to result in a significant inconvenience or hardship for patients.” This assertion is not supported by any evidence.

PQLC believes that removing so-called UHDO pills from the market will indeed result in significant inconvenience and hardship for palliative care patients. Most patients receiving palliative care are taking multiple other medications to treat the underlying illness(es) that have necessitated a focus on palliation. One study of patients being admitted to hospice showed the average number of medications prescribed per patient was 15.7.<sup>12</sup> If FDA were to act on this petition, many palliative care patients would see their already large and frequent pill regimen grow even larger and more unmanageable.

Increasing the number of pills for palliative care patients would be very problematic for four reasons:

1. Many palliative care patients have problems swallowing. Dysphagia, or disordered swallowing, and recurrent aspiration are common symptoms of patients receiving palliative care. Palliative treatment for dysphagia is not only for the dying patient because patients with difficulty swallowing can live for a long time.<sup>13</sup> One article estimates the prevalence of dysphagia in residential care facilities is 50-75 percent.<sup>14</sup> Increasing the number of pills these patients must swallow will make it difficult for their clinicians to maintain proper pain management and will likely lead to more patients suffering.
2. Increasing the number of pills a patient takes has been proven to decrease medication adherence. One study found that compliance with medication regimens decreases as dosing per day increases, with very little compliance at a greater than four times per day dosing requirement.<sup>15</sup>

---

<sup>12</sup> Sera L, McPherson ML, Holmes HM. Commonly prescribed medications in a population of hospice patients. *Am J Hosp Palliat Care*. 2014;31(2):126-131. doi:10.1177/1049909113476132.

<sup>13</sup> Langmore SE1, Grillone G, Elackattu A, Walsh M. Disorders of swallowing: palliative care. *Otolaryngol Clin North Am*. 2009 Feb;42(1):87-105, ix. doi: 10.1016/j.otc.2008.09.005.

<sup>14</sup> Marik PE, Kaplan D. Aspiration pneumonia and dysphagia in the elderly. *Chest*. 2003;124(1):328–36.

<sup>15</sup> Eisen SA1, Miller DK, Woodward RS, Spitznagel E, Przybeck TR. The effect of prescribed daily dose frequency on patient medication compliance. *Arch Intern Med*. 1990 Sep;150(9):1881-4.

3. Some insurance companies are beginning to limit the number of opioid pills they will cover per day, per month, or per prescription. Similarly, some states are considering placing caps on the number of opioid pills pharmacists are allowed to dispense. The action requested in this petition would severely cut the amount of medication a patient taking UHDUs has access to at any given time. At the least, this would require that patient to make more frequent trips to the pharmacy to fill their scripts, and potentially more trips to the doctor to have scripts written. At the worst, some patients would likely have coverage or fulfillment of their needed prescriptions denied, and be forced to pay full price or suffer in pain.
4. Increasing the number of pills in circulation will also increase the number of pills available for diversion or misuse – thereby potentially accomplishing the opposite of the petitioner’s stated objectives. A recent study found that in patients who received opioids for the first time following surgery, the misuse of these medications was correlated with the receipt of larger quantities of opioid medications, or longer prescription durations – but not higher dosages.<sup>16</sup>

The petitioners also claim that “for patients that may have difficulty swallowing it is important to note that opioid analgesics are available in liquid preparations, sublingual preparations, patches, and suppositories.” It is not easy – and, in fact, often not possible – to switch seamlessly from a pill to one of these other preparations. In most cases there is a strong clinical reason to prescribe the pill and/or not prescribe the medication in a different form. In patients with trouble swallowing, it is good clinical practice to consider other forms of medications. If these other forms have already been rejected, they were rejected for good reason. For example, some of the liquid formulations have low concentrations (e.g. liquid hydromorphone 1mg/1ml), which can also present problems for patients who have dysphagia. Moreover, not only are liquid and suppository formulations not always readily available at community pharmacies, but ongoing national drug shortages have resulted in some of the alternate formulations more commonly used in hospice and palliative care (e.g. rectal suppositories) no longer being available.

Examples in pediatric palliative care are particularly illustrative. Removing UHDUs from the market would be a large problem in the pediatric population, where volume and number of pills add to the burden of medication administration for the child and family. By removing the higher concentration formulations, the pediatric patient who often struggles with swallowing pills or retching, will be burdened with increasing numbers of pills to swallow or a larger volume of liquid medication. Toddlers and younger children do not have the oral skills necessary to swallow one pill, let alone a series of pills. Increased retching, gagging or outright vomiting may lead to a more rapid decline in weight, potential for aspiration and pneumonia, and contribute to the symptom burden and suffering of these children.

Removing UH DU options is particularly problematic for pediatric patients during end-of-life care, where there are not many good options for sublingual administration. Additionally, for younger children nearing the end of life, clinicians must take volume of ingested material into account. Higher doses of these medications allow pain relief to be delivered without as much accompanying volume. Without any ability for hospice or palliative care clinicians to write prescriptions for the more concentrated formulations, pediatric patients may be left without adequate interventions for pain and symptom management at end of life.

---

<sup>16</sup> Brat GA ; Agniel D ; Beam A; et al. Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study. *BMJ.* 2018; 360

# Appendix: PQLC Consensus Document

*Patient Quality of Life Coalition  
Comments on: FDA-2017-P-5396  
February 28, 2018  
Page 5*

In conclusion, PQLC strongly opposes the citizen petition to remove so-called UHDU oral and transmucosal analgesics from the market, and encourages FDA to reject the petition. While FDA and other policymakers need to find ways to address the opioid crisis, we believe this proposal does not properly maintain access to effective and safe pain management for palliative care patients. We look forward to working with FDA on solutions that do properly balance benefit and risks while maintaining access for patients who need pain management.

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the citizen petition. If you have any questions, please contact Keysha Brooks-Coley, Chair of the Patient Quality of Life Coalition, at 202-661-5720 or [Keysha.Brooks-Coley@cancer.org](mailto:Keysha.Brooks-Coley@cancer.org).

Sincerely,

Academy of Integrative Pain Management  
American Academy of Hospice and Palliative Medicine  
American Cancer Society Cancer Action Network  
American Society of Clinical Oncology  
Association of Pediatric Hematology / Oncology Nurses  
Capital Caring  
Center to Advance Palliative Care  
ElevatingHOME  
National Coalition for Hospice and Palliative Care  
National Palliative Care Research Center  
National Patient Advocate Foundation  
Oncology Nursing Society  
Pediatric Palliative Care Coalition  
Prevent Cancer Foundation  
ResolutionCare Network  
St. Baldrick's Foundation  
Supportive Care Coalition